

EXECUTIVE SUMMARY

EVALUATION DATED MARCH 30, 2017 FOR SIX CERTIFICATE OF NEED APPLICATIONS, EACH PROPOSING TO ADD DIALYSIS STATION CAPACITY TO PIERCE COUNTY PLANNING AREA #5

BACKGROUND INFORMATION

On March 29, 2016 the department sent a memo to its ESRD listserv. The memo focused on the 44-station need in Pierce County planning area #5. The memo reads as follows:

“This is an unusually large number of stations. Because of this unusually large station need in Pierce 5 the department is willing to accept applications that are for a single location and propose to bring stations into service in a phased manner. An application that is submitted for Pierce 5 using this approach must provide sufficient information about each phase so the department can determine each phase’s compliance independently.” [source: DOH memo, dated March 29, 2016]

It should be noted, the department does not ordinarily accept phased projects or sub-projects within applications for kidney dialysis facilities. The department’s decision to accept these phased applications was based on the unusually high need specific to the Pierce #5 planning area. It should not be assumed the department will accept phased kidney dialysis applications in the future.

BRIEF APPLICANT AND PROJECT DESCRIPTIONS

CHI Franciscan

Catholic Health Initiatives (CHI) is a not-for-profit entity and is the parent company of Franciscan Health Systems (FHS). CHI, through its subsidiary FHS, owns or operates six dialysis centers in Washington. This application proposes to establish a 44-station dialysis facility in two phases, to be located in the city of Lakewood within the Pierce County ESRD planning area #5.

The facility would be known as Franciscan Lakewood Dialysis Center. If approved, the first full year of operation of phase one would be 2018 and 2020 would be year three. If approved, the first full year of operation of phase two would be 2021 and 2023 would be year three.

If the full 44-station facility is approved, the estimated expenditure for the project would be \$6,624,827. If only the 28-station phase one is approved, the estimated capital expenditure would be \$5,034,895. These costs would be associated with building construction, equipment, taxes, fees, and permits. [source: Application p7, p9, p32]

Puget Sound Kidney Centers

Puget Sound Kidney Centers (PSKC) is a not-for-profit entity that provides kidney dialysis services in Washington State. Currently, PSKC owns and operates six dialysis centers and a mobile dialysis services that provides acute services to area hospitals. This application proposes to establish a 44-station dialysis facility in two phases, to be located in the city of Lakewood within the Pierce County ESRD planning area #5. [source: Application pp1-3]

The facility would be known as PSKC – Lakewood. If approved, the first full year of operation of phase one would be 2019 and 2021 would be year three. If approved, the first full year of operation of phase two would be 2022 and 2024 would be year three.

If the full 44-station facility is approved, the estimated capital expenditure for the project would be \$10,888,800.

PSKC also provided financial information to support approval of phase one only – whether as a 16, 20, or 22 station project. The capital expenditures for each of these options are below. [sources: Application p30, Screening Response Attachment 3]

- As a 16-station project, the capital expenditure would be \$6,608,944
- As a 20-station project, the capital expenditure would be \$6,688,319
- As a 22-station project, the capital expenditure would be \$6,795,531

For each proposed configuration, these costs would be associated with land purchase, building construction, equipment, taxes, fees, and permits. [sources: Application p30, Screening Response Attachment 3]

Fresenius Medical Care

Renal Care Group Northwest (RCGNW) is one of three entities owned by Renal Care Group, Inc. (RCG). RCGN is responsible for the operation of facilities under three separate legal entities. These entities include Pacific Northwest Renal Services (PNRS), Renal Care Group Northwest (RCGNW), and Inland Northwest Renal Care Group (IN-RCG). In March of 2006, Fresenius Medical Care Holdings (FMC) became the sole owner of RCG. FMC, through its subsidiaries, owns and operates 18 dialysis centers in Washington State.

This application proposes to establish a 24-station dialysis facility to be located in the city of Tacoma, within the Pierce #5 planning area. The facility would be known as FKC Fredrickson. [source: Application pp8-11]

If approved, the first full year of operation of phase one would be 2018 and 2020 would be year three. [source: Application p14]

The estimated capital expenditure associated with the 24-station facility would be \$2,155,782. These costs would be associated with building construction, equipment, and architect and engineering fees. [source: Screening Response p2]

DaVita Healthcare Partners, Inc.

In late 2012, DaVita, Inc. a for-profit end stage renal care provider was acquired by HealthCare Partners Holding, Inc. To reflect the combination of the two companies, DaVita, Inc. changed its name to DaVita HealthCare Partners Inc. Throughout this evaluation, DaVita HealthCare Partners Inc. will be referenced as ‘DaVita.’ [source: CN historical files]

DaVita submitted three separate applications during this concurrent review cycle. One application proposes to expand an existing facility in Pierce County planning area #5 [DaVita-Lakewood Community Dialysis Center]; one proposes to establish a new 44-station dialysis center in two phases [DaVita-Towne Center]; and the third application proposes to establish a new 44-station dialysis center in three phases [DaVita-Canyon Road]. The three applications are summarized below.

DaVita – Lakewood Community Dialysis Center

DaVita’s Lakewood Community Dialysis Center currently operates with 11 stations. This application proposes to add 15 stations for a facility total of 26 stations. This facility currently provides in-center hemodialysis, backup dialysis service, home hemodialysis and home peritoneal dialysis training, a

dedicated isolation station, a permanent bed station, and shifts beginning after 5 pm. [source: Application, p1 & pp10-11]

The capital expenditure associated with the 15 station addition is \$303,830. [source: Application, p10 & Appendix 7]

If this project is approved, DaVita anticipates the additional 15 stations would become operational by the end of December 2017. Under this timeline, 2018 would be the facility's first full calendar year of operation and 2020 would be year three. [source: Application, p14]

DaVita – Towne Center

This application proposes to establish a 44-station dialysis center. The dialysis center would be located in the Lakewood Towne Center at 5831 Main Street in Lakewood [98499], within Pierce County planning area #5. DaVita-Towne Center would provide in-center hemodialysis, backup dialysis service, home hemodialysis and home peritoneal dialysis training, a dedicated isolation station, a permanent bed station, and shifts beginning after 5 pm. [source: Application, p12]

The 44-station center could be established by one of two ways. Below is a discussion of both.

- This option would not have phases. A 44 station facility would be built and 33 new stations would be added to the planning area. The 11-station Lakewood Community Dialysis Center [referenced above] would relocate to the new site, resulting in a 44-station center. [source: Screening response, p1 & p3]

The capital expenditure associated

with adding 33 new stations and relocating 11 existing stations is \$4,861,872 and all costs would be paid by DaVita. [source: Screening Response, Appendix 21]

If this project is approved, DaVita anticipates all 44 stations would be operational at the new site by the end of September 2017. Under this timeline, 2018 would be the facility's first full calendar year of operation with 44 stations and 2020 would be year three. [source: Application, p4 & Appendix 9 and screening response, p4 & Appendix 22]

- A 44 station dialysis center would be built and 44 new stations would be added to the planning area in two phases. Phase one is the establishment of a 33-station center and phase two is the addition of the remaining 11 stations. [source: Screening Response, p1 & p3]

The capital expenditure associated with adding 44 new stations in two phases is \$5,043,257 and all costs would be paid by DaVita. [source: Screening Response, Appendix 21]

If this project is approved, DaVita anticipates phase 1—or 33 stations—would be operational by the end of September 2017. Phase 2—adding 11 new stations to the center—would occur by January 2021. Under this timeline, 2021 would be the facility's first full calendar year of operation with 44 stations and 2023 would be year three. [source: Application, p4 & Appendix 9 and Screening Response, p4 & Appendix 22]

This application also includes an option of adding only 33 new dialysis stations to the planning area. This option would be implementation of only phase 1 described above, without the relocation of 11 stations from the existing center. Below is a description of this option.

- A 33 station dialysis center would be built and only 33 new stations would be added to the planning area. This option would not have phases. [source: Screening Response, pp1-2]

The capital expenditure associated with establishing a 33-station center with no phases is \$4,847,372 and all costs would be paid by DaVita. [source: Screening Response, Appendix 21]

If this project is approved, DaVita anticipates the 33-station center would be operational by the end of September 2017. Under this timeline, 2018 would be the facility’s first full calendar year of operation with 33 stations and 2020 would be year three. [source: Screening Response, p4 & Appendix 22]

DaVita – Canyon Road

This application proposes to establish a 44-station dialysis center in three phases. The dialysis center would be located at 18504 Canyon Road East in Tacoma [98446], within Pierce County planning area #5. The three phases are outlined in the table below. [source: Screening Response, p1]

Phase	# of Stations Added	Facility Total
One	24	24
Two	12	36
Three	8	44

DaVita-Canyon Road would provide in-center hemodialysis, backup dialysis service, home hemodialysis and home peritoneal dialysis training, a dedicated isolation station, a permanent bed station, and shifts beginning after 5 pm. [source: Application, p12]

The capital expenditure associated with establishment of the 44-station facility in three phases is \$5,021,182; and all costs would be paid by DaVita. [source: Application, p10 & Appendix 7]

This application also included the option of implementing phase one alone (24 stations) or phases one and two (36 stations). The capital expenditures for these options would be \$4,662,362 or \$4,868,117, respectively. All costs would be paid by DaVita. [source: Application, p10 & Appendix 7]

If this project is approved, DaVita anticipates Phase one—24 stations—would become operational by the end of December 2017; phase two would be completed by December 2020; all 44 stations would be operational beginning in year 2023. Under this timeline, 2018 would be the facility’s first full calendar year of operation and 2025 would be year three following project completion. [source: Screening response, Appendix 22]

APPLICABILITY OF CERTIFICATE OF NEED LAW

These six projects are subject to Certificate of Need (CN) review because they propose one of the following:

- The construction, development, or other establishment of a healthcare facility under the provisions of Revised Code of Washington (RCW) 70.38.105(4)(a) and Washington Administrative Code (WAC) 246-310-020(1)(a); or
- An increase in the number of dialysis stations in a kidney disease center under provisions of RCW 70.38.105(4)(h) and WAC 246-310-020(1)(e).

CONCLUSIONS

CHI Franciscan

For the reasons stated in this evaluation, the application submitted by CHI Franciscan proposing to establish a two-phase 44-station dialysis facility in Lakewood, within the Pierce County planning area #5 is not consistent with applicable criteria of the Certificate of Need Program.

Puget Sound Kidney Centers

For the reasons stated in this evaluation, the application submitted by Puget Sound Kidney Centers proposing to establish a two-phase 44-station dialysis facility in Lakewood, within the Pierce County planning area #5, is consistent with applicable criteria of the Certificate of Need Program, provided Puget Sound Kidney Centers agrees to the following in its entirety.

Fresenius Medical Care

For the reasons stated in this evaluation, the application submitted by Fresenius proposing to establish a 24-station dialysis facility in Tacoma, within the Pierce County planning area #5 is not consistent with applicable criteria of the Certificate of Need Program.

DaVita – Lakewood Community Dialysis Center

For the reasons stated in this evaluation, the application submitted by DaVita proposing to add 15 stations to Lakewood Community Dialysis Center in Lakewood, within the Pierce County planning area #5, is consistent with applicable criteria of the Certificate of Need Program, provided DaVita agrees to the following in its entirety.

DaVita – Lakewood Towne Center

For the reasons stated in this evaluation, the application submitted by DaVita proposing to establish a two-phase 44-station dialysis facility in Lakewood, within the Pierce County planning area #5 is not consistent with applicable criteria of the Certificate of Need Program.

DaVita – Canyon Road

For the reasons stated in this evaluation, the application submitted by DaVita proposing to establish a 36 or 44-station dialysis facility in Tacoma, within the Pierce County planning area #5, is consistent with applicable criteria of the Certificate of Need Program.

For the reasons stated in this evaluation, the application submitted by DaVita proposing to establish a 24-station dialysis facility in Tacoma, within the Pierce County planning area #5 is not consistent with applicable criteria of the Certificate of Need Program.

Approved Projects

Though 3 out of the 6 applications met the applicable review criteria, the department completed a superiority review throughout this evaluation. Based on this superiority review, the department determined that the one of the PSKC projects and one of DaVita's projects should be approved. The stations are distributed as follows:

Puget Sound Kidney Centers

Project Description:

This certificate approves the establishment of a 29-station dialysis facility in Lakewood, within Pierce County planning area #5. Services to be provided at PSKC-Lakewood would include in-center hemodialysis, home hemodialysis and home peritoneal dialysis training and support for dialysis patients, one permanent bed station, an isolation station, and a shift beginning after 5:00 p.m. A breakdown of all stations at project completion is shown below:

Private Isolation Station	1
Permanent Bed Station	1
Other In-Center Station	27
Total In-Center Stations	29

Conditions:

1. Approval of the project description as stated above. Puget Sound Kidney Centers further agrees that any change to the project as described in the project description is a new project that requires a new Certificate of Need.
2. Prior to commencement of the project, Puget Sound Kidney Centers shall submit to the department an updated Community Service Statement that is consistent with the draft provided in the application, but that includes Pierce County.
3. Puget Sound Kidney Centers shall finance this project using existing capital reserves, as described in the application.
4. Puget Sound Kidney Centers shall provide a copy of the executed Medical Director contract, consistent with the draft in the application.
5. Puget Sound Kidney Centers shall provide a copy of the executed patient transfer agreement, consistent with the draft in the application.

Approved Costs:

The department concluded that costs associated with Puget Sound Kidney Centers' application for a 22-station facility were reasonable. The department also concluded that the costs associated with Puget Sound Kidney Centers' application for a 44-station facility were reasonable. In order to ensure that the approved capital expenditure for the 29-station facility is appropriate, the department calculated the cost per station at 22 stations and applied this cost to the 29-station facility.¹ The approved capital expenditure for this 29-station facility is \$8,957,745.

¹At 22 stations, the estimated capital expenditure was \$6,795,531. The cost per station for this project was \$308,888. \$308,888 * 29 stations = \$8,957,745.

DaVita – Lakewood Community Dialysis Center

Project Description:

This certificate approves the addition of 15 dialysis stations to DaVita Lakewood Community Dialysis Center, for a facility total of 26 dialysis stations. At completion of the station addition, DaVita is approved to certify and operate 26 stations at DaVita Lakewood Community Dialysis Center. Services provided at DaVita Lakewood Dialysis Center include in-center hemodialysis, home hemodialysis and home peritoneal dialysis training and support for dialysis patients, a permanent bed station, an isolation station, and a shift beginning after 5:00 p.m. A breakdown of all stations at project completion is shown below:

Private Isolation Station	1
Permanent Bed Station	1
Other In-Center Station	24
Total In-Center Stations	26

Conditions:

1. Approval of the project description as stated above. DaVita Healthcare Partners, Inc. further agrees that any change to the project as described in the project description is a new project that requires a new Certificate of Need.
2. DaVita Healthcare Partners, Inc. shall maintain compliance with the terms and conditions outlined in the October 22, 2014, Corporate Integrity Agreement with Department of Health and Human Services.
3. Prior to providing services, DaVita HealthCare Partners, Inc. will provide to the department for review and approval a copy of an executed transfer agreement with a local hospital. The executed agreement must be consistent with the draft agreement provided in the application.
4. DaVita Healthcare Partners, Inc. shall finance this project using existing capital reserves, as described in the application.

Approved Costs:

The approved capital expenditure for this 15-station addition is \$303,830

EVALUATION DATED MARCH 30, 2017 FOR SIX CERTIFICATE OF NEED APPLICATIONS, EACH PROPOSING TO ADD DIALYSIS STATION CAPACITY TO PIERCE COUNTY PLANNING AREA #5

BACKGROUND INFORMATION

On March 29, 2016 the department sent a memo to its ESRD listserv. The memo focused on the 44-station need in the Pierce County planning area #5. The memo reads as follows:

“This is an unusually large number of stations. Because of this unusually large station need in Pierce 5 the department is willing to accept applications that are for a single location and propose to bring stations into service in a phased manner. An application that is submitted for Pierce 5 using this approach must provide sufficient information about each phase so the department can determine each phase’s compliance independently.” [source: DOH memo, dated March 29, 2016]

It should be noted, the department does not ordinarily accept phased projects or sub-projects within applications for kidney dialysis facilities. The department’s decision to accept these phased applications was based on the unusually high need specific to the Pierce #5 planning area. It should not be assumed the department will accept phased kidney dialysis applications in the future.

APPLICANT DESCRIPTION

CHI Franciscan

Catholic Health Initiatives (CHI) is a not-for-profit entity and the parent company of CHI Franciscan Health System (FHS). In Washington State, FHS operates as the governance of a board of directors and an executive team that consists of a CEO and a number of vice presidential roles in finance, nursing, strategy, ethics, operations, and others. CHI Franciscan owns or operates a variety of healthcare facilities and services under the “CHI Franciscan Health” name. This includes eight hospitals, an ambulatory surgery center, a hospice agency, a hospice care center, and six dialysis centers. Below is a listing of the six dialysis centers owned or operated by CHI Franciscan Health. Throughout this evaluation, the department will refer to CHI and all of its subsidiaries as “CHI Franciscan.” [sources: CHI Franciscan Health website, Application Exhibits 1 & 2]

Pierce

St Joseph Medical Center
Greater Puyallup Dialysis Center
Franciscan Eastside Dialysis Center
Franciscan South Tacoma Dialysis Center
St Joseph Dialysis Center Gig Harbor
Franciscan Bonney Lake Dialysis Center²

Puget Sound Kidney Centers

Puget Sound Kidney Centers (PSKC) is a not-for-profit entity that provides kidney dialysis services in Washington State. PSKC was established in 1981 as a community-based provider in northern Snohomish County, and is governed by a board of directors and 5-member executive team that includes the president/CEO, chief financial officer, chief operating officer, chief medical officer, and an executive director for the PSKC Foundation. [source: PSKC website, Application, p1]

² As of the writing of this evaluation, this facility is expected to be operational in December 2017. [source: December 2016 progress report for CN #1574]

Currently, PSKC owns and operates six dialysis facilities in three separate counties. PSKC also operates a mobile dialysis service that provides dialysis services to patients in area hospitals. Below is a listing of the six dialysis facilities owned or operated by PSKC. [source: Application, p3]

Skagit

PSKC – Anacortes

Island

PSKC – Whidbey Island

Snohomish

PSKC – Everett

PSKC – Monroe

PSKC – South

PSKC – Smokey Point

[sources: PSKC website, Application p3, Exhibit 1]

Fresenius Medical Care

Renal Care Group Northwest (RCGNW) is one of three entities owned by Renal Care Group, Inc. (RCG). RCGN is responsible for the operation of facilities under three separate legal entities. These entities include Pacific Northwest Renal Services (PNRS), Renal Care Group Northwest (RCGNW), and Inland Northwest Renal Care Group (IN-RCG). In March of 2006, Fresenius Medical Care Holdings (FMC) became the sole owner of RCG. In addition to the three entities listed above, FMC also operates two other entities, including QualiCenters, Inc. and National Medical Care, Inc. As all of these subsidiaries are owned by one parent corporation, this evaluation shall refer to the applicant and all subsidiaries as Fresenius, or FMC. FMC operates outpatient dialysis centers in 48 states, the District of Columbia, and Puerto Rico through these subsidiaries. In Washington State, FMC owns, operates, or manages 18 kidney dialysis facilities. These facilities are listed below. [source: Application pp8-11, CMS Dialysis Facility Compare website]

Adams County

FMC Leah Layne Dialysis Center

Benton County

FMC Columbia Basin

Clark County

PNRS Fort Vancouver

PNRS Clark County Dialysis Clinic

PNRS Salmon Creek

Grant County

FMC Moses Lake Dialysis Unit

Grays Harbor County

FMC Aberdeen

Lewis County

FMC Chehalis

Mason County

FMC Shelton

Okanogan County

FMC Omak Dialysis Center

Spokane County

FMC Spokane Kidney Center

FMC Northpointe Dialysis Unit

Panorama Dialysis

FMC North Pines Dialysis Unit

Stevens County

FMC Colville

Thurston County

FMC North Thurston County Dialysis Center

FMC Lacey

Walla Walla County

Qualicenters – Walla Walla LLC

DaVita Healthcare Partners, Inc.

DaVita, Inc. is a for-profit end stage renal care provider that was acquired by HealthCare Partners Holding, Inc. in late 2012. To reflect the combination of the two companies, DaVita, Inc. changed its name to DaVita HealthCare Partners Inc. Throughout this evaluation, DaVita HealthCare Partners Inc. will be referenced as ‘DaVita.’

Currently DaVita operates or provides administrative services in approximately 2,303 dialysis facilities located in the United States. [source: Applications, p6] In Washington State, DaVita owns or operates 42³ kidney dialysis facilities in 18 separate counties. Listed on the following page are the names of the facilities owned or operated by DaVita in Washington State. [source: CN historical files and Application, p7]

Benton

Chinook Dialysis Center
Kennewick Dialysis Center

Clark

Vancouver Dialysis Center
Battle Ground Dialysis Center

Chelan

Wenatchee Valley Dialysis Center

Douglas

East Wenatchee Dialysis Center

Franklin

Mid-Columbia Kidney Center

Island

Whidbey Island Dialysis Center

King

Bellevue Dialysis Center
Federal Way Dialysis Center
Kent Dialysis Center
Olympic View Dialysis Center (management only)
Renton Dialysis Center
Redondo Heights Dialysis Center
Westwood Dialysis Center

Pacific

Seaview Dialysis Center

Pierce

Elk Plains Dialysis Center
Graham Dialysis Center
Lakewood Community Dialysis Center
Parkland Dialysis Center
Puyallup Community Dialysis Center
Rainier View Dialysis Center
Redondo Heights
Tacoma Dialysis Center

Skagit

Cascade Dialysis Center

Snohomish

Everett Dialysis Center
Lynnwood Dialysis Center
Mill Creek Dialysis Center
Pilchuck Dialysis Center

Spokane

Downtown Spokane Renal Center
North Spokane Renal Center
Spokane Valley Renal Center

Stevens

Echo Valley Dialysis Center

³ As of the writing of this evaluation, four of DaVita’s CN approved dialysis facilities are not yet state surveyed and operational. The four facilities are: Centralia Dialysis Center [CN #1572 issued on April 15, 2015]; Elk Plains Dialysis Center [CN #1568 issued on March 23, 2015]; Renton Dialysis Center [CN #1501R issued on December 3, 2015]; and Lynnwood Dialysis Center [CN #1588 issued on October 21, 2016].

Kittitas
Ellensburg Dialysis Center

Lewis
Centralia Dialysis Center

Mason
Belfair Dialysis Center

Thurston
Olympia Dialysis Center
Tumwater Dialysis Center

Yakima
Mt. Adams Dialysis Center
Union Gap Dialysis Center
Yakima Dialysis Center
Zillah Dialysis Center

Pivotal Unresolved Issue (PUI)

Background Information:

During the review of this project, the Office of Investigations and Inspections (OII) within the Department of Health provided correspondence between CHI Franciscan and a DOH surveyor. This correspondence indicated that some or all of CHI Franciscan’s dialysis facilities were going to be sold to Fresenius Medical Care.

In response to this new information, the department declared a Pivotal Unresolved Issue (PUI) to determine the scope of this transaction, and to determine whether it had any effect on the project proposed by CHI Franciscan. Documentation related to the PUI is below:

Department PUI Questions:

- (1) *Please provide a detailed description of the upcoming transaction between CHI Franciscan and Fresenius Medical Care, relating to the purchase of dialysis facilities in Washington.*
- (2) *Please describe how each of the following facilities will be affected by the upcoming transaction:*

Facility Name	CMS Number	Status
<i>St. Joseph Medical Center Nephrology</i>	<i>500108</i>	<i>Operational</i>
<i>Greater Puyallup Dialysis Center</i>	<i>503507</i>	<i>Operational</i>
<i>St Joseph Dialysis Gig Harbor</i>	<i>503510</i>	<i>Operational</i>
<i>Franciscan Dialysis Eastside</i>	<i>503511</i>	<i>Operational</i>
<i>St Joseph Medical Center South</i>	<i>503512</i>	<i>Operational</i>
<i>Bonney Lake Facility</i>	<i>n/a</i>	<i>Approved – Not Yet Operational</i>
<i>Proposed Pierce 5</i>	<i>n/a</i>	<i>Under CN Review</i>
<i>Proposed King 5</i>	<i>n/a</i>	<i>Under CN Review</i>

- (3) *Please provide a timeline for the transaction, as it relates to each facility.*

CHI Franciscan Response:

FMCNA [Fresenius] proposes to acquire substantially all of the assets (excluding accounts receivable) of CHI-Franciscan Health relating to the chronic renal dialysis programs and the home dialysis programs at the following locations listed below.... With respect to the CHI-Franciscan Health project under development at Bonney Lake (vi) and two pending CN applications (vii) and (viii), CHI-Franciscan Health intends to complete the CN review process (as applicable) and complete and operate those projects. After each of said facilities has been operational for a specified period of time (yet to be determined), FMCNA will have an exclusive option to purchase the facility.

Facility Name	CMS Number	Status	Effect on Facility	Timeframe
<i>St Joseph Medical Center Nephrology</i>	<i>500108</i>	<i>Operational</i>	<i>To be Transitioned to Fresenius</i>	<i>February to May 2017</i>
<i>Greater Puyallup Dialysis Center</i>	<i>503507</i>	<i>Operational</i>	<i>To be Transitioned to Fresenius</i>	<i>February to May 2017</i>
<i>St Joseph Dialysis Gig Harbor</i>	<i>503510</i>	<i>Operational</i>	<i>To be Transitioned to Fresenius</i>	<i>February to May 2017</i>
<i>Franciscan Dialysis Eastside</i>	<i>503511</i>	<i>Operational</i>	<i>To be Transitioned to Fresenius</i>	<i>February to May 2017</i>
<i>St Joseph Medical Center South</i>	<i>503512</i>	<i>Operational</i>	<i>To be Transitioned to Fresenius</i>	<i>February to May 2017</i>
<i>Bonney Lake Facility</i>	<i>n/a</i>	<i>CN Approved – not yet operational</i>	<i>To be Completed and Operated by CHI</i>	<i>Projected date of operation per CN App: December 2017</i>
<i>Proposed Pierce 5</i>	<i>n/a</i>	<i>Under CN Review</i>	<i>To be Completed and Operated by CHI</i>	<i>Projected date of operation per CN App: January 2018</i>
<i>Proposed King 5</i>	<i>n/a</i>	<i>Under CN Review</i>	<i>To be Completed and Operated by CHI</i>	<i>Projected date of operation per CN App: July 2018</i>

[source: CHI Franciscan PUI Response pp2-3]

PUI Public Comments:

PSKC and DaVita provided comments related to the PUI.

PSKC Public Comments

“In reviewing the PUI documents, it appears that CHI is positioning itself to discontinue operating kidney centers by the end of May 2017. As PSKC understands it, as outlined in the CHI PUI response, Fresenius (FMC) will acquire substantially all of CHI's dialysis assets (including all 80 of its current stations) no later than May 2017-60 days after the scheduled decision date in the matter of the Pierce 5 applications.

In its PUI response, CHI indicates that it intends to complete and operate three other facilities – two of which are still under CN review. Specifically, in the transaction description included with its January 12, 2017, letter, CHI states, "with respect to the CHI Franciscan Health project under development at Bonney Lake and two pending CN applications {including Lakewood}, CHI Franciscan Health intends to complete the CN review process (as applicable) and complete and operate those projects." Of particular note, however, the letter further states, "After each of said facilities has been operational for a specified period of time" (yet to be determined), FMC "will have an exclusive option to purchase."

The lack of specificity in these broad statements is concerning. Does CHI intend to sell the "operational" facilities 24 hours or 12 months after completing and opening them? Further, because CHI will effectively discontinue operating kidney centers by May 2017 CHI will not have staff, providers, or other infrastructure with which to make the facilities operational.

Its CN application states that Phase 1 of its application will be operational within 12 months of CN approval-nearly a year after it has sold its dialysis assets to FMC. But CHI's current Pierce 5 CN application's structure and process and financial feasibility sections all rely on CHI's current experience, operating history, and staff. However, none of this infrastructure will be in place after May 2017, rendering the information contained in these sections invalid for purposes of CN analysis.

CHI's response effectively confirms PSKC's belief that any stations awarded to CHI, under this concurrent review process for Pierce 5, will, in effect, be an award to FMC, yet another for-profit dialysis provider. FMC already has a CN application under consideration in Pierce 5; FMC should not be allowed to inherit the history and nonprofit status of CHI for an award, but rather FMC's application should stand on its own merits.

In the end, if the CN Program wants to award stations to CHI, we strongly urge that any such award include a condition requiring CHI to operate the stations for a specified period of time (without entering into a management or operational agreement with FMC). PSKC believes, consistent with current rules, that the timeframe should be at least 3-5 years. Without such a condition, PSKC believes that FMC will assume ownership of these stations immediately after they are made operational in a manner inconsistent with both the letter and spirit of the CN laws.

As the only remaining acceptable alternative offering a nonprofit choice to patients in this sea of for-profit providers in Pierce County, PSKC is a high quality, community-focused, nonprofit dialysis provider. We have an outstanding, high quality record, and we have a proven history of constructing and operating patient-focused dialysis centers. As an organization, we are disappointed by CHI's business decision to exit the dialysis market place because we believed CHI offered patients a viable, high quality, nonprofit choice." [source: PSKC PUI Public comment pp1-2]

DaVita Public Comments

"Franciscan's response states that its proposed Pierce 5 facility will "be completed and operated" by Franciscan, but Fresenius "will have an exclusive option to purchase the facility." While Franciscan describes this as an "option," there should be no doubt through the remainder of Franciscan's response that if Franciscan is approved for a Pierce 5 facility, it will be sold to Fresenius.

As the chart provided by Franciscan demonstrates, all of Franciscan's operational dialysis facilities are being transitioned to Fresenius, including the facility within St. Joseph Medical Center itself. It is inconceivable that Franciscan's strategy is to divest all of its existing dialysis facilities to Fresenius, including its hospital-based facility, and then start over with respect to outpatient dialysis by opening and operating new dialysis facilities itself.

Franciscan's response confirms that it has made a decision to not be an outpatient dialysis provider going forward. If it had any intention of continuing to provide outpatient dialysis, it would at minimum continue to operate the dialysis facility at St Joseph's. The fact that it is transitioning all of its dialysis operations to Fresenius confirms that it has no intention of providing these patient services in the future. Therefore, Franciscan's description of Fresenius's "option" to purchase the Pierce 5 facility if it is approved should be recognized as an admission that the facility will be sold to Fresenius if it is approved.

Fresenius, not Franciscan, will be the owner and operator of the facility that Franciscan has applied to build. Given that there is no CN review of sales of dialysis facilities, the Department should take this information into account in its evaluation of Franciscan's application.

As DaVita noted in its November 16 rebuttal comments, the significance of the rumored Franciscan-Fresenius transaction, now confirmed by Franciscan's PUI response, is that there are, for all practical purposes three, not four, applicants to meet the need for additional capacity in Pierce 5: DaVita, PSKC, and Fresenius.” [source: DaVita PUI Public Comment pp1-2]

CHI Franciscan Rebuttal:

“CHI has the expertise, infrastructure, staff and capacity to develop and operate the project. Regardless of the proposed transaction with Fresenius, CHI operates extensive health care services in the community with eight hospitals, over 200 ambulatory care facilities, 11,000 employees and over \$2.6 billion in revenue annually. We have extensive experience developing and operating all types of health care facilities, including ESRD facilities, and will continue to have such capabilities into the future.

No request for relocation has been made. Contrary to PSKC's assertion, neither the statute nor the regulations requires a party granted a CN to operate a new facility for a specified period of time. PSKC's reference to operation for a minimum period of years presumably is to the relocation rule, which does not apply to this situation. No authority exists for the Department to consider PSKC's request that CHI operate the facility for a minimum period of operation.

Nonprofit status is not a CN review criteria. PSKC appears to argue that an applicant's status as a nonprofit organization is relevant to the Department's review. Neither the statute nor the rules, however, identify an applicant's status as a nonprofit as a relevant review criteria and no authority exists for the Department to consider such a distinction.

CHI is a valid applicant and its project should be reviewed. It is possible that the proposed transaction with Fresenius will not close and even if it does, that CHI will choose to develop and operate the project as proposed. CHI has invested significant resources into this project for almost two years, and its application should be fully reviewed on the merits according to the criteria set forth in the relevant statute and regulations.” [source: CHI Franciscan PUI Rebuttal pp1-2]

Department Evaluation:

In their above comments, PSKC suggested that the assumptions CHI Franciscan used in their application would no longer be reliable if the facility was sold to FMC. This included CHI’s financial projections. PSKC suggested if CHI was approved, that the department attach a condition requiring CHI to operate the facility for a number of years prior to it being sold to FMC.

CHI Franciscan did not offer the department any assurance that their projected volumes or financials would be unchanged as a result of the transaction.

The department offered CHI Franciscan the opportunity to provide a detailed description of the transaction between them and Fresenius. Their response to this PUI question included a broad outline of the transaction. It did not offer the level of specificity the department would need to reasonably conclude that the volume and financial projections within the application would maintain any integrity following the transaction. A more detailed analysis of this will be found later on in this evaluation under WAC 246-310-284(6), WAC 246-310-220(1) and (2), and WAC 246-310-230(2) and (4).

PROJECT DESCRIPTIONS

CHI Franciscan

This project focuses on the establishment of a 44-station dialysis facility in Lakewood, within the Pierce #5 planning area. CHI Franciscan proposes to establish this facility in two phases. Phase one would include 28 stations, and phase two would include an additional 16 stations. In their application, CHI Franciscan provided sufficient information to evaluate the 28-station phase one as a stand-alone project. The facility would be known as the Franciscan Lakewood Dialysis Center (Franciscan Lakewood).

Services to be provided at Franciscan Lakewood would include in-center hemodialysis, visitor dialysis, home hemodialysis and home peritoneal dialysis training and backup, a dedicated isolation station, and two permanent bed stations. Franciscan Lakewood would offer a shift beginning after 5:00 pm. All of these services would be offered in phase one. CHI Franciscan also noted that at project completion, the facility could accommodate up to 12 bed stations “should demand warrant.” CHI Franciscan indicated that the facility would be designed with the appropriate lighting and station configuration to implement a nocturnal dialysis program. [source: Application p7 & p28, Screening Response p1]

The capital expenditure associated with the full 44-station facility in two phases would be \$6,624,827.⁴ The capital expenditure associated with the 28-station phase one as a stand-alone project would be \$5,034,895. Under both scenarios, approximately 50% of the capital expenditure would be associated with building construction, 34% would be associated with equipment, and the remaining 15% would be associated with fees, taxes, permits, and inspections. [source: Screening Response p37]

If this project is approved, CHI Franciscan anticipates that phase one would be complete and Franciscan Lakewood would be operational by January 1, 2018. Under this timeline, year 2018 would be the facility’s first full calendar year of operation, and 2020 would be year three. If phase two is approved, construction would commence in mid-2020; all 44 stations would be operational by 2021. Under this timeline, 2021 would be the facility’s first full calendar year of operation as a 44-station facility and 2023 would be year three. [source: Application p9]

Puget Sound Kidney Centers

This project focuses on the establishment of a 44-station dialysis facility in Lakewood, within the Pierce #5 planning area. PSKC proposes to establish this facility in two phases. Phase one would include 22 stations, and phase two would include an additional 22 stations. PSKC also provided alternative scenarios in which phase one would include 16 stations or 20 stations; phase two for these proposals would include 28 and 24 stations, respectively. PSKC provided sufficient information to evaluate each version of phase one as stand-alone projects. The facility would be known as PSKC – Lakewood.

Services to be provided at PSKC – Lakewood would include in-center hemodialysis, home hemodialysis and home peritoneal dialysis training, a dedicated isolation station, and a permanent bed station. PSKC – Lakewood would offer a shift beginning after 5:00 pm. [sources: Application p1, p8, p39]

⁴ For this project description, as well as for the following five project descriptions, the estimated capital expenditure includes *only* the expenditures for which the applicant is responsible. Costs to be covered by the landlord, the developer, or identified as allocated construction costs associated with an existing facility – while included by the applicants – would only be evaluated in the context of a tie-breaker analysis.

The capital expenditure associated with the full 44-station facility in two phases would be \$10,888,800. Of this amount, 63% would be associated with the land purchase and building construction, 19% would be associated with equipment, and the remaining 18% would be associated with fees, taxes, and permits.

PSKC also provided financial information to support approval of phase one only – whether as a 16, 20, or 22 station project. The capital expenditures for each of these options are below:

- The capital expenditure associated with the 16-station phase one as a stand-alone project would be \$6,608,944. Of this amount, 67% would be associated with the land purchase and building construction, 15% would be associated with equipment, and the remaining 18% would be associated with fees, taxes, and permits. [sources: Application p30, Screening Response Attachment 3]
- The capital expenditure associated with the 20-station phase one as a stand-alone project would be \$6,688,319. Of this amount, 66% would be associated with the land purchase and building construction, 16% would be associated with equipment, and 18% would be associated with fees, taxes, and permits.
- The capital expenditure associated with the 22-station phase one as a stand-alone project would be \$6,795,531. Of this amount, 65% would be associated with the land purchase and building construction, 17% would be associated with equipment, and 18% would be associated with fees, taxes, and permits.

If this project is approved, PSKC anticipates that phase one would be complete and PSKC – Lakewood would be operational by summer of 2018. Under this timeline, year 2019 would be the facility's first full calendar year of operation, and 2021 would be year three. If phase two is approved, construction would commence in 2021, with the full 44-station facility operational by 2022. Under this timeline, 2022 would be the facility's first full calendar year of operation as a 44-station facility and 2024 would be year three. [sources: Application p8, Exhibit 9]

Fresenius Medical Care

This project focuses on the establishment of a 24-station dialysis facility in Tacoma, within the Pierce #5 planning area. The facility would be known as FKC Fredrickson.

Services to be provided at FKC Fredrickson would include in-center hemodialysis, home hemodialysis and home peritoneal dialysis training, a dedicated isolation station, and a permanent bed station. FKC Fredrickson would offer a shift beginning after 5:00 pm. [source: Application p13]

The estimated capital expenditure associated with the 24-station facility would be \$2,155,782. Of this amount, 69% would be associated with building construction, 25% would be associated with equipment, and 6% would be associated with architect and engineering fees. The remainder of the costs associated with this project (land purchase, permits and fees, etc.) would be assigned to the landlord of the property. [source: Screening Response p2]

If this project is approved, FMC anticipates that the project would be complete and FKC Frederickson would be operational by October of 2017. Under this timeline, 2018 would be the facility's first full calendar year of operation, and 2020 would be year three. [source: Application p14]

DaVita-Lakewood Community Dialysis Center

This application proposes to add 15 stations to DaVita's Lakewood Community Dialysis Center located in Lakewood for a facility total of 26 stations. This facility currently provides in-center hemodialysis, backup dialysis service, home hemodialysis and home peritoneal dialysis training, a dedicated isolation station, a permanent bed station, and shifts beginning after 5 pm. [source: Application, p1 & pp10-11]

The capital expenditure associated with the 15 station addition is \$303, 830. [source: Application, p10 & Appendix 7]

If this project is approved, DaVita anticipates the additional 15 stations would become operational by the end of December 2017. Under this timeline, 2018 would be the facility's first full calendar year of operation with 26 stations and 2020 would be year three. [source: Application, p14]

DaVita-Towne Center

This application proposes to establish a 44-station dialysis center. The dialysis center would be located in the Lakewood Towne Center at 5831 Main Street in Lakewood [98499], within Pierce County planning area #5. The new center would provide in-center hemodialysis, backup dialysis service, home hemodialysis and home peritoneal dialysis training, a dedicated isolation station, a permanent bed station, and shifts beginning after 5 pm. [source: Application, p12]

The 44-station center could be established by one of two ways. Below is a discussion of both.

- This option would not have phases. A 44 station facility would be built and 33 new stations would be added to the planning area. The 11-station Lakewood Community Dialysis Center [referenced above] would be relocated to the new site, resulting in a 44-station center. [source: Screening Response, p1 and p3]

The capital expenditure associate with adding 33 new stations and relocating 11 existing stations is \$4,861,872 and all costs would be paid by DaVita. [source: Screening Response, Appendix 21]

If this project is approved, DaVita anticipates all 44 stations would be operational at the new site by the end of September 2017. Under this timeline, 2018 would be the facility's first full calendar year of operation with 44 stations and 2020 would be year three. [source: Application, p4 & Appendix 9 and Screening Response, p4 and Appendix 22]

- A 44 station dialysis center would be built and 44 new stations would be added to the planning area in two phases. Phase one is the establishment of a 33-station center and phase two is the addition of the remaining 11 stations. [source: Screening Response, p1 & p3]

The capital expenditure associated with adding 44 new stations in two phases is \$5,043,257 and all costs would be paid by DaVita. [source: Screening Response, Appendix 21]

If this project is approved, DaVita anticipates phase 1—or 33 stations—would be operational by the end of September 2017. Phase 2—adding 11 new stations to the center—would occur by January 2021. Under this timeline, 2021 would be the facility's first full calendar year of operation with 44 stations and 2023 would be year three. [source: Application, p4 & Appendix 9 and Screening Response, p4 & Appendix 22]

This application also includes an option of adding only 33 new dialysis stations to the planning area. This option would be implementation of only phase 1 described above, without the relocation of 11 stations from the existing center. Below is a description of this option.

- A 33 station dialysis center would be built and only 33 new stations would be added to the planning area. This option would not have phases. [source: Screening Response, pp1-2]

The capital expenditure associated with establishing a 33-station center with no phases is \$4,847,372 and all costs would be paid by DaVita. [source: Screening Response, Appendix 21]

If this project is approved, DaVita anticipates the 33-station center would be operational by the end of September 2017. Under this timeline, 2018 would be the facility’s first full calendar year of operation with 33 stations and 2020 would be year three. [source: Screening Response, p4 and Appendix 22]

DaVita Healthcare Partners, Inc.-DaVita-Canyon Road

This application proposes to establish a 44-station dialysis center in three phases. The dialysis center would be located at 18504 Canyon Road East in Tacoma [98446], within Pierce County planning area #5. The three phases are outlined in the table below. [source: Screening Response, p1]

Phase	# of Stations Added	Facility Total
One	24	24
Two	12	36
Three	8	44

DaVita-Canyon Road would provide in-center hemodialysis, backup dialysis service, home hemodialysis and home peritoneal dialysis training, a dedicated isolation station, a permanent bed station, and shifts beginning after 5 pm. [source: Application, p12]

The capital expenditure associated with establishment of the 44-station facility in three phases is \$5,021,182; and all costs would be paid by DaVita. [source: Application, p10 & Appendix 7]

This application also included the option of implementing phase one alone (24 stations) or phases one and two (36 stations). The capital expenditures for these options would be \$4,662,362 or \$4,868,117, respectively. All costs would be paid by DaVita. [source: Application, p10 & Appendix 7]

If this project is approved, DaVita anticipates phase one—24 stations—would become operational by the end of December 2017; phase two would be completed by December 2020; and all 44 stations would be operational beginning in year 2023. Under this timeline, 2018 would be the facility’s first full calendar year of operation and 2025 would be year three following project completion. [source: Screening Response, Appendix 22]

APPLICABILITY OF CERTIFICATE OF NEED LAW

These six projects are subject to Certificate of Need (CN) review because they propose one of the following:

- The construction, development, or other establishment of a healthcare facility under the provisions of Revised Code of Washington (RCW) 70.38.105(4)(a) and Washington Administrative Code (WAC) 246-310-020(1)(a); or
- An increase in the number of dialysis stations in a kidney disease center under provisions of RCW 70.38.105(4)(h) and WAC 246-310-020(1)(e).

CHI Franciscan

CHI Franciscan's project is subject to Certificate of Need review as the construction, establishment, or other development of a health care facility under RCW 70.38.105(4)(a) and WAC 246-310-020(1)(a).

Puget Sound Kidney Centers

PSKC's project is subject to Certificate of Need review as the construction, development, or other establishment of a health care facility under RCW 70.38.105(4)(a) and WAC 246-310-020(1)(a).

Fresenius Medical Care

FMC's project is subject to Certificate of Need review as the construction, development, or other establishment of a health care facility under RCW 70.38.105(4)(a) and WAC 246-310-020(1)(a).

DaVita HealthCare Partners, Inc.

DaVita's Lakewood Community Dialysis Center project is subject to review as an increase in the number of dialysis stations in a kidney disease center under provisions of RCW 70.38.105(4)(h) and WAC 246-310-020(1)(e).

DaVita's Towne Center and Canyon Road projects are subject to Certificate of Need review as the construction, development, or other establishment of a health care facility under RCW 70.38.105(4)(a) and WAC 246-310-020(1)(a).

EVALUATION CRITERIA

WAC 246-310-200(1)(a)-(d) identifies the four determinations that the department must make for each application. WAC 246-310-200(2) provides additional direction on how the department is to make its determination. 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 services 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 service or facilities for health services proposed, the department may consider standards not in conflict with those standards in accordance with subsection (2)(b) of this section; and*
 - (iii) *The relationship of the proposed project to the long-range plan (if any) of the person proposing the project.”*

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

(b) 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.*

WAC 246-310-280 through 289 contain service or facility specific criteria for dialysis projects and must be used to make the required determinations.

To obtain Certificate of Need approval, an applicant must demonstrate compliance with the applicable criteria found in WAC 246-310-210 (need); 246-310-220 (financial feasibility); 246-310-230 (structure and process of care); and 246-310-240 (cost containment). For this project, all applicants must demonstrate compliance with applicable kidney disease treatment center criteria outlined in WAC 246-310-280 through 289.

TYPE OF REVIEW

As directed under WAC 246-310-282(1) the department accepted these six applications under the Kidney Disease Treatment Centers-Concurrent Review Cycle #2 for calendar year 2016. The chronologic summary of the concurrent review is contained in Appendix A, following this evaluation.

AFFECTED PERSONS

Washington Administrative Code 246-310-010(2) defines “affected” person as:

“...an “interested person” who:

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

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

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

(g) *Any person regularly using health care facilities within the geographic area to be served by the applicant.*

Under concurrent review, each applicant is an affected person for the other application.

No other entities requested interested or affected person status for any of the six applications.

SOURCE INFORMATION REVIEWED

- CHI Franciscan Health Certificate of Need application received May 31, 2016
- Puget Sound Kidney Centers Certificate of Need application received May 31, 2016
- Fresenius Medical Care Certificate of Need application received May 31, 2016
- DaVita HealthCare Partners, Inc.-Lakewood Community Dialysis Center Certificate of Need application received May 31, 2016
- DaVita HealthCare Partners, Inc.-Towne Center Certificate of Need application received May 31, 2016
- DaVita HealthCare Partners, Inc.- Canyon Road Certificate of Need application received May 31, 2016
- CHI Franciscan Health screening response received July 29, 2016
- Puget Sound Kidney Centers screening response received July 29, 2016
- Fresenius Medical Care screening response received July 29, 2016
- DaVita HealthCare Partners, Inc.-Lakewood Community Dialysis Center screening response received July 29, 2016
- DaVita HealthCare Partners, Inc.-Towne Center screening response received July 29, 2016
- DaVita HealthCare Partners, Inc.-Canyon Road screening response received July 29, 2016
- Public comment received by 5:00pm on October 17, 2016
- Rebuttal response received by 5:00pm on November 16, 2016
- PUI response from CHI Franciscan Health received by 5:00 pm on January 13, 2017
- PUI public comment from DaVita Healthcare Partners received by 5:00 pm on January 30, 2017
- PUI public comment from Puget Sound Kidney Centers received by 5:00 pm on January 30, 2017
- PUI rebuttal from CHI Franciscan Health received by 5:00 pm on February 10, 2017
- Years 2010 through 2015 historical kidney dialysis data obtained from the Northwest Renal Network
- Year 2015 Northwest Renal Network December 31, 2015 (fourth quarter) utilization data released February 5, 2016
- Licensing data provided by the Medical Quality Assurance Commission, Nursing Quality Assurance Commission, and Health Systems Quality Assurance Office of Customer Service
- CHI Franciscan Health website at <https://www.chifranciscan.org/>
- Puget Sound Kidney Centers website at www.pskc.net
- Fresenius Medical Care website at <https://www.freseniuskidneycare.com/>
- DaVita HealthCare Partners, Inc. website at www.davitahealthpartners.com
- Northwest Renal Network website at www.nwrn.org
- Centers for Medicare and Medicaid website at www.medicare.gov/dialysisfacilitycompare
- Certificate of Need historical files

CONCLUSIONS

CHI Franciscan

For the reasons stated in this evaluation, the application submitted by CHI Franciscan proposing to establish a two-phase 44-station dialysis facility in Lakewood, within the Pierce County planning area #5 is not consistent with applicable criteria of the Certificate of Need Program.

Puget Sound Kidney Centers

For the reasons stated in this evaluation, the application submitted by Puget Sound Kidney Centers proposing to establish a two-phase 44-station dialysis facility in Lakewood, within the Pierce County planning area #5, is consistent with applicable criteria of the Certificate of Need Program, provided Puget Sound Kidney Centers agrees to the following in its entirety.

Fresenius Medical Care

For the reasons stated in this evaluation, the application submitted by Fresenius proposing to establish a 24-station dialysis facility in Tacoma, within the Pierce County planning area #5 is not consistent with applicable criteria of the Certificate of Need Program.

DaVita – Lakewood Community Dialysis Center

For the reasons stated in this evaluation, the application submitted by DaVita proposing to add 15 stations to Lakewood Community Dialysis Center in Lakewood, within the Pierce County planning area #5, is consistent with applicable criteria of the Certificate of Need Program, provided DaVita agrees to the following in its entirety.

DaVita – Lakewood Towne Center

For the reasons stated in this evaluation, the application submitted by DaVita proposing to establish a two-phase 44-station dialysis facility in Lakewood, within the Pierce County planning area #5 is not consistent with applicable criteria of the Certificate of Need Program.

DaVita – Canyon Road

For the reasons stated in this evaluation, the application submitted by DaVita proposing to establish a 36 or 44-station dialysis facility in Tacoma, within the Pierce County planning area #5, is consistent with applicable criteria of the Certificate of Need Program.

For the reasons stated in this evaluation, the application submitted by DaVita proposing to establish a 24-station dialysis facility in Tacoma, within the Pierce County planning area #5 is not consistent with applicable criteria of the Certificate of Need Program.

Approved Projects

Though 3 out of the 6 applications met the applicable review criteria, the department completed a superiority review throughout this evaluation. Based on this superiority review, the department determined that the one of the PSKC projects and one of DaVita's projects should be approved. The stations are distributed as follows:

Puget Sound Kidney Centers

Project Description:

This certificate approves the establishment of a 29-station dialysis facility in Lakewood, within Pierce County planning area #5. Services to be provided at PSKC-Lakewood would include in-center hemodialysis, home hemodialysis and home peritoneal dialysis training and support for dialysis patients, one permanent bed station, an isolation station, and a shift beginning after 5:00 p.m. A breakdown of all stations at project completion is shown below:

Private Isolation Station	1
Permanent Bed Station	1
Other In-Center Station	27
Total In-Center Stations	29

Conditions:

1. Approval of the project description as stated above. Puget Sound Kidney Centers further agrees that any change to the project as described in the project description is a new project that requires a new Certificate of Need.
2. Prior to commencement of the project, Puget Sound Kidney Centers shall submit to the department an updated Community Service Statement that is consistent with the draft provided in the application, but that includes Pierce County.
3. Puget Sound Kidney Centers shall finance this project using existing capital reserves, as described in the application.
4. Puget Sound Kidney Centers shall provide a copy of the executed Medical Director contract, consistent with the draft in the application.
5. Puget Sound Kidney Centers shall provide a copy of the executed patient transfer agreement, consistent with the draft in the application.

Approved Costs:

The department concluded that costs associated with Puget Sound Kidney Centers' application for a 22-station facility were reasonable. The department also concluded that the costs associated with Puget Sound Kidney Centers' application for a 44-station facility were reasonable. In order to ensure that the approved capital expenditure for the 29-station facility is appropriate, the department calculated the cost per station at 22 stations and applied this cost to the 29-station facility.⁵ The approved capital expenditure for this 29-station facility is \$8,957,745.

⁵At 22 stations, the estimated capital expenditure was \$6,795,531. The cost per station for this project was \$308,888. \$308,888 * 29 stations = \$8,957,745.

DaVita – Lakewood Community Dialysis Center

Project Description:

This certificate approves the addition of 15 dialysis stations to DaVita Lakewood Community Dialysis Center, for a facility total of 26 dialysis stations. At completion of the station addition, DaVita is approved to certify and operate 26 stations at DaVita Lakewood Community Dialysis Center. Services provided at DaVita Lakewood Dialysis Center include in-center hemodialysis, home hemodialysis and home peritoneal dialysis training and support for dialysis patients, a permanent bed station, an isolation station, and a shift beginning after 5:00 p.m. A breakdown of all stations at project completion is shown below:

Private Isolation Station	1
Permanent Bed Station	1
Other In-Center Station	24
Total In-Center Stations	26

Conditions:

1. Approval of the project description as stated above. DaVita Healthcare Partners, Inc. further agrees that any change to the project as described in the project description is a new project that requires a new Certificate of Need.
2. DaVita Healthcare Partners, Inc. shall maintain compliance with the terms and conditions outlined in the October 22, 2014, Corporate Integrity Agreement with Department of Health and Human Services.
3. Prior to providing services, DaVita HealthCare Partners, Inc. will provide to the department for review and approval a copy of an executed transfer agreement with a local hospital. The executed agreement must be consistent with the draft agreement provided in the application.
4. DaVita Healthcare Partners, Inc. shall finance this project using existing capital reserves, as described in the application.

Approved Costs:

The approved capital expenditure for this 15-station addition is \$303,830

CRITERIA DETERMINATIONS

A. Need (WAC 246-310-210)

CHI Franciscan

Based on the source information reviewed, the department concludes that the CHI Franciscan project – whether as a 28-station facility in one phase or a 44-station facility in two phases – does not meet the need criteria in WAC 246-310-210 and does not meet the applicable kidney disease treatment facility criteria in WAC 246-310-280 through 289.

Puget Sound Kidney Centers

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department concludes that the Puget Sound Kidney Centers project – whether as a 16-station, 20-station, 22-station, or 44-station facility (regardless of configuration) – has met the need criteria in WAC 246-310-210 and has met the applicable kidney disease treatment facility criteria in WAC 246-310-280 through 289.

Fresenius Medical Care

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department concludes that the Fresenius Medical Care project has met the need criteria in WAC 246-310-210 and has met the applicable kidney disease treatment facility criteria in WAC 246-310-280 through 289.

DaVita Healthcare Partners, Inc.

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department concludes that the DaVita Lakewood Community Dialysis Center project has met the need criteria in WAC 246-310-210 and has met the applicable kidney disease treatment facility criteria in WAC 246-310-280 through 289.

DaVita Healthcare Partners, Inc.

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department concludes that the DaVita Towne Center project – whether as a new 33 or 44-station facility – has met the need criteria in WAC 246-310-210 and has met the applicable kidney disease treatment facility criteria in WAC 246-310-280 through 289.

Based on the source information reviewed, the department concludes that the DaVita Towne Center project for 33 new stations and 11 relocated stations does not meet the need criteria in WAC 246-310-210 and does not meet the applicable kidney disease treatment facility criteria in WAC 246-310-280 through 289.

DaVita Healthcare Partners, Inc.

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department concludes that the DaVita Canyon Road project – whether as a new 36 or 44-station facility – has met the need criteria in WAC 246-310-210 and has met the applicable kidney disease treatment facility criteria in WAC 246-310-280 through 289.

Based on the source information reviewed, the department concludes that the DaVita Canyon Road project for 24 stations does not meet the need criteria in WAC 246-310-210 and does not meet the applicable kidney disease treatment facility criteria in WAC 246-310-280 through 289.

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

WAC 246-310-284 requires the department to evaluate kidney disease treatment center applications based on the populations need for the service and determine whether other services and facilities of the type proposed are not, or will not, be sufficiently available or accessible to meet that need as required in WAC 246-310-210. The kidney disease treatment center specific numeric methodology applied is detailed under WAC 246-310-284(4). WAC 246-310-210(1) criteria is also identified in WAC 246-310-284(5) and (6).

WAC 246-310-284 Kidney Disease Treatment Center Numeric Methodology

WAC 246-310-284 contains the methodology for projecting numeric need for dialysis stations within a planning area. This methodology projects the need for kidney dialysis treatment stations through a regression analysis of the historical number of dialysis patients residing in the planning area using verified utilization information obtained from the Northwest Renal Network (NRN).⁶

The first step in the methodology calls for the determination of the type of regression analysis to be used to project resident in-center station need. [WAC 246-310-284(4)(a)] This is derived by calculating the annual growth rate in the planning area using the year-end number of resident in-center patients for each of the previous six consecutive years, concluding with the base year.⁷

In planning areas experiencing high rates of growth in the dialysis population (6% or greater growth in each of the last five annual change periods), the method uses exponential regression to project future need. In planning areas experiencing less than 6% growth in any of the last five annual change periods, linear regression is used to project need. In planning areas experiencing less than 6% growth in any of the last five annual change periods, linear regression is used to project need.

Once the type of regression is determined as described above, the next step in the methodology is to determine the projected number of resident in-center stations needed in the planning area based on the planning area's previous five consecutive years NRN data, again concluding with the base year. [WAC 246-310-284(4)(b) and (c)]

WAC 246-310-284(5) identifies that for all planning areas except Adams, Columbia, Douglas, Ferry, Garfield, Jefferson, Kittitas, Klickitat, Lincoln, Okanogan, Pacific, Pend Oreille, San Juan, Skamania, Stevens, and Wahkiakum counties, the number of projected patients is divided by 4.8 to determine the number of stations needed in the planning area. For the specific counties listed above, the number of projected patients is divided by 3.2 to determine needed stations.

⁶ Northwest Renal Network was established in 1978 and is a private, not-for-profit corporation independent of any dialysis company, dialysis unit, or transplant center. It is funded by Centers for Medicare and Medicaid Services, Department of Health and Human Services. Northwest Renal Network collects and analyzes data on patients enrolled in the Medicare ESRD programs, serves as an information resource, and monitors the quality of care given to dialysis and transplant patients in the Pacific Northwest. [source: Northwest Renal Network website]

⁷ WAC 246-310-280 defines base year as "the most recent calendar year for which December 31 data is available as of the first day of the application submission period from the Northwest Renal Network's Modality Report or successor report." For this project, the base year is 2015.

Additionally, the number of stations projected as needed in the target year is rounded up to the nearest whole number.

Finally, once station need has been calculated for the projection year, the number of CN approved in-center stations are then subtracted from the total need, resulting in a net need for the planning area. [WAC 246-310-284(4)(d)]

WAC 246-310-280(9) identifies the ESRD planning areas for the state. Each applicant proposes to add dialysis station capacity to Pierce County planning area #5. There are 16 zip codes included in this planning area. The zip codes are listed below:

Zip	City	Zip	City
98303	Anderson Island	98444	Parkland
98327	Dupont	98445	Parkland
98387	Spanaway	98446	Parkland
98388	Steilacoom	98447	Tacoma
98430	Tacoma	98467	University Place
98433	Tacoma	98498	Lakewood
98438	Tacoma	98499	Lakewood
98439	Lakewood	98580	Roy

The department calculates the numeric methodology for each of the 57 planning areas and posts the results to its website. Below is a discussion of each applicant’s numeric methodology.

The department’s evaluation of each methodology will be discussed at the end of this sub-criterion.

CHI Franciscan

CHI Franciscan performed each of the steps of the methodology as described above and also concluded need for 44 stations in the Pierce County #5 planning area by the end of year 2019. [source: Application pp20-22]

Public Comment

None

Rebuttal

None

Puget Sound Kidney Centers

Puget Sound Kidney Centers performed each of the steps of the methodology as described above and also concluded need for 44 stations in the Pierce County #5 planning area by the end of year 2019. [source: Application pp18-20]

Public Comment

None

Rebuttal

None

Fresenius Medical Care

Fresenius performed each of the steps of the methodology as described above and also concluded need for 44 stations in the Pierce County #5 planning area by the end of year 2019. [source: Application pp20-22]

Public Comment

None

Rebuttal

None

DaVita Healthcare Partners, Inc.

While DaVita submitted three separate applications, each application included the same need projection methodology. DaVita performed each of the steps of the methodology as described above and also concluded need for 44 stations in the Pierce County #5 planning area by the end of year 2019. [source: Lakewood Community Dialysis Center application, pp17-19; Towne Center application, pp18-20; Canyon Road application, pp17-19]

Public Comment

None

Rebuttal

None

Department Evaluation of the Numeric Methodology for the Applications

Based on the calculation of the annual growth rate in the planning area as described above, each applicant and the department used the linear regression to determine planning area need. The number of projected patients was divided by 4.8 to determine the number of stations needed in the planning area. The result of each applicant's and the department's numeric methodology is shown in Table 1 below.

**Table 1
Pierce County Planning Area #5 Numeric Methodology Summary**

	4.8 in-center patients per station		
	2019 Projected # of stations	Minus Current # of stations	2019 Net Need or (Surplus)
CHI-Franciscan	86	42	44
PSKC	86	42	44
FMC	86	42	44
DaVita	86	42	44
Department	86	42	44

As shown in Table 1, the department's methodology also showed a need for 44 dialysis stations in the planning area by the end of year 2019. The department's methodology is included in this evaluation as Appendix B.

The department concludes each applicant **met this numeric methodology standard**. For this standard, each application is equivalent to the other.

In addition to the numeric need, the department must determine whether other services and facilities of the type proposed are not or will not be sufficiently available or accessible to meet the dialysis station need.⁸ The department uses the standards in WAC 246-310-284(5) and WAC 246-310-284(6).

WAC 246-310-284(5)

WAC 246-310-284(5) requires all CN approved stations in the planning area be operating at a certain utilization before new stations are added. For Pierce County planning area #5, the utilization is 4.8 in-center patients per station.

The department’s evaluation of each applicant’s compliance with this standard will be discussed at the end of this standard.

CHI Franciscan

CHI Franciscan relied on the NRN quarterly modality report for December 31, 2015, released on February 5, 2016 to demonstrate compliance with this standard. CHI Franciscan provided a table showing the utilization of each existing facility operating in the planning area as of December 31, 2015. The table is replicated below:

**Table 2
Utilization of Existing Facilities**

Facility	Number of Stations	12/31/15 Number of Patients	12/31/15 Patients/Station
DaVita Elk Plains	N/A	Not yet open; counted in DaVita Parkland	N/A
DaVita Lakewood	11	73	6.64
DaVita Parkland	21	111	5.29
DaVita Rainier View	10	48	4.80

[source: Application p23]

CHI Franciscan concluded that the 3 existing facilities are operating at or above the 4.8 patients per station standard.

Public Comment

None

Rebuttal

None

Puget Sound Kidney Centers

Puget Sound Kidney Centers relied on the NRN quarterly modality report for December 31, 2015, released on February 5, 2016 to demonstrate compliance with this standard. PSKC provided a table showing the utilization of each existing facility operating in the planning area as of December 31, 2015. The table is replicated on the following page:

⁸ WAC 246-310-210(1)(b).

**Table 3
Utilization of Existing Facilities**

Facility	Number of Stations	12/31/15 Number of Patients	12/31/15 Patients/Station
DaVita Elk Plains	N/A	Not yet open; counted in DaVita Parkland	N/A
DaVita Lakewood	11	73	6.64
DaVita Parkland	21	111	5.29
DaVita Rainier View	10	48	4.80

[source: Application p21]

PSKC concluded that the 3 existing facilities are operating at or above the 4.8 patients per station standard.

Public Comment

None

Rebuttal

None

Fresenius Medical Care

Fresenius relied on the NRN quarterly modality report for December 31, 2015, released on February 5, 2016 to demonstrate compliance with this standard. Fresenius provided a table showing the utilization of each existing facility operating in the planning area as of December 31, 2015. The table is replicated below:

**Table 4
Utilization of Existing Facilities**

Facility	Number of Stations	12/31/15 Number of Patients	12/31/15 Patients/Station
DVA Lakewood	11	73	6.64
DVA Parkland	21	111	5.29
DVA Rainier View	10	48	4.80

[source: Application p23]

PSKC concluded that the 3 existing facilities are operating at or above the 4.8 patients per station standard.

Public Comment

None

Rebuttal

None

DaVita Healthcare Partners, Inc.

While DaVita submitted three separate applications, each application included the same data to evaluate this standard. DaVita relied on the NRN quarterly modality report for December 31, 2015, released on February 5, 2016 to demonstrate compliance with this standard. DaVita provided a table showing the utilization of each facility operating in the planning area as of

December 31, 2015. The table is replicated below. [source: Lakewood Application, p20; Towne Center Application, p21; and Canyon Road Application, p21]

**Table 5
Utilization of Existing Facilities**

Existing Latest Quarterly Utilization of Existing Stations			
Reporting Period	31-Dec-15		
Existing Dialysis Facilities	Approved Stations	Patients	Patients Per Station
Lakewood Community Dialysis Center	11	73	6.6
Parkland Dialysis Center	21	111	5.3
Rainier View Dialysis Center	10	48	4.8

DaVita concluded that the three existing dialysis centers are operating at or above the 4.8 standard.

Public Comment

None

Rebuttal

None

Department Evaluation of WAC 246-310-284(5) for all six applications

The department uses data ‘from the most recent quarterly modality report or successor report from the Northwest Renal Network as of the first day of the application submission period’ to evaluate this standard. For these six applications submitted on May 31, 2016, the most recent quarterly data is December 31, 2015, available as of February 15, 2016.⁹

There are four dialysis centers located in Pierce County planning area #5 and all four are owned by DaVita. Table 6 below shows the operational status and a summary of the utilization of each center located in the planning area.

**Table 6
Department’s Facility Utilization Calculations**

Facility Name	# of Approved Stations	# of Operational Stations	# of Pts	# Pts/Station
Elk Plain Dialysis Center	11	0	0	0.00
Lakewood Community Dialysis Center	11	11	73	6.64
Parkland Dialysis Center	10	21	108	5.14
Rainier View Dialysis Center	10	10	48	4.80

As noted in Table 6 above, the planning area has 42 dialysis stations. On March 23, 2016, CN #1568 was issued to DaVita approving the establishment of a new 11-station dialysis center [Elk Plain] in the planning area by relocating 11 stations from its Parkland facility to a new facility.

⁹ First quarter 2016 data was posted to the NRN website on July 14, 2016.

Since the new center was approved after December 31, 2015, the new dialysis center was not operational and had no census for this review.¹⁰

All applicants acknowledged that the new dialysis center was not operational when these applications were submitted in May 2016. The December 2015 quarterly data confirmed that DaVita was operating all 42 stations in three dialysis centers, and each center was operating at or above the 4.8 standard. It is noted that all applicants identified 111 patients for DaVita Parkland Dialysis Center. It is unclear where the applicants obtained the data for the number of patients because the December 2015 year end NRN data identifies 108 patients dialyzing at the facility. This discrepancy does not significantly impact the utilization at DaVita Parkland; the utilization at 108 patients is 5.14 patients per station.

Table 6 above shows that the existing operational dialysis centers in Pierce County planning area #5 satisfy this standard. Meeting this standard indicates that the existing facilities are effectively and appropriately serving the population. Meeting this standard also indicates stations are not or will not be sufficiently available to meet future need. **This standard is met for the planning area.**

WAC 246-310-284(6)

WAC 246-310-284(6) requires new in-center dialysis stations be operating at a required number of in-center patients per station by the end of the third full year of operation. For Pierce County planning area #5, the requirement is 4.80 in-center patients per approved station. [WAC 246-310-284(6)(a)]

CHI Franciscan

CHI Franciscan provided the following table in response to this sub-criterion.

**Table 7
CHI Franciscan Projected Station Utilization**

Year 3	# of Stations	# of In-Center Patients	Patients/Station
44 Stations in Two Phases			
2023	44	215	4.89
28 Stations in One Phase			
2020	28	150	5.36

[source: CHI application p24]

In addition to the table above, CHI Franciscan provided the following statement confirming the timing of the station addition in Phase 2.

“The 16 Phase 2 stations are expected to come online effective January 2021. The 28 Phase 1 stations would operate the entire calendar year of 2020, and the occupancy estimate for 2020 in Table 12 is representative of only Phase 1 stations because the additional 16 stations in Phase 2 will not come online until January 2021. Phase 1 will have three full years of operation before Phase 2 comes online (i.e., 2020 would be the 3rd full year of operation for Phase 1).” [source: Screening Response p4]

¹⁰ DaVita submitted its application to relocate the 11 stations to new a new site in Spanaway on August 31, 2015. Within the application, DaVita stated the new center would be operational in September 2018. Based on the CN quarterly progress reports submitted by DaVita, the opening of the dialysis center is delayed to November 2018.

Public Comment

None

Rebuttal

None

Department Evaluation

As shown in Table 7 above, CHI Franciscan’s application would meet this standard as a 28-station facility in one phase, and as a 44-station facility in two phases. Though the standard would be met under CHI ownership and control, information found in the PUI led the department to conclude that CHI Franciscan’s volume projections are not reliable. It is unclear whether the facility will remain under CHI Franciscan’s ownership and control for the entire projection period. **This sub-criterion is not met.**

Puget Sound Kidney Centers

PSKC provided the following information in response to this sub-criterion. The table below shows each scenario proposed by the applicant, including three single-phase projects of 16, 20, and 22 stations, and one two-phase project of 44 stations. As stated earlier in this evaluation, PSKC proposed 3 different configurations of the two-phase 44-station project. Year three in the 44-station facility is not impacted by the size of phase one. [source: Application Exhibit 9, Screening Response Attachment 5]

**Table 8
PSKC Station Utilization: All Projects**

Year 3	# of Stations	# of In-Center Patients	Patients/Station
44 Stations in Two Phases¹¹			
2024	44	212	4.82
22 Stations in One Phase			
2021	22	113	5.14
20 Stations in One Phase			
2021	20	113	5.65
16 Stations in One Phase			
2021	16	92	5.75

Public Comment

None

Rebuttal

None

Department Evaluation

As shown in Table 8 above, PSKC’s application meets this standard for every scenario presented.

¹¹ The utilization for PSKC’s project as a 44-station facility in two phases is identical, regardless of how phases one and two are configured.

Fresenius Medical Care

Fresenius provided the following table in response to this sub-criterion.

**Table 9
Fresenius Projected Station Utilization**

Year 3	# of Stations	# of In-Center Patients	Patients/Station
2020	24	116	4.83

[source: Application p14]

Public Comment

None

Rebuttal

None

Department Evaluation

As shown in Table 9 above, FMC’s application meets the standard.

DaVita – Lakewood Community Dialysis Center

DaVita provided the following statements in response to this sub-criterion. [source: Application, p19]

“This application does not address the entirety of the 44 station need forecasted for Pierce 5. Rather, the 15 additional stations provided in this expansion project are designed to address current, urgent needs in the planning area. This expansion will be available to patients within a fiscal quarter after project approval, as minimal work is required to make these stations operational. Current utilization at the Lakewood facility is so high (6.6 patients per station as of December 2015) and station need is so dramatic in the service area (2015 data shows a present deficit of 27 stations in Pierce 5) that DaVita anticipates that these expansion stations will be operating at 4.8 utilization by mid to late 2017, assuming 01 2017 approval of the project. The DaVita Lakewood Dialysis expansion presents the most efficient and immediate solution to providing partial capacity relief to the Pierce 5 ESRD planning area.”

DaVita projects that the additional 15 stations would be operational at the Lakewood Community Dialysis Center by December 2017. Under this timeline, 2018 would be year one and 2020 would be year three. Table 10 below shows the projected utilization for year three. [source: Application, p12 screening response, Appendix 22]

**Table 10
Lakewood Community Dialysis Center
Third Year Projected Facility Utilization**

Year 3	# of Stations	# of In-Center Patients	Patients/Station
2020	26	151	5.80

Public Comment

None

Rebuttal

None

Department Evaluation

As shown in Table 10 above, DaVita’s application meets the standard.

DaVita – Towne Center

DaVita provided the following statements in response to this sub-criterion. [source: Application, p21]

“Lakewood Community is scheduled to open in late-2017, assuming an uncontested approval during the first quarter of 2017. Therefore, calendar year 2018 would be the first full year of operation at this facility with year 2020 being the third year full utilization. 2020 is one complete year beyond the station need methodology projection timeframe. Using the methodology found in WAC 246-310-284 as guidance and patient origin information for the planning area for years 2011 through 2015, the methodology projects 408.4 in-center dialysis patients for the year 2019 requiring 86 stations, well outstripping the current 42-station capacity in existing centers. This would require 44 additional dialysis stations for the area at the 4.8 patients per shift standard minimum for the planning area in 2019. Growth in dialysis patient demand will continue beyond 2019 and is sufficient to achieve the 4.8 patients per station standard for utilization for the 33 station phase one facility in the third full year of operation in 2020. The additional 11 stations will be added in 2021 and DaVita anticipates that these stations will achieve 4.8 patients per station capacity by the end of 2022.”

DaVita projects that the new 44-station center would meet this standard. DaVita proposed three different options in this application, therefore the department will evaluate each of the three options for this standard. Table 11 below shows the projected utilization for year three for each of the options separately. [source: Application, p12 & Screening Response, Appendix 22]

**Table 11
DaVita Towne Center
Third Year Projected Facility Utilization**

Year 3	# of Stations	# of In-Center Patients	Patients/Station
44 New Stations in Two Phases			
2023	44	215	4.88
33 New Stations and 11 Relocated from LCDC			
2020	44	211	4.79
33 New Stations in One Phase			
2020	33	159	4.81

Public Comment

None

Rebuttal

None

Department Evaluation

As shown in Table 11 above, two of DaVita’s options meet this standard. One option—33 new stations and 11 relocated from Lakewood Community Dialysis Center—does not meet this standard. This standard must be met before an application is approved. Since this standard is not met, department will not continue an evaluation of DaVita’s option to establish a 44-station facility with 33 new stations and relocation of 11 stations from Lakewood Community Dialysis Center.

DaVita – Canyon Road

DaVita provided the following statements in response to this sub-criterion. [source: Application, p21]

“Canyon Road is scheduled to open in late-2017, assuming an uncontested approval during the first quarter of 2017. Therefore, calendar year 2018 would be the first full year of operation at this facility with year 2020 being the third year full utilization. 2020 is one complete year beyond the station need methodology projection timeframe. Using the methodology found in WAC 246-310-284 as guidance and patient origin information for the planning area for years 2011 through 2015, the methodology projects 408.4 in-center dialysis patients for the year 2019 requiring 86 stations, well outstripping the current 42-station capacity in existing centers. This would require 44 additional dialysis stations for the area at the 4.8 patients per shift standard minimum for the planning area in 2019. Growth in dialysis patient demand will continue beyond 2019 and is sufficient to achieve the 4.8 patients per station standard for utilization for the 24 station phase one facility in the third full year of operation in 2020. DaVita likewise anticipates that the 12 phase two stations and 8 phase three stations will achieve the 4.8 patients per station utilization standard in 2022 and 2023 respectively.”

DaVita projects that the new 44-station center would meet this standard in all three phases. Since this project proposes three separate options, Table 12 below shows the projected utilization for each option in year three. [source: Application, p12]

**Table 12
DaVita Canyon Road
Third Year Projected Facility Utilization**

Year 3	# of Stations	# of In-Center Patients	Patients/Station
44 New Stations in Three Phases			
2024	44	223	5.07
36 New Stations – Phases One and Two Only			
2023	36	212	5.89
24 New Stations – Phase One Only			
2020	24	115	4.79

Public Comment

None

Rebuttal

None

Department Evaluation

As shown in Table 12 above, DaVita’s 44-station option and its 36 station option both meet this standard. Phase one alone—24 station option—does not meet this standard. As a result, the remainder of this evaluation will not include a separate review of DaVita’s Canyon Road 24-station option.

Department Superiority Review

For the applications that met the 4.8 patients per station utilization standard, each application is equivalent to the other.

WAC 246-310-287

The department shall not approve new stations in a planning area if the projections in WAC 246-310-284(4) show no net need, and shall not approve more than the number of stations projected as needed unless:

- (1) All other applicable review criteria and standards have been met; and*
- (2) One or more of the following have been met:*
 - (a) The department finds the additional stations are needed to be located reasonably close to the people they serve; or*
 - (b) Existing dialysis stations in the dialysis facility are operating at six patients per station. Data used to make this calculation must be from the most recent quarterly modality report or successor report from the Northwest Renal Network as of the first day of the application submission period; or*
 - (c) The applicant can document a significant change in ESRD treatment practice has occurred, affecting dialysis station use in the planning area; and*
- (3) The department finds that exceptional circumstances exist within the planning area and explains the approval of additional stations in writing.*

Department Evaluation

This sub-criterion is not applicable to any of the six applications under review.

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

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

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

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

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

A facility's charity care policy should show a willingness of a provider to provide services to patients who have exhausted any third-party sources, including Medicare and Medicaid, and whose income is equal to or below 200% of the federal poverty standards, adjusted for family size or is otherwise not sufficient to enable them to pay for the care or to pay deductibles or coinsurance

amounts required by a third-party payer.¹² With the passage of the Affordable Care Act (ACA), the amount of charity care is expected to decrease, but not disappear. The policy should also include the process one must use to access charity care at the facility.

CHI Franciscan

CHI provided the following statement related to this sub-criterion:

“CHI Franciscan has a proven history of developing and providing services to meet the healthcare needs of persons residing in its service area. CHI Franciscan is committed to providing services to all patients regardless of income, race, sex, or physical or mental limitations. Copies of the proposed admission policies/procedures, non-discrimination policy and charity care policy for the proposed Franciscan Lakewood are included in Exhibit 9.” [source: Application p24]

As stated above, copies of the admission policy, non-discrimination policy, and charity care policy were included with the application.

Medicare and Medicaid Programs

All operational CHI Franciscan dialysis facilities are currently Medicare and Medicaid certified. CHI provided its projected payer mix for the proposed FHS Lakewood facility, shown below in Table 13. [source: Application, p10]

**Table 13
FHS Lakewood Payer Mix**

Source	Net Revenue	Patients
Medicare	69%	79%
Medicaid	5%	11%
Other ¹³	26%	10%
Total	100%	100%

CHI Franciscan provided the following statement to describe the assumptions used project the payer mix shown above:

“CHI Franciscan does not presently operate a facility in Pierce 5. The payer mix used for this application is based on our Franciscan South Tacoma facility which is located in the adjacent planning area, and currently serves about 49 patients from Pierce 5 (or 37% of the facility’s total patients).” [source: Application p9]

Public Comment

None

Rebuttal

None

Department Evaluation

CHI Franciscan has been providing dialysis services to the residents of Washington State and Pierce County for many years. The admission policy explicitly states *“It is the policy of*

¹² WAC 246-453-010(4).

¹³ “Other” includes all other payer sources, including but not limited to commercial insurance and managed care.

Franciscan Health System to recognize and respect the rights of all patients. Discrimination in any form is prohibited.” [source: CHI Franciscan application p150]

The nondiscrimination policy states *“FHS does not exclude, deny benefits to, or otherwise against any person on the basis of race, color, national origin, religion, sexual orientation, physical, mental, or other disability, economic status, citizenship, medical condition, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by Franciscan Health System directly or through a contractor or any other entity with which Franciscan Health System arranges to carry out its programs and activities.”* [source: Application p154]

All operational CHI Franciscan dialysis centers are Medicare and Medicaid certified. Documentation provided in the application demonstrates that proposed Lakewood facility would be both Medicare and Medicaid certified. CHI projected the Medicare revenues for the new facility to be 69% of total revenues, regardless of facility size. The proposed facility’s Medicaid revenues are projected to be at 5% of total revenues, regardless of facility size. Pro forma financial data provided in the application shows Medicare and Medicaid revenues. [source: Screening Response, Attachment 10]

CHI Franciscan provided a charity care policy that is consistent with all other approved CHI Franciscan dialysis centers. The policy provides the necessary information and process a patient would use to obtain charity care at a CHI Franciscan facility. A charity care line item was also included as a deduction from revenue within the pro forma financial data. [source: Screening Response, Attachments 9 & 10]

As previously stated, in Washington State, most dialysis patients qualify for either Medicare or Medicaid services. Charity care is generally not used by dialysis providers. Typically, the department requires applicants to submit a copy of the charity care policy to demonstrate a willingness to provide charity care if necessary. The department concludes CHI Franciscan’s project **meets this sub-criterion.**

Puget Sound Kidney Centers

PSKC provided the following statement related to this sub-criterion:

“All individuals in need of dialysis services have access to PSKC’s dialysis centers. PSKC’s Community Service Statement policy, attached as Exhibit 8, prohibits discrimination on the basis of race, income, ethnicity, sex, or handicap. PSKC reinvests into the community and does not turn patients away on the basis of income or payment resources. PSKC is committed to caring for the underserved, and is truly a nonprofit provider in every sense of the word. Our policy differentiates us from many other dialysis providers in that we identify patients prospectively and qualify them as eligible for charity care (as opposed to re-categorizing bad debt). We are proud of our policy and are aware of how it has benefited dialysis patients over the years.” [source: Application p22]

A copy of the PSKC community service policy was included with the application. This policy includes language that speaks to patient admission, non-discrimination, and charity care. PSKC did not provide a separate policy entitled “Charity Care,” however indicated that if this project is approved, a revised policy would be provided to include Pierce County. [sources: Application Exhibit 8, screening response p16]

Medicare and Medicaid Programs

All operational PSKC dialysis facilities are currently Medicare and Medicaid certified. PSKC provided its projected payer mix for the proposed PSKC – Lakewood facility, shown below in Table 14. [source: Application, p10]

**Table 14
PSKC Lakewood Payer Mix**

Source	Net Revenue	Patients
Medicare	71%	81%
Medicaid	5%	8%
Commercial	24%	11%
Total	100%	100%

PSKC provided the following statement to describe the assumptions used to project the payer mix shown above:

“[The] payer mix [was] based on the current experience of PSKC for all modalities... The percentages provided are based on PSKC actual experience.” [source: Screening Response Attachment 10]

Public Comment

The public comments received related to this sub-criterion relate to access and geographic location of the proposed facility.

FMC Public Comment

“The location of PSKC's proposed facility is extremely close, less than one (1) mile, to the existing DVA Lakewood facility, and is within five (5) miles of the other two existing dialysis facilities, DVA Parkland and DVA Rainier View. Considering that there is substantial and immediate need for dialysis stations in Pierce Five, a new facility should expand access for patients living in regions not currently served by existing dialysis facilities - PSKC's proposed project does not meet this criterion.

PSKC Lakewood facility will not improve patient access to dialysis care because it would be located within close proximity to DVA Lakewood, and would also be within five (5) miles of the other two existing dialysis facilities, DVA Rainier View and DVA Parkland.

In addition to the geographic concentration of dialysis facilities, there is a clear lack of access to dialysis stations in eastern Pierce Five, specifically in and around the city of Spanaway. In fact, the Spanaway zip code has the third highest number of dialysis patients in Pierce Five. [source: NWRN Modality Report, 12/31/15]

The two zip codes with the highest concentration of dialysis patients in Pierce Five are 98444 (Parkland) and 98499 (Lakewood). Both of these zip codes are located in the northernmost geographic regions of the planning area and are well-served by three existing DaVita facilities (Figure 1). However, the zip code with the third highest concentration of patients is located in the central-eastern region of Pierce Five, in zip code 98387 (Spanaway).

Currently, dialysis patients residing in the northern geographic area of Pierce Five have convenient access to three (3) dialysis facilities with a combined total of 42 stations. However,

dialysis patients residing in the central-eastern region, specifically in and around Spanaway, are not served by a reasonably close facility - the nearest facility, DVA Parkland is, on average, more than five (5) miles from these patients. Only two applicants propose facilities that improve access for the underserved patient population in Pierce Five: FMC proposing the FKC Fredrickson facility, and one of DVA's three requests, its proposed Canyon Road facility.

Pierce Five is a large geographic planning area with a number of highly populated cities. It is not advantageous to place the overwhelming majority of dialysis facilities in the same city when there are a number of patients in other cities within the planning area (Figure 2). Patients residing in the central-eastern area of Pierce Five currently need access to a dialysis facility – all existing facilities are located beyond five (5) miles and are overcrowded.

Fundamentally, PSKC's proposal to add another facility in the city of Lakewood, and in the northern region of Pierce Five in general, will not improve patient access in the service area. As such, PSKC's proposal fails to meet Need criteria outlined in WAC 246-310-210 and its project should be denied in favor of a superior proposal, which we believe to be our proposed FKC Fredrickson.” [source: FMC public comment pp6-9]

Rebuttal

“Contrary to FMC’s arguments, PSKC has put forth a compelling and strong application to develop a new dialysis center in the Pierce 5 planning area that will improve access and that will provide a high-quality choice for patients. FMC’s comments focus solely on tiebreakers. Related to tiebreakers, FMC fails to recognize that it would “lose” because it is proposing 24 stations, only 55% of the need. WAC 246-310-288 (1)(e) states that those applicants proposing the number of stations that most closely approximates the projected need gets a tiebreaker point. This tiebreaker requirement was established to ensure access and the right number of stations in a market; FMC’s proposal fails to meet this access tiebreaker.

FMC’s entire “access” argument is related to geography. Yet, as the CN Program is aware, there are already four existing and/or CN approved facilities located in the Planning Area, and...there are no real population centers remaining that are more than three miles from any of these facilities. The zip code in which FMC proposes to locate its facility has approximately 15 patients only.

Further, FMC failed to acknowledge that access is also—and predominantly—considered under WAC 246-310-210 (1) and (2) which specifically state:

- 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.*
- 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.*

Access is also suggested in WAC 246-310-220 (2) which states:

‘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’

PSKC proposes to establish a 44-station dialysis center that meets all of the projected need in the Pierce 5 dialysis planning area. FMC fails to note that PSKC will improve access through providing another choice of provider in Pierce 5. And, even more importantly, PSKC is the only applicant in this concurrent review process that will provide patients and payers with a lower cost, higher quality, provider of dialysis services. As noted in Table 2, replicated in response to #3, of PSKC's public comment, PSKC's net revenue per treatment is expected to be 2.4 times less than FMC's. Clearly, PSKC's proposal's is superior to FMC's in its ability to meet the requirements of all applicable access related criterion, and it will serve all patients in need of care." [source: PSKC rebuttal pp4-6]

Department Evaluation

PSKC has been providing dialysis services to the residents of Washington State for many years. The Community Service Statement for the Puget Sound Kidney Centers provides the assurance that PSKC-Lakewood would accept patients for treatment without regard to *"age, race, color ethnicity, sex or sexual orientation, religious or political beliefs, medical disease, disorder or disability, or on the basis of income or payment resources."* [source Application Exhibit 8]

All operational PSKC dialysis centers are Medicare and Medicaid certified. Documentation provided in the application demonstrates that proposed Lakewood facility would be both Medicare and Medicaid certified. PSKC projected the Medicare revenues for the new facility to be 71% of total revenues, regardless of facility size. The proposed facility's Medicaid revenues are projected to be at 5% of total revenues, regardless of facility size. Pro forma financial data provided in the application shows Medicare and Medicaid revenues. [source: Screening Response, Attachment 10]

PSKC did not provide a policy specifically entitled "Charity Care" for PSKC or PSKC-Lakewood. However its Community Service Statement for the Puget Sound Kidney Centers provides the assurance that PSKC would provide services to all patients requiring dialysis services without regard to ability to pay. In Washington State, most dialysis patients qualify for either Medicare or Medicaid services. Charity care is generally not used by dialysis providers. PSKC further demonstrated its intent to provide charity care to its PSKC-Lakewood patients by including a 'charity' line item as a deduction from revenue within the pro forma income statement. If approved, the department would attach a condition to this sub-criterion, requiring that PSKC submit the revised policy prior to commencement of the project. [source: Screening Response, Attachment 10]

FMC raised the issue that the proposed PSKC facility location would not improve patient access. Their comments speak to the geographic location of the proposed PSKC facility being too close to existing providers. PSKC argued in their rebuttal comments that this point would only be relevant within a tie-breaker analysis. The department agrees that for this Pierce 5 concurrent review, geographic location, while relevant, does not rise to the significance of a denial under this sub-criterion. Instead, it would be relevant in a comparative analysis, which will be completed following the analysis of each project.

With the following condition, the department concludes PSKC's project **meets this sub-criterion.**

- Prior to commencement of the project, PSKC shall submit to the department an updated Community Service Statement that includes Pierce County.

Fresenius Medical Care

Fresenius provided the following statement related to this sub-criterion:

“RCG [FMC] has a documented and proven history of providing charity care in all of our Washington facilities. All individuals identified as being in need of dialysis services will have access to FKC Fredrickson. RCG's admission policies prohibit discrimination on the basis of race, income, ethnicity, sex or handicap. A copy of the admission policy is contained in Exhibit 12. A copy of our charity care policy is contained in Exhibit 13.” [source: Application p24]

As stated above, copies of the admission policy with non-discrimination language and the charity care policy were included with the application. [source: Application Exhibit 13, Screening Response Exhibit 12]

Medicare and Medicaid Programs

All operational FMC dialysis facilities in Washington State are currently Medicare and Medicaid certified. FMC provided its projected payer mix for the proposed FKC Fredrickson facility, shown below in Table 15. [source: Application p15]

**Table 15
FKC Fredrickson Payer Mix**

Source	Net Revenue	Patients
Medicare	30.24%	74.57%
Medicaid	3.76%	9.16%
Commercial	62.46%	9.60%
Other	3.54%	6.67%
Total	100%	100%

FMC provided the following statement to describe the assumptions used project the payer mix shown above:

“Actual data was used from comparable Fresenius facilities in Chehalis, Shelton and Grays Harbor to model payer mix in terms of percentages of number of treatment and share of net revenues..” [source: Screening Response p3]

Public Comment

CHI Franciscan and PSKC both provided public comment in relation to this sub-criterion, focusing on the number of stations requested by FMC.

CHI Franciscan Public Comment

“Despite projecting need per the methodology outlined in WAC 246-310-284 for 44 stations, FMC submitted a proposal to establish only a 24 station facility. While acknowledging that Pierce 5 has “the highest projected need for inpatient dialysis stations of all Planning Areas in the State of Washington...” FMC elected to apply for only 24 stations. As such FMC fails WAC 246-310-210 (2) which requires that applicants assure adequate access to the proposed health service or services. By applying for only 24 stations, or 20 less than the number needed, many Pierce 5 dialysis patients would not have adequate access. Further, if the FMC application proceeded to tiebreakers in WAC 246-310-288, it would fail because it is not an “exact match” to the need.” [source: CHI Franciscan public comment p7]

PSKC Public Comment

"FMC proposes only a 24 station facility, and therefore its project is not an exact match to the 44 station need. In the unlikely event its project proceeds to tiebreakers, it would not garner a point for addressing need. As a standalone application we also believe that FMC fails WAC 246-310-210 which states that:

(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.

By definition, when the need is for 44 stations, many residents would not have adequate access, as 20 station's worth of patients (or 96 patients at 80% occupancy) would still have to travel out of area for care." [source: PSKC Public Comment p5]

Rebuttal

FMC did not provide rebuttal comments relating to CHI Franciscan's public comments.

"The fundamental flaw of PSKC's argument is simply that WAC 246-310-210 criteria do not require an applicant to meet all projected need in a given planning area. In other words, PSKC's assertion that "many residents would not have adequate access" simply because the proposed project does not meet all projected need is not a reason for the project to fail Need. Rather, the Need criterion outlined in WAC 246-310-210 requires that there is a sufficient and demonstrated need for the project and that "[a]ll residents of the service area ... have adequate access". This condition prevents duplication and concentration of services - to receive CN approval, applicants must demonstrate that there is a need for the project services through the use of reasonable and commonly-accepted metrics and mathematical models.

Projection of need for kidney dialysis facilities is outlined in WAC 246-310-284. Application of this methodology results in a projected net need for 44 dialysis stations in 2019. As Fresenius' project requests only 24 stations, there is more than sufficient demonstrated need for the project to ensure efficient utilization of resources.

A prospective applicant would fail to meet Need criterion if: (1) the applicant requested more stations than projections determine to be needed; (2) an applicant did not show provider occupancy levels were above capacity standards; or (3) there was concern of difficulties in access for patients with special needs (e.g. handicap access, indigent patient, etc.).

Fresenius is proposing to provide new dialysis care in a currently unserved region of Pierce 5. We believe the best care delivery option for patients is a smaller facility. This determination conforms to all the regulations outlined in WAC 246-310-210 in general and in WAC 246-310-210(2) specifically.

Our proposed FKC Fredrickson would utilize a clear and unambiguous patient acceptance policy that ensures patients with varying needs are accommodated at all of our facilities. Further, we allocate the most revenue to charity care of any of the concurrent applicants in this review cycle, which better guarantees access of all patients at our proposed FKC Fredrickson facility.

Our 24-station facility will drastically improve access to dialysis care for the large number of patients residing in eastern regions of Pierce Five. Although this will not remediate all patient

need in the entire Pierce Five planning area, the proposed FKC Fredrickson will be a significant improvement to the current and projected high need for dialysis stations, particularly in a currently unserved region of a service area with a growing population.

All Pierce Five residents who need access to dialysis stations in the eastern region of Pierce Five will have the option of receiving care at FKC Fredrickson. Our project fully conforms to Need criteria as outlined in WAC 246-310-210 and WAC 246-310-284 and, if approved, will be a beneficial addition of new dialysis services to the Pierce Five service area.” [source: FMC rebuttal pp5-6]

Department Evaluation

FMC has been providing dialysis services to the residents of Washington State for many years. The admission policy states *“Where medically appropriate and consistent with this policy, facilities shall admit and treat patients needing dialysis without regard to race, creed or religion, color, age, sex, disability, national origin, marital status, diagnosis and/or sexual orientation..”* [source: Application Exhibit 12]

All operational FMC dialysis centers in Washington State are Medicare and Medicaid certified. Documentation provided in the application demonstrates that proposed FKC-Fredrickson would be both Medicare and Medicaid certified. FMC projected the Medicare revenues for the new facility to be 30.24% of total revenues. The proposed facility’s Medicaid revenues are projected to be at 3.76% of total revenues. Pro forma financial data provided in the application shows Medicare and Medicaid revenues. [source: Screening Response, Exhibit 14]

FMC provided an “Indigence Policy” that provides the necessary information and process a patient would use to obtain charity care at an FMC Franciscan facility. A charity care line item was also included as a deduction from revenue within the pro forma financial data. [source: Screening Response, Exhibit 14]

As previously stated, in Washington State, most dialysis patients qualify for either Medicare or Medicaid services. Charity care is generally not used by dialysis providers. Typically, the department requires applicants to submit a copy of the charity care policy to demonstrate a willingness to provide charity care if necessary.

Both CHI Franciscan and PSKC stated in their public comments that the FKC-Fredrickson facility would not improve patient access, as the application is only for 24 stations out of the 44 stations needed.

FMC responded, asserting that their application met the applicable need criteria. The department agrees that the requirements under WAC 246-310-210 are met. Furthermore, whether the applicant requests to meet the full need of the planning area would only be relevant in a concurrent review under tiebreakers.

The department concludes FMC’s project **meets this sub-criterion.**

DaVita – Lakewood Community Dialysis Center

DaVita provided the following statement related to this sub-criterion:

“Appendix 14 includes a copy of the admission, patient financial evaluation, and patient involuntary transfer policies which documents that access is not denied due to indigence, racial or ethnic identity, gender or handicapped status. Further, DaVita is a for-profit organization and contributes tax revenues to support a statewide broad array of social services. The pro forma shows that funds have been budgeted to provide charity care.” [source: Application, p20]

As stated above, DaVita provided copies of the following policies used at all DaVita dialysis centers, including Lakewood Community Dialysis Center. [source: Application, Appendix 14]

- Accepting End Stage Renal Disease Patient for Treatment [Admission Policy] – Revised and Approved March 2016
- Patient Financial Evaluation Policy – Reviewed and Approved April 2014
- Patient Behavior Agreements, 30 Day Discharge, Involuntary Discharge or Involuntary Transfer Policy – Reviewed and Approved September 2015

Medicare and Medicaid Programs

Lakewood Community Dialysis Center is currently Medicare and Medicaid certified. DaVita provided its percentage of sources of revenues by payer and by patient which is shown in Table 16 below. [source: Application, p12]

**Table 16
Lakewood Community Dialysis Center Payer Mix**

Source	Revenue	Patient
Medicare	67.66%	44.74%
Medicaid	1.46%	0.88%
Insurance/HMO	30.87%	54.38%
Total	100.0%	100.0%

Public Comment

FMC provided comments related to this sub criterion for Lakewood Community Dialysis Center.

Revenue Sources

“The determination of need criteria specified in WAC 246-310-210 includes the following:
[restatement of (2) here]

The criterion specifically states ‘adequate access’ for low income and other underserved patients. DVA’s proposed expansion fails this requirement due to the combination of an abnormally low Medicaid patient population and the small percentage of charity care available at the facility. The utilization of dialysis care at DVA Lakewood by Medicare, Medicaid, and medically indigent patients can be determined by examining the percentage of payers by payor data. The data DVA provided in its requested expansion is reproduced in Table 2 below.

[continued on next page]

Table 2 DVA Lakewood Dialysis Center Percentage of Patients by Payor

Table 5 DaVita Lakewood Dialysis Center Sources of Revenue Percentage of Patients per Payor	
<i>Revenue Source</i>	<i>% of Patients</i>
<i>Medicare</i>	44.74%
<i>Medicaid/State</i>	0.88%
<i>Insurance/HMO/Other</i>	54.38%
Total	100%

As seen in Table 2, there are significantly fewer patients (0.88%) enrolled in Medicaid or state insurance plans at the DVA Lakewood facility than is typical at other dialysis facilities (5-10%). In fact, DVA reported its company-wide average percentage of Medicaid/State patients to be 7.7% in its most recent Pierce Five relocation request (DVA Elk Plains), which is reproduced below in Table 3.”

Table 3 DVA Company-Wide Percentage of Patients by Payor

Table 5 DaVita Company-wide Sources of Revenue Percentage of Patients per Payor	
<i>Revenue Source</i>	<i>% of Patients</i>
<i>Medicare</i>	78.9%
<i>Medicaid/State</i>	7.7%
<i>Insurance/HMO/Other</i>	13.4%
Total	100%

[source: FMC public comment, pp9-10]

Charity Care

“It is also questionable if indigent patients or patients with state-sponsored health insurance plans have, or will have, adequate access to DVA Lakewood - this facility has a noticeably higher percentage of patients with private insurance: 54.38% in the "insurance, HMO or other" category, and an abnormally low (0.88%) number of patients with Medicaid or other State insurance. It is unknown whether this is an anomaly within the nearby population, if this facility attracts particular types of payers and/or patients or DVA made a mistake in its application materials. Of further concern is that DVA allocates just 1.3% of its total gross revenues to charity care, much lower than FMC's allocation of 2.0% of total gross revenues to charity care.

Based on the aforementioned issues, particularly lack of meeting patient access needs, DVA's CN request for an expansion of its existing DVA Lakewood facility fails CN criteria for Need (WAC 246-310-210) for ...failing to improve patient access, both geographically and for low-income and underserved populations.”

[source: FMC public comment, pp4-5]

Rebuttal

“Fresenius suggests that DaVita made a mistake in its payor mix. Fresenius is wrong. As Fresenius well knows, revenue per treatment can vary significantly between facilities depending on individual patients’ insurance coverage at a given time. We note that we also provided a national payor mix and the regional revenue per treatment, used for the Lakewood Community and Canyon Road application. Therefore, the Department has all data necessary to evaluate each of DaVita’s applications.” [source: DaVita rebuttal comment, p9]

Department Evaluation of WAC 246-310-210

DaVita has been providing dialysis services to the residents of Washington State and Pierce County for many years. The Accepting End Stage Renal Disease Patients for Treatment provides the assurance that DaVita would accept patients for treatment without regard to “*race, color, national origin, gender, sexual orientation, age, religion, or disability...*” provided that the patient is a candidate for dialysis services.

All DaVita dialysis centers are Medicare and Medicaid certified. Documentation provided in the application demonstrates that Lakewood Community Dialysis Center is both Medicare and Medicaid certified. DaVita projected the Medicare revenues for the center to be 67.6% of total revenues. Pro forma financial data provided in the application shows Medicare revenues. [source: Application, p12 & Screening Response, Appendix 22]

Lakewood Community Dialysis Center’s Medicaid revenues are projected to be 1.46% of total revenues. Pro forma financial data provided in the application shows Medicaid revenues. [source: Application, p12 & Screening Response, Appendix 22]

FMC states that the dialysis center’s Medicaid patient population is ‘*abnormally low.*’ To substantiate its position, FMC compares Lakewood Community Dialysis Center with Elk Plain Dialysis Center, the new facility located in Pierce County planning area #5. The comparison focused on each center’s percentage of Medicaid patients. The comparison shows that Lakewood Community Dialysis Center’s percentage is lower than Elk Plain Dialysis Center. FMC does not take into account that Lakewood Community Dialysis Center is a well-established facility that has been operating in the planning area for many years. The percentage shown in the Elk Plain Dialysis Center project is projected and not an equal comparison with a well-established facility.

FMC also questions whether Lakewood Community Dialysis Center is available to charity care patients. As previously stated, in Washington State, most dialysis patients qualify for either Medicare or Medicaid services. Charity care is generally not used by dialysis providers. The low percentage of charity care at Lakewood Community Dialysis Center is a result of this practice.

DaVita did not provide a policy specifically entitled “Charity Care.” However DaVita’s Patient Financial Evaluation Policy provides the necessary information and process a patient would use to obtain charity care at a DaVita facility. DaVita further demonstrated its intent to provide charity care to Lakewood Community Dialysis Center patients by including a ‘charity’ line item as a deduction from revenue within the pro forma income statement. [source: Screening Response, Appendix 22]

Typically, the department requires applicants to submit a copy of the charity care policy to demonstrate a willingness to provide charity care if necessary. The department concludes DaVita’s project **meets this sub-criterion.**

DaVita – Towne Center

DaVita provided the following statement related to this sub-criterion:

“Appendix 14 includes a copy of the admission, patient financial evaluation, and patient involuntary transfer policies which documents that access is not denied due to indigence, racial or ethnic identity, gender or handicapped status. Further, DaVita is a for-profit organization and contributes tax revenues to support a statewide broad array of social services. The pro forma shows that funds have been budgeted to provide charity care.” [source: Application, pp21-11]

As shown above, DaVita provided copies of the following policies used at all DaVita dialysis centers, including the new Towne Center facility. [source: Application, Appendix 14]

- Accepting End Stage Renal Disease Patient for Treatment [Admission Policy] – Revised and Approved March 2016
- Patient Financial Evaluation Policy – Reviewed and Approved April 2014
- Patient Behavior Agreements, 30 Day Discharge, Involuntary Discharge or Involuntary Transfer Policy – Reviewed and Approved September 2015

Medicare and Medicaid Programs

DaVita proposes that its Towne Center facility would be Medicare and Medicaid certified regardless of the number of operational stations. DaVita provided its company-wide percentages of revenues by payer and patient to be used for this facility. The percentages are shown in Table 17 below. [source: Application, p13]

**Table 17
DaVita-Towne Center Projected Payer Mix**

Source	Revenue	Patient
Medicare	56.7%	78.9%
Medicaid	4.5%	7.7%
Insurance/HMO	38.8%	13.4%
Total	100.0%	100.0%

Public Comment

None

Rebuttal

None

Department Evaluation of WAC 246-310-210

DaVita has been providing dialysis services to the residents of Washington State and Pierce County for many years. The Accepting End Stage Renal Disease Patients for Treatment provides the assurance that DaVita would accept patients for treatment without regard to “*race, color, national origin, gender, sexual orientation, age, religion, or disability...*” provided that the patient is a candidate for dialysis services.

All DaVita dialysis centers are Medicare and Medicaid certified. Documentation provided in the application demonstrates that the Towne Center facility would be both Medicare and Medicaid certified. DaVita projected the Medicare revenues for the new center to be 56.7% of total revenues regardless of whether the facility has 33 or 44 dialysis stations. Pro forma financial data provided

in the application shows Medicare revenues. [source: Application, p13 & Screening Response, Appendix 22]

The Towne Center facility's Medicaid revenues are projected to be 4.5% of total revenues regardless of whether the facility has 33 or 44 dialysis stations. Pro forma financial data provided in the application shows Medicaid revenues. [source: Application, p13 & Screening Response, Appendix 22]

DaVita did not provide a policy specifically entitled "Charity Care." However DaVita's Patient Financial Evaluation Policy provides the necessary information and process a patient would use to obtain charity care at a DaVita facility. DaVita further demonstrated its intent to provide charity care for patients by including a 'charity' line item as a deduction from revenue within the pro forma income statement. [source: Screening Response, Appendix 22]

As previously stated, in Washington State, most dialysis patients qualify for either Medicare or Medicaid services. Charity care is generally not used by dialysis providers. Typically, the department requires applicants to submit a copy of the charity care policy to demonstrate a willingness to provide charity care if necessary. The department concludes DaVita's project **meets this sub-criterion.**

DaVita – Canyon Road

DaVita provided the following statement related to this sub-criterion:

"Appendix 14 includes a copy of the admission, patient financial evaluation, and patient involuntary transfer policies which documents that access is not denied due to indigence, racial or ethnic identity, gender or handicapped status. Further, DaVita is a for-profit organization and contributes tax revenues to support a statewide broad array of social services. The pro forma shows that funds have been budgeted to provide charity care." [source: Application, pp21-11]

As shown above, DaVita provided copies of the following policies used at all DaVita dialysis centers, including the new Canyon Road center. [source: Application, Appendix 14]

- Accepting End Stage Renal Disease Patient for Treatment [Admission Policy] – Revised and Approved March 2016
- Patient Financial Evaluation Policy – Reviewed and Approved April 2014
- Patient Behavior Agreements, 30 Day Discharge, Involuntary Discharge or Involuntary Transfer Policy – Reviewed and Approved September 2015

Medicare and Medicaid Programs

DaVita proposes that its new Canyon Road facility would be Medicare and Medicaid certified regardless of the number of operational stations. DaVita provided its company-wide percentages of revenues by payer and patient to be used for this facility. The percentages are shown in Table 18 on the following page. [source: Application, p12]

Table 18
DaVita-Canyon Road Projected Payer Mix

Source	Revenue	Patient
Medicare	56.7%	78.9%
Medicaid	4.5%	7.7%
Insurance/HMO	38.8%	13.4%
Total	100.0%	100.0%

Public Comment

None

Rebuttal

None

Department Evaluation

DaVita has been providing dialysis services to the residents of Washington State and Pierce County for many years. The Accepting End Stage Renal Disease Patients for Treatment provides the assurance that DaVita would accept patients for treatment without regard to “*race, color, national origin, gender, sexual orientation, age, religion, or disability...*” provided that the patient is a candidate for dialysis services.

All DaVita dialysis centers are Medicare and Medicaid certified. Documentation provided in the application demonstrates that the new Canyon Road facility would be both Medicare and Medicaid certified. DaVita projected the Medicare revenues for the new center to be 56.7% of total revenues regardless of whether the facility has 24, 36, or 44 dialysis stations. Pro forma financial data provided in the application shows Medicare revenues. [source: Application, p12 & Screening Response, Appendix 22]

The new Canyon Road facility’s Medicaid revenues are projected to be 4.5% of total revenues regardless of whether the facility has 24, 36, or 44 dialysis stations. Pro forma financial data provided in the application shows Medicaid revenues. [source: Application, p13 & Screening Response, Appendix 22]

DaVita did not provide a policy specifically entitled “Charity Care.” However DaVita’s Patient Financial Evaluation Policy provides the necessary information and process a patient would use to obtain charity care at a DaVita facility. DaVita further demonstrated its intent to provide charity care for patients by including a ‘charity’ line item as a deduction from revenue within the pro forma income statement. [source: Screening Response, Appendix 22]

As previously stated, in Washington State, most dialysis patients qualify for either Medicare or Medicaid services. Charity care is generally not used by dialysis providers. Typically, the department requires applicants to submit a copy of the charity care policy to demonstrate a willingness to provide charity care if necessary. The department concludes DaVita’s project **meets this sub-criterion.**

Superiority Ranking

For this sub-criterion, the department used the total percentage of projected Medicare and Medicaid patients to be served at the proposed facility as the indicator of availability and accessibility to all

populations within the planning area. The department used data already provided within this sub-criterion to perform this superiority review. Though some applicants proposed more than one sub-project within a single application, there was no difference in the patient mix. Therefore, the department completed this superiority review by ranking the applications – not the sub-projects. Using this format, each sub-project within a single application would be tied. The superiority review is shown below in Table 19.

**Table 19
Department Superiority Review of WAC 246-310-210(2)**

Applicant/Application	Medicare and Medicaid Patients	Ranking
CHI Franciscan:	90%	1
Puget Sound Kidney Centers	89%	2
Fresenius	84%	4
DaVita – Lakewood Community	46%	5
DaVita – Towne Center	87%	3
DaVita – Canyon Road	87%	3

In the event that one or more applications meet all of the applicable review criteria, this superiority information may be used in the departments evaluation of WAC 246-310-240(1) Step 3. In the event that only one application meets all of the applicable review criteria, this superiority information will not be used.

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

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

Department Evaluation

This sub-criterion is not applicable to any of the six applications.

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

Department Evaluation

This sub-criterion is not applicable to any of the six applications.

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

Department Evaluation

This sub-criterion is not applicable to any of the six applications.

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

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

Department Evaluation

This sub-criterion is not applicable to any of the six applications.

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

Department Evaluation

This sub-criterion is not applicable to any of the six applications.

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

Department Evaluation

This sub-criterion is not applicable to any of the six applications.

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

CHI Franciscan

Based on the source information reviewed, the department concludes that the CHI Franciscan project – whether as a 28-station facility in one phase or a 44-station facility in two phases – does not meet the financial feasibility criteria in WAC 246-310-220.

Puget Sound Kidney Centers

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department concludes that the Puget Sound Kidney Centers project – whether as a 16-station, 20-station, 22-station, or 44-station (regardless of configuration) – has met the financial feasibility criteria in WAC 246-310-220.

Fresenius Medical Care

Based on the source information reviewed, the department concludes that the Fresenius Medical Care project for a 24-station facility does not meet the financial feasibility criteria in WAC 246-310-220.

DaVita Healthcare Partners, Inc.

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department concludes that the DaVita Lakewood Community Dialysis Center project has met the financial feasibility criteria in WAC 246-310-220.

DaVita Healthcare Partners, Inc.

Based on the source information reviewed, the department concludes that the DaVita Towne Center project – whether as a new 33 or 44-station facility – does not meet the financial feasibility criteria in WAC 246-310-220.

DaVita Healthcare Partners, Inc.

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department concludes that the DaVita Canyon Road project – whether as a new 36 or 44-station facility – has met the financial feasibility criteria in WAC 246-310-220.

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

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

CHI Franciscan

CHI Franciscan anticipates that the first phase would become operational by January 2018. Under this timeline, 2018 would be the facility's first full calendar year of operation, and 2020 would be year three. Phase two, if approved, would become operational by January 2021. Under this timeline, 2021 would be the facility's first full calendar year of operation as a 44-station facility, and 2023 would be year three.

CHI Franciscan provided the assumptions used to project in-center and home treatments and patients for calendar years 2018 through 2023. Below is a summary of these assumptions. [sources: Application Exhibit 10, Screening Response p3]

- Approximately 50% of Pierce 5 patients (currently being served in CHI Franciscan Pierce 4 facilities) would transfer to the proposed Franciscan [source: Screening Response p3]
- Payer mix and volumes were based on actuals at the Franciscan South Tacoma facility
- 148 treatments per patient, annually [source: Application, Exhibit 10]
- The station need in the planning area is 44 stations. This application requests 28 stations in its first phase, and the remaining 16 in the second phase.

Using the assumptions above, CHI Franciscan projected the number of treatments to be provided in the projection years.

Table 20
CHI Franciscan Treatments

	Phase 1			Phase 2		
	2018	2019	2020	2021	2022	2023
Stations	28	28	28	44	44	44
Total In-Center Patients	100	130	150	175	195	215
Total In-Center Treatments	14,800	19,240	22,200	25,900	28,860	31,820
Total Home Hemodialysis	296	444	444	592	592	740
Total Home Peritoneal Dialysis	888	1,184	1,628	1,776	2,072	2,220
Total Treatments	15,984	20,868	24,272	28,268	31,524	34,780

[sources: Application p24, Exhibit 10]

The assumptions CHI Franciscan used to project revenue, expenses, and net income for the proposed facility for years 2018-2023 are restated below:

- Net Revenue Per Treatment: \$404 (based on actuals at Franciscan South Tacoma)
- Charity Care: 0.5% of Gross Revenue/Treatment
- Bad Debt: 1.0% of Gross Revenue/Treatment
- Direct Expenses: based on actuals at Franciscan South Tacoma
- Depreciation:
 - Leasehold improvements: straight line depreciation with 10 year life
 - Dialysis Machines: straight line depreciation with 5 year life
 - Other equipment: straight line depreciation with 7 year life
- Salaries/Benefits: based on CHI Franciscan current wages, benefits at 29%
[source: Application Exhibit 10, Screening Response p14]

Using the assumptions listed above, CHI Franciscan projected the revenue, expenses, and net income for the proposed Franciscan Lakewood facility. The department asked CHI to confirm that their pro forma financial projections showed Phase One as a stand-alone project, not just as Phase One of Two. CHI confirmed “*these pro formas contain Phase 1 financials only*” as a stand-alone project. [source: Screening Response, p14 & Attachment 10]

Table 21
Franciscan Lakewood: Revenue, Expenses, and Net Income

	Phase 1 – 28 Stations		
	2018	2019	2020
Net Revenue	\$6,105,907	\$7,952,336	\$9,148,177
Total Expenses ¹⁴	\$6,375,097	\$7,521,786	\$8,478,765
Net Profit/(Loss)	(\$269,190)	\$430,550	\$669,412

Table 22
Franciscan Lakewood: Revenue, Expenses, and Net Income

	Phase 2 – 44 Stations		
	2021	2022	2023
Net Revenue	\$10,702,768	\$11,898,608	\$13,154,240
Total Expenses ¹⁵	\$9,724,005	\$10,623,388	\$11,505,549
Net Profit/(Loss)	\$978,763	\$1,275,220	\$1,648,691

The “Net Revenue” line includes gross in-center and training revenue, minus deductions for bad debt and charity care.

The “Total Expenses” line item includes all expenses related to the projected operation of the proposed Franciscan Lakewood facility, including allocated costs. The line item also includes medical director costs consistent with the Medical Director Agreement provided in the application. [source: Application, Exhibit 10 and July 29, 2016 Screening Responses, attachment 10]

Also included in the expense category is the lease cost for the proposed facility. CHI Franciscan provided a copy of the executed lease agreement and the first two amendments to the lease. The lease is between CHI Franciscan and Dennis Zentil, as Trustee of the Charles Tomas 1994 Trust dba Lakewood Cinema Plaza. The lease was executed on November 23, 2015 and amended on March 2, 2016. The first amendment related to the addition of contingency rent, to be paid by CHI until CN approval. The term identified within the lease does not begin until after CN approval. The second amendment was executed on May 23, 2016, and relates to the “expansion space” proposed in phase two. [source: Application, Exhibit 8]

Public Comment

DaVita provided public comments related to this sub-criterion, focusing on the reliability of the utilization proposed by CHI as well as whether their application has sufficiently documented site control.

DaVita Public Comment

“Franciscan's project is not financially feasible. If Franciscan's utilization in 2020 is 4.8, a reasonable forecast, its facility will lose hundreds of thousands of dollars that year, which would cause it to fail the Department's well-established standard that a facility must be profitable by its third full year of operation to be considered financially feasible. Therefore, Franciscan has artificially inflated its Year 3 utilization to a rate well above that projected by any of the other applicants, in order to project enough revenue to offset its expenses. The Department should reject

¹⁴ Including depreciation

¹⁵ Including depreciation

this manipulation and deny Franciscan's application based on its failure to demonstrate financial feasibility.

The Fresenius project, the PSKC project, and both of the DaVita new-facility projects each project utilization between 4.0 and 4.8 in Year 2020. Yet Franciscan projects utilization of 5.4, substantially higher than any of the other applicants.

“If Franciscan's 2020 utilization is reduced to 4.8, the project is not financially feasible.

*Franciscan apparently needed this utilization projection to show a Year 3 profit. Franciscan's pro forma (Screening Responses, Ex. 10) shows net revenue in 2020 of \$9,148,176. If that is reduced to reflect a reduction in utilization from 5.4 to 4.8, that would mean a reduction in revenue of \$1,016,464 [$9,148,176 - 9,148,176 * 4.8/5.4$]. But Franciscan's profit in 2020 is only \$669,411. Therefore, if Franciscan's revenue were reduced by \$1,016,464, based on achieving only 4.8 utilization, it would lose \$347,053 in Year 3 [$669,411 - 1,016,464$].*

*Franciscan presumably could mitigate this to some extent by reducing expenses. But even if it could reduce its "medical supplies," "laboratory & other expense," "EPO Expense," and "Pharmacy Expense" commensurately with the reduction in revenue - which it probably could not, because there likely are some fixed costs in these figures - that would reduce expenses by only \$249,001 [$2,241,008 - 2,241,008 * 4.8/5.4$]. Therefore, Franciscan would still lose \$98,052 in Year 3 [$347,053 - 249,001$].*

Franciscan cannot show financial feasibility for this proposed facility. This would be a new facility, with 28 stations to fill in three years. Franciscan may be able to achieve a utilization rate of 4.8, as DaVita and Fresenius each project for their respective facilities. But that would not be enough to show financial feasibility for Franciscan's project. Franciscan can only show financial feasibility by artificially inflating its utilization rate to 5.4 in just the third year of operation. Without this unreasonable utilization projection, Franciscan cannot show financial feasibility in Year 3.

Moreover, the Department should not have to recalculate Franciscan's financials based on assumptions that Franciscan did not use. Franciscan chose an unrealistic utilization projection that renders its pro forma unreliable. Therefore it failed to demonstrate financial feasibility.”
[source: DaVita Public Comment pp1-2]

“Franciscan does not have site control.

Franciscan proposes to locate its facility in an existing building at 2510 84th Street S., Lakewood, Washington (the "Premises"), pursuant to a lease from Dennis P. Zentil, as Trustee of the Charles Tomas 1994 Trust ("Landlord").

Franciscan provided a signed lease. The problem is that Franciscan failed to demonstrate that the Landlord is the legal owner of the real property where the Premises are located (the "Property"), such that the Landlord could enter into a legally enforceable lease for the Premises. The Applicant provided a printout of County tax assessor data showing "Lakewood Cinema Plaza," purportedly a DBA of the Charles Thomas 1994 Trust, as the taxpayer for the Premises, but that printout only establishes that an entity known as Lakewood Cinema Plaza pays the taxes for the Property; the taxpayer for a property is not necessarily its owner.

Moreover, publicly available information suggests that the Landlord identified in Franciscan's application may not be the current owner of the real property that includes the Premises (the "Property"). The most recent recorded documents available on the County recorder's website appear to show title to the Property as vested in entities other than the Charles Tomas 1994 Trust. Additionally, the Lease documents themselves also indicate that title and/or authority issues may exist that could affect the enforceability of the Lease. The Third Amendment to the Lease was executed by Dennis P. Zentil, as Successor Trustee of the Article 5 Trust for Daughters UA Dated 12/16/94, as Amended, although the publicly available real property records for the Property do not show any conveyances between the Charles Tomas 1994 Trust and the Article 5 Trust for Daughters UA Dated 12/16/94.

If the Landlord is not the current owner of the Property, then the Lease is unenforceable and Franciscan does not have site control. Publicly available documents suggest that the Landlord may not be the current owner. But it is not the Department's obligation to uncover who owns the Property; it was Franciscan's responsibility to demonstrate, in its application materials, that its purported Landlord is the owner. It failed to do so." [source: DaVita Public Comment p4]

Rebuttal

"DV questions our ability to achieve more than 4.8 occupancy in Year 3 of Phase 1 and wrongly suggests that the proposal is not feasible at 4.8 patients per stations in 2020. The CHI Franciscan is feasible at 4.8, but more importantly, we are confident that our utilization assumptions are both reasonable and attainable. In terms of the 4.8 utilization threshold, DV's 'math' is incorrect.

First, DV failed to correctly adjust revenue nor did they make the necessary adjustments for variable (per treatment) expenses. The simplest way to discard their argument is to look at Year 2 (2019) of the pro forma. In that year, as noted in Table 3 of the application, Franciscan Lakewood was projected to be operating at 130 patients or 4.64 patients per station (lower than the 4.8 utilization threshold referenced by DV). At that lower utilization, as Attachment 10 of the July 2016 screening response demonstrates, Franciscan Lakewood's total net revenue is projected to be \$7,952,336 and our net income is estimated at \$430,550. In other words, at 4.64 patients per station CHI Franciscan has a positive bottom line.

Attachment 10 reflects the lower operating costs and correctly accounts for revenue. Increasing utilization—even if it is only from 4.64 to 4.8 would result in an even greater positive net income. Table 1 details the specific numbers associated with this analysis. At the reduced utilization of 4.8, Franciscan Lakewood would be expected to have 135 patients or 19,980 incenter treatments (CHI Franciscan has assumed 148 treatments per patient). The reduction in net revenue in DV's calculation is incorrect. Table 1 below provides the correct calculations:

[continued on next page]

Franciscan Lakewood's Estimated Change in Net Income at 4.8 Patients per Station

	2020		Notes
Total Revenue (at projected utilization)	\$9,148,176		
Total Incenter Treatments (at projected utilization)	22,200		Attachment 10, Screening Response
Incenter Treatments at reduced utilization (4.8 patients/station)	19,980		Assume 148 treatments per patient
Difference (reduction in treatments)	2,220		
Average Revenue Per Treatment	\$404		Financial assumptions, Exhibit 10 (CN app)
Reduction in Net Revenue	\$896,680		
Reduction in Expenses*	SW&B	\$223,837	
	Med, Lab, Pharm	\$201,901	
	Other	\$24,334	
	<u>Indirect</u>	<u>\$227,171</u>	
	<u>Total</u>	<u>\$677,242</u>	
Change in Net Income	\$219,637		
New Net Income	\$449,774		

*variable expenses – medical supplies, laboratory and other expenses, EPO expenses, pharmacy expenses and overhead allocation, staffing expenses

DV's calculations are inaccurate and its arguments unfounded.

CHI Franciscan's utilization rate is reasonable and attainable.

As the Certificate of Need Program (CN Program) is well aware, there is no requirement that a proposed project be operating only at only 4.8 patients per station by the end of its third full year of operation; rather 4.8 is the minimum occupancy. Specifically, WAC 246-310-284(6) requires that:

(6) By the third full year of operation, new in-center kidney dialysis stations must reasonably project to be operating at:

(a) 4.8 in-center patients per station for those facilities required to operate at 4.8 in-center patients as identified in subsection (5) of this section...

In recent Pierce County CN applications, DV has projected its own utilization to be above the 4.8 patient per station standard. In fact, in DV's most recent CN applications, it was projecting utilization (by Year 3) as follows:

Certificate of Need Utilization (Year 3) for Recent DV Applications

Application	# of Stations	# of Patients (Year 3)	Patients/Station (Year 3)	Citation
DaVita Rainier View	10	60	6.00	March 2014 Evaluation p9
DaVita Elk Plains	11	57	5.18	March 2019 Evaluation p11
DaVita Federal Way	16	85	5.31	March 2016 Evaluation p20
DaVita Lynnwood	7	34	4.86	Sept 2016 Evaluation p21
DaVita Centralia	6	32	5.33	June 2015 Evaluation p19
DaVita Fife	9	44	4.89	May 2015 Evaluation p22

Just because DV is proposing, in the current Pierce 5 concurrent review process, to be only at 4.8 patients per station, it does not mean that the CHI Franciscan application must also project to be at the same utilization. As the above demonstrates, consistent with the requirement of WAC 246-310-284(6), the CN Program concluded that all these DV applications met the standard and accepted DV’s assumptions and projections. CHI Franciscan has also submitted applications that proposed varying utilization levels, for example, CHI Franciscan proposed that its Bonney Lake facility would be operating at 5.2 patients per station in Year 3. The CN Program concluded that the standard was met. Franciscan Lakewood is no different.

CHI Franciscan has site control

CHI Franciscan has documented site control through its executed lease agreement and DV has offered no evidence to the contrary. However, to eliminate any possible concerns that the CN Program might have, we have obtained a letter from the Trustee that clarifies the connection between the Charles Tomas 1994 Trust and the Article 5 Trust for Daughters UA Dated 12/16/94 and that the lease and amended lease documents have been correctly signed by the authorized individual, Dennis P. Zentil, Trustee. Included in Attachment 2 is a letter from Mr. Zentil as well as a quit claim deed (dated May 2016) that conveyed the title of the shopping center from the Charles Tomas 1994 Trust to the Article 5 Trust for Daughters UA Dated 12/16/94, as amended. CHI Franciscan reminds the CN Program that the lease was signed on November 30, 2015 (before the conveyance in May 2016) and the correct signee on the lease agreement and the first amendment of the lease (which was signed in March 2016) was Mr. Zentil as a representative of the Charles Tomas 1994 Trust. As Mr. Zentil points out in his November 9, 2016 letter, when the second amendment was signed, he correctly signed as a representative of the Article 5 Trust for Daughters UA Dated 12/16/94, as amended because of the change that resulted with the filing of the quit claim deed on May 11, 2016. The 2nd amendment was signed on May 20, 2016.” [source: CHI Franciscan rebuttal pp1-6]

Department Evaluation

The assumptions for CHI Franciscan’s proposed project – whether as a 28-station facility or as a 44-station, 2-phase facility – are the same. Therefore they will be reviewed as one project under this sub-criterion.

As shown above, DaVita contested the reasonableness of CHI Franciscan’s utilization projections within phase one¹⁶ (including the reasonableness of their assumption that they would exceed 4.8 patients per station in year 3), as well as whether they had appropriately demonstrated site control.

As stated by the applicant, revenues and expenses were based on actual figures within Pierce County – this assumption is reasonable. Furthermore, they demonstrated that these assumptions would result in revenues exceeding expenses by year two at the proposed Lakewood facility. CHI demonstrated that even at just 4.8 patients per station in year three, revenue would still exceed expenses. The data in the application showed that revenue exceeded expenses by year three.

In a related statement, DaVita questioned whether CHI’s assumptions surrounding patient volumes were reasonable. Central to CHI’s volume projection is the assumption that nearly 50% patients from their nearby Pierce 4 facility would transfer to the proposed Pierce 5 facility, with the following statement:

“At the time that this application was prepared, FHS estimated that about 50% of its Pierce 5 patients would prefer to transfer to the proposed Franciscan Lakewood facility. We continue to believe this estimate is reasonable based on our interactions and experiences with our dialysis patients. Given that dialysis is typically necessary three times per week, proximity to home is often a factor for patients choosing a dialysis facility.” [source Screening Response p4]

In their rebuttal, CHI Franciscan noted that it is not uncommon for dialysis providers to project that they will exceed the 4.8 patient per station in year three, citing six recent DaVita applications that also proposed to exceed that standard in their third year of operation. DaVita’s comments on this sub-criterion are without merit. CHI Franciscan’s utilization projections are reasonable.

Finally, DaVita questioned whether CHI Franciscan had site control, namely whether the landlord is in fact the owner of the property. CHI’s rebuttal statements included documentation that clarifies the connection between the Charles Tomas 1994 Trust and the Article 5 Trust for Daughters UA Dated 12/16/94. [source: CHI Franciscan rebuttal pp1-6]

CHI Franciscan points out that the lease and its first amendment were signed by Dennis Zentil, as Trustee of the Charles Tomas 1994 Trust dba Lakewood Cinema Plaza. Information on the Pierce County Assessor’s website supports that Lakewood Cinema Plaza is the owner of the property. Site control is demonstrated through the first amendment to the lease. As noted above, the lease was executed on November 23, 2015 and amended on March 2, 2016. The first amendment related to the addition of contingency rent, to be paid by CHI until CN approval. The term identified within the lease does not begin until after CN approval.

DaVita correctly notes that the second amendment to the lease is signed by Dennis Zentil as Successor Trustee of the Article 5 Trust for Daughters UA Dated 12-16-94. What DaVita fails to note is that the second lease specifically states that “Dennis Zentil as Successor Trustee of the Article 5 Trust for Daughters UA Dated 12-16-94” is “the successor to Dennis Zentil, as Trustee of the Charles Tomas 1994 Trust” – consistent with the original lease and first amendment.

¹⁶ Within their application, CHI Franciscan assumed that Phase 1 revenues and expenses would not change if Phase 2 is approved.

It is clear from the second amendment that the lessor changed names, hence the reference to the original trust. In summary, Dennis Zentil had legal authority to sign for the Charles Tomas 1994 Trust dba Lakewood Cinema Plaza. It is clear from text in the second amendment to the lease and supporting documentation in CHI Franciscan's rebuttal that the Charles Tomas 1994 Trust dba Lakewood Cinema Plaza has been succeeded by the Article 5 Trust for Daughters UA Dated 12-16-94. Dennis Zentil continues to have the authority to sign on behalf of this trust as well. DaVita's confusion appears to stem entirely from the name change of the property owner and lessor.

The second amendment was executed on May 23, 2016, and relates to the "expansion space" proposed in phase two. The costs within the lease are clearly identifiable and consistent with the values found in the pro forma financial projections. [source: Application, Exhibit 8, Screening Response Attachment 10]

While the assumptions and information provided by CHI Franciscan could be reasonable under their own ownership and control, the department received no assurance that this facility would remain under CHI Franciscan ownership and control for the entire projection period. Information found in the PUI led the department to conclude that CHI Franciscan's volume projections are not reliable. The department cannot reasonably conclude that the project's volumes, revenue, and expenses would not change as a result of the transaction. The department concludes CHI Franciscan's project **does not meet this sub-criterion.**

Puget Sound Kidney Centers

PSKC anticipates that the first phase – regardless of size – would become operational by summer 2018. Under this timeline, 2019 would be the facility's first full calendar year of operation, and 2021 would be year three. Phase two, if approved, would become operational by January 2022. Under this timeline, 2022 would be the facility's first full calendar year of operation as a 44-station facility, and 2024 would be year three.

PSKC provided the assumptions used to project in-center and home treatments and patients for calendar years 2018 through 2024. Below is a summary of these assumptions. [source: Screening Response Attachment 10]

- *Patients – In-Center. Census was based on anticipated growth for new facilities based on PSKC prior experiences. Future growth increases of 20 patients per year through 2021. This growth rate is about the same rate of growth in patient census that is found in the methodology contained in WAC 246-310-284.*
 - *Phase 2 increases range from 28-39 patients per year.*
- *Patients – Home Program. Increases in patient census by modality were projected based upon PSKC-South's historical experience (+2.2% annual increase in PD patients and +1.0% increase in HHD patients).*
- *Treatments – In-Center. Treatments were based on PSKC-South experience and assumed an average of 124 treatments per patient per year during the patient's initial year. For existing patient census in subsequent years, we assumed an average of 154 treatments per patient per year.*
- *Treatments – Home Program. Treatments were based on PSKC-South experience and assumed an average of 360 treatments per PD patient per year and 240 treatments per HHD patient per year.*

- *Phase 2 Construction.* Phase 2 construction is estimated to begin in early 2021 to build a second floor on the phase 1 building. Phase 2 services are estimated to start January 1, 2022.

Using the assumptions above, PSKC projected the number of treatments to be provided in the projection years. The projected treatments by year are shown below in Tables 23, 24, and 25 below which demonstrate the three different one phase scenarios proposed by PSKC, as well as the three different two-phase scenarios. [sources: Application Exhibit 9. Screening Response Attachment 5]

Table 23
PSKC Treatments – 44-Stations in 2 Phases

	Phase 1 – 16 Stations				Phase 2 – 44 Stations		
	2018	2019	2020	2021	2022	2023	2024
Stations	16	16	16	16	44	44	44
Total In-Center Patients	43	69	89	92	140	180	212
Total In-Center Treatments	5,031	9,872	13,126	14,081	20,168	26,560	31,720
Total Home Treatments	1,680	2,520	3,360	4,200	5,040	5,880	6,720
Total Treatments	6,711	12,392	16,486	18,281	25,208	32,440	38,440

Table 24
PSKC Treatments – 44-Stations in 2 Phases

	Phase 1 – 20 stations				Phase 2 – 44 stations		
	2018	2019	2020	2021	2022	2023	2024
Stations	20	20	20	20	44	44	44
Total In-Center Patients	43	69	89	113	152	180	212
Total In-Center Treatments	5,031	9,872	13,126	16,706	22,277	26,908	31,720
Total Home Treatments	1,680	2,520	3,360	4,200	5,040	5,880	6,720
Total Treatments	6,711	12,392	16,486	20,906	27,317	32,788	38,440

Table 25
PSKC Treatments – 44-Stations in 2 Phases

	Phase 1 – 22 stations				Phase 2 – 44 stations		
	2018	2019	2020	2021	2022	2023	2024
Stations	22	22	22	22	44	44	44
Total In-Center Patients	43	69	89	113	152	180	212
Total In-Center Treatments	5,031	9,872	13,126	16,706	22,277	26,908	31,720
Total Home Treatments	1,680	2,520	3,360	4,200	5,040	5,880	6,720
Total Treatments	6,711	12,392	16,486	20,906	27,317	32,788	38,440

PSKC used the following assumptions to project revenue, expenses, and net income for the proposed facility for years 2018-2024. [source: Screening Response Attachment 10]

- *Revenues and current payer mix were based on the current experience of PSKC for all modalities. The percentages provided are based on PSKC actual experience. The Medicare information presented includes Medicare program administered by the government and those subcontracted out to other insurance companies (Medicare Advantage plans).*
- *The revenues presented in the exhibits were net of contractual adjustments.*

- *Charity care is assumed to be 1.6% of net revenue.*
- *Bad debts are assumed to be 1.2% of net revenue*
- *Staffing expenses were based on our staffing model increased for growth as patient population increases.*
- *Medical Director fees are based on medical director agreements applicable to PSKC Lakewood*
- *Expenses related to patient treatments (medical supplies, pharmacy (including Epogen and Aranesp), were based on cost per treatment experience for PSKC.*
- *Office and miscellaneous expenses include office supplies, small equipment, information technology expenses (including licenses, software maintenance, and IT-related supplies), equipment rent, and other miscellaneous expenses.*
- *Occupancy costs include building repairs/maintenance, and utilities.*
- *Other expenses were based on current actual experience at PSKC facilities.*
- *As stated on page 11 of the application, PSKC intends to use existing cash reserves for the financing of the proposed facility. Use of existing cash does not require interest expense be incurred for this project.*
- *Depreciation expenses were estimated based on the actual useful lives PSKC assigned to certain equipment classifications. Classifications are as follows*
 - *Building: 40 years*
 - *Building Improvements: 15 years*
 - *Medical Equipment: 7 years*
 - *Furniture and Office Equipment: 7 years*
- *PSKC does not anticipate that we will incur any material amortizable intangible assets for this project. Therefore, no amortization schedules have been presented.*
- *Indirect expenses are estimated based on actual experience by estimating how our allocations would be modified with an additional facility.*
- *Corporate medical director fees are allocated to PSKC-Lakewood and included in the overhead allocation.*

Using the assumptions above, PSKC projected the revenue, expenses, and net income for the proposed PSKC Lakewood facility. These projections are shown below in Table 26 through 31 which demonstrate the three different one phase scenarios proposed by PSKC, as well as the three different two-phase scenarios. [source: Application Exhibit 9, Screening Response Attachment 5]

Table 26
PSKC Revenue, Expenses, and Net Income – 16-Station Project

	2018	2019	2020	2021
Net Revenue	\$1,732,675	\$3,243,222	\$4,314,138	\$4,748,186
Total Expenses	\$1,692,295	\$3,251,189	\$3,939,150	\$4,426,381
Net Profit/(Loss)	\$40,380	(\$7,967)	\$374,988	\$321,805

Table 27
PSKC Revenue, Expenses, and Net Income – 44 Station Project

	Phase 1 – 16 Stations			
	2018	2019	2020	2021
Net Revenue	\$1,732,675	\$3,243,222	\$4,314,138	\$4,748,186
Total Expenses	\$1,695,295	\$3,257,189	\$3,945,150	\$4,432,381
Net Profit/(Loss)	\$37,380	(\$13,967)	\$368,988	\$315,805
	Phase 2 – 44 Stations			
	2022	2023	2024	
Net Revenue	\$6,603,900	\$8,544,105	\$10,143,023	
Total Expenses	\$6,062,161	\$7,373,192	\$8,531,915	
Net Profit/(Loss)	\$541,739	\$1,170,913	\$1,611,108	

Table 28
PSKC Revenue, Expenses, and Net Income – 20 Station Project

	2018	2019	2020	2021
Net Revenue	\$1,732,675	\$3,243,222	\$4,314,138	\$5,475,364
Total Expenses	\$1,697,965	\$3,240,208	\$3,949,784	\$4,986,767
Net Profit/(Loss)	\$34,710	\$3,014	\$364,354	\$488,597

Table 29
PSKC Revenue, Expenses, and Net Income – 44 Station Project

	Phase 1 – 20 Stations			
	2018	2019	2020	2021
Net Revenue	\$1,732,675	\$3,243,222	\$4,314,138	\$5,475,364
Total Expenses	\$1,700,965	\$3,246,208	\$3,955,784	\$4,992,767
Net Profit/(Loss)	\$31,710	(\$2,986)	\$358,354	\$482,597
	Phase 2 – 44 Stations			
	2022	2023	2024	
Net Revenue	\$7,188,136	\$8,640,508	\$10,143,023	
Total Expenses	\$6,274,040	\$7,344,378	\$8,535,331	
Net Profit/(Loss)	\$914,096	\$1,296,130	\$1,607,692	

Table 30
PSKC Revenue, Expenses, and Net Income – 22 Station Project

	2018	2019	2020	2021
Net Revenue	\$1,732,675	\$3,243,222	\$4,314,138	\$5,475,364
Total Expenses	\$1,689,136	\$3,233,686	\$3,897,651	\$4,853,828
Net Profit/(Loss)	\$43,539	\$9,536	\$416,487	\$621,536

**Table 31
PSKC Revenue, Expenses, and Net Income – 44 Station Project**

	Phase 1 – 22 Stations			
	2018	2019	2020	2021
Net Revenue	\$1,732,675	\$3,243,222	\$4,314,138	\$5,475,364
Total Expenses	\$1,692,136	\$3,239,686	\$3,903,651	\$4,859,828
Net Profit/(Loss)	\$40,539	\$3,536	\$410,487	\$615,536
	Phase 2 – 44 Stations			
	2022	2023	2024	
Net Revenue	\$7,188,136	\$8,640,508	\$10,143,023	
Total Expenses	\$6,220,896	\$7,229,886	\$8,227,087	
Net Profit/(Loss)	\$967,240	\$1,410,622	\$1,915,936	

The “Net Revenue” line is gross in-center and training revenue, minus deductions for bad debt and charity care.

The “Total Expenses” line item includes all expenses related to the projected operation of the proposed PSKC – Lakewood facility, including allocated costs and depreciation. The line item also includes medical director costs consistent with the Medical Director Agreement provided in the application. [sources: Application, Exhibit 9 & Screening Response, Attachment 5]

PSKC provided an executed purchase and sale agreement for the site. In addition, PSKC provided a letter of financial commitment to fund the project from corporate reserves. Copies of PSKC’s year-end financial statements were provided to support this letter. [source: Application, Exhibit 7, Screening Response Attachments 2 and 11]

Public Comment

CHI Franciscan and DaVita both provided public comments relating to this sub-criterion.

CHI Franciscan Public Comment

“PSKC does not operate in Pierce 5 nor does it operate in any other planning area in Pierce County. In fact, its closest facility is located in Snohomish County. This means that it may experience more difficulty in recruiting patients, providers and staff. In addition, its proposal has the highest capital cost of any of the applications under review.

CHI Franciscan does acknowledge that PSKC has a proven history of operating quality facilities and quality programs. Its potential flaws do not rise to the level of either DV or FMC, and we do believe that they would ultimately be successful.” [source: CHI Public Comment p9]

DaVita Public Comment

“PSKC’s pro forma is unreliable. [It] assumes a missed-treatment rate of 1.3%. See Application, Attachment 10 (“For existing patient census in subsequent years, we assumed an average of 154 treatments per year.”). This is unrealistic. DaVita applies a missed treatment rate of 5% to its projections, appropriately recognizing that dialysis patients experience unpredictable events with other healthcare of transportation issues. PSKC’s unrealistic missed-treatment rate artificially inflates its projected revenue and renders its pro forma unreliable.” [source: DaVita Public Comment p5]

Rebuttal

PSKC did not provide rebuttal to CHI Franciscan's public comments.

PSKC provided the following statements in response to DaVita's public comments:

"DV calls PSKC Lakewood's pro forma financials unreliable because its missed treatment assumption varies from DV's own assumption. As DV pointed out in its public comments, we assumed a missed treatment rate of 1.3% for existing patients (or 154 treatments per patient per year). This is, in fact, our historical experience. What DV failed to include in its comments is the fact that PSKC's new patients were expected to begin with approximately only 124 treatments per year as they are expected to dialyze for less than a year.

Therefore, by the 3rd year of Phase 2, the average number of treatments per patient per year is about the same as DV's 5% missed treatment rate (or an average of 148 treatments per patient). Again, DV's criticisms are not factually based. PSKC's estimates are reliable and accurate, and are based on 35 years of operating dialysis centers in Washington State. We know what we are doing." [source: PSKC rebuttal p4]

Department Evaluation

The department concludes that the assumptions PSKC used to determine the number of patients and treatments at their proposed Lakewood facility are reasonable – at each of the proposed station configurations (16, 20, and 22 station single-phase; 44-station two-phase with varying phase one size). The assumptions used by PSKC to project revenue, expenses, and net income for the proposed facility were based on PSKC actuals, and are also reasonable. For each scenario highlighted above, the department confirmed that each Phase 1 scenario had the same revenues assumed for its two-phase counterpart, but expenses changed. This is reasonable, as overhead costs changed as well. Revenues exceeded expenses by year three.

PSKC would be a new provider to the planning area. With their application, PSKC provided the executed purchase and sale agreement, which demonstrates control over the proposed site. PSKC proposed to build a brand new facility on this land under PSKC sole ownership. Therefore, no lease agreement was provided or would be required.

DaVita questioned whether PSKC's 1.3% missed treatment rate was accurate. PSKC responded, citing that this figure was also based on PSKC actual performance, and that by year three their missed treatment rate is closer to those proposed by DaVita. The department agrees that the assumptions based on actual performance at PSKC facilities are reasonable.

The department concludes PSKC's project **meets this sub-criterion.**

Fresenius Medical Care

FMC anticipates that FKC – Fredrickson would be operational by October 2017. Under this timeline, 2018 would be the facility's first full calendar year of operation, and 2020 would be year three.

FMC provided the assumptions used to project in-center and home treatments and patients for calendar years 2017 through 2020. Below is a summary of these assumptions. [source: Screening Response Exhibit 14]

- The number of in-center patients is expected to start at 45 in 2017, increase by 25 patients per year over 2018 and 2019, then by 21 patients, up to 116 patients in 2020, the third full year of operation. These projections are based on Fresenius' prior experience operating similar facilities in comparable planning areas.
- The number of home patients is expected to be much smaller, reaching 14 patients in year 3 (2020).

Using the assumptions above, FMC projected the number of treatments to be provided in the projection years.

Table 32
FKC Fredrickson Treatments

	2017 ¹⁷	2018	2019	2020	2021
Stations	24	24	24	24	24
Total In-Center Patients	45	70	95	116	126
Total In-Center Treatments	1,764	10,080	13,680	16,704	18,144
Total Home Treatments	144	1,008	1,584	2,016	2,448
Total Treatments	1,908	11,088	15,264	18,720	20,592

[source: Application p14]

The assumptions FMC used to project revenue, expenses, and net income for the proposed facility for years 2017-2020¹⁸ are restated below.[source: Screening Response Exhibit 14]

- *In-center gross and net revenues are taken from comparable Fresenius facilities, Chehalis, Shelton, Gray Harbor and Pacific Northwest Home, a FMC provider in Olympia WA, in terms of expected payer mix at FKC Fredrickson. Revenues are calculated by payer, by treatment for both gross and net revenues.*
- Charity Care: 2.0% of Net Revenue/Treatment
- Bad Debt: “Calculated on a per treatment basis for in-center and home treatments from comparable Fresenius' operations in WA, as stated above.”
- Expenses have been calculated on a per treatment basis for variable expenses from FMC facilities, as identified above, and FMC's Olympia home care service.
- Depreciation is straight-line; assumes 10 years on leaseholds and 8 years on equipment.

Using the assumptions listed above, FMC projected the revenue, expenses, and net income for the proposed FKC – Fredrickson facility. [source: Screening Response Exhibit 14]

Table 33
FKC – Fredrickson: Revenue, Expenses, and Net Income

	2018	2019	2020	2021
Net Revenue	\$1,099,521.17	\$6,898,707.12	\$9,479,934.70	\$11,619,990.01
Total Expenses ¹⁹	\$703,798.34	\$3,451,819.68	\$4,541,801.01	\$5,440,828.69
Net Profit/(Loss)	\$395,722.83	\$3,446,887.44	\$4,938,133.69	\$6,179,161.32

¹⁷ Partial year only (October to December)

¹⁸ Though FMC provided volume projections through the fourth full year of operation, only the first full 3 years of financial information was provided.

¹⁹ Including depreciation

The “Net Revenue” line is gross in-center and training revenue, minus deductions for bad debt and charity care.

The “Total Expenses” line item includes expenses related to the projected operation of the proposed FKC – Fredrickson facility, including allocated costs. Taxes were not included. The line item also includes medical director costs consistent with the Medical Director Agreement provided in the application. [source: Screening Response, Exhibit 14]

Also included in the expense category is the lease cost for the proposed facility. FMC provided a copy of the executed lease agreement the first amendment to the lease. The lease also includes the development budget for the construction of the proposed facility. The lease is between Renal Care Group Northwest [FMC] and Tacoma Renal Construction, LLC. The lease was executed on May 27, 2016 and amended on July 22, 2016. The first amendment related to the term of the lease and the rent schedule. [source: Application, Exhibit 11, Screening Response Exhibit 11]

Public Comment

CHI Franciscan and DaVita both provided public comment relating to this sub-criterion.

CHI Franciscan Public Comment

“FMC proposes to lease the selected site from a developer, Tacoma Renal Construction, LLC (TRC), a Texas limited liability company. TRC has entered into a purchase and sales agreement with the owner of the site. There are several issues that affect the project’s ability to conform with the applicable Financial Feasibility criteria contained in WAC, including:

Developer’s Capital Costs:

P2 of FMC’s July 2016 screening response indicates that the developer’s costs are estimated to be \$2,868,506; of which \$526,018 are for the costs of the land. As indicated in Amended Exhibit F to the lease, the developer’s costs of \$2,868,506 were used to determine the lease payments (\$27.79/SF). However, the executed purchase and sales agreement (included in Exhibit 11 of the July 2016 screening response) indicates that the purchase price of the land is \$1,500,000; not \$526,018. Therefore, the lease agreement does not meet the CN Program’s ‘exact match’ requirement.

Further, Section 5.6 of the lease agreement (“Expansion Rights”) indicates that FMC has rights to the entire property and therefore, the developer does not have the ability develop the property for other uses. This is another reason that that full purchase price should be included in the capital cost and lease expenses associated with this project.

In addition, according to the agreement, the property must be purchased prior to December 29, 2016 or the developer will no longer have control of the property. Although there is a CN approval period, the specific ‘out clause’ in the purchase and sales agreement is:

‘Purchaser shall have a period commencing on the date after the expiration of the Feasibility Period and continuing until the date that Purchaser’s proposed tenant receives CON approval from the Department in final and non-appealable form or until December 29, 2016, which is sooner (“CON Approval Period”) At which time this agreement shall terminate unless Purchaser is awarded the CON.’

Section 26.22 of the lease agreement provides a CN contingency that apparently conflicts with the above cited CN contingency. These contingencies directly impact Section 26.23 of the lease agreement which references the Contingency for Purchase of Property. This contingency requires that the developer purchase the property 360 days following full execution of the lease (the lease agreement was executed on 5/27/2016). However, the tenant, FMC, is allowed under the lease agreement to have 36 months to obtain a CN.

In CHI's experience, no developer would agree to take 100% of the risk for purchasing property without some assurances or without having the ability to develop a portion of the property for other uses (which is prohibited under Section 5.6—see above).

And, finally our Real Estate Department notes that the Purchase and Sales Agreement was signed before the lease agreement. The fact that the Developer agreed to purchase the property without any assurance of a CN, or hold the property for up to 36 months while a CON is obtained, or allow no other development of this property other than FMC expansion throughout the term of the lease suggests that it is something other than an arms-length transaction.

For all the above reasons, the CN Program will be unable to determine conformance with the financial feasibility criteria and the FMC application must be denied.” [source: CHI Franciscan Public Comment pp 7-8]

DaVita Public Comment

“Fresenius has failed to demonstrate site control.

An applicant for a CN is required to “[p]rovide documentation that the applicant has sufficient interest in the site or facility proposed.” “Sufficient interest” exists where the applicant has clear legal title to the proposed site, a lease for at least a five-year term (including any options to renew), or a legally enforceable agreement to provide such title or such lease in the event that a CN is issued for the project proposed by the application. The CN application submitted by Fresenius does not meet the “sufficient interest” requirement.

Fresenius proposes to locate its facility at 17521 50th Ave. Ct. E., Tacoma, Washington (the “Site”), pursuant to a lease from Tacoma Renal Construction, LLC (“TRC”). Application §I(B). Because the Site, which is part of a larger parcel of real property (the “Property”), is currently owned by Avila Berg Development Group, LLC (“Seller”), TRC, Fresenius's proposed Landlord, must purchase the Site from Seller. See Appendix 1 (Parcel Summary for 0319254081) and Purchase and Sale Agreement (as defined below), p. 1. Additionally, Fresenius must lease the Site from the owner of the Property. If either transaction does not occur, then Fresenius will not have a legally enforceable interest in the property and cannot proceed with its project. While Fresenius provided a purchase and sale agreement between Seller and TRC as buyer (the “Purchase and Sale Agreement” or “PSA”), for “[a]pproximately 1.4 acres of an approximately 5.5 acre tract assigned Parcel Number 0319254081,” and a Lease Agreement between TRC, as landlord, and Fresenius, as tenant, dated May 27, 2016 (as amended by an undated amendment, the “Lease”), neither document establishes that Fresenius has a “sufficient interest” in the Site.

1. The Purchase and Sale Agreement provided by Fresenius is unenforceable because it does not contain a legal description for the Site and does not include an adequate legal description of the Property.

The Purchase and Sale Agreement includes the legal description for the entire Property but does not contain a legal description for the 1.4-acre Site, even though the Purchase and Sale Agreement

contemplates the sale to TRC of only the Site. Exhibit A to the Purchase and Sale Agreement provides: "The final legal description [is] to be determined by the final Survey and agreed upon by the Parties." (Emphasis added.)

*In Washington, a purchase and sale agreement that does not contain a legal description is not enforceable by the buyer against the seller; a legal description is an essential element of a purchase and sale agreement. See, e.g., Martin v. Siegel, 35 Wash.2d 223, 229 (1949); Valley Garage, Inc. v. Nyseth, 4 Wash. App. 316, 318 (1971) ("[A] description of the property subject to sale and a method for the determination of a price which may be specifically enforced" are the "essential elements of a cash sale"). In a case presenting substantially similar factual circumstances as the Purchase and Sale Agreement, the Washington Court of Appeals held that a purchase and sale agreement that allowed the legal description to be modified after the execution of the agreement and before the closing of the transaction by the mutual agreement of the buyer and the seller (who, like TRC and the Seller, planned to modify the boundaries of the legally described property, such that the purchaser would purchase only a portion of the originally-described property) was not enforceable because the legal description was not sufficiently definite and certain. See Gagnon v. Morton, 81 Wash. App. 1017, 1996WL183217, *2 (April 16, 1996); see also Kruse v. Hemp, 121 Wn.2d 715 (1993) (holding that purchase option in lease was not enforceable as an agreement to purchase real property because it did not contain a legal description). Additionally, a purchase and sale agreement that does not include a legal description of the property to be conveyed violates the statute of frauds, rendering it void and unenforceable. See Key Design Inc. v. Moser, 138 Wn.2d 875, 881 (1999); RCW 64.04.010.*

Additionally, the Purchase and Sale Agreement's failure to include a specific legal description is problematic because Seller does not have an obligation to convey the Site (as it is described in the Application) to TRC, but rather some portion of the Property measuring "approximately 1.4 acres." PSA, Exhibit A. This may or may not be the same as the Site identified by Fresenius in its application, may or may not be the same property contemplated to be leased to Fresenius through the Lease, and may or may not be consistent with Fresenius's site plan.

2. The Purchase and Sale Agreement provided by Fresenius also is unenforceable because it is illegal.

The Purchase and Sale Agreement also violates Washington's subdivision requirements and is unenforceable for that reason. Under Washington law, it is illegal to convey, agree to convey, or offer to convey property that does not constitute a legal lot. The Site is not itself a legal lot; it is part of a larger parcel of real property (the "Property") identified by the Pierce County Assessor as Parcel Number 0319254081, but TRC is only purchasing the Site and not the remainder of the Property. PSA, Ex. A (describing the property to be purchased as a portion of Parcel 0319254081). Accordingly, the Site must be subdivided from the rest of the Property before it can be legally conveyed to TRC. Ch. 58.17 RCW; Pierce County Code ("PCC") 18F.10.020 (requiring County approval for any division of land). The subdivision of the Property is not, however, a condition precedent to the closing of the sale of the Site, and the sale could, under the terms of the Purchase and Sale Agreement, occur even if the Property is not subdivided. Such a sale or offer to sell is illegal under state and local law; indeed, it constitutes a gross misdemeanor, punishable by imprisonment in the county jail for a maximum term of 364 days and/or a fine up to \$5,000. RCW 58.17.300; RCW 9A.20.021; Chs. 18F.10, 18.140 PCC. The Purchase and Sale Agreement therefore is void as an agreement to violate a statute or municipal ordinance. See Evans v. Luster, 84 Wash. App. 447, 451 (1996).

3. Fresenius has failed to demonstrate site control because the Lease fails to satisfy the statute of frauds and because the Lease does not describe the correct property as the leased premises.

The Lease violates the statute of frauds because it lacks a sufficiently definite legal description. See Key Design Inc. v. Moser, 138 Wn.2d 875, 881 (1999); RCW 64.04.010. Like the Purchase and Sale Agreement, the Lease describes the Premises as a to-be determined portion of a larger property: "Approximately 1.4 acres on the corner of Brookdale Road East and Canyon Road to be agreed-up by Seller and Purchaser and subdivided out of a portion of the approximately 7.99 acre tract of land owned by Seller and assigned Parcel Number 4015415881, Pierce County, Washington. The final legal description [is] to be determined by the final survey of the property prior to closing." Lease, Exhibit A.

Moreover, the property that TRC agrees to lease to Fresenius under the Lease is not the same property that TRC is under contract to purchase in connection with the application. The legal description in the Purchase and Sale Agreement provides: "Approximately 1.4 acres of an approximately 5.5 acre tract assigned Parcel Number 0319254081 ... The final legal description to be determined by the Final Survey and agreed on by the Parties." PSA, Ex. A. The legal description in the Lease provides: "Approximately 1.4 acres on the corner of Brookdale Road East and Canyon Road to be agreed-up by Seller and Purchaser and subdivided out of a portion of the approximately 7.99 acre tract of land owned by Seller and assigned Parcel Number 4015415881, Pierce County, Washington. The final legal description [is] to be determined by the final survey of the property prior to closing." Lease, Ex. A Compare Appendix 1 (Parcel Summary for 0319254081) with Appendix 2 (Parcel Summary for 4015415881). Accordingly, the Lease does not provide Fresenius a lease for the Site, it provides a lease for other property.

4. Fresenius has failed to demonstrate site control for several additional reasons.

The Purchase and Sale Agreement provided by Fresenius is unenforceable-indeed, it is illegal-for the reasons discussed above. But Fresenius also has failed to meet the "sufficient interest" requirement for several additional reasons:

- *TRC's purchase of the Property is contingent upon Fresenius obtaining a CN on or before December 29, 2016, and on TRC receiving "all applicable and necessary governmental approvals, licenses, permits, changes in zoning or land use, variances, plats or maps, replats or map amendments, special or conditional use designations, and/or subdivision(s)" in final and non-appealable form on or before June 15, 2017. Id., § 5. If TRC is unable to obtain such approvals before June 15, 2017, or if any of such approvals are received with conditions, limitations or restrictions that are unacceptable to TRC, TRC can terminate the Purchase and Sale Agreement. Notably, this contingency would allow TRC to terminate the Purchase and Sale Agreement after Fresenius obtained a CN. There would be no consequences to TRC under the Lease or the Purchase and Sale Agreement in doing so-under the Lease, TRC's obligations to Fresenius to purchase and develop the Site are contingent upon TRC's purchase of the Site. Lease, § 26.23.*
- *TRC will finance its purchase of the Site and development of the facility through investment by third party "Referral Sources" -individuals or entities that provide patient referrals to Fresenius or its affiliates or subsidiaries, purchase items or services from Fresenius or its affiliates or subsidiaries that are reimbursable by a federal or state health care program, or sell to Fresenius or its affiliates or subsidiaries items or services for which Fresenius or any of its affiliates or subsidiaries makes claims for reimbursement under a federal or state health care program. Lease, § 26.20.*

- *The application requires an applicant to "[d]escribe any of the following which would currently restrict usage of the proposed site and/or alternative site for the proposed project: (a) mortgages; (b) liens; (c) assessments; (d) mineral or mining rights; (e) restrictive clauses in the instrument of conveyance; (f) easements and right of ways; (g) building restrictions; (h) water and sewage access; (i) probability of flooding; U) special use restrictions; (k) existence of access roads; (l) access to power and/or electricity sources; (m) shoreline management/environmental impact; (n) others". Fresenius states that there are no such restrictions on the Site, but did not provide as part of its Application Exhibit D to the Lease, which are conditions, covenants and/or restrictions affecting TRC's title to the Property and disclosed by TRC to Fresenius that conflict with the Lease or prohibit Fresenius's proposed use.*
- *The application form requires an applicant to "[p]rovide documentation that the proposed site may be used for the proposed project Include a letter from any appropriate municipal authority indicating that the site for the proposed project is properly zoned for the anticipated use and scope of the project or a written explanation of why the proposed project is exempt." Fresenius did not provide a letter from Pierce County confirming that the proposed project is properly zoned for the anticipated use and scope of the Project.*

5. Fresenius's application must be denied based on lack of site control.

When Fresenius similarly failed to demonstrate site control for its recent Pierce 4 application, the Department denied the application on this ground. The Department correctly rejected Fresenius's argument that the "intent to lease" documentation it provided demonstrated site control, because "it cannot be considered binding on the landlord." See Pierce 4 Evaluation, May 22, 2015, page 28. The same is true of the documentation provided by Fresenius here: an unenforceable purchase and sale agreement that does not bind the property owner to sell the Site.

Because Fresenius does not have site control, the Department would have no assurance that Fresenius could even move forward with its project, or at what cost. The Department must deny Fresenius's application for this reason. See In Re Certificate of Need Applications of Springstone and Signature Healthcare Services, LLC, Case Nos. M2015-1260 & M2015-1417, Initial Order, April 21, 2016, at 18 (denying application under WAC 246-310-220(2) based on lack of site control; "Without a valid lease, there is no way to reasonably judge whether there is any impact, either reasonable or unreasonable" on cost and charges for services) (emphasis added). Fresenius's multiple site-control problems may result from the fact that Fresenius appears to have chosen its site simply to obtain a technical win on the "patient geographical access" tiebreaker point, even though Fresenius's proposed location hardly would "result in services being offered closer to people in need of them"-which is the purpose of that tiebreaker point Perhaps Fresenius believed it needed to do so to compensate for the fact that it proposed only a 24-station project, which would not qualify for the "meeting the projected need" tie-breaker point." [source: DaVita Public Comment pp1-5]

DaVita provided further public comment under this sub-criterion, relating to the pro forma financial statements:

"Fresenius has failed to provide the Department with a reliable pro forma, which means that it has failed to demonstrate the financial feasibility of its proposed facility. The following table compares the revenue per treatment projected by Fresenius with the revenue per treatment projected by the planning area's existing provider, DaVita, as well as the revenue per treatment projected by

Franciscan, which does not have a Pierce 5 facility, but has experience operating facilities in Pierce County generally.

Comparison of Net Revenue Per Treatment Projections of Fresenius, DaVita, and Franciscan

	Fresenius	DaVita Lakewood Community	DaVita Canyon Road	DaVita Lakewood	Franciscan
<i>Net Revenue in 2020</i>	\$11,619,989	\$11,302,848	\$8,195,574	\$9,686,184	\$9,148,176
<i>Total Treatments in 2020</i>	18,720	26,377	19,126	25,013	22,644
<i>Net Revenue per Treatment</i>	\$621	\$429	\$429	\$387	\$404
<i>Source</i>	Screening Response, Ex 14	Application, Appendix 9	Application, Appendix 9	Application, Appendix 9	Application, Ex 10

As shown in the table above, DaVita and Franciscan projected net revenue per treatment between \$387 and \$429. Fresenius projected net revenue per treatment of \$621. We are not suggesting that net revenue per treatment of \$621 at a dialysis facility is unreasonable. Nor are we suggesting that Fresenius's application should be denied because it expects \$621 per treatment-if this were an accurate projection. However, this is not a realistic projection for the Pierce 5 planning area.

DaVita and Franciscan each have extensive experience operating dialysis facilities in Pierce County, and DaVita has extensive experience operating dialysis facilities in Pierce 5 specifically. DaVita and Franciscan each projected net revenue per treatment in the \$387-\$429 range, in their independent applications. If Pierce County's existing dialysis providers report that, based on their experience, \$387-\$429 is a realistic net revenue per treatment projection in Pierce 5, the Department should question how Fresenius can possibly project that it will receive \$621 per treatment, approximately 45% above the top of the range.

The fact is that Fresenius cannot achieve this projected net revenue per treatment in Pierce 5, and therefore Fresenius has not provided a reliable pro forma to the Department. Because Fresenius has failed to provide a reliable pro forma, it has failed to demonstrate the financial feasibility of its proposed facility.” [source: DaVita Public Comment pp5-6]

Rebuttal

Fresenius did not provide rebuttal to CHI Franciscan’s public comments.

Fresenius provided the following statements related to DaVita’s public comments relating to revenue projections. FMC provided no rebuttal statements in response to DaVita’s arguments surrounding site control.

“DVA criticizes Fresenius for its revenue projections in its CON Application, stating that Fresenius’ “projected net revenue per treatment of \$621... is not a realistic projection for the Pierce 5 planning area.” DVA goes on to claim that Fresenius “cannot achieve this projected net revenue per treatment in Pierce 5, and therefore FMC has not provided a reliable pro forma to the Department”. DVA also urges the Department to “question how Fresenius can possible project that it will receive \$621 per treatment, approximately 45% above [DVA’s projections].”

While Fresenius does have the highest net revenue, and net profit, of all applicants in this concurrent review cycle, this is simply because Fresenius benefits from greater bargaining abilities as a national provider of health care services. Fresenius has the ability to negotiate better rates

with payers of commercial insurance, which ultimately ensures better coverage for indigent patients or patients with other special needs. Further, it also means that the Fresenius' facility will be able to cover operating expenses if patient volumes are lower than expected or if there is an unforeseen facility cost.

Although it is impossible to know for certain what the future payer breakdown will be at Fresenius' proposed FKC Fredrickson, Fresenius negotiates its rates with providers at a company-wide level, not on a per-facility basis. In other words, costs and charges for health services at Fresenius dialysis facilities are the same for commercial insurance payers regardless of size or cost of the facility. This also allows Fresenius to accurately project revenue at its new dialysis facilities – since Fresenius receives the same reimbursement rates from commercial insurance companies across all its facilities, we are able more accurately predict net revenue per treatment for our new facilities.

We are not claiming or implying that our projected revenue per treatment figures will be the exact and actual operational revenue per treatment at the proposed FKC Fredrickson. Our pro forma projections are predictions of future scenarios, which, by definition, are estimates. All other applicants' pro forma projections are also estimates, including DVA, since it is impossible to know future scenarios. As DVA has experience providing dialysis services in the planning area, its projections are likely based on actual operational revenue and payer mix. However, our projections do not render our pro forma "unreliable" – we are confident that our projections are conservative and within reasonable error margins...

...Fresenius is proposing a facility that will improve access to high-quality dialysis care for patients at pre-negotiated rates for payers. We have used our best available data to determine sensible and conservative estimates for our payer mixes. Even if our assumptions are inaccurate, as DVA is claiming, our FKC Fredrickson facility is guaranteed to be successful considering that there is reasonable room for fluctuation in our estimates for all of our assumptions, including patient volumes and payer sources. Our project will meet both short- and long-term operational goals and will have pre-determined reimbursement rates which helps to guarantee that all patients, regardless of insurance status, will have access to our proposed FKC Fredrickson facility."
[source: FMC rebuttal pp9-10]

Department Evaluation

The department concludes that the assumptions FMC used to determine the number of patients and treatments at their proposed FKC-Fredrickson facility are reasonable.

Both CHI Franciscan and DaVita commented on FMC's net revenue per treatment. They asserted that the \$621 per treatment proposed by FMC exceeds the next highest projection for Pierce 5 by nearly \$200 and is therefore not reasonable. FMC responded, that they "*benefit from greater bargaining abilities as a national provider of health care services.*" [source: FMC rebuttal pp9-10]

While CHI and DaVita both correctly point out that FMC's projected net revenue per treatment is much higher than their competitors, the value is based on FMC actuals. The department cannot substantiate whether FMC's higher net revenue per treatment is the result of greater bargaining

abilities or due to higher charges, as their application included only net revenue – not gross.²⁰ Therefore the basis for the assumptions used by FMC to project revenues are acceptable.

Both DaVita and CHI Franciscan identified section 5C within the purchase and sale agreement, which states:

*“CON Approval Period. Seller and Purchaser understand and agree that the establishment of any chronic outpatient dialysis facility in the State of Washington is subject to Tenant obtaining a Certificate of Need ("CON") from the Washington State Department of Health ("Department"), and, thus, Purchaser's proposed tenant may not establish a dialysis facility on the premises or execute a binding real estate lease in connection therewith unless Tenant obtains a CON from the Department. If Purchaser has not terminated this Agreement on or prior to the expiration of the Feasibility Period, then Purchaser shall have a period commencing on the date after the expiration of the Feasibility Period and continuing until the date that Purchaser's proposed tenant receives CON approval from the Department in final and non-appealable form **or until December 29, 2016, whichever is sooner ("CON Approval Period") At which time this agreement shall terminate unless Purchaser is awarded The CON.** During the CON Approval Period, Seller covenants and agrees to use its best efforts to cooperate with all efforts to receive CON approval, including the execution by Seller of all required or necessary applications, affidavits, statements or other documents, and to provide such information and documentation as necessary or appropriate in connection with the process of receiving the CON Approval.”* [source: Screening Response pp90-91]

This passage notes that the purchase and sale agreement would terminate unless FMC was awarded the CON by December 29, 2016. This date has already passed – and would have already passed even in the event that the decision timeline had not been altered by the PUI.

DaVita also identified several concerns relating to the legality of the lease, which FMC did not respond to in their rebuttal.

The assumptions used by FMC to project their expenses (and consequently their net income) could not be substantiated, as they did not demonstrate control of their proposed site. FMC does not have site control. **FMC does not meet this sub-criterion.**

DaVita – Lakewood Community Dialysis Center

DaVita anticipates the additional 15 stations would become operational by the end of December 2017. Under this timeline, 2018 would be the facility’s first full calendar year of operation and 2020 would be year three. [source: Application, p14]

DaVita provided the assumptions used to project in-center and home treatments and patients for calendar years 2018 through 2020. Below is a summary of the assumptions. [source: Application, pp18-19]

- Patient volume is based on a 4-year projection of the Pierce County ESRD planning area #5 patients using a regression of five years historical data.
- In-Center treatments are based on an assumption of three treatments per week per patient for 52 weeks with a 5% allowance for missed treatments.

²⁰ None of the applicants within this review provided gross revenue – only net revenue. It is customary for ESRD applicants to only include net revenue, however this prevents the department from substantiating any claims regarding “bargaining abilities.”

- The station need in the planning area is 44 stations. This application requests only 15 of the 44 needed stations. Since current utilization of the Lakewood facility is above 6.0 patients per station, the additional 15 stations are expected to be operational at 4.8 utilization by mid to late year 2017.

Using the assumptions stated above, DaVita’s projected number of in-center and home dialyses and patients for Lakewood Community Dialysis Center with a total of 26 stations is shown in Table 34 below. [source: Application, p18]

Table 34
DaVita-Lakewood Community Dialysis Center
Projected Patients and Dialyses for Years 2018-2020

	Year 1 – 2018	Year 2 - 2019	Year 3 - 2020
# of Stations	26	26	26
Total Treatments	22,025	23,135	25,013
Total Patients	129	142	151

DaVita provided the following statement regarding the assumptions used to project revenue, expenses, and net income for DaVita-Lakewood for years 2018 through 2020. [source: Screening Response, p6]

“No assumptions were made. LCDC is an existing facility, therefore actual revenue and expenses were used to inform future financials.”

DaVita projected the revenue, expenses, and net income for Lakewood Community Dialysis Center with 26 in-center dialysis stations and its home dialysis treatment program. DaVita provided data for current year 2016, partial year 2017, and projection years 2018 through 2021. A summary of the projections for years 2018 through 2020 is in Table 35 below. [source: Screening Response, Appendix 22]

Table 35
Lakewood Community Dialysis Center
Projected Revenue and Expense Statement for Years 2017 - 2020

	CY 2018	CY 2019	CY 2020
Net Revenue	\$ 8,936,577	\$ 9,386,869	\$ 10,148,940
Total Expenses	\$ 4,971,171	\$ 5,313,407	\$ 5,711,461
Net Profit / (Loss)	\$ 3,965,406	\$ 4,073,462	\$ 4,437,479

The ‘Net Revenue’ line item is gross in-center and training revenue, minus deductions for bad debt and charity care.

The ‘Total Expenses’ line item includes all expenses related to the current and projected operation of Lakewood Community Dialysis Center, including allocated costs. The line item also includes medical director costs consistent with the Medical Director Agreement provided in the application. [source: Application, Appendix 3 & Screening Response, pp6-7]

Also included in the expense category is the lease cost for Lakewood Community Dialysis Center. DaVita provided a copy of the executed lease agreement and the second and third amendments to

the agreement. The lease agreement is between Total Renal Care Inc. (DaVita) and MBK Northwest, the building owner. The initial lease was executed on January 15, 1996 and renewed on June 14, 2001, the second amendment was executed on October 21, 2002, and the third was executed on November 22, 2013. [source: Application, Appendix 15]

Public Comment

FMC provided comments related to Lakewood Community Dialysis Center’s stated percentages of revenue by payer and patient.

“Examination of the DVA Lakewood revenue by payor and by patient provided in its CN applications reveals alarming inconsistencies, particularly when compared with the two other DVA requests. In fact, the data DVA provided for its Medicare category is impossible. DVA provided its revenue by payor and by patient for its Lakewood facility in its CN application, reproduced below in Table 5. These projections for its other two requests, DVA Lakewood Community and DVA Canyon Road, are identical, thus only one version is reproduced below in Table 6.”

Table 5 Existing DVA Lakewood Facility Revenue by Type of Payor and Revenue by Patients Per Payor

Table 4 DaVita Lakewood Dialysis Center Sources of Revenue By Type of Payor	
<i>Revenue Source</i>	<i>% of Revenue</i>
<i>Medicare</i>	<i>67.66%</i>
<i>Medicaid/State</i>	<i>1.46%</i>
<i>Insurance/HMO/Other</i>	<i>30.87%</i>
Total	100%

Table 5 DaVita Lakewood Dialysis Center Sources of Revenue Percentage of Patients per Payor	
<i>Revenue Source</i>	<i>% of Patients</i>
<i>Medicare</i>	<i>44.74%</i>
<i>Medicaid/State</i>	<i>0.88%</i>
<i>Insurance/HMO/Other</i>	<i>54.38%</i>
Total	100%

Table 6 Proposed DVA Lakewood Community and DVA Canyon Road Facility Revenue by Type of Payor and Revenue by Patients Per Payor

Table 4 DaVita Company-wide Sources of Revenue By Type of Payor	
<i>Revenue Source</i>	<i>% of Revenue</i>
<i>Medicare</i>	<i>56.7%</i>
<i>Medicaid/State</i>	<i>4.5%</i>
<i>Insurance/HMO/Other</i>	<i>38.8%</i>
Total	100%

Table 5 DaVita Company-wide Sources of Revenue Percentage of Patients per Payor	
<i>Revenue Source</i>	<i>% of Patients</i>
<i>Medicare</i>	<i>78.9%</i>
<i>Medicaid/State</i>	<i>7.7%</i>
<i>Insurance/HMO/Other</i>	<i>13.4%</i>
Total	100%

As evidenced by the patient distribution at DVA Lakewood (Table 5), there is an extremely low percentage of patents with Medicaid or State insurance that receive care at the existing DVA Lakewood facility. This is certainly an anomaly-DVA itself projects 7.7% of patients in the Medicaid/Sate category for its proposed DVA Lakewood Community and DVA Canyon Road facilities (Table 6). The other three applicants in this concurrent also project a noticeably higher percentage of Medicaid patients, at or above 4%.

It is curious that DVA projects its requested DVA Lakewood Community facility to have more than 7 times the percentage of patients with Medicaid or State insurance than its existing Lakewood facility. Presumably, DVA used existing data from DVA Lakewood to generate these projections as it has unique insight of the existing market in that region. Based on the significant discrepancies shown in Tables 5 and 6, it is unknown why DVA chose to provide its company-wide patient distribution. As a result, it is unknown how DVA generated its revenue projections for its new facility proposals. At the very least, this represents poor financial modeling for its other requests. At worst, it is a significant accounting mistake that must be corrected.

Further, in comparison to the other applicants' (FMC, PSKC, Franciscan) estimated revenue by payor and by patient, DVA Lakewood has an abnormally high percentage of patients with private insurance, HMO, and other payment methods (54.38%). All other applicants including DVA itself (see Table 6), project this category of patients between about 10-15%.

This discrepancy is also reflected in the unusually low percentage of Medicare-enrolled patients, which, as indicated in DVA's own projections in Table 6, typically make up approximately 80% of the patients at dialysis facilities. Again the drastic differences between the DVA Lakewood Community revenue and patient projections and the existing, and available, data from DVA Lakewood indicate that DVA's revenue data is misleading and erroneous.

Of added concern is the fact that DVA's data for revenue and patients in the Medicare category is simply impossible-DVA states that only 44.74% of its patients are enrolled in Medicare, yet Medicare reimbursements comprise 67.66% of the facility's total revenue (Table 5). This is particularly alarming considering that DVA projects 78.9% of patients enrolled in Medicare to generate 56.7% of revenue at its proposed new facilities (Table 6). In other words, the existing DVA Lakewood has fewer patients enrolled in Medicare, yet somehow earns a higher percentage of revenue compared to its other two proposed projects. Considering that Medicare reimbursements are typically consistent across provider and facility, this data is contradictory and clearly inaccurate.

These significant discrepancies highlight crucial errors in the data DVA provided for its Lakewood facility revenue sources by patient and by payor. As a result, DVA's request fails to disclose its actual sources of revenue by patient and by payor, which calls into question the revenue projections for its other two requests. Considering that DVA is currently the only provider in the Pierce Five service area, it should have consistent revenue and patient projections across its proposals, particularly in the Lakewood region. This indicates likely errors and/or inaccurate modeling in DVA's other two dialysis facility requests, and, as a result, none of its applications meet the financial feasibility criteria."

[source: FMC public comment, pp12-13]

Rebuttal

"Fresenius suggests that DaVita made a mistake in its payor mix. Fresenius is wrong. As Fresenius well knows, revenue per treatment can vary significantly between facilities depending on individual patients' insurance coverage at a given time. We note that we also provided a national payor mix and the regional revenue per treatment, used for the Lakewood Community and Canyon Road application. Therefore, the Department has all data necessary to evaluate each of DaVita's applications."

[source: DaVita rebuttal comment, p9]

Department Evaluation

Since Lakewood Community Dialysis Center is a well-established center in Pierce County planning area #5, DaVita took into consideration the existing utilization, patient payer mix, and the number of stations needed in the planning area in its assumptions.

FMC provided comments questioning the reasonableness of DaVita's assumptions for their payer mix, specifically Medicaid patients. As shown above, DaVita does assume a larger population of Medicaid patients in their new facilities, consistent with company-wide assumptions. This is reasonable. At the existing Lakewood Community Dialysis Center, DaVita does serve a smaller percentage of Medicaid patients than their company-wide benchmark. It is reasonable for an existing facility to use actual data, when available. Though the Medicaid percentage at the Lakewood Community Dialysis Center is lower than the other DaVita applications, the department already determined that the payer mix proposed in this application was reasonable under WAC 246-310-210(2).

The assumptions used by DaVita to determine the number of patients and treatments at Lakewood Community Dialysis Center as a 26-station dialysis center are reasonable. The assumptions used by DaVita to project revenues, expenses, and net income for Lakewood Community Dialysis Center are also reasonable. Further, revenues exceed expenses in year three. **This sub-criterion is met.**

DaVita – Towne Center

DaVita proposes a 44-station facility in Lakewood Towne Center established in two phases. Below is a summary of the project.

- A 44 station dialysis center would be built and 44 new stations would be added to the planning area in two phases. Phase one is the establishment of a 33-station center and phase two is the addition of the remaining 11 new stations. [source: Screening Response, p1 & p3]

This application also includes an option of adding only 33 new dialysis stations to the planning area. This option would be implementation of only phase 1 described above. Below is a description of this option.

- A 33 station dialysis center would be built and only 33 new stations would be added to the planning area. This option would not have phases. [source: Screening Response, pp1-2]

For the remainder of this evaluation, the department will review each of the two options described above separately.

44 New Stations in Two Phases

DaVita provided the assumptions used to project in-center and home treatments and patients for calendar years 2018 through 2020 for this option. Below is a summary of the assumptions. [source: Application, pp18-19]

- The new facility would commence operations as a 33-station facility in year 2018.
- In year 2021, the remaining 11 stations are added (phase two), for a 44-station center.
- Utilization is based on the projected number of patient treatments in Pierce 5.
- 2023 is the third complete year of operation after project completion with 44 stations.

- Patient volume is based on a 4-year projection of Pierce 5 patients using a regression of 5 years historical data.
- In-center treatments are based on an assumption of 3 treatments per week per patient for 52 weeks with a 5% allowance for missed treatments.

Using the assumptions stated above, DaVita’s projected number of in-center and home dialyses and patients for the 44-station facility is shown in Table 36 below. [source: Screening Response, Appendix 22]

Table 36
44 New Stations - Two Phases
Projected Patients and Dialyses for Years 2018-2023

	Year 1 – 2018	Year 2 - 2019	Year 3 - 2020	Year 4 - 2021	Year 5 - 2022	Year 6 - 2023
# of Stations	33	33	33	44	44	44
Total Treatments	21,667	24,725	26,377	32,564	35,032	36,488
Total Patients	161	172	184	229	244	248

DaVita provided the following assumptions used to project revenue, expenses, and net income for this option. [source: Screening Response, p10]

“DaVita used its historical experience operating facilities in the state of Washington and in Pierce 5 to estimate the future revenue and expenses of a Canyon Road facility. These estimates are primarily driven by census assumptions from current Network 16 ESRD patient data as well as knowledge of our patients’ geographic locations and preferences. We believe that we are the only provider to make a realistic assumption of the patient transfers required for a new facility in Pierce 5 to meet the required utilization by Full Year 3. These were included as Appendix 2 of the application. All of the assumed rates, then multiplied by annual census, are an actual blend of the regional geography identified as “North Star Region 1.” Region 1 includes all facilities in Pierce 5 as well as DaVita Federal Way, Tacoma, Graham, and Kent.”

DaVita projected the revenue, expenses, and net income with 44 in-center dialysis stations and its home dialysis treatment program. Since the facility would be operational in 2018 with 33 stations, and in 2021 with 44 stations, DaVita provided data for projection years 2018 through 2023. A summary of the projections for years 2018 through 2023 is in Table 37 below. [source: Screening Response, Appendix 22]

Table 37
44 New Stations - Two Phases
Projected Revenue and Expense Statement for Years 2018 - 2023

	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Net Revenue	\$ 9,728,143	\$ 11,100,936	\$ 11,842,793	\$ 14,620,700	\$ 15,728,889	\$ 16,382,338
Total Expenses	\$ 5,585,350	\$ 6,188,606	\$ 6,621,121	\$ 8,118,167	\$ 8,757,571	\$ 9,060,605
Net Profit / (Loss)	\$ 4,142,793	\$ 4,912,330	\$ 5,221,672	\$ 6,502,533	\$ 6,971,318	\$ 7,321,733

The ‘Net Revenue’ line item is gross in-center and training revenue, minus deductions for bad debt and charity care.

The 'Total Expenses' line item includes all expenses related to the projected operation of the new 44-station facility, including allocated costs. The line item also includes medical director costs consistent with the draft Medical Director Agreement provided in the application. [source: Application, Appendix 3 & Screening Response, pp10-11]

Also included in the expense category is the lease cost for the space at Lakewood Towne Center for a 44-station facility. DaVita provided a copy of the executed lease agreement between Total Renal Care Inc. (DaVita) and RPAI Lakewood, LLC, the building owner. The lease was executed on June 29, 2016. The lease agreement provides the costs for the site from execution through at least 15 years. [source: Screening Response, Appendix 23]

Public Comment

During the review of the Towne Center project, both CHI Franciscan and FMC provided comments focusing on DaVita's documentation provided for site control. The comments relate to the 44-station facility or a 33-station facility. The comments focusing on the Towne Center project and DaVita's rebuttal statements will be addressed below, but not repeated in the 33-station review.

FMC Comments

"DVA did not provide an executed lease agreement for its proposed facility location at 5831 Main Street in the city of Lakewood. The only site control DVA has provided is an Intent to Lease for the location, which is not signed by the landlord, RPAI Lakewood, LLC, and does not constitute a legally binding agreement. Further, DVA did not provide any documentation that the landlord identified in the Intent to Lease owns the property and/or the building.

As stated in the Project Description section of the CN Application, applicants are required to provide documentation that the selected site may be used for the proposed project, and that the applicant has demonstrated sufficient interest in the site. DVA has not done so, providing only a letter that outlines DVA's requested lease terms. There is no formalized or signed documentation indicating that the Landlord is amenable to these terms. In fact, there are no assurances that the landlord is holding the proposed location for DVA's requested project.

While DVA's Letter of Intent specifies general lease issues, these are only requested items and do not constitute final, mutually-agreed upon, binding terms as the landlord has not signed or otherwise indicated agreement to this issue. Further, DVA asks for crucial information from the landlord. For example, DVA requested that the landlord provide the following additional expenses for the property:

[E]stimated annual cost per square foot for any and all additional operating expenses for which [DVA] will be responsible for paying including Taxes, Insurance and CAM ...

[W]hat, if any, utility costs [DVA] will be responsible for paying that are not included in operating expenses or Base Rent.

This excerpt clearly indicates that DVA does not have all necessary cost data for its facility. As a result, DVA's Intent to Lease for its requested site location does not specify the total associated costs for leasing the space. Since DVA has not identified all of the costs associated with its proposed rental, it has underestimated its capital expenditures as well as its operating costs. This means that DVA's Pro Forma and proposed capital expenditures are likely incorrect and subject to change outside of DVA's CN application.

In addition to the lack of cost assurance, there are excerpts in the Intent to Lease that state "to be defined further in lease" or "under further review by Landlord's operations department." These statements are clear evidence that DVA does not have site control. DVA has failed to adequately secure its proposed site location and, in doing so, has failed to provide accurate and reliable capital expenditures and future operating expenses.

[source: FMC public comment, p18]

CHI Franciscan Comments

"The application does not identify any landlord tenant improvements and the application states: "There are no landlord hard costs associated with the project because the building is accepted in 'as is' condition. Tenant is responsible for all construction necessary to make the facility dialysis ready." This is in direct conflict with Section 9 and Exhibit F-1 of its lease agreement which specifically describes the landlord's work. Exhibit F-1 states:

At a minimum, the landlord shall provide the following Base Building Improvements to meet Tenant's requirements for an Existing Base Building Improvements at Landlord's sole costs.

While several items are noted as being accepted 'as is' in Exhibit F-1, there are several items that are not; indicating that the landlord is responsible for all work and related costs. These costs could total hundreds of thousand dollars and are identified immediately below:

- *8.0 – Demising wall: "Landlord will bring demising wall up to meet the ratings/UL requirements.*
- *13.0 – Thermal Insulation: "Landlord to replace any missing and/or damaged wall or ceiling insulation with R-13, 19 or R30 insulation."*
- *14.0 – Exterior Doors: "Any missing weather stripping, damage to doors or frames will be repaired or replaced by Landlord. "*
- *16.0 – Plumbing*
- *18.0 – Electrical: "Tenant will not accept multiple services to obtain the necessary capacity. Should this not be available Landlord to upgrade electrical service..." "Existing electrical raceway, wire and cable extending through the Tenant's space but serving areas outside the Tenant's space shall be re-rerouted outside the Tenant's space and reconnected as required at the Landlord's cost." If fire alarm system is unable to accommodate Tenant requirements and/or FA system is not within applicable code compliance, Landlord to upgrade panel at landlord's cost."*
- *20.0 Mechanical/Heating Ventilation Air Conditioning: "If determined by Tenant that the units need to be replaced and/or additional units are needed, Landlord will be responsible for the cost of the replacement/additional HVAC units."*

Importantly, the lease contains a landlord contingency. Section 2.1 contains the following: Tenant acknowledges and confirms that Landlord's obligations under this Lease and the enforceability against Landlord of all its terms and conditions is contingent upon the Landlord obtaining written consent from Burlington Coat Factory, Famous Footwear, Firestone, PetSmart, Ross and the parties to restrictive covenants encumbering the Shopping Center... Upon notice by Landlord to Tenant that this contingency cannot be satisfied, this Lease shall automatically terminate..." DV has provided no additional information regarding these restrictions and the landlord's ability to successfully meet this contingency. Based on the above, DV has not demonstrated site control on its preferred option.

It has been the CN Program's practice to require an exact match between the lease agreement and the pro forma financial. CHI Franciscan's Real Estate Division reviewed the lease and even with

their expertise, they find the lease to be confusing. They are unable to determine exactly when DV is required to begin its lease payments. As such, we cannot determine whether there is an “exact match” with the pro forma financial.” [source: CHI Franciscan public comment, pp2-4]

Rebuttal Comment

*“Fresenius challenges DaVita’s site control. However, Fresenius’s comments relate to the “intent to lease” document provided as Appendix 15 to DaVita’s application. Fresenius appears to have overlooked the fact that DaVita provided a **signed lease** as Appendix 23 to its July 29, 2016 screening response. [emphasis in original] Therefore, Fresenius’s assertion that DaVita “did not provide an executed lease agreement” is simply wrong. Fresenius’s claim that “DaVita “did not provide any documentation that the landlord ... owns the property[.]” is similarly mistaken. DaVita provided a signed and notarized verification of the Landlord that it owns the property (Lease, Section 23: “Landlord is the owner in fee simple of the Premises, including the Shopping Center and all improvements thereon and has the right and authority to enter into this Lease.”). [Footnote in rebuttal comment: This also is a matter of public record. See <https://armsweb.co.pierce.wa.us/RealEstate/SearchImage.aspx> (Special Warranty Deed, conveying property to Inland Western Lakewood, L.L.C.); see also State of Delaware, Division of Corporations, Certificate of Amendment, File No. 3809716 (name change from Inland Western Lakewood, L.L.C. to RPAI Lakewood, L.L.C., recorded August 24, 2012) (courtesy copy attached).]*

The remainder of Fresenius’s comments – relating to lack of specificity in the intent to lease – similarly are resolved by the executed lease, which contains all cost terms.”

*“Franciscan points out that the Landlord has agreed that the property meets certain standards and has accepted responsibility if it does not. Specifically, Franciscan points to the following sections of Exhibit F-1 to the Lease: “**If** it does not meet this [demising wall standards], Landlord will bring demising wall up to meet the ratings/UL requirements...” (8.0); “Landlord to replace **any** missing and/or damaged wall or ceiling insulation...” (13.0); “**If not** [i.e., if doors do not meet barrier-free requirements] Landlord at his cost will need to bring them up to code...” (14.0); “Any existing hose bibs **will be** in proper working condition...” (16.0); “**Should** this not be available [electrical capacity] Landlord to upgrade electrical service...” (18.0); “**If** Fire Alarm system” is inadequate, “Landlord to upgrade...” (18.0); “**If** determined by Tenant that the [HVAC] units need to be replaced ... Landlord will be responsible...” (20.0). [emphasis in original]*

*Franciscan then makes a wild leap of logic: because the Landlord agreed to correct any such problems **if** they exist, they **do** exist, will have to be repaired, and therefore must be included in the project budget. [emphasis in original] All known costs have been included in the project costs. Franciscan has not identified any cost that will have to be incurred that was not so disclosed. Franciscan’s argument that because DaVita successfully negotiated a term with the Landlord regarding **hypothetical** problems, the Department should assume that these problems **will** occur and add to the project cost, is completely illogical. [emphasis in original]*

*The language cited by Franciscan in Section 2.1 is a standard commercial term. Franciscan’s suggestion that the Landlord should have obtained these approvals **prior** to signing the lease would turn standard real estate industry practice on its head. Moreover, DaVita is already operating a facility in this center, so Franciscan’s supposition that the Landlord will fail to obtain approvals under the existing covenants has no basis in reality.*

Finally, Franciscan reports that it finds DaVita's lease to be "confusing." We do not understand the source of Franciscan's confusion; the terms seem straightforward to us. However, the only specific point of confusion identified by Franciscan - the lease start date - is easily addressed: Per Section 2.1, the lease start date is the date that the landlord delivers possession. The delivery of possession requirements are identified in Section 2.2. [source: DaVita rebuttal comment, pp6-8]

Department Evaluation

DaVita submitted an executed lease agreement in its July 29, 2016, screening response under Appendix 23. The executed agreement addresses the concerns of site control and terms of the agreement raised by FMC.

CHI Franciscans statements focused on the following areas of the executed lease:

- the 'as is' section of the lease agreement and the landlord contingency that addresses obligations of the landlord if the building is lacking in certain areas;
- the start date of the lease; and
- verification of lease expenses in the projected financial statements.

In rebuttal, DaVita provided explanations for the wording of the 'as is' section of the lease and confirmed that the section is a result of DaVita's negotiation of 'hypothetical' issues that may arise. DaVita's approach of using an 'as is' section and landlord contingency statements is reasonable.

For the start date of the lease, DaVita provided references to sections in the executed lease. The relevant sections of the lease are restated below.

2.1 Term. *The term of this Lease (the "Term") shall commence upon the Possession Date, as hereafter defined."*

2.2 Estimated Possession Date; Delay in Delivery

Landlord shall apply for building permits ("Building Permits") for Landlord's Work (defined below) within 20 days following receipt of Tenant's Notice to Proceed ("Application Deadline"), shall diligently pursue receipt of same. Should Landlord not receive the necessary permits within 130 days following the Application Deadline through no fault of Landlord, Landlord may terminate this Lease upon written notice to Tenant. Landlord shall deliver possession of the Premises to Tenant with all of Landlord's Work (as defined in Section 9) completed on or before the date which is 150 days following issuance of the Building Permits (the "Estimated Possession Date"). Landlord may extend the Estimated Possession Date by 60 days, upon 20 days' prior written notice to Tenant. The date Landlord actually delivers possession of the Premises to Tenant is referred to herein as the "Possession Date." In the event Tenant fails to deliver to Landlord the Delivery Items (as hereinafter defined) by the Possession Date, Landlord shall have the right to delay physical turnover of the Premises to Tenant until Tenant has delivered the Delivery Items to Landlord; provided, however, for all purposes of this Lease, the Possession Date shall be deemed to have occurred when Landlord was ready to deliver physical turnover of the Premises to Tenant pursuant to the terms of this Lease even though Landlord elected not to do so pending receipt of the Delivery Items. As used herein, "Delivery Items" shall mean executed copies of policies of insurance or certificates thereof (as required of Tenant pursuant to Section 18.2). If the Possession Date has not occurred by the Estimated Possession Date (as it may be extended), and

such failure is not due to force majeure or Tenant delays, Tenant shall receive one day of Base Rent and Additional Rent abatement (in an amount equal to the applicable rent rate for periods following any rent abatement) for each day of delay beyond the Estimated Possession Date. Should the Possession Date not have occurred by the date which is 120 days following the Estimated Possession, and such failure is not due to force majeure or Tenant delays, Tenant may elect to terminate this Lease by written notice to Landlord given at any time prior to the occurrence of the Possession Date.

It is true that the possession date or ‘start date’ is not a specific date within the executed lease agreement. Rather, it is buried in legal terms above that specify the events that must occur before possession will occur. As stated by DaVita in its rebuttal comment, Section 2.2 of the lease agreement provides direction of the ‘delivery of possession’ requirements.

CHI Franciscans states it is unable to verify the annual lease costs in the pro forma financial statements. DaVita did not provide rebuttal comment on this topic. Within its screening response, DaVita provided the formula used to determine the lease costs in each of the years of operation. The formula is restated below. [source: Screening Response, p11]

“The formula to calculate rent applies a base rent of \$12.00 per square foot for an 19,290 square foot building. There is no annual escalator until lease year 5 (2021) at which time rent escalates by 12.5%. This figure is added to a base Tax & Common Area Maintenance (CAM) fee of \$3.57 multiplied by an annual escalator of 3% which is a conservative approximation of the Consumer Price Index (CPI) rate (generally between 2-3%). The \$3.57 figure was provided by the landlord and is broken down as such: CAM (\$1.82), Tax (\$1.61), Insurance (\$0.15).”

The formula above is substantiated in the lease agreement in Section 3.1 and Section 8.1. Based on the formula above, the department was able to calculate the annual lease costs and substantiate the lease amounts in the pro forma financial statements. It is noted that regardless of the number of operational stations, DaVita’s Towne Center facility’s annual lease amounts are the same.

DaVita provides the following statement related to its assumptions used for the Towne Center revenue and expense projections.

“DaVita used its historical experience operating facilities in the state of Washington and in Pierce 5 to estimate the future revenue and expenses of a Canyon Road facility. ...”

[source: Screening Response, p10] [emphasis added]

DaVita does not explain why an estimation of future revenue and expenses for its Canyon Road facility would reliably translate to future revenue and expenses for its Towne Center project. While both the Canyon Road and Towne Center facilities are proposed to be located in the same planning area, the department requires all applications to include specific information related to the project submitted. The reference above for the Towne Center project does not meet this requirement.

The department concludes that the assumptions used by DaVita to determine the number of patients and treatments at the 44-station DaVita-Towne Center cannot be substantiated. As a result, the projected revenues, expenses, and net income for the 44-station DaVita-Towne Center cannot be substantiated. **This sub-criterion is not met.**

33 New Stations

DaVita provided the assumptions used to project in-center and home treatments and patients for calendar years 2018 through 2022 for this option. Below is a summary of the assumptions. [source: Application, pp18-19]

- The new facility would commence operations as a 33-station facility in year 2018.
- Utilization is based on the projected number of patient treatments in Pierce 5.
- 2021 is the third complete year of operation after project completion with 33 stations
- Patient volume is based on a 4-year projection of Pierce 5 patients using a regression of 5 years historical data.
- In-center treatments are based on an assumption of 3 treatments per week per patient for 52 weeks with a 5% allowance for missed treatments.

Using the assumptions stated above, DaVita’s projected number of in-center and home dialyses and patients for the 33-station facility is shown in Table 38 below. [source: Screening Response, Appendix 22]

Table 38
33 New Stations
Projected Patients and Dialyses for Years 2018-2021

	Year 1 – 2018	Year 2 - 2019	Year 3 - 2020	Year 4 - 2021
# of Stations	33	33	33	33
Total Treatments	21,667	24,725	26,377	28,140
Total Patients	161	172	184	196

DaVita provided the following assumptions used to project revenue, expenses, and net income for this option. [source: Screening Response, p10]

“DaVita used its historical experience operating facilities in the state of Washington and in Pierce 5 to estimate the future revenue and expenses of a Canyon Road facility. These estimates are primarily driven by census assumptions from current Network 16 ESRD patient data as well as knowledge of our patients’ geographic locations and preferences. We believe that we are the only provider to make a realistic assumption of the patient transfers required for a new facility in Pierce 5 to meet the required utilization by Full Year 3. These were included as Appendix 2 of the application. All of the assumed rates, then multiplied by annual census, are an actual blend of the regional geography identified as “North Star Region 1.” Region 1 includes all facilities in Pierce 5 as well as DaVita Federal Way, Tacoma, Graham, and Kent.”

DaVita projected the revenue, expenses, and net income with 33 in-center dialysis stations and its home dialysis treatment program. Since the facility would be operational in 2018 with 33 stations, DaVita provided data for projection years 2018 through 2022. A summary of the projections for years 2018 through 2021 is in Table 39 below. [source: Screening Response, Appendix 22]

Table 39
33 New Stations
Projected Revenue and Expense Statement for Years 2018 - 2021

	CY 2018	CY 2019	CY 2020	CY 2021
Net Revenue	\$ 9,728,143	\$ 11,100,936	\$ 11,842,793	\$ 12,634,619
Total Expenses	\$ 5,554,224	\$ 6,157,479	\$ 6,589,995	\$ 7,079,288
Net Profit / (Loss)	\$ 4,173,919	\$ 4,943,457	\$ 5,252,798	\$ 5,555,331

The ‘Net Revenue’ line item is gross in-center and training revenue, minus deductions for bad debt and charity care.

The ‘Total Expenses’ line item includes all expenses related to the projected operation of the new 33-station facility, including allocated costs. The line item also includes medical director costs consistent with the draft Medical Director Agreement provided in the application. [source: Application, Appendix 3 & Screening Response, pp10-11]

Also included in the expense category is the lease cost for the space at Lakewood Towne Center for a 33 station facility. DaVita provided a copy of the executed lease agreement between Total Renal Care Inc. (DaVita) and RPAI Lakewood, LLC, the building owner. The lease was executed on June 29, 2016. The lease agreement provides the costs for the site from execution through at least 15 years. [source: Screening Response, Appendix 23]

Public Comment

During the review of the Towne Center project, both CHI Franciscan and FMC provided comments focusing on DaVita’s documentation provided for site control and its lease agreement. The comments relate to the 44-station facility or a 33-station facility. The comments and DaVita’s rebuttal statements are addressed in the 44-station review above and are not repeated in this 33-station review.

Rebuttal

See above statements

Department Evaluation

DaVita provides the following statement related to its assumptions used for the Towne Center revenue and expense projections.

“DaVita used its historical experience operating facilities in the state of Washington and in Pierce 5 to estimate the future revenue and expenses of a Canyon Road facility. ...”

[source: Screening Response, p10] [emphasis added]

DaVita does not explain why an estimation of future revenue and expenses for its Canyon Road facility would reliably translate to future revenue and expenses for its Towne Center project. While both the Canyon Road and Towne Center facilities are proposed to be located in the same planning area, the department requires all applications to include specific information related to the project submitted. The reference above for the Towne Center project does not meet this requirement.

The department concludes that the assumptions used by DaVita to determine the number of patients and treatments at the 44-station DaVita-Towne Center cannot be substantiated. As a

result, the projected revenues, expenses, and net income for the 44-station DaVita-Towne Center cannot be substantiated. **This sub-criterion is not met.**

DaVita – Canyon Road

This application proposes to establish a 44-station dialysis center in three phases. The dialysis center would be located at 18504 Canyon Road East in Tacoma [98446], within Pierce County planning area #5. The three phases are outlined in the table below. [source: Screening Response, p1 & p3]

Phase	Operational Date	# of Stations Added	Facility Total
One	Year 2018	24	24
Two	Year 2021	12	36
Three	Year 2023	8	44

Within the application, DaVita provided the separate financial statements, capital costs, and staffing for phase one alone [24 stations], phases one and two alone [36 stations], and all three phases [44 stations]. Since the department concluded that the 24-station option does not meet the utilization standard in WAC 246-310-286(4), the department will review each of the remaining options separately.

- 44 new stations in three phases
- 36 new stations in two phases

44 new stations in three phases

DaVita provided the assumptions used to project in-center and home treatments and patients for calendar years 2018 through 2025 for this option. Below is a summary of the assumptions. [source: Application, pp17-19]

- The Canyon Road proposal will add stations in three phases. The first phase adds 24 stations; phase two adds an additional 12 stations, for a total station count of 36 stations; the final phase adds the remaining 8 stations for a total station count of 44 stations and is projected to reach 80% of 3-shift utilization by the end of 2023, the facility's sixth full year of operation. Year 2024 is the third year of operation with 44 stations.
- Utilization is based on the projected number of patient treatments in Pierce 5.
- 2025 is the third complete year of operation after project completion with 44 stations.
- Patient volume is based on a 4-year projection of Pierce 5 patients using a regression of 5 years historical data.
- In-center treatments are based on an assumption of 3 treatments per week per patient for 52 weeks with a 5% allowance for missed treatments.

Using the assumptions stated above, DaVita’s projected number of in-center and home dialyses and patients for the 44-station facility is shown in Table 40 below. [source: Screening Response, Appendix 22]

Table 40
44 New Stations [Three Phases]
Projected Patients and Dialyses for Years 2018-2025

	Year 1 – 2018	Year 2 - 2019	Year 3 - 2020	Year 4 – 2021
# of Stations	24	24	24	36
Total Treatments	15,712	17,927	19,126	26,473
Total Patients	117	125	133	187

	Year 5 – 2022	Year 6 - 2023	Year 7 - 2024	Year 8 - 2025
# of Stations	36	44	44	44
Total Treatments	28,646	34,818	36,684	37,669
Total Patients	200	244	251	258

DaVita provided the following assumptions used to project revenue, expenses, and net income for this option. [source: Screening Response, pp8-9]

“DaVita used its historical experience operating facilities in the state of Washington and in Pierce 5 to estimate the future revenue and expenses of a Canyon Road facility. These estimates are primarily driven by census assumptions from current Network 16 ESRD patient data as well as knowledge of our patients’ geographic locations and preferences. We believe that we are the only provider to make a realistic assumption of the patient transfers required for a new facility in Pierce 5 to meet the required utilization by Full Year 3. These were included as Appendix 2 of the application. All of the assumed rates, then multiplied by annual census, are an actual blend of the regional geography identified as “North Star Region 1.” Region 1 includes all facilities in Pierce 5 as well as DaVita Federal Way, Tacoma, Graham, and Kent.”

DaVita projected the revenue, expenses, and net income with 44 in-center dialysis stations and its home dialysis treatment program. Since the facility would be operational in 2018 with 24 stations and add 12 stations in year 2021, and another 8 stations in year 2023, DaVita provided data for projection years 2018 through 2025. A summary of the projections is shown in Table 41 below. [source: Screening Response, Appendix 22]

Table 41
44 New Stations [Three Phases]
Projected Revenue and Expense Statement for Years 2018 - 2020

	CY 2018	CY 2019	CY 2020	CY 2021
Net Revenue	\$ 7,054,408	\$ 8,048,947	\$ 8,587,082	\$ 11,886,033
Total Expenses	\$ 4,169,232	\$ 4,608,343	\$ 4,924,489	\$ 6,645,082
Net Profit / (Loss)	\$ 2,885,176	\$ 3,440,604	\$ 3,662,593	\$ 5,240,951

	CY 2022	CY 2023	CY 2024	CY 2025
Net Revenue	\$ 12,861,404	\$ 15,632,948	\$ 16,470,745	\$ 16,912,784
Total Expenses	\$ 7,183,644	\$ 8,635,593	\$ 8,977,960	\$ 9,202,628
Net Profit / (Loss)	\$ 5,677,760	\$ 6,997,355	\$ 7,492,785	\$ 7,710,156

The ‘Net Revenue’ line item is gross in-center and training revenue, minus deductions for bad debt and charity care.

The 'Total Expenses' line item includes all expenses related to the projected operation of the new 44-station facility, including allocated costs. The line item also includes medical director costs consistent with the draft Medical Director Agreement provided in the application. [source: Application, Appendix 3 & Screening Response, 9-10]

Also included in the expense category is the lease cost for the space at Canyon Road. DaVita provided a copy of the draft lease agreement between Total Renal Care Inc. (DaVita) and Pinion, LLC, the building owner. The draft lease provides the costs for the site for a total of 120 months [ten years]. [source: Application, Appendix 15]

Public Comment

During the review of the Canyon Road project, both CHI Franciscan and FMC provided comments focusing on DaVita's documentation provided for site control and its lease agreement. The comments relate to the 44-station facility or a 36-station facility. The comments and DaVita's rebuttal statements will be addressed below, but not repeated in the 36-station review.

FMC Comments

...it is unclear if the proposed site for DVA's Canyon Road facility is actually within the Pierce Five service area - the site is located on the zip code border between Pierce Five and Pierce One planning areas. In fact, mapping programs list the site address as 98375, which is a Pierce One zip code. Regardless of site conformance to location requirements, a facility location adjacent to another planning area will not improve patient access exclusively for Pierce Five patients - there is a risk of patient infiltration from the neighboring service area which reduces access by Pierce Five patients. [source: FMC public comment, p4]

"DVA did not provide any documentation that the landlord identified in the Intent to Lease owns the property and/or the building site location at 18504 Canyon Road East. As stated in the Project Description section of the CN Application, applicants are required to provide documentation that the selected site may be used for the proposed project, and that the applicant has demonstrated sufficient interest, or site control, in the site. There is no legal documentation showing the named Landlord has rights to the proposed property. As such, DVA has failed to adequately secure its proposed site location. Due to its lack of disclosure for crucial site location information and its lack of documented site control, DVA's proposed Canyon Road facility should be denied."

[source: FMC public comment, p15]

CHI Franciscan Comments

"The effective date on page 2 of the lease agreement is blank. This is significant because, without an effective date, the tenant is not obligated by the lease agreement. Again, because DV has filed multiple applications requesting more than double the number of stations needed, CHI Franciscan is not surprised that it would submit documentation that provides such an out-clause. Section 2.2 of the lease agreement allows DV to lease less than the 18,000 SF that it has indicated it would use for this project. Specifically, the lease agreement states: "If Tenant determines that Tenant does not require the entire Premises delivered to Tenant on the Effective Date of this Lease, in Tenant's Notice to Proceed Tenant shall notify Landlord of the portion of the Premises that Tenant requires..." This means that without knowing the exact square footage to be leased, the CN Program will be unable to determine if there is an exact match with the pro forma financials. As DV pointed out in the 2014 concurrent review cycle in Pierce 1, "the Program has repeatedly denied applications for lease expense errors..." [source: CHI Franciscan public comment, p4]

Rebuttal

“Fresenius argues that the proposed facility is in the Pierce 1 planning area, not the Pierce 5 planning area. Fresenius is mistaken. Kathryn Cullen of DaVita met with Janis Sigman and Karen Nidermayer, prior to submitting the application, to confirm that the identified location is in the Pierce 5 planning area. The Department agreed with DaVita that the physical location of the building is in Pierce 5, although the federal and mailing zip code designation is different. At the Department’s request, Ms. Cullen provided a letter from the Pierce County Assessor, confirming that the building is located in Pierce 5, at which point this issue was considered resolved.” [source: DaVita Rebuttal comment, p8]

“Fresenius also asserts that DaVita “did not provide any documentation that the landlord ... owns the property[.]” Fresenius is mistaken. DaVita provided a signed and notarized verification of the Landlord that it owns the property (Lease, Section 23: “Landlord is the owner in fee simple of the Premises, including the Building and all improvements thereon and has the right and authority to enter into this Lease.”).”

[source: DaVita Rebuttal comment, pp8-9]

“Franciscan suggests that there is “no effective date” for DaVita’s lease. Franciscan is mistaken. Although the date is not filled in at the top of the first page of the lease, the “Effective Date” is defined pursuant to Section 2.1, which states: “This Lease shall be effective upon full execution and delivery (the “Effective Date”).” Therefore, the “Effective Date” was May 27, 2016, the date it was signed by both parties. The notarized signatures of both Landlord and Tenant are at the end of the lease.

Franciscan suggests that the “square footage to be leased is uncertain.” Franciscan is again mistaken. DaVita has secured 18,000 square feet with an option to only take 15,000. There is a re-measurement provision in Section 3 and all of DaVita’s financial assumptions, including the smaller, phased projects, used the full 18,000 square feet. No costs have been omitted. Note that the useable square footage, as compared to the leased square footage, is 17,883, as indicated in the proposed floorplan and square footage chart.”

Department Evaluation

FMC first questions whether the Canyon Road site is in the Pierce 5 planning area. Documentation provided during the review demonstrates that the site is in the correct planning area for this review.

FMC questions whether DaVita has site control and states that DaVita did not provide documentation that the landlord has rights to the site. In rebuttal, DaVita stated it has site control and sited the section of the draft lease agreement that confirms the landlord is the owner of the premises.

CHI Franciscan’s statements focused on the start date of the lease and square footage to be leased by DaVita. For the start date issue, DaVita provided the specific sections of the lease that address the start date that is identified as May 27, 2016. DaVita clarifies that depending on the size of the dialysis center approved by the department, a smaller square footage may be leased. The difference could be 19,000 sq/ft if a 44-station facility is approved, which could reduce to 15,000 sq/ft if less than 44 stations are approved. Since DaVita’s application ultimately proposes a 44-station facility in three phases, the financial statements for each phase calculates lease costs using 19,000 sq/ft. This approach by DaVita is both prudent and correct. The costs for the lease can be substantiated in the financial statements.

The department concludes that the assumptions used by DaVita to determine the number of patients and treatments at the 44-station DaVita-Canyon Road are reasonable. The assumptions used by DaVita to project revenues, expenses, and net income for the 44-station DaVita-Canyon Road are also reasonable. Further, revenues exceed expenses in year three.

While DaVita would not be a new provider in the planning area, its Canyon Road facility would be a new facility. DaVita provided a draft lease agreement for the site. If DaVita’s project is approved, the department would include a condition requiring DaVita to provide a copy of the executed lease agreement consistent with the draft agreement provided in the application. With the following condition, the department concludes DaVita’s project **meets this sub-criterion**.

- Prior to commencing the project, DaVita HealthCare Partners, Inc. will provide to the department for review and approval a copy of an executed lease agreement for the site. The executed agreement must be consistent with the draft agreement provided in the application.

36 New Stations in Two Phases

DaVita provided the assumptions used to project in-center and home treatments and patients for calendar years 2018 through 2023 for this option. Below is a summary of the assumptions. [source: Application, pp17-19]

- The Canyon Road proposal will add stations in phases. For a 36-station center, phase one begins with 24 stations and phase two adds the remaining 12 stations, for a total station count of 36 stations. The facility is projected to reach 80% of 3-shift utilization by the end of 2023, the third year of operation with 36 stations.
- Utilization is based on the projected number of patient treatments in Pierce 5.
- 2023 is the third complete year of operation after project completion with 36 stations.
- Patient volume is based on a 4-year projection of Pierce 5 patients using a regression of 5 years historical data.
- In-center treatments are based on an assumption of 3 treatments per week per patient for 52 weeks with a 5% allowance for missed treatments.

Using the assumptions stated above, DaVita’s projected number of in-center and home dialyses and patients for the 36-station facility is shown in Table 42 below. [source: Screening Response, Appendix 22]

Table 42
36 New Stations [Phases One and Two]
Projected Patients and Dialyses for Years 2018-2023

	Year 1 – 2018	Year 2 - 2019	Year 3 - 2020
# of Stations	24	24	24
Total Treatments	15,712	17,927	19,126
Total Patients	117	125	133

	Year 4 – 2021	Year 5 - 2022	Year 6 - 2023
# of Stations	36	36	36
Total Treatments	23,740	28,680	32,960
Total Patients	187	200	245

DaVita provided the following assumptions used to project revenue, expenses, and net income for this option. [source: Screening Response, pp8-9]

“DaVita used its historical experience operating facilities in the state of Washington and in Pierce 5 to estimate the future revenue and expenses of a Canyon Road facility. These estimates are primarily driven by census assumptions from current Network 16 ESRD patient data as well as knowledge of our patients’ geographic locations and preferences. We believe that we are the only provider to make a realistic assumption of the patient transfers required for a new facility in Pierce 5 to meet the required utilization by Full Year 3. These were included as Appendix 2 of the application. All of the assumed rates, then multiplied by annual census, are an actual blend of the regional geography identified as “North Star Region 1.” Region 1 includes all facilities in Pierce 5 as well as DaVita Federal Way, Tacoma, Graham, and Kent.”

DaVita projected the revenue, expenses, and net income with 36 in-center dialysis stations and its home dialysis treatment program. Since the facility would be operational in 2018 with 24 stations and add 12 stations in year 2021, DaVita provided data for projection years 2018 through 2023. A summary of the projections is shown in Table 43 below. [source: Screening Response, Appendix 22]

Table 43
36 New Stations [Phases One and Two]
Projected Revenue and Expense Statement for Years 2018 - 2023

	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Net Revenue	\$ 7,054,408	\$ 8,048,947	\$ 8,587,082	\$ 10,658,897	\$ 12,876,779	\$ 14,798,686
Total Expenses	\$ 4,145,079	\$ 4,584,191	\$ 4,900,337	\$ 6,241,215	\$ 7,168,339	\$ 8,341,743
Net Profit / (Loss)	\$ 2,909,329	\$ 3,464,756	\$ 3,686,745	\$ 4,417,682	\$ 5,708,440	\$ 6,456,943

The ‘Net Revenue’ line item is gross in-center and training revenue, minus deductions for bad debt and charity care.

The ‘Total Expenses’ line item includes all expenses related to the projected operation of the new 36-station facility, including allocated costs. The line item also includes medical director costs consistent with the draft Medical Director Agreement provided in the application. [source: Application, Appendix 3 & screening response, 9-10]

Also included in the expense category is the lease cost for the space at Canyon Road. DaVita provided a copy of the draft lease agreement between Total Renal Care Inc. (DaVita) and Pinion, LLC, the building owner. The draft lease provides the costs for the site for a total of 120 months [ten years]. [source: Application, Appendix 15]

Public Comment

During the review of the Canyon Road project, both CHI Franciscan and FMC provided comments focusing on DaVita’s documentation provided for site control and its lease agreement. The comments relate to the 44-station facility or a 36-station facility. The comments and DaVita’s rebuttal statements are addressed in the 44-station review above and are not repeated in this 36-station review.

Rebuttal

See above statements

Department Evaluation

The department concludes that the assumptions used by DaVita to determine the number of patients and treatments at the 36-station DaVita-Canyon Road are reasonable. The assumptions used by DaVita to project revenues, expenses, and net income for the 36-station DaVita-Canyon Road are also reasonable. Further, revenues exceed expenses in year three.

While DaVita would not be a new provider in the planning area, its Canyon Road facility would be a new facility. DaVita provided a draft lease agreement for the site. If DaVita’s project is approved, the department would include a condition requiring DaVita to provide a copy of the executed lease agreement consistent with the draft agreement provided in the application. With the following condition, the department concludes DaVita’s project **meets this sub-criterion**.

- Prior to commencing the project, DaVita HealthCare Partners, Inc. will provide to the department for review and approval a copy of an executed lease agreement for the site. The executed agreement must be consistent with the draft agreement provided in the application.

(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.

CHI Franciscan

The actual costs that CHI Franciscan would pay for Phase 1 alone would be \$5,034,895. The actual costs that CHI Franciscan would pay for both phases would be \$6,624,827. These costs are related to building construction, fixed and moveable equipment, and assorted fees, taxes, and permits. CHI also identified costs to be incurred by the landlord. For tie-breaker purposes only, CHI Franciscan provided the allocated historical cost of building construction, calculated from the existing parcel value. The capital cost breakdown for the proposed facility – both as a 28-station facility and as a 44-station facility are shown below in Tables 44 and 45, respectively.

[sources: Screening Response p10, p37]

Table 44
Phase 1 – 28 Station Facility Estimated Capital Costs

Item	Actual	Landlord	Allocated	Totals
Construction	\$2,530,480	\$30,000	\$633,944	\$3,194,424
Fixed and Moveable Equipment	\$1,746,145	-----	-----	\$1,746,145
Fees, taxes, permits	\$758,270	\$77,439	-----	\$835,709
Total Estimated Capital Costs	\$5,034,895	\$107,439	\$633,944	\$5,776,278

Table 45
Phases 1 and 2 – 44 Station Facility Estimated Capital Costs

Item	Actual	Landlord	Allocated	Totals
Construction	\$3,345,295	\$30,000	\$756,232	\$4,131,527
Fixed and Moveable Equipment	\$2,281,186	-----	-----	\$2,281,186
Fees, taxes, permits	\$998,346	\$77,439	-----	\$1,075,785
Total Estimated Capital Costs	\$6,624,827	\$107,439	\$756,232	\$7,488,498

The application provided step-by-step calculation for the allocated facility costs. [source: Screening Response pp9-10].

CHI Franciscan provided the following statement related to this sub-criterion, specifically related to costs and charges:

“CHI Franciscan’s charges for dialysis services are not impacted by, nor established based on, a facility’s specific capital cost. In fact, we negotiate a global rate charge with insurers, which does not single out specific services, such as dialysis, or specific facilities such as Franciscan Lakewood. Thus, the costs and charges for dialysis paid by commercial insurers, as well as Medicare/Medicaid, would remain the same regardless of whether CHI Franciscan did nothing or undertakes the project described in this application.” [source: Application p33]

The application assumed net revenue per treatment at \$404 – consistent with actuals at the Franciscan South Tacoma facility, which is located in the Pierce 4 planning area. [source: Application Exhibit 10]

Public Comment

Only DaVita provided public comment related to this sub-criterion.

DaVita Public Comment

“Franciscan's proposal includes unreasonable costs.

Franciscan has designed its facility to accommodate twelve permanent bed stations. See Application, p. 7, fn. 2 (“The facility has been designed to accommodate up to a total of 12 bed stations (eight in Phase 1 and four in Phase 2), should demand warrant.”). In other words, 27% of the total stations at Franciscan's proposed facility (12/44) will be built to accommodate permanent beds. But Franciscan effectively concedes that this number of permanent bed stations is not actually needed. See Application, p. 7, fn. 2 (“That said, at this time we are proposing that Phase 1 include only two dedicated/permanent bed stations. Phase 2 is not projected to include any permanent beds at this time.”).

Franciscan's project costs, at \$6.7 million, are much higher than DaVita's project costs, which are approximately \$5 million for either of DaVita's 44-station proposals. Franciscan's inexplicable decision to design a facility with 27% permanent bed stations obviously is not the only reason that Franciscan's project is so expensive compared to DaVita's projects, but it illustrates how Franciscan has failed to control costs in its proposal. These additional costs, including the additional square footage necessary to accommodate twelve permanent bed stations, are unnecessary.” [source: DaVita public comment pp3-4]

Rebuttal

“CHI Franciscan proposes to construct a 44 station dialysis facility in two phases at an estimated capital expenditure of \$6,732,266 (including landlord costs). The \$6.7 million capital expenditure includes 100% of the design costs, construction costs, permitting fees and associated taxes for 14,142 square feet. The capital expenditure also includes the costs to equip and operate the 44 stations. In addition, it should also be noted that unlike any of the other applicants, CHI Franciscan must go through the Department of Health’s Construction Review Services as it operates each of its dialysis facilities as an outpatient department of the hospital. Building dialysis units to hospital code requirements adds additional costs as well as regulatory review that the other providers do not have to meet. CHI Franciscan also reminds the CN Program that the capital costs of its project do not impact the costs and charges for health care services. In fact, all the other applicants have stated the same. Included in Attachment 1 are the relevant citations from the DV, FMC and PSKC applications.

Lastly, as DV is well aware, the sole purpose of identifying the capital costs (including allocating previous or future capital costs) in a dialysis concurrent review is to evaluate the economies of scale criteria found in the tie breakers. And, unlike DV, we have provided all of the required costs. Please note that our response to screening question #19 included the requested allocation of historical building costs. DV was also asked this question and in its screening response noted that it was only required to disclose the costs to improve the space (and was not required to disclose the costs incurred by the landlord to construct the building). If the tiebreaker criteria are applied the CN Program will not have the information needed to determination the cost per station for any of DV’s three applications and these applications must be denied.” [source: CHI Franciscan rebuttal p4]

Department Evaluation

Consistent with Certificate of Need Program practices, CHI Franciscan submitted a letter of intent identifying the total costs for the project to be \$6.2 million. The actual cost identified within the application – \$6,624,827 – is within the 12% deviation allowed. As a single phase, 28-station facility, the estimated capital expenditure would be \$5,034,895. [source: Application, Exhibit 4; Screening Response p37]

Based on the definition of “capital expenditure,” under WAC 246-310-280(2) CHI Franciscan identified costs that will be covered by the landlord, as well as allocated costs related to the value of the land and existing structure. CHI provided its formula for determining this additional cost allocation for this project. [sources: Screening Response pp9-10, p37]

Documentation provided in the application shows that the Franciscan Lakewood Dialysis Center’s Medicare and Medicaid reimbursements are projected to equal 74% of the revenue at the dialysis center. The department notes that Medicare and Medicaid patients typically make up the largest percentage of patients served by a dialysis facility. CMS implemented an ESRD Prospective Payment System (PPS). Under the new ESRD PPS, Medicare pays dialysis facilities a bundled rate per treatment. The rate is not the same for each facility.

Each facility, within a given geographic area, may receive the same base rate. However, there are a number of adjustments both at the facility and at patient-specific level that affects the final reimbursement rate each facility will receive. What a dialysis facility receives from its commercial payers will also vary. Even if two different dialysis providers billed the same commercial payer the same amount, the actual payment to each facility will depend on the negotiated discount rate obtained by the commercial payer from each individual provider. The department does not have an

adopted standard on what constitutes an unreasonable impact on charges for health services. Based on department's understanding of how dialysis patients may qualify for Medicare payments, the department concludes that the information presented by CHI Franciscan about its revenue indicates this project may not have an unreasonable impact on charges for Medicare and Medicaid, since that revenue is dependent upon cost based reimbursement. The remaining 26% of Franciscan Lakewood Dialysis Center's revenue will be derived through a variety of reimbursement sources such as private insurance.

Based on the information, the actual costs for the project are reasonable. If this evaluation includes a 'tie breaker' review under WAC 246-310-288, the actual costs plus allocated costs for this project would be used in the review. That amount is \$5,776,278 for a single-phase 28 station facility, and \$7,488,498 for a two-phase 44 station facility.

DaVita presented public comments, stating that CHI Franciscan's application included unreasonable costs, as it would be designed to accommodate 12 bed stations. In response, CHI stated that *"the capital costs of its project do not impact the costs and charges for health care services"* and referenced that all other applicants made the same point. [source: CHI Franciscan rebuttal p4]

The comments from DaVita incorrectly identify the CHI Franciscan as having 12 permanent bed stations. The application states:

"The facility has been designed and sized to accommodate up to a total of 12 bed stations (eight in Phase 1 and four in Phase 2), should demand warrant. That said, at this time we are proposing that Phase 1 include only two dedicated/permanent bed stations. Phase 2 is not projected to include any permanent beds at this time. In addition, the home training rooms and the isolation room have also been configured to accommodate a bed. The equipment list includes a total of four beds: two beds for the permanent bed stations; 1 bed for home training, and 1 extra bed for back up." [source: Application p7]

"Franciscan Lakewood will include the necessary lighting and configuration that would allow for the establishment of a small nocturnal program at such time that there is sufficient patient demand for such a program." [source: Screening Response p1]

Based on information provided by CHI Franciscan, and a review of the single line drawings and equipment list provided, it appears that their facility design is consistent with their statements. [source: Application Exhibit 6, Screening Response Attachment 5]

While the assumptions and information provided by CHI Franciscan could be reasonable under their own ownership and control, the department received no assurance that this facility would remain under CHI Franciscan ownership and control for the entire projection period. Information found in the PUI led the department to conclude that the facility would ultimately be sold. CHI did not provide any assurance throughout the PUI process that this subsequent transaction would not have an effect on costs and charges for healthcare services. The department cannot reasonably conclude that the project would not have an unreasonable impact on costs and charges for healthcare services in Pierce County planning area #5. The department concludes CHI Franciscan's project **does not meet this sub-criterion.**

Puget Sound Kidney Centers

The costs associated with PSKC’s proposed Lakewood facility differ based on which variation of the project is selected. Certain factors such as the cost of the land do not change from situation to situation. There are no allocated costs or landlord costs, as the facility would be brand new and owned by PSKC. The costs by proposed station configuration and phases are shown in the tables below. [sources: Screening Response Attachment 3]

**Table 46
PSKC Lakewood – Single Phase Project Capital Expenditures**

	16-Station Facility	20-Station Facility	22-Station Facility
Construction	\$4,421,861	\$4,421,861	\$4,421,861
Fixed and Moveable Equipment	\$989,036	\$1,067,590	\$1,173,076
Fees, taxes, permits	\$1,198,047	\$1,198,868	\$1,200,595
Total Estimated Capital Costs	\$6,608,944	\$6,688,319	\$6,795,532

**Table 47
PSKC Capital Expenditure – Two Phases for a Total of 44 Stations**

	Phase 1 (16 Stations)	Phase 2 (28 Stations)	Total (44 stations)
Construction	\$4,640,839	\$2,281,022	\$6,921,861
Fixed and Moveable Equipment	\$989,036	\$1,058,592	\$2,047,628
Fees, taxes, permits	\$1,219,069	\$700,243	\$1,919,312
Total Estimated Capital Costs	\$6,848,944	\$4,039,857	\$10,888,801

**Table 48
PSKC Capital Expenditure – Two Phases for a Total of 44 Stations**

	Phase 1 (20 Stations)	Phase 2 (24 Stations)	Total (44 stations)
Construction	\$4,640,839	\$2,281,022	\$6,921,861
Fixed and Moveable Equipment	\$1,067,590	\$980,038	\$2,047,628
Fees, taxes, permits	\$1,219,890	\$699,422	\$1,919,312
Total Estimated Capital Costs	\$6,928,319	\$3,960,482	\$10,888,801

**Table 49
PSKC Capital Expenditure – Two Phases for a Total of 44 Stations**

	Phase 1 (22 Stations)	Phase 2 (22 Stations)	Total (44 stations)
Construction	\$4,640,839	\$2,281,022	\$6,921,861
Fixed and Moveable Equipment	\$1,173,076	\$874,552	\$2,047,628
Fees, taxes, permits	\$1,221,617	\$697,695	\$1,919,312
Total Estimated Capital Costs	\$7,035,532	\$3,853,269	\$10,888,801

PSKC provided the following statement related to this sub-criterion, specifically related to costs and charges:

“PSKC does not expect the project to affect the charges for its services, and will have no effect on billed rates to patients, providers, or payers. [source: Application p31]

Public Comment

DaVita and FMC provided public comments related to this sub-criterion.

DaVita Public Comment

“DaVita, Franciscan, Fresenius, and PSKC collectively have presented twelve options to the Department: four options to provide all 44 needed stations, and eight options to provide between 15 and 33 stations. What is immediately apparent when comparing the twelve options is that the PSKC proposals - both its 44-station option and its 22-station option – are far more expensive than any of the other options proposed by DaVita, Franciscan, or Fresenius.

PSKC's 44-station option is far more expensive than the other three 44-station options.

The Department has been presented with four options to meet the full 44-station need. [T]hree of the options (the Franciscan and DaVita proposals) would cost between \$5 million and \$6.7 million, a per-station cost between \$114,000 and \$152,000. The fourth option (the PSKC proposal) would cost nearly \$11 million, a per station cost of nearly \$250,000. In other words, PSKC's 44-station project would be far more expensive than FHS's 44-station project and more than twice as expensive as either of DaVita's 44-station projects.

There is no justification for the Department approving PSKC's proposed \$11 million expenditure given the choice between three other options costing between \$5 million and \$6.7 million to meet the full planning-area need.

PSKC's 22-station option is far more expensive than the other options to provide less than 44 stations.

The picture does not improve for PSKC when its 22-station Phase 1 is considered. The Department has been presented with eight options to partially meet the 44-station need. [E]ven excluding the 15-station DaVita Lakewood expansion project - which at \$20,255 per station obviously is well below the cost of any of the other projects - Phase 1 of the PSKC option is still far more expensive than any of the other six options that would partially meet the 44-station need. Each of the other six options would cost between \$137,000 and \$210,000. The PSKC option would cost approximately \$320,000, which would be 53% higher than the most expensive of the other new-facility options smaller than 44 stations (Fresenius); it would be 133% higher than the least expensive of the other new-facility options smaller than 44 stations (DaVita Canyon Road Phases 1 & 2).

There is no justification for the Department approving a \$7 million expenditure to meet half the need when there are three options (the Franciscan option and the two DaVita options) that would meet the full need for less than that, and there also are five other options that would provide 24-36 additional stations at far lower cost than PSKC proposes to spend to provide 22 stations.

PSKC's smaller Phase 1 options are even more expensive, on a per station basis, than PSKC's 22-station option.

PSKC suggests that it could build out a 16-station or 20-station Phase 1 project, rather than the 22-station Phase 1 project proposed in its application. In screening, it provided cost information regarding these smaller options. However, these smaller options would be even more expensive, on a per-station basis, than PSKC's 22-station option.

PSKC's 16-station option, at a cost of \$413,059 per station, and PSKC's 20-station option, at a cost of \$334,416 per station, would be even more expensive, on a per-station basis, than PSKC's 22-station Phase 1, which at \$319,797 per station already is far more expensive than any of the options proposed by any of the other applicants.

DaVita proposed a 15-station option (Lakewood) that would cost only \$303,830 in total, or \$20,255 per station. PSKC proposes a 16-station option that would cost \$6.6 million in total, or more than \$400,000 per station. In other words, PSKC's 16-station proposal would cost more per station than DaVita's 15-station proposal would cost in its entirety.” [source: DaVita Public Comment pp2-5]

FMC Public Comment

“PSKC's 44-station project is the highest cost facility of all current applicants in Pierce Five, with a total estimated project cost of \$10,888,800. In fact, this is the most expensive facility proposed in the past ten years, millions of dollars more than the second most expensive dialysis facility request in this time frame. Second to PSKC's current request, the next highest requested capital expenditures for a dialysis facility in the State of Washington in the past 10 years is the proposed CHI-FH facility, also in Pierce Five, with a proposed cost of \$6.6 million, followed by another PSKC's proposal in 2013 to relocate 12 stations from its existing PSKC Everett Dialysis facility to a new facility in Snohomish Two, which had capital expenditures of \$5.947 million.

The large number of stations (44) PSKC requested for this project do not compensate for the large capital expenditures, as PSKC's current proposal also has the highest capital expenditures per treatment (\$421.21) through Phase 1, of any of the six applicants in Pierce Five. In other words, no matter how its proposal is evaluated, it is very high cost-the highest cost of any of the six applicants.

PSKC's facility is simply not cost-effective. An overly expensive facility is more likely to negatively impact patients who ultimately bear the burden of cost, particularly if expected patient volumes are not reached. Considering that this facility is unprecedented in its size, it is unknown if patient volumes will follow the same trends as smaller dialysis facilities.

The extremely high cost of PSKC's proposed facility combined with unknown future patient volumes leads to uncertainty regarding the effect of project costs on patient costs and charges. As a result, PSKC's project fails to meet Financial Feasibility criteria.” [source: Fresenius Public Comment p10]

“PSKC's project is extremely expensive, both in terms of total capital expenditures and capital expenditures per station and per treatment as detailed above. PSKC's capital expenditures make it, by far, the most costly proposal across the six Pierce Five applicants.

While there is demonstrated need for 44 additional dialysis stations in the Pierce Five planning area in 2019, it is unknown if an abnormally large dialysis facility will reach expected patient capacity. This is of particular concern when patient access is not improved by the facility, as in the case of PSKC's proposal. As a result, there is a high probability that, once built, PSKC's facility will be idle because of its size. Idle capacity is an inefficient use of space and scarce, costly resources, putting pressure on patient costs and charges to compensate for the low patient volume.

The combination of high direct project costs and the significant number of proposed stations results in a facility that is very likely to negatively impact patient costs and charges. PSKC's Pro Forma shows that it is barely breaking even, with only a net profit margin of \$36.85 three years after the first phase, and \$60.40 three years after the second phase. This is a very narrow window to operate an extremely expensive facility - if patient volumes are even slightly lower than expected, the facility will not be able to cover operational expenses. Raising patient costs and charges in the event of low volumes is the only feasible approach that PSKC could implement to keep its facility operational and avoid operating losses.

As a result of these issues, PSKC's project does not meet the following Financial Feasibility criteria in WAC 246-310-220. As demonstrated above, PSKC's proposal does not guarantee that it can meet long-range capital and operating costs of its facility if future patient volumes are lower than projected, which is very likely with such a large facility. If PSKC is unable to meet long-range capital and operating costs, it will likely pass along losses to patients in the form of costs and charges for health services.

In the first few years of operation, the high facility costs may adversely affect patients. Again, this is particularly applicable in the probable event that PSKC's proposed facility does not reach expected patient volumes. Even if it only opens the first stage of its project (22 stations), the extremely high cost of the facility will translate into an extremely high cost per station, rendering its project inefficient and a misuse of scarce resources. These losses are likely to negatively and unreasonably impact costs and charges for health services.

Due to the likelihood for idle capacity, which will result in lower project net profits in both the short- and long-run, PSKC's proposed facility in the City of Lakewood fails to fulfill the CN Financial Feasibility standards.” [source: FMC Public Comment pp10-11]

Rebuttal

PSKC provided the following statements in response to DaVita's public comments:

“DV argues that PSKC Lakewood's capital costs are the most expensive of all the applications under review and that the CN Program should deny it for this reason alone. PSKC fully acknowledges that our up front construction costs are higher than those “reported” by the other applicants; this is purposeful. PSKC builds high quality buildings that are designed to be used for 30-40 years. It does not remodel abandoned buildings that were not originally designed or intended to provide dialysis services. Instead, PSKC invests in the communities it serves by owning the facilities where it operates, including the land – which is a non-depreciating asset. DV attempts to compare apples to oranges by applying artificial labels to the “costs” of their facility. The proper comparison is between the annual depreciation attributed to PSKC's owned assets compared against the depreciation plus rent that is paid by DV on an annual basis. A review of the applications shows that PSKC's facility costs are actually lower than DV's and FMC's. And, 10 years from now, PSKC will own the building, and the land itself will actually have appreciated in value. DV and FMC will have nothing of value. PSKC is making a true investment in the Pierce 5 Planning Area in every sense of the word.

For the record, DV noted in their CN applications (pages 22, 23 and 23) that the capital costs of their projects have no impacts on the costs and charges for dialysis services. If this is true for DV, it must also be true for PSKC. More importantly, of all the applications under review, PSKC

proposes to charge the lowest per treatment (by at least 55%) of any applicant, DV included. Table 2 of PSKC’s public comment is replicated below:

**Pierce 5 Dialysis Applications
Net Revenue Per Treatment
Opening Year and Project Completion Year**

<i>Net Revenue Per Treatment</i>	<i>CHI Franciscan Lakewood</i>	<i>PSKC Lakewood</i>	<i>DV Lakewood (station add)</i>	<i>DV Lakewood (new)</i>	<i>DV Tacoma</i>	<i>FMC</i>
<i>Year 1</i>	2018: \$404	2018: \$256.69	2018 \$405.75	2018: \$448.96	2018: \$448.98	2017: \$623.31
<i>Project Completion</i>	2023: \$404	2024: \$262.80	2020: \$405.75	2023: \$448.99	2025: \$448.98	2020: \$620.73

[source: PSKC rebuttal p3]

PSKC provided the following rebuttal to FMC’s public comment:

“FMC, like DV, argues incorrectly that PSKC’s proposed construction costs are somehow a weakness of our proposal. In fact, the opposite is true. As noted in response to our DV public comment, PSKC purchased land and is proposing to custom-build a beautiful kidney center that will be a long term asset to the community. The patients, physicians, and payers know they can rely on PSKC to be there for them for the long haul. We demonstrate a long-term commitment to health care services wherever we operate. Their argument of PSKC not improving access to care is nonsense.

PSKC’s proposal will not negatively affect costs and charges to patients and payers. As described earlier and as noted in Table 2 of PSKC’s public comment, PSKC’s costs and charges are the lowest of all of the applications.

FMC’s conclusion is wrong, and the material included in the record demonstrates our significantly lower net revenue per treatment.

FMC also attempts to disqualify PSKC because we propose to meet all of the 44 station need in Pierce 5 (and they do not). FMC argues that a 44 station PSKC facility will somehow result in higher charges to patients and payers. This argument is patently false and quite frankly, FMC knows better. All they have to do is look at our public record over the past 35 years to determine the highest-quality, lowest cost, provider of dialysis in Washington State. As demonstrated in our application and other sections of this rebuttal, FMC’s statements are not accurate. A PSKC facility will actually result in lower charges to patients and payers due to PSKC’s high quality operations.

Without any data or analysis in support of its position, FMC also states that PSKC’s proposal will somehow charge too much for our ancillary and support services. PSKC does not understand the point being made by FMC. We are committed not to overcharge for our services. We provide reasonably priced services and our ancillary and support services are built into our charges. PSKC is confident that our Lakewood operations will be successful and cost-conscious. FMC’s criticisms are without merit.” [source: PSKC rebuttal pp6-7]

Department Evaluation

Documentation provided in the application shows that PSKC – Lakewood’s Medicare and Medicaid reimbursements are projected to equal 76% of the revenue at the dialysis center. The

department notes that Medicare and Medicaid patients typically make up the largest percentage of patients served by a dialysis facility. CMS implemented an ESRD Prospective Payment System (PPS). Under the new ESRD PPS, Medicare pays dialysis facilities a bundled rate per treatment. The rate is not the same for each facility.

Each facility, within a given geographic area, may receive the same base rate. However, there are a number of adjustments both at the facility and at patient-specific level that affects the final reimbursement rate each facility will receive. What a dialysis facility receives from its commercial payers will also vary. Even if two different dialysis providers billed the same commercial payer the same amount, the actual payment to each facility will depend on the negotiated discount rate obtained by the commercial payer from each individual provider. The department does not have an adopted standard on what constitutes an unreasonable impact on charges for health services. Based on department’s understanding of how dialysis patients may qualify for Medicare payments, the department concludes that the information presented by CHI Franciscan about its revenue indicates this project may not have an unreasonable impact on charges for Medicare and Medicaid, since that revenue is dependent upon cost based reimbursement. The remaining 24% of PSKC – Lakewood’s revenue will be derived through a variety of reimbursement sources such as private insurance.

Fresenius expressed concerns about whether a 44-station facility would prohibit PSKC from reaching their projected volumes, and, consequently, whether their revenue and expense assumptions were too low under WAC 246-310-220(1). FMC stated that this would result in an increase in their costs and charges. The department already concluded that PSKC’s volume, revenue, and expenses were reasonable under WAC 246-310-220(1). Therefore, FMC’s comments regarding the effect of project cost on these assumptions are without merit.

Both DaVita and Fresenius provided comments relating to this sub-criterion, arguing that the higher capital costs associated with PSKC’s proposed facility would have an effect on their financial feasibility. This sub-criterion evaluates whether the capital costs would have an effect on costs and charges.

The department completed a review of charges in each scenario, and noted that revenue per treatment is consistent in every scenario presented by PSKC, reproduced below showing year 3 data:

**Table 50
PSKC – Lakewood Net Revenue per Treatment – In-Center and Total**

	16 Station (1 phase)	20 Station (1 phase)	22 Station (1 phase)	44 Station (all configurations)
Estimated Capital Expenditure	\$6,848,944	\$6,928,319	\$7,035,532	\$10,888,801
In-Center Treatments	14,081	16,706	16,706	31,720
In-Center Revenue	\$4,013,085	\$4,761,210	\$4,761,210	\$9,040,200
Net Revenue per Treatment	\$285	\$285	\$285	\$285
Total Treatments	18,281	20,906	20,906	38,440
Total Net Revenue	\$4,748,186	\$5,475,364	\$5,475,364	\$10,143,023
Net Revenue per Treatment	\$259.73	\$261.90	\$261.90	\$263.87

[source: Application, Exhibit 9, Screening Response, Attachments 3 and 5]

As shown above, in-center net revenue per treatment was unaffected by the capital expenditure.

Based on the above information, the department concludes that this project would probably not have an unreasonable impact on the costs and charges for healthcare services in Pierce County planning area #5. **This sub-criterion is met.**

Fresenius Medical Care

The actual costs that FMC would pay for the proposed facility would be \$2,155,782. These costs are related to tenant improvement construction, fixed equipment, and architect and engineering fees. FMC indicated that moveable equipment was included within the fixed equipment line item. FMC also identified costs to be incurred by the landlord/developer. For tie-breaker purposes only, FMC provided these allocated costs. The capital cost breakdown for the proposed facility is shown below in Table 51. [sources: Screening Response p2, p7]

**Table 51
FKC Fredrickson Estimated Capital Costs**

Item	Actual	Landlord	Totals
Land and Construction	\$1,492,362	\$1,966,605	\$3,458,967
Fixed and Moveable Equipment	\$536,049	\$0	\$536,049
Fees, taxes, permits	\$127,371	\$901,901	\$1,029,272
Total Estimated Capital Costs	\$2,155,782	\$2,868,506	\$5,024,288

FMC provided the following statement related to this sub-criterion, specifically related to costs and charges:

“This project has no impact on either charges or payment, as reimbursement for kidney dialysis services is based on a prospective composite per diem rate. Further, it is important to understand the basis for FKC reimbursement, given this Department question, which raises the issue of capital expenditures and their potential effect on costs and charges for health services.

In the case of government payers, reimbursement is based on CMS (Center for Medicaid and Medicare) fee schedules which have nothing to do with capital expenditures by providers such as FKC.

In the case of private sector payers, FKC negotiates national, state, and regional contracts with payers. These negotiated agreements include consideration/negotiation over a number of variables, including number of covered lives being negotiated; the provider's accessibility, including hours of operation; quality of care; the provider's patient education and outreach; its performance measures such as morbidity and/or mortality rates; and increasingly, consideration of more broad performance/quality measures, such as the CMS Quality Incentive Program ("QIP") Total Performance Score ("TPS").

FKC does not negotiate any of its contracts at the facility-level, thus, the proposed FKC Fredrickson facility's capital costs would have no impact on payer negotiations or levels of reimbursement. In this regard, facility-level activities, such as number of FTEs, operating expenses or capital expenditures have no effect on negotiated rates, since such negotiations do not consider facility-level operations. As such, the proposed FKC facility would have no effect on rates FKC would receive in the Pierce Five ESRD Planning Area.” [source: Application pp27-28]

Public Comment

PSKC submitted comments related to this sub-criterion.

PSKC Public Comment

“[T]he FMC application fails financial feasibility 246-310-220, simply because information pivotal to the Program being able to demonstrate conformance is missing or understated. Specifically, FMC reports the purchase price of the land at \$1,500,000; yet its capital expenditure breakout includes only \$526,018 in land costs. The landlord is paying for the land and per the lease agreement, any costs to the landlord are passed to FMC in its lease payment.

FMC provides no explanation regarding why the entire purchase price of the property has not been included in the landlord’s total project costs. In reviewing the purchase and sales agreement (Screening Response, Exhibit 11 Revised) together with the lease agreement (CN Application, Exhibit 11) it is evident that the landlord, Tacoma Renal Construction, LLC was established exclusively for the purpose of developing a dialysis facility in Tacoma. It is also evident, per Section 5.6 of the Lease Agreement, that the land can be used only for a dialysis facility; therefore the nearly \$1 million of excluded land costs must be included. When these costs are included, the lease costs are not an exact match with the Pro Forma and in the past, the Program has denied applications for these types of errors.

FMC ‘claims’ that its project is less costly than the PSKC proposal. FMC compares PSKC’s total project cost of approximately \$10million for 44 stations to its 24 station proposal. As our CN demonstrates, PSKC is proposing a two phased 44 station project with 22 stations in Phase 1. Therefore, the correct comparison should be between PSKC’s phase 1 (22 stations) and Fresenius’ total project (24 stations). Even this analysis becomes compromised, however, because FMC has omitted nearly \$1 million in land costs.

Ironically, and worth noting, while commenting on PSKC’s capital costs, FMC states explicitly in its own application (p. 28) that capital costs have no impact on either costs or charges for health care services.

For FMC to raise this as an issue against PSKC is inconsistent with its own conclusion as FMC states:

‘FKC does not negotiate any of its contracts at the facility-level, thus, the proposed FKC Fredrickson facility’s capital costs would have no impact on payer negotiations or levels of reimbursement. In this regard, facility-level activities, such as number of FTEs, operating expenses or capital expenditures have no effect on negotiated rates, since such negotiations do not consider facility-level operations. As such, the proposed FKC facility would have no effect on rates FKC would receive in the Pierce Five ESRD Planning Area.’

PSKC is on record with the CN Program with a similar statement: Our capital costs have no bearing on the rates that we charge for services. In fact, despite the costs of PSKC’s proposed project, our charges and net revenue per treatment is well below all of the applicants in this concurrent review process. Stated another way, PSKC spends more on providing high quality patient care environments all while charging less for providing superior care.

Finally, the record must reflect that of all the applications submitted, FMC’s has the highest net revenue per treatment. Therefore, while rates may not be affected by their capital costs of a

particular project (as described above), the costs and charges to payers will increase if FMC is approved. If PSKC is approved, costs and charges to patients would actually decrease.”

PSKC provided the following table to further support of their comments:

**Pierce 5 Dialysis Applications
Net Revenue Per Treatment
Opening Year and Project Completion Year**

Net Revenue Per Treatment	CHI Franciscan Lakewood	PSKC Lakewood	DV Lakewood (station add)	DV Lakewood (new)	DV Tacoma	FMC
Year 1	2018: \$404	2018: \$256.69	2018 \$405.75	2018: \$448.96	2018: \$448.98	2017: \$623.31
Project Completion	2023: \$404	2024: \$262.80	2020: \$405.75	2023: \$448.99	2025: \$448.98	2020: \$620.73

[source: PSKC public comment pp5-7]

Rebuttal

Fresenius provided the following statements related to PSKC’s public comments:

“PSKC criticizes Fresenius for having a high revenue per treatment.

PSKC then provides a table comparing the applicants' net revenue per treatment for the opening and project completion years. First, PSKC is comparing net revenue, rather than net profit. This is an important distinction as operational expenses vary widely across provider. Net revenue does not reflect whether a provider's project is financially feasible, since there are many expenses in operating a dialysis facility. A much more appropriate comparison is to use net profit per treatment, as provided below in Table 1.

Pierce 5 Concurrent Review, Net Profit per Treatment, Year 3

	FMC	CHI Franciscan	PSKC	DVA Lakewood	DVA Lakewood Community	DVA Canyon Road
Net Profit, Year 3	\$6,791,874	\$669,411	\$615,536	\$5,021,350	\$5,852,439	\$4,119,955
Phase II Year 3	--	\$1,648,691	\$1,915,936	--	Not reported	\$8,485,493
Net Profit per Treatment, Year 3	\$406.60	\$30.15	\$36.85	\$231.28	\$256.35	\$248.88
Phase II	--	\$51.81	\$60.40	--	Not reported	\$279.16

As is evident in Table 1 above, comparison of net profit per treatment shows the significant financial risk of PSKC and CHI-Franciscan's proposed projects - with profit margins between \$30 and \$60 per treatment, there is little to no room for deviations from the applicants' operating and expense assumptions. If PSKC does not meet expected patient volumes or if its facility has higher than-expected operational expenses, its facility will likely not be financially feasible. It is in these

instances specifically that patients bear the financial burden - without higher costs and charges for patient services, PSKC simply will not be able to keep its facility open and operational.

While Fresenius does have the highest net profit of all applicants in this concurrent review cycle, it is simply because Fresenius benefits from greater bargaining abilities as a national provider of health care services and its recognized clinical quality by payers. Fresenius has the ability to negotiate better rates with payers of commercial insurance, which ensures better coverage for indigent patients or patients with other special needs. Further, it also ensures that the facility will be able to cover operating expenses if patient volumes are lower than expected or if there is an unforeseen facility cost.

PSKC erroneously compares Fresenius' statement in its CON Application that its capital costs have no impact on costs and charges for health care services to its own application. However, this is essentially an "apples and oranges" comparison, since Fresenius negotiates its rates with providers at a company-wide level, not on a per-facility basis. In other words, costs and charges for health services at Fresenius dialysis facilities are the same regardless of size or cost of the facility.

PSKC, as a provider of dialysis care in the Pacific Northwest only, does not have the same negotiating ability as Fresenius, and must adjust its costs and charges depending on the cost of the facility. In this instance, PSKC is requesting the single most expensive dialysis facility ever proposed, with extremely slim profit margins. It is unlikely that PSKC will be able to cover the facility costs without adjusting its net profit per treatment. Thus, it is clear there is very significant financial risk involved with PSKC's project. Combined with the fact that it is also requesting the largest dialysis facility ever proposed, along with CHI-Franciscan and DVA, PSKC is requesting approval for an extremely high-risk project. There are a number of assumptions that PSKC has made to even achieve the minimal profit it has projected in its Pro Forma - if its facility does not meet and maintain projected patient volumes, if its facility requires unforeseen expenses, or if its facility is not able to meet or maintain expected revenue by payer goals, its facility risks having to increase costs of its services or it may face closure.

Fresenius is proposing a facility that will improve access to high-quality dialysis care for patients at pre-negotiated rates for payers. Its project is much more likely to be successful considering its reasonable assumptions, including patient volumes and payer sources. Thus, our project is more likely to meet both short- and long-term operational goals over PSKC's higher-risk project."
[source: FMC rebuttal pp10-12]

"PSKC claims that Fresenius should have included the entire purchase price of the land (\$1,500,000) as identified in the Purchase and Sales Agreement provided in Fresenius' Screening Responses instead of the associated land costs of \$526,018 included in Fresenius' projected Capital Expenditures for its proposed FKC Fredrickson.

PSKC has misinterpreted Fresenius' capital expenditures and its Purchase and Sales Agreement - the \$1,500,000 is for the entire 5.5-acre property, while the \$526,018 figure is specifically for the 1.4-acre site on which the dialysis will be located. Thus, only \$526,018 are costs directly applicable to the land purchase.

As is evident in Exhibit F of Fresenius' Lease Agreement, Fresenius did, in fact, include all purchase costs of the land for its capital expenditures. Exhibit F of the Lease Agreement includes a

Pro Forma Development Budget for the leased site. This exhibit contains Gross Development Costs which include \$935,829 in total direct land purchase costs, as well as additional costs for hard construction costs, soft development costs, financing, legal, insurance and other administrative costs, overhead, and general contingency. The total development costs for the Landlord are \$2,868,506 as identified in Fresenius' Capital Expenditures.

Although the sub-categories are divided differently for Fresenius' Capital Expenditures breakdown based on CON standards, the total expenditure figures are consistent across Fresenius' CON Application #16-37, its Lease Agreement, and its Purchase and Sales Agreement provided in its Screening Responses: \$2,868,506.00 in Landlord capital expenditures. Thus, Fresenius included all associated land and development costs for its proposed FKC Fredrickson.

In addition to PSKC's mistake in claiming that Fresenius omitted land costs, PSKC concludes that review of Fresenius' site control documents imply that "it is evident that the landlord, Tacoma Renal Construction, was established exclusively for the purpose of developing a dialysis facility in Tacoma." This is also an incorrect assumption. Fresenius is not purchasing the land for this dialysis facility, and thus the land is not an asset of Fresenius or its affiliates. The purchaser and developer of the land, Tacoma Renal Construction, LLC ("TRC") is purchasing the property as outlined in the Purchase and Sales Agreement provided in our Screening Responses. Fresenius is not affiliated with TRC - Fresenius is not directly funding nor involved in funding the project. Thus, Fresenius does not have any monetary or other investment gain from TRC's purchase of the property.

As a result, the appropriate costs for the FKC Fredrickson project include the land costs on which the dialysis facility will be located to account for the full expenditures of the project at-hand. Since the full property is not an asset and is not involved in or used for facility operations, the footprint of FKC Fredrickson includes only costs that are directly applicable to the CON application. The total area of the land purchased is 1.4 acres, while the footprint of the FKC Fredrickson site is 9,134 rentable square feet ("RSF"). As per CON guidelines, we calculated the percentage of the purchase costs that apply to the proposed facility. Again, as stated above, these costs are outlined in Exhibit F of Fresenius' Lease Agreement.

PSKC also justifies its assertions by claiming that Section 5.6 in Fresenius' Lease Agreement requires that the land "be used only for a dialysis facility." We are unsure how PSKC reached this conclusion, as Section 5.6 of the lease agreement reads as follows:

'5.6. Expansion Right. During the Lease Term, Tenant shall have the right to expand the square footage of the Building, parking areas, and/or the Premises (the "Expansion Space"), as the case may be, up to the maximum extent allowed by local zoning, building, and other requirements. Tenant shall send Landlord written notice of its intent to expand. Within five (5) days after Landlord's receipt of said notice, the parties shall appoint a mutually acceptable independent real estate appraiser/broker (the "Expansion Appraiser/Broker") ... to provide an opinion of the fair market rental value of the proposed Expansion Space. The cost of the Expansion Appraiser/Broker shall be shared equally by Landlord and Tenant. .. Landlord shall have ten (10) days from the date the Expansion Appraiser/Broker renders its opinion to notify Tenant as to whether Landlord shall construct the Expansion Space at Landlord's sole cost and expense. In the event Landlord elects to build the Expansion Space, the Expansion Appraiser's/Broker's opinion shall serve as the Base Rent for the Expansion Space, which shall commence upon the date landlord delivers the completed Expansion Space to Tenant ... In the event Landlord elects not to build the Expansion

Space, Tenant shall have the right to construct the Expansion Space at its sole cost and expense, and Tenant shall not be obligated to pay Base Rent for the Expansion Space during the remainder of the term of the Lease or any future option periods. In such event, Tenant shall be responsible for obtaining all permits and approvals required by governmental authorities having jurisdiction, including but not limited to any zoning, building and/or other requirements. Further, Tenant shall expand the Building, parking areas, and/or the Premises in a first class, good and workmanlike manner consistent with construction standards utilized in constructing the Building, which shall include but not be limited to comparable precautions for dealing with mine subsidence. Prior to commencement of construction, Tenant shall furnish to Landlord the plans and specifications of the work to be undertaken, and shall obtain Landlord's written approval of the plans and specifications, which consent shall not be unreasonably withheld. Failure of Landlord to respond to Tenant's written request for approval on or before the 30th following Landlord's receipt of Tenant's written request for approval shall result in Landlord being deemed to have consented to Tenant's written request for approval'

As is clearly evident in this section, there are no limitations to how the leased property (the "Premises") may be used. We question if perhaps PSKC intended to refer to Article 4.1 of the FKC Fredrickson lease agreement, which covers "Permitted Use" for the Premises. This section requires the Tenant to use the Premises "for the purposes of an outpatient dialysis facility and related office and administrative uses ("the Permitted Use")." Thus, even in this section which seems to fit PSKC's criticism more closely, it is not a Landlord restriction on the Premises, but a Tenant restriction. This is a reasonable and common clause.

There is also a section in Fresenius' Lease Agreement which references Assignment and Subleasing (Article 16) and restricts the Landlord's right to "sell or transfer any portion of its interest in the Property without first obtaining written consent of the Tenant" prior to the Commencement Date. This is a reasonable legal protection for both the Landlord and the Tenant and is commonly found in lease agreements.

Finally, there is also an exclusivity clause in Article 26.21, which states:

'Provided that Tenant is then open and operating within the Premises, and is not then in default under any of the provisions of this Lease, Landlord and its affiliates and subsidiaries shall not lease space or sell real property within a five (5) mile radius of the Property to any other tenant/buyer for the purpose of the Permitted Use.'

Again, the above is a reasonable and legal non-compete clause for the Premises to protect both the Tenant and the Landlord. This clause does prevent the Landlord from utilizing the Premises for other means, but only while the Tenant is operating under the Permitted Use as a dialysis facility. Thus, it protects the Tenant while under Permitted Use, and protects the Landlord in the event that a Tenant decided to conduct non-approved activities at the Premises.

Based on the actual passages in Fresenius' Lease Agreement, there are no limitations to what the Landlord may do with the area of the property that is not leased to FKC Fredrickson. The clauses in the Lease that limit Landlord actions within the Premises are legal protections for both the Tenant and the Landlord during the Lease Term. We are unaware of any passages that suggest, or might appear to suggest, that the Landlord is limited to operating a dialysis facility for the property outside of the Premises.

It may be that PSKC misinterpreted or otherwise misunderstood Fresenius' Lease Agreement to reach its unfounded and incorrect conclusions. However, as PSKC did not quote or cite Fresenius' Lease more specifically, by, for example, including reference to specific passages or page numbers, it is impossible to know for certain to what PSKC is referring when it asserts that Fresenius' lease requires the land to be used only for a dialysis facility. Thus, we are limited in our ability to adequately and appropriately respond to PSKC's comments.

In conclusion, PSKC's assertion that Fresenius omitted land costs for its proposed project is simply wrong. Fresenius is not involved in the purchase of the property, either directly or indirectly, and is not affiliated in any manner with the developer, TRC. Further, Fresenius allocated the appropriate percentage of the land costs as paid by TRC for its project, which represents the actual space used for the FKC Fredrickson facility. Fresenius complied with all regulations and historical precedents to determine the associated capital expenditures for its project and is confident that the expenditures are accurate and appropriate. This figures are well documented within Fresenius' CON Application, its Lease Agreement, and its Screening Responses.” [source: FMC rebuttal comments pp7-10]

Department Evaluation

Documentation provided in the application shows that FKC Fredrickson’s Medicare and Medicaid reimbursements are projected to equal 34% of the revenue at the dialysis center. The department notes that Medicare and Medicaid patients typically make up the largest percentage of patients served by a dialysis facility. CMS implemented an ESRD Prospective Payment System (PPS). Under the new ESRD PPS, Medicare pays dialysis facilities a bundled rate per treatment. The rate is not the same for each facility.

Each facility, within a given geographic area, may receive the same base rate. However, there are a number of adjustments both at the facility and at patient-specific level that affects the final reimbursement rate each facility will receive. What a dialysis facility receives from its commercial payers will also vary. Even if two different dialysis providers billed the same commercial payer the same amount, the actual payment to each facility will depend on the negotiated discount rate obtained by the commercial payer from each individual provider. The department does not have an adopted standard on what constitutes an unreasonable impact on charges for health services. Based on department’s understanding of how dialysis patients may qualify for Medicare payments, the department concludes that the information presented by CHI Franciscan about its revenue indicates this project may not have an unreasonable impact on charges for Medicare and Medicaid, since that revenue is dependent upon cost based reimbursement. The remaining 66% of FKC Fredrickson’s revenue will be derived through a variety of reimbursement sources such as private insurance. [source: Application p15]

The department noted that these percentages were significantly different than the other applicants, with a seemingly disproportionate amount of revenue coming from commercial payers. FMC offered the following statement related to their assumptions:

“Actual data was used from comparable Fresenius facilities in Chehalis, Shelton and Grays Harbor to model payer mix in terms of percentages of number of treatment and share of net revenues.” [source: Screening Response p3]

Furthermore, FMC identified that 83.73% of their patient mix would be comprised of Medicare or Medicaid patients.

Puget Sound Kidney Centers argues that FMC’s application should be denied based on costs that were not properly identified within the application. After reviewing the application, screening responses, and, specifically, Exhibit F of the lease, it shows that FMC did identify that only \$526,018 was included within the land costs, but provided no formula or rationale for this allocation of cost.

Though it is the responsibility of the applicant to provide clear and easily replicated formulas for cost allocations, the department attempted to produce a formula that would substantiate the identified \$526,018 in land costs. Ultimately, the department could not substantiate the \$526,018 land cost allocated to the project.

The estimated capital expenditure presented by FMC cannot be substantiated by the lease agreement or purchase and sale agreement. Therefore, the department cannot reliably conclude that the project would not have an unreasonable impact on costs and charges for health services. **This sub-criterion is not met.**

DaVita – Lakewood Community Dialysis Center

The actual costs that DaVita will pay for this 15 station addition is \$303,830 and these costs are solely for moveable equipment. DaVita also identified allocation of construction costs that were expended in previous years when the facility was operating up to 21 dialysis stations. With \$650,650 in allocated construction costs, associated equipment and leasehold improvements, DaVita identified a total cost of \$954,480 for the project. The capital cost breakdown is shown in Table 52 below. [source: Application, p10 & Appendix 7; Screening Response, pp2-4 & Appendix 21]

**Table 52
Lakewood Community Dialysis Center Estimated Capital Costs**

Item	Actual	Allocated	Totals
Construction/Leasehold Improvements	\$ 42,000	\$ 650,650	\$ 692,650
Professional Service/Architect Fees	\$ 8,000	-----	\$ 8,000
Fixed and Moveable Equipment	\$ 253,830	-----	\$ 253,830
Total Estimated Capital Costs	\$ 303,830	\$ 650,650	\$ 954,480

DaVita provided a breakdown of the actual costs of \$303,830 to add the additional 15 stations. The breakdown shows that the majority of the costs are for fixed and moveable equipment necessary to accommodate the additional stations and patients. [source: Screening Response, Appendix 21]

DaVita provided its step-by-step calculations and methodology used to determine the allocated costs identified in the table above. [source: Screening Response, pp3-4] DaVita also provided the following statements related to this sub-criterion and the identification of allocated costs. [source: Application, p21]

“Appendix 7 lists the Capital Expenditures required for the project. The proposed expansion also requires the disclosure of known historical costs associated with any prior constructed expansion space. As indicated by the Certificate of Need Department, disclosure of these prior expenses are for tiebreaker purposes only and should not be included toward the Total Capital Costs of this CN application.”

Public Comment

None

Rebuttal

None

Department Evaluation

Consistent with Certificate of Need Program practices, DaVita submitted a letter of intent identifying the total costs for the project to be \$299,818. The actual capital costs identified in the application are consistent with the costs identified in the letter of intent. [source: Application, Appendix 5 & Appendix 7]

Based on the definition of 'capital expenditure' under WAC 246-310-280(2), DaVita identified construction costs already spent, yet allocated to this project. DaVita also provided its formula for determining the additional cost allocations for this project. [source: Application, p21 & screening response, pp3-4]

Documentation provided in the application shows Lakewood Community Dialysis Center's Medicare and Medicaid reimbursements are projected to equal 69.12% of the revenue at the dialysis center. The department notes that Medicare and Medicaid patients typically make up the largest percentage of patients served by a dialysis facility. CMS implemented an ESRD Prospective Payment System (PPS). Under the new ESRD PPS, Medicare pays dialysis facilities a bundled rate per treatment. The rate is not the same for each facility.

Each facility, within a given geographic area, may receive the same base rate. However, there are a number of adjustments both at the facility and at patient-specific level that affects the final reimbursement rate each facility will receive. What a dialysis facility receives from its commercial payers will also vary. Even if two different dialysis providers billed the same commercial payer the same amount, the actual payment to each facility will depend on the negotiated discount rate obtained by the commercial payer from each individual provider. The department does not have an adopted standard on what constitutes an unreasonable impact on charges for health services. Based on department's understanding of how dialysis patients may qualify for Medicare payments, the department concludes that the information presented by DaVita about its revenue indicates this project may not have an unreasonable impact on charges for Medicare and Medicaid, since that revenue is dependent upon cost based reimbursement. The remaining 30.87% of Lakewood Community Dialysis Center's revenue will be derived through a variety of reimbursement sources such as private insurance.

Based on the information, the actual costs for the project are reasonable. If this evaluation includes a 'tie breaker' review under WAC 246-310-288, the actual costs plus allocated costs for this project would be used in the review. That amount is \$954,480.

Based on the above information, the department concludes that this station addition project would probably not have an unreasonable impact on the costs and charges for health services in Pierce County planning area #5. **This sub-criterion is met.**

DaVita – Towne Center

44 New Stations in Two Phases

DaVita identified the costs for this project, which includes construction costs for a 44-station facility with two phases. The capital cost breakdown is shown in Table 53 below. [source: Application, Appendix 7 & Screening Response, pp9-10 & Appendix 21]

**Table 53
Estimated Capital Costs for
44 New Stations in Two Phases**

Item	Totals
Construction/Leasehold Improvements	\$ 3,079,130
Professional Service/Architect Fees	\$ 337,000
Fixed and Moveable Equipment	\$ 1,505,127
Architect/Engineering Fees	\$ 2,000
Real Estate Commission	\$ 120,000
Total Estimated Capital Costs	\$ 5,043,257

DaVita provided the following statements related to the construction costs and equipment costs. [source: Screening response, p9]

“The line items included in construction and leasehold improvements, with corresponding expenses, are as such:

Item	Totals
<i>Gross Interiors</i>	<i>\$ 2,387,650</i>
<i>Gross MBBI</i>	<i>\$ 498,750</i>
<i>Life Safety Systems* [fire alarm</i>	<i>\$ 192,730</i>
Total Construction Costs	\$ 3,079,130

**Life Safety includes items such as fire alarms and security system*

These are expenses that are specific to the square footage of the building, not the size of the treatment floor. These costs are necessary to make the Canyon Road property ready for dialysis and will be incurred irrespective of the size of the award.”

“DaVita budgeted for the cost of entirely new stations for the full 44 station (Phase 1 and 2) and 33 station (Phase 1) facility. We do not anticipate the use of any refurbished chairs, machines, or stations as part of this project. Should the Department approve 33 stations with 11 stations to be relocated from the existing Lakewood facility, the NLF [new Lakewood facility] has budgeted for 36 new chairs and dialysis machines and assumed that the remainder would be transferred from the existing Lakewood facility.”

Public Comment

During the review of the three DaVita applications, CHI Franciscan provided comments focusing on DaVita’s ‘lease holding’ fees for both its Towne Center and Canyon Road projects. The comments focusing on the Towne Center project and DaVita’s rebuttal statements will be addressed below for the 44-station review but not repeated in the 33 station review.

CHI Franciscan

“DV invested significant resources in submitting three applications, requesting a total of 103 new stations. CHI Franciscan concludes that the costs associated with DV’s commitments to its different projects in this concurrent review must be included as part of the capital expenditure of any project. Two of these three applications include executed lease agreements that require DV to pay holding fees of \$9,645/month and \$10,406, respectively. DV will incur these costs regardless of the outcome of this CN process and regardless of which (if any) of its projects are approved. Therefore, these costs should be included across all projects, including the 15 station expansion.”

[source: CHI Franciscan public comment, p2]

FMC Comments

“While there is demonstrated need for 44 additional dialysis stations in the Pierce Five planning area in 2019, it is unknown if an abnormally large dialysis facility will reach expected patient capacity. As a result, there is a high probability that, once built, DVA's facility will be idle because of its size. Idle capacity is an inefficient use of space and scarce resources, putting pressure on patient costs and charges to compensate for the low patient volume. The combination of high direct project costs and the significant number of proposed stations results in a facility that may negatively impact patient costs and charges. If patient volumes are lower than expected, which is likely as DVA predicts as many as 115 patients by the third full year of operation after Phase I, and 212 patients by the third full year after Phase II. If this is the case, DVA's facility will not be able to cover operational expenses. Raising patient costs and charges in the event of low volumes is the only feasible approach that DVA could implement to keep its facility operational and avoid operating losses.

In the first few years of operation the high facility costs may adversely affect patients. Again, this is particularly applicable in the probably event that DVA’s proposed facility does not reach expected patient volumes. Even if it only opens the first phase of its project (33 stations), the high capital expenditures of the facility will translate into high cost per station, rendering its project inefficient and a misuse of scarce resources. These losses are likely to negatively and unreasonably impact costs and charges for health services. Due to the likelihood of idle capacity, which will result in lower project net profits, in both the short- and long-run, DVA’s proposed facility in the city of Lakewood fails to fulfill the CN financial feasibility standards.”

The single line drawing provided in Appendix 16 of DVA’s CN #16-35 shows expansion space for up to 3 additional stations beyond its current request for 44 stations, with total facility build-out capacity of 47 dialysis stations. DVA does not otherwise mention these additional stations in its CN application.

The department has recently denied several CN applications for the inclusion of undisclosed expansion space in the single line drawing. ...As a result of the overbuilt project, the department finds that ‘it is reasonable to expect [non-Medicare/Medicaid patient] rates are higher than necessary to support the unnecessary capital operating costs of this overbuilt facility.’ ...In this instance, DVA’s single line drawing for its proposed Lakewood Community facility shows that the three additional stations would be located in the main treatment area. Thus, the space for these expansion stations would need to be completed as part of this initial project. DVA did not explain if it planned to utilize space allocated for future stations productively and cost-effectively, or if it will leave this space as idle capacity. Based on existing, available information, it appears this space will be idle. DVA’s requested 44-station facility already has high risk of idle capacity. Three additional dialysis stations at its proposed facility will not be necessary for many years, if at all. As

a result, this space will likely remain idle and the costs to build out the expansion station space will be paid for by costs and charges for dialysis treatments provided by the 44-stations. [source: FMC public comment, p10-11]

Rebuttal

“Franciscan argues that the lease holding fees for all the proposed DaVita projects should be counted as costs for each project. In other words, that Canyon Road lease costs should be included as costs for the Lakewood Community project, and vice-versa. This is completely illogical. The Department has always analyzed applications individually. Canyon Road costs are no more attributable to the Lakewood Community project than are the costs for DaVita’s recently approved Snohomish 3 project, and vice-versa.” [source: DaVita rebuttal comment, p4]

“Fresenius apparently does not accept the Department’s need methodology: it applied for only 24 stations: it applied for only 24 stations. All other applicants applied to meet the Department’s projected 44-station need. Fresenius criticizes these applications, arguing that they will have idle capacity (apparently based on Fresenius’s rejection of the Department’s need forecast), will have difficulty staffing 44 stations, and undermine continuity of care. The Department should approve 44 stations consistent with its need methodology. DaVita, and all other applicants with the exception of Fresenius, applied to meet the 44-station need through a sensible, staged approach.”

Additionally, Fresenius implies a faulty definition of “continuity of care”. Having a greater number of stations actually reduces the per-square-foot cost of a dialysis station, as many fixed costs remain the same regardless of the facility size. This is demonstrated by the inefficiencies of Fresenius’s approach which proposed a higher capital budget than DaVita to meet half the need that DaVita would meet. Most importantly, however, providing care continuity is not a function of facility size, but rather of maintaining proper staffing and a well-designed floorplan that allows for optimal line-of-sight for the clinicians to patients. In this respect, DaVita is the only applicant that has a proposed a facility that will both meet the demonstrated need and maximize patient safety and continuity of care.

Fresenius criticizes DaVita’s inclusion of space for three expansion stations at the proposed new Lakewood Community and Canyon Road facilities. These floorplans were designed prior to completion of the ongoing rulemaking process: we accounted for a +1 (consistent with the one-time isolation station adjustment) and a future +2 special circumstances application should circumstances warrant. Including space for these three future stations clearly is not excessive “over-building.” However, if the Department would prefer that DaVita shell this space as a condition for approval, DaVita would accept that condition.

Department Evaluation

CHI Franciscan asserted that lease agreement holding fees expended by DaVita for its two new dialysis centers (Towne Center and Canyon Road) should be included as capital expenditure for all three projects, including the Lakewood Community Dialysis Center station addition. WAC 246-310-280(2) provides the following definition of ‘capital expenditure’ as it relates to dialysis centers.

"Capital expenditures," as defined by Generally Accepted Accounting Principles (GAAP), are expenditures made to acquire tangible long-lived assets. Long-lived assets represent property and equipment used in a company's operations that have an estimated useful life greater than one year. Acquired long-lived assets are recorded at acquisition

cost and include all costs incurred necessary to bring the asset to working order. The definition of a capital expenditure includes the following types of expenditures or acquisitions:

- (a) A force account expenditure or acquisition (i.e., an expenditure for a construction project undertaken by a facility as its own contractor).
- (b) The costs of any site planning services (architect or other site planning consultant) including but not limited to studies, surveys, designs, plans, working drawings, specifications, and other activities (including applicant staff payroll and employee benefit costs, consulting and other services which, under GAAP or Financial Accounting Standards Board (FASB) may be chargeable as an operating or nonoperating expense).
- (c) Capital expenditure or acquisition under an operating or financing lease or comparable arrangement, or through donation, which would have required certificate of need review if the capital expenditure or acquisition had been made by purchase.
- (d) Building owner tenant improvements including but not limited to: Asbestos removal, paving, concrete, contractor's general conditions, contractor's overhead and profit, electrical, heating, ventilation and air conditioning systems (HVAC), plumbing, flooring, rough and finish carpentry and millwork and associated labor and materials, and utility fees.
- (e) Capital expenditures include donations of equipment or facilities to a facility.
- (f) Capital expenditures do not include routine repairs and maintenance costs that do not add to the utility of useful life of the asset."

The definition above does not include lease-holding fees. Therefore, CHI Franciscan's assertion that they should have been included is without merit.

FMC asserts that a 44-station facility is *abnormally large* and may have idle capacity because of its size. The department concurs that a 44-station facility is larger than the typical Washington State dialysis center. The numeric methodology discussed in the 'need' section of this evaluation projected a 44-station need in year 2019. The 44 station need is based on the projection of more than 400 dialysis patients in the entire Pierce 5 planning area for year 2019.²¹ It is the practice of the department to allow applicants to submit an application requesting the total number of stations projected in the numeric methodology.

One station can dialyze two patients each shift. Based on three patient shifts, one station could dialyze six patients each day. This is 100% capacity of a station. An addition of 44 stations in a planning area could accommodate a total of 264 new patients. All ESRD applicants, including FMC, have relied on the assumption that the majority of new patients projected in a planning area would use the new dialysis center proposed an application.

For example, FMC's application for Pierce County planning area #5 requests 24 stations or capacity for 144 patients. FMC projects to serve 95 patients in year 2019, which calculates to 66% of the total capacity of the 24 stations. DaVita, on the other hand, projects to serve 172 patients in the 44 new stations, regardless of whether the stations were located in Towne Center or Canyon

²¹ The methodology considers full capacity to be 4.8 patients per station or 80% utilization. This is a calculation to determine need for additional stations in a planning area. It is not considered 100% utilization of a station—six patients per station is 100% utilization.

Road. The 172 patients equates to 65% of the 264 patients projected in the planning area. A comparison of the projections submitted by DaVita and FMC for their projects, shows they assume a similar ramp up of patients at their new facilities. FMC does not provide specific reasons why DaVita's 44-station facility may have idle capacity, other than it is viewed by FMC to be '*abnormally large.*' Without specific rationale, the department does not find merit in FMC's position that the new facility would have idle capacity.

FMC expressed concerns about whether a 44-station facility would prohibit DaVita from reaching their projected volumes, and, consequently, whether their revenue and expense assumptions were too low under WAC 246-310-220(1). FMC stated that this would result in an increase in their costs and charges. The department already concluded that DaVita's volume, revenue, and expenses were reasonable under WAC 246-310-220(1). Therefore, FMC's comments regarding the effect of project cost on these assumptions are without merit.

FMC's concern that DaVita would have completed space for 47 stations, rather than 44 stations is not unfounded. FMC is correct in its statement that the department has recently denied applications for the inclusion of undisclosed expansion space in a single-line drawing. FMC asserts that DaVita's application should be denied for the inclusion of space for 3 more stations.

In its rebuttal, DaVita asserts that the floorplans were designed prior to completion of the ongoing rulemaking process, so DaVita included three extra stations in anticipation of one isolation station adjustment [increase] and a two station increase under future special circumstances. This approach by DaVita is premature. Further, the 'new dialysis rules' will not be discussed in this evaluation. If this project is approved, the department would attach a condition requiring DaVita to shell in the space with the three additional stations as offered by DaVita in its rebuttal statements. It should be noted that approval of shelled expansion space is not a guarantee that future station additions would be approved.

Documentation provided in the application shows DaVita-Towne Center's Medicare and Medicaid reimbursements are projected to equal 61.12% of the revenue at the dialysis center regardless of the number of approved stations. The department notes that Medicare and Medicaid patients typically make up the largest percentage of patients served by a dialysis facility. CMS implemented an ESRD Prospective Payment System (PPS). Under the new ESRD PPS, Medicare pays dialysis facilities a bundled rate per treatment. The rate is not the same for each facility.

Each facility, within a given geographic area, may receive the same base rate. However, there are a number of adjustments both at the facility and at patient-specific level that affects the final reimbursement rate each facility will receive. What a dialysis facility receives from its commercial payers will also vary. Even if two different dialysis providers billed the same commercial payer the same amount, the actual payment to each facility will depend on the negotiated discount rate obtained by the commercial payer from each individual provider. The department does not have an adopted standard on what constitutes an unreasonable impact on charges for health services. Based on department's understanding of how dialysis patients may qualify for Medicare payments, the department concludes that the information presented by DaVita about its revenue indicates this project may not have an unreasonable impact on charges for Medicare and Medicaid, since that revenue is dependent upon cost based reimbursement. The remaining 38.88% of DaVita's Towne Center's revenue will be derived through a variety of reimbursement sources such as private insurance.

DaVita provides the following statement related to its assumptions used for the Towne Center revenue and expense projections.

“These are expenses that are specific to the square footage of the building, not the size of the treatment floor. These costs are necessary to make the Canyon Road property ready for dialysis and will be incurred irrespective of the size of the award. ...”

[source: Screening Response, p9] [emphasis added]

DaVita does not explain why the costs required for the Canyon Road property would reliably translate to the costs required for the Towne Center project. While both the Canyon Road and Towne Center facilities are proposed to be located in the same planning area, the department requires all applications include specific information related to the project submitted. The reference above for the Towne Center project does not meet this requirement.

The department concludes that the assumptions used to demonstrate that the establishment of a 44-station dialysis center in Towne Center would probably not have an unreasonable impact on the costs and charges for healthcare services in Pierce County planning area #5 cannot be substantiated. **This sub-criterion is not met.**

33 New Stations

DaVita identified the costs for this project which is shown in Table 54 below. [source: Application, Appendix 7 & Screening Response, pp9-10 & Appendix 21]

**Table 54
Estimated Capital Costs for 33 New Stations**

Item	Totals
Construction/Leasehold Improvements	\$ 3,079,130
Professional Service/Architect Fees	\$ 337,000
Fixed and Moveable Equipment	\$ 1,309,242
Architect/Engineering Fees	\$ 2,000
Real Estate Commission	\$ 120,000
Total Estimated Capital Costs	\$ 4,847,372

DaVita provided the following statements related to the construction costs and equipment costs. [source: Screening Response, p9]

“The line items included in construction and leasehold improvements, with corresponding expenses, are as such:

Item	Totals
<i>Gross Interiors</i>	<i>\$ 2,387,650</i>
<i>Gross MBBI</i>	<i>\$ 498,750</i>
<i>Life Safety Systems* [fire alarm</i>	<i>\$ 192,730</i>
Total Construction Costs	\$ 3,079,130

**Life Safety includes items such as fire alarms and security system*

These are expenses that are specific to the square footage of the building, not the size of the treatment floor. These costs are necessary to make the Canyon Road property ready for dialysis and will be incurred irrespective of the size of the award. DaVita budgeted for the cost of entirely new stations for the full 44 station (Phase 1 and 2) and 33 station

(Phase 1) facility. We do not anticipate the use of any refurbished chairs, machines, or stations as part of this project. Should the Department approve 33 stations with 11 stations to be relocated from the existing Lakewood facility, the NLF [new Lakewood facility] has budgeted for 36 new chairs and dialysis machines and assumed that the remainder would be transferred from the existing Lakewood facility.”

Public Comment

CHI Franciscan provided comments focusing on DaVita’s ‘lease holding’ fees for its Towne Center and Canyon Road projects. The comments relate to the 44-station facility or a 33-station facility. For this Towne Center review, the comments and DaVita’s rebuttal statements are addressed in the 44-station review above and are not repeated in this 33-station review.

FMC provided comments related to idle capacity at a 44-station facility and the floor plans showing three stations, for a facility total of 47. For the Towne Center project, FMC’s comments appeared to focus on the 44-station center, rather than the 33-station center.

Rebuttal

See above statements

Department Evaluation

Documentation provided in the application shows DaVita-Towne Center’s Medicare and Medicaid reimbursements are projected to equal 61.12% of the revenue at the dialysis center regardless of the number of approved stations. The department notes that Medicare and Medicaid patients typically make up the largest percentage of patients served by a dialysis facility. CMS implemented an ESRD Prospective Payment System (PPS). Under the new ESRD PPS, Medicare pays dialysis facilities a bundled rate per treatment. The rate is not the same for each facility.

Each facility, within a given geographic area, may receive the same base rate. However, there are a number of adjustments both at the facility and at patient-specific level that affects the final reimbursement rate each facility will receive. What a dialysis facility receives from its commercial payers will also vary. Even if two different dialysis providers billed the same commercial payer the same amount, the actual payment to each facility will depend on the negotiated discount rate obtained by the commercial payer from each individual provider. The department does not have an adopted standard on what constitutes an unreasonable impact on charges for health services. Based on department’s understanding of how dialysis patients may qualify for Medicare payments, the department concludes that the information presented by DaVita about its revenue indicates this project may not have an unreasonable impact on charges for Medicare and Medicaid, since that revenue is dependent upon cost based reimbursement. The remaining 38.88% of DaVita-Towne Center’s revenue will be derived through a variety of reimbursement sources such as private insurance.

DaVita provides the following statement related to its assumptions used for the Towne Center revenue and expense projections.

“These are expenses that are specific to the square footage of the building, not the size of the treatment floor. These costs are necessary to make the Canyon Road property ready for dialysis and will be incurred irrespective of the size of the award. ...”

[source: Screening Response, p9] [emphasis added]

DaVita does not explain why the costs required for the Canyon Road property would reliably translate to the costs required for the Towne Center project. While both the Canyon Road and Towne Center facilities are proposed to be located in the same planning area, the department requires all applications include specific information related to the project submitted. The reference above for the Towne Center project does not meet this requirement.

The department concludes that the assumptions used to demonstrate that the establishment of a 44-station dialysis center in Towne Center would probably not have an unreasonable impact on the costs and charges for healthcare services in Pierce County planning area #5 cannot be substantiated. **This sub-criterion is not met.**

DaVita – Canyon Road

44 New Stations in Three Phases

DaVita identified the costs for this project which is shown in Table 55 below. [source: Application, Appendix 7 & Screening Response, pp6-8 & Appendix 21]

Table 55
Estimated Capital Costs for 44 New Stations [Three Phases]

Item	Totals
Construction/Leasehold Improvements	\$ 3,115,025
Professional Service/Architect Fees	\$ 337,000
Fixed and Moveable Equipment	\$ 1,502,157
Architect/Engineering Fees	\$ 3,000
Real Estate Commission	\$ 64,000
Total Estimated Capital Costs	\$ 5,021,182

DaVita provided the following statements related to the construction costs and equipment costs. [source: Screening Response, pp6-7]

“The line items included in construction and leasehold improvements, with corresponding expenses, are as such:

Item	Totals
<i>Gross Interiors</i>	<i>\$ 2,387,650</i>
<i>Gross MBBI</i>	<i>\$ 579,875</i>
<i>Life Safety Systems* [fire alarm</i>	<i>\$ 147,500</i>
Total Construction Costs	\$ 3,115,025

**Life Safety includes items such as fire alarms and security system*

“These are expenses that are specific to the square footage of the building, not the size of the treatment floor. These costs are necessary to make the Canyon Road property ready for dialysis and will be incurred irrespective of the size of the award. The overwhelming majority of costs are fixed, regardless of the ultimate size of the patient treatment floor. The cost difference that the Department notes is limited to Fixed and Moveable equipment that is purchased and maintained in direct proportion to the ultimate number of operational stations. For example, the Department may reference in Appendix 2 that 24 operational stations requires 27 dialysis machines while a 44 station unit requires 48 dialysis machines, an incremental addition of 21 machines over the life of the project.

If the Department approves the 44-station project, the casework cost for all 44 stations would be incurred as part of Phase I. If, however, the Department approves fewer than 44 stations, there would be less casework, reflecting fewer stations. Our construction company who will complete the Canyon Road project estimates that every station receives 8 feet of casework at a cost of \$324 per station. This cost includes the material, countertops, cabinet, shipping, and installation.

Therefore, if the Department were to approve 36 stations instead of 44, the equation to reduce final expenditures would be:

$$8 \text{ fewer stations} * \$324 \text{ per station} = \$2,592 \text{ cost reduction.}$$

Similar, if the Department were to approve 24 stations instead of 44, the equation to reduce final expenditures would be:

$$20 \text{ fewer stations} * \$324 \text{ per station} = \$6,480 \text{ cost reduction.}$$

It should be noted that these types of expenses are minimal due to the fact that the largest project expenses, such as HVAC, electrical, and sewage, must be accrued regardless of the final size of the treatment floor.”

Public Comment

CHI Franciscan provided comments focusing on DaVita’s ‘lease holding’ fees for both its Towne Center and Canyon Road projects. The comments focusing on the Canyon Road site and DaVita’s rebuttal statements will be addressed below for the 44-station review below, but not readdressed in the 36-station review.

CHI Franciscan

“DV invested significant resources in submitting three applications, requesting a total of 103 new stations. CHI Franciscan concludes that the costs associated with DV’s commitments to its different projects in this concurrent review must be included as part of the capital expenditure of any project. Two of these three applications include executed lease agreements that require DV to pay holding fees of \$9,645/month and \$10,406, respectively. DV will incur these costs regardless of the outcome of this CN process and regardless of which (if any) of its projects are approved. Therefore, these costs should be included across all projects, including the 15 station expansion.”

[source: CHI Franciscan public comment, p2]

FMC Comments

“While there is demonstrated need for 44 additional dialysis stations in the Pierce Five planning area in 2019, it is unknown if an abnormally large dialysis facility will reach expected patient capacity. As a result, there is a high probability that, once built, DVA's facility will be idle because of its size. Idle capacity is an inefficient use of space and scarce resources, putting pressure on patient costs and charges to compensate for the low patient volume. The combination of high direct project costs and the significant number of proposed stations results in a facility that may negatively impact patient costs and charges. If patient volumes are lower than expected, which is likely as DVA predicts as many as 115 patients by the third full year of operation after Phase I, and 212 patients by the third full year after Phase II. If this is the case, DVA's facility will not be able to cover operational expenses. Raising patient costs and charges in the event of low volumes is the only feasible approach that DVA could implement to keep its facility operational and avoid operating losses.

In the first few years of operation the high facility costs may adversely affect patients. Again, this is particularly applicable in the probably event that DVA's proposed facility does not reach expected patient volumes. Even if it only opens the first phase of its project (24 stations), the high capital expenditures of the facility will translate into high cost per station, rendering its project inefficient and a misuse of scarce resources. These losses are likely to negatively and unreasonably impact costs and charges for health services. Due to the likelihood of idle capacity, which will result in lower project net profits, in both the short- and long-run, DVA's proposed facility in the city of Lakewood fails to fulfill the CN financial feasibility standards."

The single line drawing provided in Appendix 16 of DVA's CN #16-36 shows expansion space for up to 3 additional stations beyond its current request for 44 stations, with total facility build-out capacity of 47 dialysis stations. DVA does not otherwise mention these additional stations in its CN application.

The department has recently denied several CN applications for the inclusion of undisclosed expansion space in the single line drawing. ...As a result of the overbuilt project, the department finds that 'it is reasonable to expect [non-Medicare/Medicaid patient] rates are higher than necessary to support the unnecessary capital operating costs of this overbuilt facility.' ...In this instance, DVA's single line drawing for its proposed Canyon Road facility shows that the three additional stations would be located in the main treatment area. Thus, the space for these expansion stations would need to be completed as part of this initial project. DVA did not explain if it planned to utilize space allocated for future stations productively and cost-effectively, or if it will leave this space as idle capacity. Based on existing, available information, it appears this space will be idle. DVA's requested 44-station facility already has high risk of idle capacity. Three additional dialysis stations at its proposed facility will not be necessary for many years, if at all. As a result, this space will likely remain idle and the costs to build out the expansion station space will be paid for by costs and charges for dialysis treatments provided by the 44-stations. [source: FMC public comment, pp8-9]

Rebuttal

"Franciscan argues that the lease holding fees for all the proposed DaVita projects should be counted as costs for each project. In other words, that Canyon Road lease costs should be included as costs for the Lakewood Community project, and vice-versa. This is completely illogical. The Department has always analyzed applications individually. Canyon Road costs are no more attributable to the Lakewood Community project than are the costs for DaVita's recently approved Snohomish 3 project, and vice-versa." [source: DaVita rebuttal comment, p4]

"Fresenius apparently does not accept the Department's need methodology: it applied for only 24 stations. All other applicants applied to meet the Department's projected 44-station need. Fresenius criticizes these applications, arguing that they will have idle capacity (apparently based on Fresenius's rejection of the Department's need forecast), will have difficulty staffing 44 stations, and undermine continuity of care. The Department should approve 44 stations consistent with its need methodology. DaVita, and all other applicants with the exception of Fresenius, applied to meet the 44-station need through a sensible, staged approach."

Additionally, Fresenius implies a faulty definition of "continuity of care". Having a greater number of stations actually reduces the per-square-foot cost of a dialysis station, as many fixed costs remain the same regardless of the facility size. This is demonstrated by the inefficiencies of Fresenius's approach which proposed a higher capital budget than DaVita to meet half the need

that DaVita would meet. Most importantly, however, providing care continuity is not a function of facility size, but rather of maintaining proper staffing and a well-designed floorplan that allows for optimal line-of-sight for the clinicians to patients. In this respect, DaVita is the only applicant that has a proposed a facility that will both meet the demonstrated need and maximize patient safety and continuity of care.

Fresenius criticizes DaVita's inclusion of space for three expansion stations at the proposed new Lakewood Community and Canyon Road facilities. These floorplans were designed prior to completion of the ongoing rulemaking process: we accounted for a +1 (consistent with the one-time isolation station adjustment) and a future +2 special circumstances application should circumstances warrant. Including space for these three future stations clearly is not excessive "over-building." However, if the Department would prefer that DaVita shell this space as a condition for approval, DaVita would accept that condition. [source: DaVita rebuttal comment, p6]

Department Evaluation

CHI Franciscan asserted that lease agreement holding fees expended by DaVita for its two new dialysis centers (Towne Center and Canyon Road) should be included as capital expenditure for all three projects, including the Lakewood Community Dialysis Center station addition. WAC 246-310-280(2) provides the following definition of 'capital expenditure' as it relates to dialysis centers.

"Capital expenditures," as defined by Generally Accepted Accounting Principles (GAAP), are expenditures made to acquire tangible long-lived assets. Long-lived assets represent property and equipment used in a company's operations that have an estimated useful life greater than one year. Acquired long-lived assets are recorded at acquisition cost and include all costs incurred necessary to bring the asset to working order. The definition of a capital expenditure includes the following types of expenditures or acquisitions:

- (a) A force account expenditure or acquisition (i.e., an expenditure for a construction project undertaken by a facility as its own contractor).*
- (b) The costs of any site planning services (architect or other site planning consultant) including but not limited to studies, surveys, designs, plans, working drawings, specifications, and other activities (including applicant staff payroll and employee benefit costs, consulting and other services which, under GAAP or Financial Accounting Standards Board (FASB) may be chargeable as an operating or nonoperating expense).*
- (c) Capital expenditure or acquisition under an operating or financing lease or comparable arrangement, or through donation, which would have required certificate of need review if the capital expenditure or acquisition had been made by purchase.*
- (d) Building owner tenant improvements including but not limited to: Asbestos removal, paving, concrete, contractor's general conditions, contractor's overhead and profit, electrical, heating, ventilation and air conditioning systems (HVAC), plumbing, flooring, rough and finish carpentry and millwork and associated labor and materials, and utility fees.*
- (e) Capital expenditures include donations of equipment or facilities to a facility.*
- (f) Capital expenditures do not include routine repairs and maintenance costs that do not add to the utility of useful life of the asset."*

The definition above does not include lease-holding fees. Therefore, CHI Franciscan's assertion that they should have been included is without merit.

FMC asserts that a 44-station facility is *abnormally large* and may have idle capacity because of its size. The department concurs that a 44-station facility is larger than the typical Washington State dialysis center. The numeric methodology discussed in the 'need' section of this evaluation projected a 44-station need in year 2019. The 44 station need is based on the projection of more than 400 dialysis patients in the entire Pierce 5 planning area for year 2019.²² It is the practice of the department to allow applicants to submit an application requesting the total number of stations projected in the numeric methodology.

One station can dialyze two patients each shift. Based on three patient shifts, one station could dialyze six patients each day. This is 100% capacity of a station. An addition of 44 stations in a planning area could accommodate a total of 264 new patients. All ESRD applicants, including FMC, have relied on the assumption that the majority of new patients projected in a planning area would use the new dialysis center proposed an application.

For example, FMC's application for Pierce County planning area #5 requests 24 stations or capacity for 144 patients. FMC projects to serve 95 patients in year 2019, which calculates to 66% of the total capacity of the 24 stations. DaVita, on the other hand, projects to serve 172 patients in the 44 new stations, regardless of whether the stations were located in Towne Center or Canyon Road. The 172 patients equates to 65% of the 264 patients projected in the planning area. A comparison of the projections submitted by DaVita and FMC for their projects, shows they assume a similar ramp up of patients at their new facilities. FMC does not provide specific reasons why DaVita's 44-station facility may have idle capacity, other than it is viewed by FMC to be '*abnormally large.*' Without specific rationale, the department does not find merit in FMC's position that the new facility would have idle capacity.

FMC expressed concerns about whether a 44-station facility would prohibit DaVita from reaching their projected volumes, and, consequently, whether their revenue and expense assumptions were too low under WAC 246-310-220(1). FMC stated that this would result in an increase in their costs and charges. The department already concluded that DaVita's volume, revenue, and expenses were reasonable under WAC 246-310-220(1). Therefore, FMC's comments regarding the effect of project cost on these assumptions are without merit.

FMC's concern that DaVita would have completed space for 47 stations, rather than 44 stations is not unfounded. FMC is correct in its statement that the department has recently denied applications for the inclusion of undisclosed expansion space in a single-line drawing. FMC asserts that DaVita's application should be denied for the inclusion of space for 3 more stations. It should be noted that approval of shelled expansion space is not a guarantee that future station additions would be approved.

In its rebuttal, DaVita asserts that the floorplans were designed prior to completion of the ongoing rulemaking process, so DaVita included three extra stations in anticipation of one isolation station adjustment [increase] and a two station increase under future special circumstances. This approach

²² The methodology considers full capacity to be 4.8 patients per station or 80% utilization. This is a calculation to determine need for additional stations in a planning area. It is not considered 100% utilization of a station—six patients per station is 100% utilization.

by DaVita is premature. Further, the ‘new dialysis rules’ will not be discussed in this evaluation. If this project is approved, the department would attach a condition requiring DaVita to shell in the space with the three additional stations as offered by DaVita in its rebuttal statements.

Documentation provided in the application shows DaVita-Canyon Road’s Medicare and Medicaid reimbursements are projected to equal 61.12% of the revenue at the dialysis center regardless of the number of approved stations. The department notes that Medicare and Medicaid patients typically make up the largest percentage of patients served by a dialysis facility. CMS implemented an ESRD Prospective Payment System (PPS). Under the new ESRD PPS, Medicare pays dialysis facilities a bundled rate per treatment. The rate is not the same for each facility.

Each facility, within a given geographic area, may receive the same base rate. However, there are a number of adjustments both at the facility and at patient-specific level that affects the final reimbursement rate each facility will receive. What a dialysis facility receives from its commercial payers will also vary. Even if two different dialysis providers billed the same commercial payer the same amount, the actual payment to each facility will depend on the negotiated discount rate obtained by the commercial payer from each individual provider. The department does not have an adopted standard on what constitutes an unreasonable impact on charges for health services. Based on department’s understanding of how dialysis patients may qualify for Medicare payments, the department concludes that the information presented by DaVita about its revenue indicates this project may not have an unreasonable impact on charges for Medicare and Medicaid, since that revenue is dependent upon cost based reimbursement. The remaining 38.88% of DaVita’s Canyon Road’s revenue will be derived through a variety of reimbursement sources such as private insurance.

Based on the above information provided in the application, the department concludes that the establishment of a 44-station dialysis center at the Canyon Road site would probably not have an unreasonable impact on the costs and charges for healthcare services in Pierce County planning area #5. This conclusion is based on DaVita’s agreement to a condition requiring that the space for the three additional stations be shelled in. Provided that DaVita agree to the space condition, **this sub-criterion is met.**

36 New Stations in Two Phases

DaVita identified the costs for this project which is shown in Table 56 below. [source: Application, Appendix 7 & Screening Response, pp6-8 & Appendix 21]

**Table 56
Estimated Capital Costs for 36 New Stations [Phases One and Two]**

Item	Totals
Construction/Leasehold Improvements	\$ 3,115,025
Professional Service/Architect Fees	\$ 337,000
Fixed and Moveable Equipment	\$ 1,349,092
Architect/Engineering Fees	\$ 3,000
Real Estate Commission	\$ 64,000
Total Estimated Capital Costs	\$ 4,868,117

DaVita provided the following statements related to the construction costs and equipment costs. [source: Screening Response, pp6-7]

“The line items included in construction and leasehold improvements, with corresponding expenses, are as such:

Item	Totals
<i>Gross Interiors</i>	<i>\$ 2,387,650</i>
<i>Gross MBBI</i>	<i>\$ 579,875</i>
<i>Life Safety Systems* [fire alarm</i>	<i>\$ 147,500</i>
Total Construction Costs	\$ 3,115,025

**Life Safety includes items such as fire alarms and security system*

“These are expenses that are specific to the square footage of the building, not the size of the treatment floor. These costs are necessary to make the Canyon Road property ready for dialysis and will be incurred irrespective of the size of the award. The overwhelming majority of costs are fixed, regardless of the ultimate size of the patient treatment floor. The cost difference that the Department notes is limited to Fixed and Moveable equipment that is purchased and maintained in direct proportion to the ultimate number of operational stations. For example, the Department may reference in Appendix 2 that 24 operational stations requires 27 dialysis machines while a 44 station unit requires 48 dialysis machines, an incremental addition of 21 machines over the life of the project.

If the Department approves the 44-station project, the casework cost for all 44 stations would be incurred as part of Phase 1. If, however, the Department approves fewer than 44 stations, there would be less casework, reflecting fewer stations. Our construction company who will complete the Canyon Road project estimates that every station receives 8 feet of casework at a cost of \$324 per station. This cost includes the material, countertops, cabinet, shipping, and installation.

Therefore, if the Department were to approve 36 stations instead of 44, the equation to reduce final expenditures would be:

$$8 \text{ fewer stations} * \$324 \text{ per station} = \$2,592 \text{ cost reduction.}$$

Similar, if the Department were to approve 24 stations instead of 44, the equation to reduce final expenditures would be:

$$20 \text{ fewer stations} * \$324 \text{ per station} = \$6,480 \text{ cost reduction.}$$

It should be noted that these types of expenses are minimal due to the fact that the largest project expenses, such as HVAC, electrical, and sewage, must be accrued regardless of the final size of the treatment floor.”

Public Comment

CHI Franciscan provided comments focusing on DaVita’s ‘lease holding’ fees for its Towne Center and Canyon Road projects. The comments relate to the 44-station facility or a 36-station facility. The comments focusing on the Canyon Road project and DaVita’s rebuttal statements are addressed in the 44-station review above and are not repeated in this 36-station review.

FMC provided comments related to idle capacity at a 44-station facility and the floor plans showing three stations, for a facility total of 47. For the Canyon Road project, FMC’s comments appeared to focus on the 44-station center, rather than the 36-station center.

Rebuttal

See above statements

Department Evaluation

Documentation provided in the application shows DaVita-Canyon Road's Medicare and Medicaid reimbursements are projected to equal 61.12% of the revenue at the dialysis center regardless of the number of approved stations. The department notes that Medicare and Medicaid patients typically make up the largest percentage of patients served by a dialysis facility. CMS implemented an ESRD Prospective Payment System (PPS). Under the new ESRD PPS, Medicare pays dialysis facilities a bundled rate per treatment. The rate is not the same for each facility.

Each facility, within a given geographic area, may receive the same base rate. However, there are a number of adjustments both at the facility and at patient-specific level that affects the final reimbursement rate each facility will receive. What a dialysis facility receives from its commercial payers will also vary. Even if two different dialysis providers billed the same commercial payer the same amount, the actual payment to each facility will depend on the negotiated discount rate obtained by the commercial payer from each individual provider. The department does not have an adopted standard on what constitutes an unreasonable impact on charges for health services. Based on department's understanding of how dialysis patients may qualify for Medicare payments, the department concludes that the information presented by DaVita about its revenue indicates this project may not have an unreasonable impact on charges for Medicare and Medicaid, since that revenue is dependent upon cost based reimbursement. The remaining 38.88% of DaVita's Canyon Road's revenue will be derived through a variety of reimbursement sources such as private insurance.

Based on the above information provided in the application, the department concludes that the establishment of a 36-station dialysis center at the Canyon Road site would probably not have an unreasonable impact on the costs and charges for healthcare services in Pierce County planning area #5. **This sub-criterion is met.**

Department Superiority Review

For this sub-criterion, the department used net revenue per treatment (including in-center and home treatments) to assist in its evaluation of what could be an unreasonable impact on costs and charges. The department used data already provided within this sub-criterion to perform this superiority review.

The department calculated net revenue per treatment by dividing a facility's net revenue (before expenses) by total projected treatments (including home treatments) in that same year.

Though some applicants proposed more than one sub-project within a single application, the difference in net revenue per treatment by sub-project was negligible. Therefore, the department completed this superiority review by ranking the applications – not the sub-projects. Using this format, each sub-project within a single application would be tied. The superiority review is shown on the next page in Table 57.

Table 57
Department Superiority Review of WAC 246-310-220(2)

Applicant/Application	Medicare	Medicaid	Commercial	Net Revenue per Treatment	Ranking
CHI Franciscan:	69%	5%	26%	≈\$377	2
Puget Sound Kidney Centers	71%	5%	24%	≈\$262	1
Fresenius	30%	4%	66%	≈\$506	5
DaVita – Lakewood Community	68%	1%	31%	≈\$406	3
DaVita – Towne Center	57%	5%	39%	≈\$449	4
DaVita – Canyon Road	57%	5%	39%	≈\$449	4

In the event that one or more applications meet all of the applicable review criteria, this superiority information may be used in the departments evaluation of WAC 246-310-240(1) Step 3. In the event that only one application meets all of the applicable review criteria, this superiority information will not be used.

(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.

CHI Franciscan

CHI Franciscan identified the capital costs for the project and included allocation of construction costs that were expended when the building was originally constructed. The actual costs that CHI Franciscan would pay for this facility would be \$6,624,827 for both phases one and two, and \$5,034,895 for phase one alone. The costs are related to construction, fixed and moveable equipment, and associated permits, fees, and taxes. [source: Screening Response Attachment 6]

CHI Franciscan intends to finance the project using existing capital reserves. CHI Franciscan provided a letter of financial commitment from the Mike Fitzgerald, CFO. [Screening Response Attachment 2]

CHI Franciscan also provided audited financial statements for fiscal years 2014 and 2015 to demonstrate availability of funding. [source: Application, Appendix 1 & Screening Response Attachment 11]

Public Comment

None

Rebuttal

None

Department Evaluation

CHI Franciscan’s actual costs to establish a 28-station, one-phase dialysis center would be \$5,034,895. CHI Franciscan’s actual costs to establish a 44-station, two-phase dialysis center would be \$6,624,827. CHI intends to finance the project with reserves and demonstrated the costs

can be financed. If this project is approved, the department would attach a condition requiring CHI to finance the project consistent with the financing description provided in the application.

With a financing condition, the department concludes the Franciscan Lakewood Dialysis Center project **meets this sub-criterion**.

Puget Sound Kidney Centers

PSKC intends to finance the project using existing capital reserves. PSKC provided a letter of financial commitment from Fontelle Jones, the Treasurer of PSKC’s Board of Directors. [Screening Response Attachment 2]

PSKC also provided audited financial statements for fiscal years 2014 and 2015 to demonstrate availability of funding. [source: Screening Response Attachment 11]

Public Comment

None

Rebuttal

None

Department Evaluation

PSKC’s actual costs to establish each of their proposed configurations of a new dialysis center are shown below in Table 58. [sources: Application p30, Screening Response Attachment 3]

**Table 58
PSKC Estimated Capital Expenditures by Phase Size**

	1 Phase Project			2-Phase Project, 44 Stations Total		
	Phase 1 Size			Phase 1 Size		
# Stations	16	20	22	16	20	22
Capital Expenditure	\$6,848,944	\$6,928,319	\$7,035,532	\$10,888,801	\$10,888,801	\$10,888,801

PSKC intends to finance the project with reserves and demonstrated the costs can be financed. If this project is approved, the department would attach a condition requiring PSKC to finance the project consistent with the financing description provided in the application.

With a financing condition, the department concludes the PSKC Lakewood project **meets this sub-criterion**.

Fresenius Medical Care

FMC intends to finance the project using existing capital reserves. FMC provided a letter of financial commitment from Mark Fawcett, Senior Vice President & Treasurer at FMC. [source: Application Exhibit 7]

FMC also provided audited financial statements for fiscal years 2013, 2014, and 2015 to demonstrate availability of funding. [source: Screening Response Exhibit 15]

Public Comment

None

Rebuttal

None

Department Evaluation

FMC's actual costs to establish a 24-station, one-phase dialysis center would be \$2,155,782. FMC intends to finance the project with reserves and demonstrated the costs can be financed. If this project is approved, the department would attach a condition requiring FMC to finance the project consistent with the financing description provided in the application.

With a financing condition, the department concludes the FKC Fredrickson project **meets this sub-criterion.**

DaVita – Lakewood Community Dialysis Center

The actual costs DaVita will pay for this 15-station addition is \$303,830 and DaVita intends to fund the project using corporate reserves. DaVita provided a letter from its corporate chief operating officer for kidney care to demonstrate an operational and financial commitment to the project. [source: Application, p22 & Appendix 6]

DaVita also provided a copy of its audited financial statements for years 2012, 2013, and 2014 to demonstrate sufficient reserves to finance the project. [source: Screening Response, Appendix 10]

Public Comment

None

Rebuttal

None

Department Evaluation

DaVita's actual costs to add 15 dialysis stations to Lakewood Community Dialysis Center is \$303,830. DaVita intends to finance the project with reserves and demonstrated the costs can be financed. If this project is approved, the department would attach a condition requiring DaVita to finance the project consistent with the financing description provided in the application.

With a financing condition, the department concludes the DaVita-Lakewood Community Dialysis Center project **meets this sub-criterion.**

DaVita – Towne Center

44 New Stations in Two Phases

DaVita identified a capital expenditure of \$5,043,257 to establish a 44-station facility in two phases. Regardless of the size of project, DaVita intends to fund the project using corporate reserves. DaVita provided a letter from its corporate chief operating officer for kidney care to demonstrate an operational and financial commitment to the project. [source: Application, p23 & Appendix 6]

DaVita also provided a copy of its audited financial statements for years 2012, 2013, and 2014 to demonstrate sufficient reserves to finance the project. [source: Screening response, Appendix 10]

Public Comment

None

Rebuttal

None

Department Evaluation

DaVita intends to finance the project with reserves and demonstrated the costs can be financed. If this project is approved, the department would attach a condition requiring DaVita to finance the project consistent with the financing description provided in the application.

With a financing condition, the department concludes the DaVita-Towne Center 44-station project **meets this sub-criterion.**

33 New Stations

DaVita identified a capital expenditure of \$4,847,372 to establish a 33-station facility with no phases. Regardless of the size of project, DaVita intends to fund the project using corporate reserves. DaVita provided a letter from its corporate chief operating officer for kidney care to demonstrate an operational and financial commitment to the project. [source: Application, p23 & Appendix 6]

DaVita also provided a copy of its audited financial statements for years 2012, 2013, and 2014 to demonstrate sufficient reserves to finance the project. [source: Screening Response, Appendix 10]

Public Comment

None

Rebuttal

None

Department Evaluation

DaVita intends to finance the project with reserves and demonstrated the costs can be financed. If this project is approved, the department would attach a condition requiring DaVita to finance the project consistent with the financing description provided in the application.

With a financing condition, the department concludes the DaVita-Towne Center 33-station project **meets this sub-criterion.**

DaVita – Canyon Road

44 New Stations in Three Phases

DaVita identified a capital expenditure of \$5,021,182 to establish a 44-station facility in three phases. Regardless of the size of project, DaVita intends to fund the project using corporate reserves. DaVita provided a letter from its corporate chief operating officer for kidney care to demonstrate an operational and financial commitment to the project. [source: Application, p23 and Appendix 6]

DaVita also provided a copy of its audited financial statements for years 2012, 2013, and 2014 to demonstrate sufficient reserves to finance the project. [source: Screening Response, Appendix 10]

Public Comment

None

Rebuttal

None

Department Evaluation

DaVita intends to finance the project with reserves and demonstrated the costs can be financed. If this project is approved, the department would attach a condition requiring DaVita to finance the project consistent with the financing description provided in the application.

With a financing condition, the department concludes the DaVita-Canyon Road 44-station project **meets this sub-criterion.**

36 New Stations in Two Phases

DaVita identified a capital expenditure of \$4,868,117 to establish a 36-station facility in two phases. Regardless of the size of project, DaVita intends to fund the project using corporate reserves. DaVita provided a letter from its corporate chief operating officer for kidney care to demonstrate an operational and financial commitment to the project. [source: Application, p23 & Appendix 6]

DaVita also provided a copy of its audited financial statements for years 2012, 2013, and 2014 to demonstrate sufficient reserves to finance the project. [source: Screening Response, Appendix 10]

Public Comment

None

Rebuttal

None

Department Evaluation

DaVita intends to finance the project with reserves and demonstrated the costs can be financed. If this project is approved, the department would attach a condition requiring DaVita to finance the project consistent with the financing description provided in the application.

With a financing condition, the department concludes the DaVita-Canyon Road 36-station project **meets this sub-criterion.**

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

CHI Franciscan

Based on the source information reviewed, the department concludes that the CHI Franciscan project – whether as a 28-station facility in one phase or a 44-station facility in two phases – has not met the structure and process of care criteria in WAC 246-310-230.

Puget Sound Kidney Centers

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department concludes that the Puget Sound Kidney Centers project – whether as a 16-station, 20-station, 22-station, or 44-station (regardless of configuration) – has met the structure and process of care criteria in WAC 246-310-230

Fresenius Medical Care

Based on the source information reviewed, the department concludes that the Fresenius Medical Care project has not met the structure and process of care criteria in WAC 246-310-230

DaVita Healthcare Partners, Inc.

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department concludes that the DaVita Lakewood Community Dialysis Center project has met the structure and process of care criteria in WAC 246-310-230

DaVita Healthcare Partners, Inc.

Based on the source information reviewed, the department concludes that the DaVita Towne Center project – whether as a new 33 or 44-station facility – has met the structure and process of care criteria in WAC 246-310-230

DaVita Healthcare Partners, Inc.

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department concludes that the DaVita Canyon Road project – whether as a new 36 or 44-station facility – has met the structure and process of care criteria in WAC 246-310-230

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

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

CHI Franciscan

Franciscan Lakewood would be a new facility in the planning area. Tables 59 and 60 below provide breakdowns of projected FTEs for calendar years 2018 through 2023. [source: Screening Response Attachment 3]

Table 59
Phase 1 FTEs – Franciscan Lakewood

Number of Stations	28	28	28	28
FTE by Type	2018	2019 increase	2020 increase	Phase 1 Total
HD Tech	12.25	3.35	2.40	18.00
Technical Service Coordinator	0.50	0.00	0.00	0.50
RNs	7.20	0.40	0.20	7.80
Clinical Nurse Manager	1.00	0.00	0.00	1.00
Dept Support	1.00	0.00	0.00	1.00
MSW	1.00	0.25	0.25	1.50
Dietician	1.00	0.25	0.25	1.50
Total Added	--	4.25	3.10	7.35
Total	23.95	28.20	31.30	31.30

Table 60
Phases 1 and 2 FTEs – Franciscan Lakewood

Number of Stations	28	44	44	44	44
FTE by Type	2020	2021 increase	2022 increase	2023 increase	Phases 1 and 2 Total
HD Tech	18.00	1.25	2.20	2.20	23.65
Technical Service Coordinator	0.50	0.00	0.25	0.25	1.00
RNs	7.80	0.40	0.20	0.20	8.60
Clinical Nurse Manager	1.00	0.00	0.00	0.00	1.00
Dept Support	1.00	0.50	0.00	0.50	2.00
MSW	1.50	0.25	0.25	0.00	2.00
Dietician	1.50	0.25	0.25	0.00	2.00
Total Added	--	2.65	3.15	3.15	16.30
Total	31.30	33.95	37.10	40.25	40.25

CHI Franciscan provided the following statements related to recruitment and retention of staff for this proposed Lakewood facility:

For an organization the size of CHI Franciscan, the staffing needs noted in Table 16 are not significant. In an effort to assure that we always have the staff needed to support our existing and proposed new programs, CHI Franciscan offers a competitive wage and benefit package as well as numerous other recruitment and retention strategies. In addition, we have some highly trained and qualified dialysis staff that live closer to Lakewood and have expressed interest in relocating.

Specific strategies for clinical, ancillary and support staff include:

- *CHI Franciscan offers, and will continue to offer, a generous benefit package for both full and part time employees that includes: Medical, Dental, Paid Time Off/Extended Illness/Injury Time, Employee Assistance Plans, and a Tuition Reimbursement Program, among other benefits.*

- *CHI Franciscan posts all of its openings on our website via our online applicant tracking system. In addition to our own website, CHI Franciscan has contracts with several job boards serving the greater South Sound area to post all of our openings on the online postings sites; nwjobs.com site operated by the Seattle Times, and southsoundjobs.com operated by The News Tribune of Tacoma.*
- *CHI Franciscan currently has contracts with more than 40 technical colleges, community colleges, and four year universities throughout the United States that enable us to offer either training and/or job opportunities. In addition, CHI Franciscan Education Services staff serves on healthcare program advisory boards and as clinical or affiliate faculty at a number of local institutions. CHI Franciscan constantly monitors the “wage” market, making adjustments as necessary to ensure that our hospitals’ wage structures remains competitive.*
- *CHI Franciscan provides a career counselor who is available to all staff to encourage development and growth within the healthcare industry. This is further supported through a tuition reimbursement program and referrals to state and federal funds for continuing education. In addition, the Franciscan Foundation has annual scholarships available for current employees to advance their education.*
- *CHI Franciscan’s various facilities serve as clinical training sites for healthcare specialties such as nursing, diagnostic imaging, physical/occupational therapy, and pharmacy (to name a few).*
- *CHI Franciscan also offers various other recruitment strategies (i.e., nursing new grad events, nursing school class visits, job fairs, career days, direct e- mail campaigns, etc.) as other ways to bring new healthcare workers to the CHI Franciscan organization.*
- *CHI Franciscan works closely with agency personnel, not only to negotiate rates but to also ensure that agency staff is able to provide the same high quality skill level that CHI Franciscan requires of our own employees.*
- *CHI Franciscan recruiters regularly attend local job fairs that reach targeted applicants within the greater Puget Sound area. These efforts have been extremely effective due, in large part, to the outstanding reputation CHI Franciscan has garnered as being an employer of choice due to our “Best Place to Work” initiatives.*

Given the above, CHI Franciscan does not anticipate any difficulty in securing the quality staff needed for the proposed Franciscan Lakewood.” [source: Application pp36-37]

The medical director was not included in these tables, as that position is filled by contract. CHI Franciscan provided a copy of the draft medical director contract between CHI Franciscan and Dr. Melissa Yeh Kaptik. The draft agreement includes all duties and responsibilities, compensation (which is consistent with the figures provided in the pro forma financial projections), and outlines a 3 year term with unlimited 1 year renewals. In addition to this, the application included a letter from Dr. Kaptik confirming her support for the project and intent to serve as the medical director. If this project is approved, the department would attach a condition related to this sub-criterion that would require CHI Franciscan to provide an executed copy of this agreement.

Public Comment

None

Rebuttal

None

Department Evaluation

CHI Franciscan is proposing to establish a new facility in the planning area. Information provided in the application demonstrates that CHI is a well-established provider of dialysis services. Specific to Washington State, CHI has been providing services in Washington State since approximately 1976. For Pierce County planning area #5, does not operate any dialysis centers; however has several centers throughout the rest of Pierce County. Based on the above information, the department concludes that CHI has the ability and expertise to recruit and retain a sufficient supply of qualified staff for this project.

The department concludes the CHI project **meets this sub-criterion.**

Puget Sound Kidney Centers

PSKC would be a new facility in the planning area. Table 61 through Table 66 below provide breakdowns of projected FTEs for calendar years 2018 through 2024 for each of the different configurations submitted by PSKC. [source: Application p34, Screening Response Attachment 7]

**Table 61
FTEs – 16-Station Facility in One Phase**

Number of Stations	16 2018 partial year	16 2019 increase	16 2020 increase	16 2021 increase	16 2021 total
Direct Care Manager	1.00	0.00	0.00	0.00	1.00
RNs	2.00	1.00	1.00	0.00	4.00
Care Coordinator	0.00	0.00	0.00	1.00	1.00
Home RN	0.20	0.00	0.20	0.00	0.40
Dialysis Tech	6.00	3.00	3.00	1.00	13.00
Technical Services	3.10	0.30	0.15	0.55	4.10
Social Worker	0.50	0.10	0.15	0.25	1.00
Dietician	0.50	0.10	0.15	0.25	1.00
Admin Coordinator	0.60	0.15	0.00	0.00	0.75
Admin Assistant	0.60	0.15	0.00	0.00	0.75
Total Added	--	4.80	4.65	3.05	--
Total	14.50	19.30	23.95	27.00	27.00

Table 62
FTEs – 44 station facility in Two Phases

Number of Stations	16	44	44	44	44
	2021	2022 increase	2023 increase	2024 increase	2024 total
Direct Care Manager	1.00	0.00	0.00	0.00	1.00
RNs	4.00	2.00	1.00	1.00	8.00
Care Coordinator	1.00	0.00	0.50	0.50	2.00
Home RN	0.40	0.10	0.10	0.20	0.80
Dialysis Tech	13.00	7.00	6.00	4.00	30.00
Technical Services	4.10	1.40	0.00	0.25	5.75
Social Worker	1.00	0.50	0.00	0.50	2.00
Dietician	1.00	0.50	0.00	0.50	2.00
Admin Coordinator	0.75	0.25	0.00	0.00	1.00
Admin Assistant	0.75	0.25	0.00	0.00	1.00
Total Added	--	12.00	7.60	6.95	--
Total	27.00	39.00	46.60	53.55	53.55

Table 63
FTEs – 20-Station Facility in One Phase

Number of Stations	20	20	20	20	20
	2018 partial year	2019 increase	2020 increase	2021 increase	2021 total
Direct Care Manager	1.00	0.00	0.00	0.00	1.00
RNs	2.00	1.00	1.00	2.00	6.00
Care Coordinator	0.00	0.00	0.00	1.00	1.00
Home RN	0.20	0.00	0.20	0.00	0.40
Dialysis Tech	6.00	2.50	3.50	4.00	16.00
Technical Services	3.10	0.30	0.15	0.55	4.10
Social Worker	0.50	0.10	0.15	0.25	1.00
Dietician	0.50	0.10	0.15	0.25	1.00
Admin Coordinator	0.60	0.15	0.00	0.00	0.75
Admin Assistant	0.60	0.15	0.00	0.00	0.75
Total Added	--	4.30	5.15	8.05	--
Total	14.50	18.80	23.95	32.00	32.00

Table 64
FTEs – 44 station facility in Two Phases

Number of Stations	20	44	44	44	44
	2021	2022 increase	2023 increase	2024 increase	2024 total
Direct Care Manager	1.00	0.00	0.00	0.00	1.00
RNs	6.00	0.00	1.00	1.00	8.00
Care Coordinator	1.00	0.00	0.50	0.50	2.00
Home RN	0.40	0.10	0.10	0.20	0.80
Dialysis Tech	16.00	4.00	4.50	5.50	30.00
Technical Services	4.10	1.40	0.00	0.25	5.75
Social Worker	1.00	0.50	0.00	0.50	2.00
Dietician	1.00	0.50	0.00	0.50	2.00
Admin Coordinator	0.75	0.25	0.00	0.00	1.00
Admin Assistant	0.75	0.25	0.00	0.00	1.00
Total Added	--	7.00	6.10	8.45	--
Total	32.00	39.00	45.10	53.55	53.55

Table 65
FTEs – 22-Station Facility in One Phase

Number of Stations	22	22	22	22	22
	2018 partial year	2019 increase	2020 increase	2021 increase	2021 total
Direct Care Manager	1.00	0.00	0.00	0.00	1.00
RNs	2.00	1.00	1.00	1.00	5.00
Care Coordinator	0.00	0.00	0.00	1.00	1.00
Home RN	0.20	0.00	0.20	0.00	0.40
Dialysis Tech	5.00	3.00	2.50	4.00	14.50
Technical Services	3.10	0.30	0.15	0.55	4.10
Social Worker	0.50	0.10	0.15	0.25	1.00
Dietician	0.50	0.10	0.15	0.25	1.00
Admin Coordinator	0.60	0.15	0.00	0.00	0.75
Admin Assistant	0.60	0.15	0.00	0.00	0.75
Total Added	--	4.80	4.15	7.05	--
Total	13.50	18.30	22.45	29.50	29.50

Table 66
FTEs – 44 station facility in Two Phases

Number of Stations	22	44	44	44	44
	2021	2022 increase	2023 increase	2024 increase	2024 total
Direct Care Manager	1.00	0.00	0.00	0.00	1.00
RNs	5.00	1.00	1.00	1.00	8.00
Care Coordinator	1.00	0.00	0.50	0.50	2.00
Home RN	0.40	0.10	0.10	0.20	0.80
Dialysis Tech	14.50	5.50	4.50	5.50	30.00
Technical Services	4.10	1.40	0.00	0.25	5.75
Social Worker	1.00	0.50	0.00	0.50	2.00
Dietician	1.00	0.50	0.00	0.50	2.00
Admin Coordinator	0.75	0.25	0.00	0.00	1.00
Admin Assistant	0.75	0.25	0.00	0.00	1.00
Total Added	--	9.50	6.10	8.45	--
Total	29.50	39.00	45.10	53.55	53.55

PSKC provided the following statements related to recruitment and retention of staff for this proposed Lakewood facility:

“PSKC offers a competitive wage and benefit package, a positive and supportive work environment, and a philosophy that encourages existing staff to receive training and additional education. For each of these reasons, PSKC has not experienced any difficulty recruiting and retaining qualified staff in any facility. Based on our historical record and performance, we do not anticipate any significant difficulties recruiting the staff needed for this new facility.

As an organization, PSKC does not recruit or otherwise disrupt other existing providers as it seeks to grow. PSKC’s goal is to “grow” its own staff, and PSKC’s training, education and flexible human resource policies have allowed PSKC to succeed with this strategy.” [source Application p35]

The medical director was not included in the tables, as all PSKC medical director positions are filled by contract. There are two physician contracts associated with this application – one for PSKC Lakewood, and one that functions as the “corporate medical director” that oversees all medical directors associated with PSKC facilities. In the case of PSKC Lakewood, the corporate and facility medical directors are one and the same – Dr. Mark Gunning. CHI Franciscan provided a copy of the draft medical director contract between PSKC and Dr. Gunning for PSKC Lakewood. The draft agreement includes all duties and responsibilities, compensation (which is consistent with the figures provided in the pro forma financial projections), and outlines a term through 2024 with automatic renewals every 2 years thereafter. [source: Screening Response, Attachment 8]

Public Comment

FMC submitted comments related to this sub-criterion.

FMC Public Comment

“It is not clear that PSKC can adequately staff a 44-station dialysis facility.

The first criterion for Structure and Process of Care is that "[a] sufficient supply of qualified staff for the project, including both health personnel and management personnel, are available or can be recruited."

A large facility requires a significant amount of staffing - PSKC's project needs approximately 29.50 full -time equivalent ("FTE") staff by the end of the third full year of operation after Phase I, and 53.55 FTEs by the end of the third full year after Phase II. This is an extremely large number of staff for a single dialysis facility, most of which will need to be hired prior to PSKC's projected opening date in July 2018. There is a very real risk that a 44-station dialysis facility will not be able to recruit such a large number of highly specialized staff by the estimated opening date, which will negatively impact patient quality of care and/or delay the facility opening date.

Even assuming that there are sufficient numbers of health care professionals in and around Pierce Five to staff PSKC's proposed facility by its estimated opening date, a large facility will result in a high concentration of staff at a single location. This will burden other dialysis providers in the Pierce Five planning area, and in neighboring planning areas, if new staff are needed, particularly in the short-term.

As PSKC's proposed project requires the most staff of any proposed project in the past ten (10) years, further documentation on PSKC's part is necessary to ensure that it can recruit and hire qualified staff for its proposed 44-station facility by its estimated opening date without negatively impacting other dialysis providers." [source: FMC Public Comment p12]

Rebuttal

PSKC provided the following statements in response to FMC's public comment:

"Although not offering any specific data or rationale, FMC indicates that it is "concerned" about PSKC's ability to staff and operate the unit it has proposed for Pierce 5. FMC implies in its comments, that PSKC will need a large number of staff as it states: "...most of which will need to be hired prior to PSKC's projected opening date in July 2018." As FMC should be well aware, PSKC knows how to staff and operate kidney centers, and knows how to establish long-lasting relationships with patients, the hospitals, physicians, communities, and payers. PSKC is proposing a two phased project that will hire staff over a seven year period. Further, PSKC reminds FMC and the CN Program that PSKC already operates in five separate planning areas and operates some of the largest dialysis facilities in the State. PSKC-Everett, until it relocated 12 stations to our Monroe location, operated a 37 station facility in Everett; it currently operates a 31 station facility in Mountlake Terrace, and a 28 station facility in Smokey Point. Because of our stellar quality, our generous wage and benefit program, and our culture of patients first, PSKC has had no problems recruiting and retaining high quality staff for these facilities, and does not envision any challenges for Pierce 5. PSKC knows how to recruit and retain staff and it is experienced in operating large facilities.

Again, while offering no evidence or data to support its baseless and incoherent claims, FMC also argues that a large PSKC facility cannot accommodate special needs or make adjustments to care. Again, this is not accurate. PSKC operates all of its facilities in conformance with all state and federal requirements. And, in fact, PSKC has some of the highest quality facilities (if not the highest) in the State of Washington. Once again, PSKC reminds the CN Program that PSKC's first priority is its patients. And, as noted earlier, PSKC Lakewood will not be staffed any differently than any other PSKC facility. These staffing ratios allow PSKC to be able to respond to any

changes in the acuity needs of each and every patient and to make any adjustments to an individual patient's care needs. FMC's arguments are groundless, unsubstantiated and must be disregarded." [PSKC rebuttal p8]

Department Evaluation

FMC raises concerns about PSKC's ability to staff a new 44-station facility based on the size of the facility, rather than a shortage of healthcare personnel. FMC did not provide any documentation to support its assertion that a 44-station facility may have difficulty staffing based on sheer size of the facility. FMC's assertion that a larger facility is more difficult to staff cannot be substantiated.

Within its rebuttal documents, PSKC provided information to support that a 44-station center could be appropriately staffed.

PSKC is proposing to establish a new facility in the planning area. Information provided in the application demonstrates that PSKC is a well-established provider of dialysis services in Washington State, and has been providing services in Washington State since approximately 1981. Based on the above information, the department concludes that PSKC has the ability and expertise to recruit and retain a sufficient supply of qualified staff for this project.

The department concludes the PSKC project **meets this sub-criterion**.

Fresenius Medical Care

FKC Fredrickson would be a new facility in the planning area. Table 67 below provides a breakdown of the projected FTEs for calendar years 2017 through 2020, [source: Application p30]

Table 67
FTEs – FKC Fredrickson

FTE by Type	2017	2018 increase	2019 increase	2020 increase	2020 total
Nurse Manager	1.00	0.00	0.00	0.00	1.00
Outpatient RN	2.25	1.25	2.00	1.00	6.50
Charge Nurse	0.00	0.00	0.00	0.75	0.75
Patient Care Tech	3.20	3.30	3.00	1.50	11.00
Equipment Tech	0.75	0.00	0.00	0.00	0.75
Social Worker	0.50	0.25	0.10	0.15	1.00
Dietician	0.50	0.25	0.10	0.15	1.00
Secretary	0.50	0.25	0.00	0.25	1.00
Home Manager	0.20	0.00	0.00	0.00	0.20
RN	1.00	0.00	0.25	0.25	1.50
Social Worker	0.10	0.00	0.05	0.05	0.20
Dietician	0.10	0.00	0.05	0.05	0.20
Total Added	---	5.30	5.55	4.15	---
Total	10.10	15.40	20.95	25.10	25.10

FMC provided the following statements related to recruitment and retention of staff for this proposed Pierce 5 facility:

By virtue of our geographic location, we anticipate recruiting staff from Pierce and Thurston Counties as well as from neighboring Counties. Nearby Counties have relatively large numbers of health care professionals. In order to be effective in staff recruitment and retention, RCG offers competitive wage and benefit packages.

Should we experience any difficulty in recruiting, we have the ability to relocate staff from FMC Lacey or one of our other existing dialysis centers in Washington to assist while the recruitment efforts continue.

For the above reasons, RCG believes that we will be successful in putting into place a qualified, core staff to provide and promote quality of care at the new facility.” [source: Application p31]

The medical director was not included in these tables, as that position is filled by contract. FMC provided a copy of the draft medical director contract between FMC and RVS, PLLC. RVS PLLC is a Washington professional service corporation comprised entirely of physicians. The draft agreement identifies Dr. Seth Thaler as the Medical Director. It includes all duties and responsibilities, compensation (which is consistent with the figures provided in the pro forma financial projections), and outlines a 7 year term.

Public Comment

None

Rebuttal

None

Department Evaluation

FMC is proposing to establish a new facility in the planning area. Information provided in the application demonstrates that FMC is a well-established provider of dialysis services. Specific to Washington State, FMC has been providing services in Washington State since approximately 1996. For Pierce County planning area #5, FMC does not operate any dialysis centers. Based on the above information, the department concludes that FMC has the ability and expertise to recruit and retain a sufficient supply of qualified staff for this project.

The department concludes the FMC project **meets this sub-criterion.**

DaVita – Lakewood Community Dialysis Center

Lakewood Community Dialysis Center is currently operating with 11 dialysis stations. If this project is approved, the center will have a total of 26 stations. Table 68 below provides a breakdown of current and projected FTEs [full time equivalents] for Lakewood Community Dialysis Center. Current year is 2016 and projected years are 2017 through 2020. [source: Screening Response, p4]

Table 68
Lakewood Community Dialysis Center
Current and Projected FTEs for Years 2016-2020

Number of Stations	11	26	26	26	26	26
FTE by Type	CY 2016 Current	CY 2017 Increase	CY 2018 Increase	CY 2019 Increase	CY 2020 Increase	Total FTEs
Administrator	1.09	0.55	0.22	0.18	0.13	2.17
Administrative Assistant	0.79	0.41	0.15	0.14	0.09	1.58
Medical Social Worker	0.73	0.37	0.14	0.12	0.09	1.45
Dietician	0.73	0.37	0.14	0.12	0.09	1.45
Patient Care Tech	6.08	3.55	1.12	1.08	0.75	12.58
RN	2.89	1.31	0.60	0.49	0.33	5.62
Biomed Tech	0.28	0.20	0.17	0.00	0.00	0.65
Other	1.09	0.55	0.22	0.18	0.13	2.17
Total FTEs	13.68	7.31	2.76	2.31	1.61	27.67

DaVita also provided the following clarifications:

- *the medical director is under contract and not included in the table above.*
- *other staff includes employees who not a full-time presence in the clinic whose services are required. Two examples are an insurance counselor and a central anemia manager whose time and wages are allocated to the facility based on the number of hours they are expected to provide services. The stated estimate is based on DaVita's extensive historical experience providing a wide range of robust specialty practices to our patients.*

[source: Screening Response, pp4-5]

DaVita provided a copy of the executed medical director agreement among Total Renal Care, Inc. (DaVita), Pacific Nephrology Associates, PS (group), and Zheng Ge, MD (physician). Pacific Nephrology Associates, PS is a company that employs physicians, including nephrologists. Dr. Ge is the physician specifically named in the agreement that currently provides medical director services at Lakewood Community Dialysis Center. The agreement was executed in November 2007 and includes two jointenders that specifically reference Lakewood Community Dialysis Center [source: Application, Appendix 3]

DaVita provided the following statements related to recruitment and retention of staff for DaVita-Lakewood Community Dialysis Center. [source: Application, p25]

“DaVita anticipates no difficulty in recruiting the necessary personnel to staff the Lakewood Dialysis Center. Based on our experience operating facilities in the planning area, DaVita anticipates that staff from the existing Lakewood Dialysis Center and the surrounding area will serve patients at the Lakewood Dialysis Center. Moreover, DaVita has been repeatedly recognized as a Top Employer and a Military Friendly Employer (davita.com/about/awards) and offers a competitive wage and benefit package to employees. DaVita posts openings nationally both internally and external to DaVita.”

Public Comment

None

Rebuttal
None

Department Evaluation

Table 68 above shows that DaVita has much of its dialysis staff in place at the Lakewood Community Dialysis Center. If this project is approved, DaVita intends to add the majority of the required FTEs in year 2017. The majority of the additional FTEs would be in the categories of nursing and HD Tech which are direct patient care positions. For future years, the table shows that the FTEs would be added incrementally based on the projected utilization and average daily census of the dialysis center.

Information provided in the application demonstrates that DaVita is a well-established provider of dialysis services in Washington State and Pierce County planning area #5. DaVita has been providing dialysis services in the planning area since approximately 1996 with its Lakewood Community Dialysis Center. Based on the above information, the department concludes that DaVita has the ability and expertise to recruit and retain a sufficient supply of qualified staff for this project. **This sub-criterion is met.**

DaVita – Towne Center

44 New Stations in Two Phases

If this project is approved, the new center will have a total of 44 stations implemented in two phases. Phase one is the establishment of a 33-station facility in year 2018 and phase two is the addition of 11 new stations in year 2021. Table 69 below provides a breakdown of projected FTEs for the Towne Center for years 2018 through 2023. [source: Screening Response, p5]

Table 69
44 New Stations in Two Phases
Projected FTEs for Years 2018-2023

Number of Stations	33	33	33	44	44	44	44
FTE by Type	CY 2018 Year 1	CY 2019 Increase	CY 2020 Increase	CY 2021 Increase	CY 2022 Increase	CY 2023 Increase	Total FTEs
Administrator	2.02	0.13	0.15	0.56	0.19	0.06	3.11
Administrative Assistant	1.47	0.10	0.10	0.41	0.14	0.04	2.26
Medical Social Worker	1.35	0.09	0.09	0.38	0.12	0.04	2.07
Dietician	1.35	0.09	0.09	0.38	0.12	0.04	2.07
Patient Care Tech	11.64	0.79	0.82	3.25	1.10	0.32	17.92
RN	5.23	0.36	0.37	1.46	0.49	0.14	8.05
Biomed Tech	0.83	0.00	0.00	0.27	0.00	0.00	1.10
Other	2.02	0.13	0.15	0.56	0.19	0.06	3.11
Total FTEs	25.91	1.69	1.77	7.27	2.35	0.70	39.69

DaVita also provided the following clarifications:

- *the medical director is under contract and not included in the table above.*
- *other staff includes employees who not a full-time presence in the clinic whose services are required. Two examples are an insurance counselor and a central anemia manager whose time and wages are allocated to the facility based on the number of hours they are expected to provide services. The stated estimate is based*

on DaVita's extensive historical experience providing a wide range of robust specialty practices to our patients.

[source: Screening Response, p8]

DaVita provided a copy of the draft medical director agreement among Total Renal Care, Inc. (DaVita), Pacific Nephrology Associates, PS (group), and Ho Won Lee, MD (physician). Pacific Nephrology Associates, PS is a company that employs physicians, including nephrologists. Dr. Lee is the physician specifically named in the agreement that would provide medical director services at the Towne Center facility. The agreement also identifies four additional pre-approved physicians that may provide medical director services as necessary. [source: Application, Appendix 3]

DaVita provided the following statements related to recruitment and retention of staff. [source: Application, p26]

“If awarded in full, a forty-four (44) station facility will have the largest staff in the state of Washington. DaVita has a demonstrated track record of its ability to sufficiently staff and operate its facilities both in Washington and in Pierce 5, specifically. Additionally, DaVita implemented a national staffing program, STAR, that has resulted in a 10% rise in overall retention for new hires. STAR proactively recruits and hires candidates who best x [sic] Lakewood Community, if approved, will become the central hub for STAR trainees, further supporting our proposal's unique ability to effectively staff a large facility for Pierce 5. Moreover, DaVita has been repeatedly recognized as a Top Employer and a Military Friendly Employer (davita.com/about/awards) and offers a competitive wage and benefit package to employees.”

Public Comment

FMC provided the following comments related to the Towne Center project and DaVita's ability to staff a 44 station dialysis center.

“A large facility requires a significant amount of staffing – DVA's project needs approximately 29.37 full-time equivalent ("FTE") staff by the end of the third full year of operation after Phase I. As DVA has not provided its projected number of FTEs for the end of the third full year of operating after Phase II, it is uncertain whether DVA intends to increase the number of staff. However, considering that DVA plans on adding 11 stations in Phase II, significantly more staff are necessary to ensure quality patient care, particularly considering that 29.37 staff will be responsible for 33 stations and 159 patients. DVA will likely increase the number of FTEs well beyond 30 to ensure adequate provision of care—it if does not do so, its proposed facility simply cannot provide adequate dialysis care.

DVA's proposed project requires a large number of staff for a single dialysis facility which will need to be hired prior to DVA's projected opening date in December 2017. There is a very real risk that a 44-station dialysis facility will not be able to recruit such a high volume of highly specialized staff by the estimated opening date, which will negatively impact patient quality of care and/or delay the facility opening date.

Even assuming that there are sufficient numbers of health care professionals in and around Pierce Five to staff DVA's proposed facility by its estimated opening date, a large facility will result in a high concentration of staff at a single location. This will burden other dialysis providers in the

Pierce Five planning area, and in neighboring planning areas, if new staff are needed, particularly in the short-term.

As DVA's proposed project is the largest dialysis facility ever proposed in the State of Washington, further documentation on DVA's part is necessary to ensure that it can recruit and hire qualified staff for its proposed 44-station facility by its estimated opening date without negatively impacting other dialysis providers.”

The other applicants requesting a 44-station dialysis facility in this concurrent review estimate needing at least 40 FTEs to accommodate 44 active dialysis stations. Thus, it is reasonable to expect that DVA will in fact add many more FTEs beyond the 21.3 that it estimated for its CN application. If DVA does not add more staff, its proposed facility will not be able to provide adequate quality of care for its projected 212 patients. DVA's proposed project requires a large number of staff for a single dialysis facility which will need to be hired prior to DVA's projected opening date in December 2017. There is a very real risk that a 44-station dialysis facility will not be able to recruit such a high volume of highly specialized staff by the estimated opening date, which will negatively impact patient quality of care and/or delay the facility opening date.

Even assuming that there are sufficient numbers of health care professionals in and around Pierce Five to staff DVA's proposed facility by its estimated opening date, a large facility will result in a high concentration of staff at a single location. This will burden other dialysis providers in the Pierce Five planning area, and in neighboring planning areas, if new staff are needed, particularly in the short-term.

As DVA's proposed project is the largest dialysis ever proposed in the State of Washington, further documentation on DVA's part is necessary to ensure that it can recruit and hire qualified staff for its proposed 44-station facility by its estimated opening date without negatively impacting other dialysis providers.” [source: FMC public comment, pp9-10]

Rebuttal

“To the criticism regarding staffing capability, DaVita has demonstrated in its application materials that it will recruit, train, and sufficiently staff its proposed facilities. This is further supported by DaVita’s historical record in the planning area, having staffed its existing Pierce 5 facilities beyond even 3-shift capacity, to include late shift and nocturnal dialysis. ...Most importantly, however, providing care continuity is not a function of facility size, but rather of maintaining proper staffing and a well-designed floorplan that allows for optimal line-of-sight for the clinicians to patients. In this respect, DaVita is the only applicant that has a proposed a facility that will both meet the demonstrated need and maximize patient safety and continuity of care.”

[source: DaVita rebuttal comment, p6]

Department Evaluation

FMC raises concerns about DaVita’s ability to staff a new 44-station facility based on the size of the facility, rather than a shortage of healthcare personnel. FMC did not provide any documentation to support its assertion that a 44-station facility may have difficulty staffing based on sheer size of the facility. FMC’s assertion that a larger facility is more difficult to staff cannot be substantiated.

Within its rebuttal documents, DaVita provided information to support that a 44-station center could be appropriately staffed.

DaVita is proposing to establish a new facility in the planning area. Information provided in the application demonstrates that DaVita is a well-established national provider of dialysis services. Specific to Washington State, DaVita has been providing services in Washington State since approximately 1996. For Pierce County planning area #5, DaVita operates all three dialysis centers in the planning area. Based on the above information, the department concludes that DaVita has the ability and expertise to recruit and retain a sufficient supply of qualified staff for this project.

The department concludes this DaVita-Towne Center project **meets this sub-criterion.**

33 New Stations

If this project is approved, the center will have a total of 33 stations beginning in year 2018. Table 70 below provides a breakdown of projected FTEs for the new facility in Lakewood for years 2018 through 2021. [source: Screening response, p8]

Table 70
33 New Stations
Projected FTEs for Years 2018-2021

Number of Stations	33	33	33	33	33
FTE by Type	CY 2018 Year 1	CY 2019 Increase	CY 2020 Increase	CY 2021 Increase	Total FTEs
Administrator	2.02	0.13	0.15	0.15	2.45
Administrative Assistant	1.47	0.10	0.10	0.11	1.78
Medical Social Worker	1.35	0.09	0.09	0.10	1.63
Dietician	1.35	0.09	0.09	0.10	1.63
Patient Care Tech	11.64	0.79	0.82	0.89	14.14
RN	5.23	0.36	0.37	0.00	5.96
Biomed Tech	0.83	0.00	0.00	0.00	0.83
Other	2.02	0.13	0.15	0.15	2.45
Total FTEs	25.91	1.69	1.77	1.50	30.87

DaVita also provided the following clarifications:

- *the medical director is under contract and not included in the table above.*
- *other staff includes employees who not a full-time presents in the clinic whose services are required. Two examples are an insurance counselor and a central anemia manager whose time and wages are allocated to the facility based on the number of hours they are expected to provided services. The stated estimate is based on DaVita’s extensive historical experience providing a wide range of robust specialty practices to our patients.*

[source: Screening Response, pp4-5]

DaVita provided a copy of the executed medical director agreement among Total Renal Care, Inc. (DaVita), Pacific Nephrology Associates, PS (group), and Zheng Ge, MD (physician). Pacific Nephrology Associates, PS company that employs physicians, including nephrologists. Dr. Ge is the physician specifically named in the agreement that currently provides medical director services at Lakewood Community Dialysis Center. The agreement was executed in November 2007 and includes two joinders that specifically reference Lakewood Community Dialysis Center [source: Application, Appendix 3]

DaVita provided the following statements related to recruitment and retention of staff. [source: Application, p26]

“If awarded in full, a forty-four (44) station facility will have the largest staff in the state of Washington. DaVita has a demonstrated track record of its ability to sufficiently staff and operate its facilities both in Washington and in Pierce 5, specifically. Additionally, DaVita implemented a national staffing program, STAR, that has resulted in a 10% rise in overall retention for new hires. STAR proactively recruits and hires candidates who best x [sic] Lakewood Community, if approved, will become the central hub for STAR trainees, further supporting our proposal's unique ability to effectively staff a large facility for Pierce 5. Moreover, DaVita has been repeatedly recognized as a Top Employer and a Military Friendly Employer (davita.com/about/awards) and offers a competitive wage and benefit package to employees.”

Public Comment

None

Rebuttal

None

Department Evaluation

DaVita is proposing to establish a new facility in the planning area. Information provided in the application demonstrates that DaVita is a well-established national provider of dialysis services. Specific to Washington State, DaVita has been providing services in Washington State since approximately 1996. For Pierce County planning area #5, DaVita operates all three dialysis centers in the planning area. Based on the above information, the department concludes that DaVita has the ability and expertise to recruit and retain a sufficient supply of qualified staff for this project.

The department concludes this DaVita-Towne Center project **meets this sub-criterion.**

DaVita – Canyon Road

44 New Stations in Three Phases

If this project is approved, the center will have a total of 24 stations beginning in year 2018, 36 in year 2021, and 44 in year 2023. Table 71 on the following page provides a breakdown of projected FTEs for the Canyon Road facility for years 2018 through 2025. [source: Screening Response, pp4-5]

Table 71
44 New Stations [Three Phases]
Projected FTEs for Years 2018-2023

Number of Stations	24	24	24	36	36
FTE by Type	CY 2018 Year 1	CY 2019 Increase	CY 2020 Increase	CY 2021 Increase	CY 2022 Increase
Administrator	1.46	0.10	0.11	0.67	0.15
Administrative Assistant	1.06	0.08	0.07	0.49	0.11
Medical Social Worker	0.98	0.06	0.07	0.45	0.10
Dietician	0.98	0.06	0.07	0.45	0.10
Patient Care Tech	8.44	0.57	0.60	3.88	0.90
RN	3.79	0.25	0.28	1.75	0.40
Biomed Tech	0.60	0.00	0.00	0.30	0.00
Other	1.46	0.10	0.11	0.67	0.15
Total FTEs	18.77	1.22	1.31	8.66	1.91

Number of Stations	44	44	44	44
FTE by Type	CY 2023 Increase	CY 2024 Increase	CY 2025 Increase	Total FTEs
Administrator	0.56	0.08	0.09	3.22
Administrative Assistant	0.41	0.06	0.06	2.34
Medical Social Worker	0.38	0.05	0.06	2.15
Dietician	0.38	0.05	0.06	2.15
Patient Care Tech	3.24	0.45	0.50	18.58
RN	1.46	0.20	0.22	8.35
Biomed Tech	0.20	0.00	0.00	1.10
Other	0.56	0.08	0.09	3.22
Total FTEs	7.19	0.97	1.08	41.11

DaVita also provided the following clarifications:

- *the medical director is under contract and not included in the table above.*
- *other staff includes employees who not a full-time presents in the clinic whose services are required. Two examples are an insurance counselor and a central anemia manager whose time and wages are allocated to the facility based on the number of hours they are expected to provided services. The stated estimate is based on DaVita's extensive historical experience providing a wide range of robust specialty practices to our patients.*

[source: Screening Response, pp5-6]

DaVita provided a copy of the draft medical director agreement among Total Renal Care, Inc. (DaVita), Pacific Nephrology Associates, PS (group), and Ho Won Lee, MD (physician). Pacific Nephrology Associates, PS is a company that employs physicians, including nephrologists. Dr. Lee is the physician specifically named in the agreement that would provide medical director services at the new Canyon Road facility. The agreement also identifies four additional pre-approved physicians that may provide services as necessary. [source: Application, Appendix 3]

DaVita provided the following statements related to recruitment and retention of staff. [source: Application, p26]

“If awarded in full, a forty-four (44) station facility will have the largest staff in the state of Washington. DaVita has a demonstrated track record of its ability to sufficiently staff and operate its facilities both in Washington and in Pierce 5, specifically. Additionally, DaVita implemented a national staffing program, STAR, that has resulted in a 10% rise in overall retention for new hires. STAR proactively recruits and hires candidates who best x [sic] Lakewood Community, if approved, will become the central hub for STAR trainees, further supporting our proposal's unique ability to effectively staff a large facility for Pierce 5. Moreover, DaVita has been repeatedly recognized as a Top Employer and a Military Friendly Employer (davita.com/about/awards) and offers a competitive wage and benefit package to employees.”

Public Comment

During the review of this project, FMC provided the following comments related to DaVita's ability to staff a 44-station dialysis center.

“A large facility requires a significant amount of staffing - DVA's project needs approximately 21.3 full-time equivalent ("FTE") staff by the end of the third full year of operation after Phase I, it will need significantly more FTEs to adequately staff a 44-station dialysis facility. r of operation after Phase II, it is uncertain whether DVA intends to increase the number of staff. As DaVita has not provided its projected number of FTEs for the end of the third full year of operating after its second and third phases, it is uncertain whether DVA intends to increase the number of staff. The other applicants requesting a 44-station dialysis facility in this concurrent review estimate needing at least 40 FTEs to accommodate 44 active dialysis stations. Thus, it is reasonable to expect that DVA will in fact add many more FTEs beyond the 21.3 that it estimated for its CN application. If DVA does not add more staff, its proposed facility will not be able to provide adequate quality of care for its projected 212 patients.

DVA's proposed project requires a large number of staff for a single dialysis facility which will need to be hired prior to DVA's projected opening date in December 2017. There is a very real risk that a 44-station dialysis facility will not be able to recruit such a high volume of highly specialized staff by the estimated opening date, which will negatively impact patient quality of care and/or delay the facility opening date.

Even assuming that there are sufficient numbers of health care professionals in and around Pierce Five to staff DVA's proposed facility by its estimated opening date, a large facility will result in a high concentration of staff at a single location. This will burden other dialysis providers in the Pierce Five planning area, and in neighboring planning areas, if new staff are needed, particularly in the short-term.

As DVA's proposed project is the largest dialysis ever proposed in the State of Washington, further documentation on DVA's part is necessary to ensure that it can recruit and hire qualified staff for its proposed 44-station facility by its estimated opening date without negatively impacting other dialysis providers.” [source: FMC public comment, p10]

Rebuttal

“To the criticism regarding staffing capability, DaVita has demonstrated in its application materials that it will recruit, train, and sufficiently staff its proposed facilities. This is further supported by DaVita's historical record in the planning area, having staffed its existing Pierce 5 facilities beyond even 3-shift capacity, to include late shift and nocturnal dialysis. ...Most

importantly, however, providing care continuity is not a function of facility size, but rather of maintaining proper staffing and a well-designed floorplan that allows for optimal line-of-sight for the clinicians to patients. In this respect, DaVita is the only applicant that has a proposed a facility that will both meet the demonstrated need and maximize patient safety and continuity of care.”

[source: DaVita rebuttal comment, p6]

Department Evaluation

FMC raises concerns about DaVita’s ability to staff a new 44-station facility based on the size of the facility, rather than a shortage of healthcare personnel. FMC did not provide any documentation to support its assertion that a 44-station facility may have difficulty staffing based on sheer size of the facility. FMC’s assertion that a larger facility is more difficult to staff cannot be substantiated.

Within its rebuttal documents, DaVita provided information to support that a 44-station center could be appropriately staffed.

DaVita is proposing to establish a new facility in the planning area. Information provided in the application demonstrates that DaVita is a well-established national provider of dialysis services. Specific to Washington State, DaVita has been providing services in Washington State since approximately 1996. For Pierce County planning area #5, DaVita operates all three dialysis centers in the planning area. Based on the above information, the department concludes that DaVita has the ability and expertise to recruit and retain a sufficient supply of qualified staff for this project.

The department concludes this DaVita-Canyon Road project **meets this sub-criterion**.

36 New Stations in Two Phases

If this project is approved, the center will have a total of 24 stations beginning in year 2018 and 36 stations beginning in year 2021. Table 72 on the following page provides a breakdown of projected FTEs for the Canyon Road facility for years 2018 through 2023. [source: Screening Response, p4-5]

Table 72
36 New Stations [Phases One and Two]
Projected FTEs for Years 2018-2023

Number of Stations	36	36	36
FTE by Type	CY 2018 Year 1	CY 2019 Increase	CY 2020 Increase
Administrator	1.46	0.10	0.11
Administrative Assistant	1.06	0.08	0.07
Medical Social Worker	0.98	0.06	0.07
Dietician	0.98	0.06	0.07
Patient Care Tech	8.44	0.57	0.60
RN	3.79	0.25	0.28
Biomed Tech	0.60	0.00	0.00
Other	1.46	0.10	0.11
Total FTEs	18.77	1.22	1.31

Number of Stations	36	36	36	36
FTE by Type	CY 2021 Increase	CY 2022 Increase	CY 2023 Increase	Total FTEs
Administrator	0.67	0.15	0.57	3.06
Administrative Assistant	0.49	0.11	0.42	2.23
Medical Social Worker	0.45	0.10	0.38	2.04
Dietician	0.45	0.10	0.38	2.04
Patient Care Tech	3.88	0.90	3.28	17.67
RN	1.75	0.40	1.48	7.95
Biomed Tech	0.30	0.00	0.00	0.90
Other	0.67	0.15	0.57	3.06
Total FTEs	8.66	1.91	7.08	38.95

DaVita also provided the following clarifications:

- *the medical director is under contract and not included in the table above.*
- *other staff includes employees who not a full-time presents in the clinic whose services are required. Two examples are an insurance counselor and a central anemia manager whose time and wages are allocated to the facility based on the number of hours they are expected to provided services. The stated estimate is based on DaVita's extensive historical experience providing a wide range of robust specialty practices to our patients.*

[source: Screening Response, pp5-6]

DaVita provided a copy of the draft medical director agreement among Total Renal Care, Inc. (DaVita), Pacific Nephrology Associates, PS (group), and Ho Won Lee, MD (physician). Pacific Nephrology Associates, PS is a company that employs physicians, including nephrologists. Dr. Lee is the physician specifically named in the agreement that would provide medical director services at the new Canyon Road facility. The agreement also identifies four additional pre-approved physicians that may provide services as necessary. [source: Application, Appendix 3]

DaVita provided the following statements related to recruitment and retention of staff. [source: Application, p26]

“If awarded in full, a forty-four (44) station facility will have the largest staff in the state of Washington. DaVita has a demonstrated track record of its ability to sufficiently staff and operate its facilities both in Washington and in Pierce 5, specifically. Additionally, DaVita implemented a national staffing program, STAR, that has resulted in a 10% rise in overall retention for new hires. STAR proactively recruits and hires candidates who best x [sic] Lakewood Community, if approved, will become the central hub for STAR trainees, further supporting our proposal's unique ability to effectively staff a large facility for Pierce 5. Moreover, DaVita has been repeatedly recognized as a Top Employer and a Military Friendly Employer (davita.com/about/awards) and offers a competitive wage and benefit package to employees.”

Public Comment

None

Rebuttal

None

Department Evaluation

DaVita is proposing to establish a new facility in the planning area. Information provided in the application demonstrates that DaVita is a well-established national provider of dialysis services. Specific to Washington State, DaVita has been providing services in Washington State since approximately 1996. For Pierce County planning area #5, DaVita operates all three dialysis centers in the planning area. Based on the above information, the department concludes that DaVita has the ability and expertise to recruit and retain a sufficient supply of qualified staff for this project.

The department concludes this DaVita-Canyon Road project **meets this sub-criterion.**

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

WAC 246-310 does not contain specific WAC 246-310-230(2) as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs what relationships, ancillary and support services should be for a project of this type and size. Therefore, using its experience and expertise the department assessed the materials contained in the application.

CHI Franciscan

CHI Franciscan provides dialysis services throughout Pierce County. The application included a list of required ancillary services to be provided on-site, and also provided the following statement related to this sub-criterion:

“Medicare requirements for dialysis certification require that social services and dietary support services be included within the program. As with all of our existing facilities, CHI Franciscan will provide regular social services and dietary support for all patients. In addition, the common ancillary and support services utilized by a dialysis program including pharmacy, laboratory, and blood administration will be available from CHI Franciscan.” [source: Application p37]

The draft medical director agreement provided by CHI Franciscan for the Franciscan Lakewood facility is with Dr. Melissa Yeh Kaptik. The agreement identifies the roles and responsibilities for all parties.

The application included a draft patient transfer agreement with St Clare Hospital. This agreement identifies the obligations of the transferring facility and the hospital.

Public Comment

None

Rebuttal

None

Department Evaluation

While CHI Franciscan is not a new provider to Washington State, or even to Pierce County, the proposed Franciscan Lakewood facility would be a new facility that would require its own ancillary and support agreements and relationships.

In the case of a new facility, the department’s long-standing approach has been to require an applicant to provide draft agreements for the new facility. If the project is approved, the department attaches a condition requiring the applicant to provide executed contracts that are consistent with those provided with the application.

CHI Franciscan provided draft documentation that it would establish the required relationships under this sub-criterion.

While the draft agreements provided by CHI Franciscan could be reasonable under their own ownership and control, the department received no assurance that this facility would remain under CHI Franciscan ownership and control for the entire projection period. Information found in the PUI led the department to conclude that the facility would ultimately be sold. CHI did not provide any assurance throughout the PUI process that this subsequent transaction would not have an effect on the viability of the draft medical director agreement or draft transfer agreement. The department cannot reasonably conclude that the proposed facility would have or maintain the required relationships and agreements outside of CHI Franciscan ownership and control. The department concludes CHI Franciscan’s project **does not meet this sub-criterion.**

Puget Sound Kidney Centers

At this time, PSKC does not provide dialysis services in Pierce County, but does in Snohomish, Island, and Skagit Counties. The application included a list of required ancillary services to be provided on-site, and also provided the following statement related to this sub-criterion:

“Medicare required ancillary and support services include the following

- *Social Services*
- *Nursing Services*
- *Patient Financial Counseling*
- *Administration*
- *Staff Education*
- *Information Systems*
- *Nutrition Services*
- *Plant Operations*
- *Patient Education*
- *Material Management*
- *Technical Services*

Consistent with all PSKC facilities, all of the above-mentioned departments/functions will be in place at PSKC - Lakewood.” [source: Application p35]

The draft medical director agreement provided by PSKC for the PSKC Lakewood facility is with Dr. Mark Gunning. The agreement identifies the roles and responsibilities for all parties.

The application included a draft patient transfer agreement with St Clare Hospital. This agreement identifies the obligations of the transferring facility and the hospital.

Public Comment

FMC submitted comments relating to this sub-criterion:

FMC Public Comments

“Considering that, if approved, PSKC's facility will operate over half of all dialysis stations in Pierce Five, it will be the main and dominant driver of costs and reimbursements for patients, ancillary and support services, and dialysis facilities. This reduces the ability for ancillary and other support services to negotiate reasonable rates because the majority of patients will be forced to receive care at a single facility.

Further, as this facility will more than double the amount of dialysis stations in the planning area in under five (5) years, it is unknown if there are adequate support and ancillary services in existence in Lakewood, or the planning area as-a-whole, to fully meet facility and patient needs. PSKC has not demonstrated any contact with existing providers of ancillary and support services to determine if a 44-station facility can be adequately supported, and further, unlike any of the other applicants in Pierce Five, PSKC has no dialysis facility operations even close to its proposed Lakewood facility, harming its ability to share staff or other resources across its facilities, even in the short run-this is a significant comparative disadvantage for PSKC.” [source: FMC Public Comment p13]

Rebuttal

PSKC provided the following statement in response to FMC’s public comments:

“Although not offering any specific data or rationale, FMC indicates that it is “concerned” about PSKC’s ability to staff and operate the unit it has proposed for Pierce 5. FMC implies in its comments, that PSKC will need a large number of staff as it states: “...most of which will need to be hired prior to PSKC’s projected opening date in July 2018.” As FMC should be well aware, PSKC knows how to staff and operate kidney centers, and knows how to establish long-lasting relationships with patients, the hospitals, physicians, communities, and payers. PSKC is proposing a two phased project that will hire staff over a seven year period. Further, PSKC reminds FMC and the CN Program that PSKC already operates in five separate planning areas and operates some of the largest dialysis facilities in the State. PSKC-Everett, until it relocated 12 stations to our Monroe location, operated a 37 station facility in Everett; it currently operates a 31 station facility in Mountlake Terrace, and a 28 station facility in Smokey Point. Because of our stellar quality, our generous wage and benefit program, and our culture of patients first, PSKC has had no problems recruiting and retaining high quality staff for these facilities, and does not envision any challenges for Pierce 5. PSKC knows how to recruit and retain staff and it is experienced in operating large facilities.” [source: PSKC rebuttal p8]

Department Evaluation

While PSKC would not be a new provider in Washington State, its proposed PSKC Lakewood facility would be a new facility that would require its own ancillary and support agreements and relationships. FMC expressed concerns about PSKC's ability to establish ancillary and support agreements because *"it is unknown if there are adequate support and ancillary services in existence in Lakewood, or the planning area as-a-whole, to fully meet facility and patient needs."* FMC appears to have misunderstood the information provided in PSKC's application. PSKC asserted that many, if not all, of their ancillary and support services would be provided on-site.

In the case of a new facility, the department's long-standing approach has been to require an applicant to provide draft agreements for a new facility. If the project is approved, the department attaches a condition requiring the applicant to provide executed contracts.

PSKC provided draft documentation that it would establish the required relationships under this sub-criterion. The department does not require that an applicant provide documentation of every exploratory meeting or effort to form relationships with every kind of ancillary or support vendor – merely the CMS required patient transfer agreement with a local hospital and medical director agreement. PSKC provided these required documents. Furthermore, PSKC has a history of operating within Washington State and has demonstrated their ability to successfully operate a dialysis facility – including required ancillary relationships.

If PSKC's project is approved, the department would include two conditions. One would require PSKC to provide a copy of the executed Medical Director agreement, and a second condition would require PSKC to provide a copy of the executed patient transfer agreement with a local hospital.

With these two conditions, the department concludes PSKC's project **meets this sub-criterion**.

Fresenius Medical Care

At this time, FMC does not provide dialysis services in Pierce County, but does in 13 other counties. The application included the following statement relating to this sub-criterion:

"Program requirements for dialysis certification require that social services and dietary support services be included within the program. As with our existing units, RCG will provide regular social services and dietary support for all patients. Other typical ancillary and support services utilized by a dialysis program including pharmacy, laboratory, and radiology will be secured well in advance of opening. Based upon our past successes, RCG does not anticipate any difficulties in meeting the clinical service demands of patients that will be cared for in the proposed facility."
[source: Application p31]

The medical director agreement provided by FMC for the FKC Fredrickson facility is with RVS, PLLC. RVS, PLLC is entirely comprised of physicians. The agreement specifically identifies Dr. Seth Thaler as the Medical Director. It includes all duties and responsibilities, compensation (which is consistent with the figures provided in the pro forma financial projections), and outlines a 7 year term.

No transfer agreement with an area hospital was provided, however FMC stated, *"We will also establish a transfer agreement with one or more local hospitals."* [source: Application p32]

Public Comment

None

Rebuttal

None

Department Evaluation

While FMC is not a new provider to Washington State, the proposed FKC Fredrickson facility would be a new facility that would require its own ancillary and support agreements and relationships. Within the application, FMC provided a draft medical director agreement.

FMC did not provide a draft transfer agreement with a local hospital, which is specifically requested in a Certificate of Need dialysis application. Though FMC provided a statement assuring that they would establish a relationship with a local hospital, no draft or executed agreement was provided. Consistent with Certificate of Need past practices and for other applications within this review, the department would attach a condition requiring an applicant to provide an executed transfer agreement consistent with a draft agreement provided within the application. In FMC's case, the department cannot place a condition on a document that does not yet exist.

In FMC's public comments relating to PSKC's project, they criticized that "*PSKC has not demonstrated any contact with existing providers of ancillary and support services.*" While PSKC did, in fact, provide a draft transfer agreement, FMC did not. By the same logic provided in FMC's criticism of another applicant within this review, FMC does not meet this sub-criterion based on their lack of documentation of ancillary and support agreements.

The department concludes that FMC's project **does not meet this sub-criterion.**

If this sub-criterion was the only item that FMC failed to meet, and if this were not a concurrent review, failure to provide a draft transfer agreement would not be grounds for denial on its own. There would, instead, be two conditions. One would require FMC to provide a draft transfer agreement for review and approval prior to their receiving a Certificate of Need. The second would be for FMC to provide an executed version of the document, consistent with the draft, prior to completion of the project.

In the case of this concurrent review, though, the department would not allow this additional consideration. The kidney dialysis Certificate of Need application specifically asks for a draft transfer agreement in question 5 under Structure and Process of Care. It asks the applicant to document:

*"The specific means by which the proposed project will promote continuity in the provision of health care to the defined population and avoid unwarranted fragmentation of services. This section should include the identification of existing and proposed formal working relationships with **hospitals, nursing homes, and other health service resources serving your primary service area.** This description should include recent, current, and pending cooperative planning activities shared service agreements, **and transfer agreements.** **Copies of relevant agreements and other documents should be included.**" [emphasis added] [source: CN application p9]*

DaVita – Lakewood Community Dialysis Center

DaVita provides dialysis services throughout Washington State and the Pierce County planning area #5. For its Lakewood Community Dialysis Center, the following ancillary and support services would be provided on site: social services, nutrition, financial counseling, pharmacy access, patient and staff education, human resources, material management, administration and biomedical technical services.

Additional services are coordinated through DaVita’s corporate offices in Denver, Colorado and support offices in Federal Way and Tacoma, Washington; El Segundo, California; Nashville, Tennessee; Berwyn, Pennsylvania; and Deland, Florida. [source: Application, p25]

The executed medical director agreement provided by DaVita for Lakewood Community Dialysis Center is with Pacific Nephrology Associates, PS (group), and Zheng Ge, MD (physician). The executed agreement was initially for ten years, with annual automatic renewals. The second joinder was executed in April 2015, and includes annual automatic renewals. The agreement identifies roles and responsibilities for DaVita, Pacific Nephrology Associates, PS and Zheng Ge, MD. [source: Application, Appendix 3]

The current patient transfer agreement for Lakewood Community Dialysis Center is being updated by DaVita. For this project, DaVita provided a copy of the draft patient transfer agreement to be used at Lakewood Community Dialysis Center. The draft agreement is between CHI Franciscan Health’s St. Clare Hospital and DaVita. DaVita provided a copy of a letter signed by St. Clare Hospital’s vice president of operations on February 11, 1997. The letter confirms a written affiliation agreement between the two entities and identifies the contract number of the agreement. [source: Application, Appendix 12]

Public Comment

None

Rebuttal

None

Department Evaluation

Based on the information reviewed in the application, the department concludes that there is reasonable assurance that Lakewood Community Dialysis Center will continue to maintain the necessary relationships with ancillary and support services to provide dialysis services with an additional 15 stations. The department concludes that approval of additional stations to Lakewood Community Dialysis Center would not negatively affect existing healthcare relationships. With the following condition related to the patient transfer agreement, the department concludes DaVita’s project **meets this sub-criterion**.

- Prior to providing services, DaVita HealthCare Partners, Inc. will provide to the department for review and approval a copy of an executed transfer agreement with a local hospital. The executed agreement must be consistent with the draft agreement provided in the application.

The department concludes this Lakewood Community Dialysis Center **meets this sub-criterion**.

DaVita – Towne Center

44 New Stations in Two Phases

DaVita provides dialysis services throughout Washington State and the Pierce County planning area #5. For its Towne Center facility, the following ancillary and support services would be provided on site: social services, nutrition, financial counseling, pharmacy access, patient and staff education, human resources, material management, administration and biomedical technical services.

Additional services are coordinated through DaVita’s corporate offices in Denver, Colorado and support offices in Federal Way and Tacoma, Washington; El Segundo, California; Nashville, Tennessee; Berwyn, Pennsylvania; and Deland, Florida. [source: Application, p26]

DaVita provided a copy of the draft medical director agreement among Total Renal Care, Inc. (DaVita), Pacific Nephrology Associates, PS (group), and Ho Won Lee, MD (physician). Pacific Nephrology Associates, PS is a company that employs physicians, including nephrologists. Dr. Lee is the physician specifically named in the agreement that would provide medical director services at the Towne Center facility. The agreement also identifies four additional pre-approved physicians that may provide services as necessary. [source: Application, Appendix 3]

DaVita provided a copy of the draft patient transfer agreement to be used at the Towne Center facility. The draft agreement does not identify a specific hospital. [source: Application, Appendix 12]

Public Comment

During the review of the Towne Center project, FMC provided comments focusing on DaVita’s ability to establish ancillary and other support services for its Towne Center facility. The comments relate to the 44-station facility or a 33-station facility. The comments focusing on the Towne Center project and DaVita’s rebuttal statements will be addressed below, but not repeated in the 33-station review.

Fresenius Medical Care

“Considering that, if approved, DVA’s facility will operate over half of all dialysis stations in Pierce Five, it will be the main and dominant driver of costs and reimbursements for patients, ancillary, and support services, and dialysis facilities. This reduces the ability for ancillary and other support services to negotiate reasonable rates because the majority of patients will be forced to receive care at a single facility. Further, as this facility will more than double the amount of dialysis stations in the planning area in under five (5) years, it is unknown if there are adequate support and ancillary services in existence in Lakewood, or the planning area as a whole, to fully meet facility and patient needs. DVA has not demonstrated any contact with existing providers of ancillary and support services to determine if a 44-station facility can be adequately supported in the service area.” [source: FMC public comment, p13]

Rebuttal

DaVita did not provide rebuttal comments that directly relate to the public comments provided by FMC above.

Department Evaluation

While DaVita would not be a new provider in Washington State, its proposed DaVita Lakewood Towne Center would be a new facility that would require its own ancillary and support agreements

and relationships. FMC expressed concerns about DaVita's ability to establish ancillary and support agreements because "[DaVita] has not demonstrated any contact with existing providers of ancillary and support services."

In the case of a new facility, the department's long-standing approach has been to require an applicant to provide draft agreements for a new facility. If the project is approved, the department attaches a condition requiring the applicant to provide executed contracts.

DaVita provided draft documentation that it would establish the required relationships under this sub-criterion. The department does not require that an applicant provide documentation of every exploratory meeting or effort to form relationships with every kind of ancillary or support vendor – merely the CMS required patient transfer agreement with a local hospital and medical director agreement. DaVita provided these required documents. Furthermore, DaVita has a history of operating within Washington State and has demonstrated their ability to successfully operate a dialysis facility – including required ancillary relationships.

If DaVita's project is approved, the department would include two conditions. One would require DaVita to provide a copy of the executed Medical Director agreement, and a second condition would require DaVita to provide a copy of the executed patient transfer agreement with a local hospital.

With the following two conditions, the department concludes DaVita's project **meets this sub-criterion**.

- Prior to providing services, DaVita HealthCare Partners, Inc. will provide to the department for review and approval a copy of an executed medical director agreement. The executed agreement must be consistent with the draft agreement provided in the application.
- Prior to providing services, DaVita HealthCare Partners, Inc. will provide to the department for review and approval a copy of an executed transfer agreement with a local hospital. The executed agreement must be consistent with the draft agreement provided in the application.

33 New Stations

DaVita provides dialysis services throughout Washington State and the Pierce County planning area #5. For its Towne Center facility, the following ancillary and support services would be provided on site: social services, nutrition, financial counseling, pharmacy access, patient and staff education, human resources, material management, administration and biomedical technical services.

Additional services are coordinated through DaVita's corporate offices in Denver, Colorado and support offices in Federal Way and Tacoma, Washington; El Segundo, California; Nashville, Tennessee; Berwyn, Pennsylvania; and Deland, Florida. [source: Application, p26]

DaVita provided a copy of the draft medical director agreement among Total Renal Care, Inc. (DaVita), Pacific Nephrology Associates, PS (group), and Ho Won Lee, MD (physician). Pacific Nephrology Associates, PS is a company that employs physicians, including nephrologists. Dr. Lee is the physician specifically named in the agreement that would provide medical director services at the Towne Center facility. The agreement also identifies four additional pre-approved physicians that may provide services as necessary. [source: Application, Appendix 3]

DaVita provided a copy of the draft patient transfer agreement to be used at the Towne Center facility. The draft agreement does not identify a specific hospital. [source: Application, Appendix 12]

Public Comment

See above.

Rebuttal

See above.

Department Evaluation

While DaVita would not be a new provider in Washington State, its proposed DaVita Lakewood Towne Center would be a new facility that would require its own ancillary and support agreements and relationships. FMC expressed concerns about DaVita's ability to establish ancillary and support agreements because "[DaVita] has not demonstrated any contact with existing providers of ancillary and support services."

In the case of a new facility, the department's long-standing approach has been to require an applicant to provide draft agreements for a new facility. If the project is approved, the department attaches a condition requiring the applicant to provide executed contracts.

DaVita provided draft documentation that it would establish the required relationships under this sub-criterion. The department does not require that an applicant provide documentation of every exploratory meeting or effort to form relationships with every kind of ancillary or support vendor – merely the CMS required patient transfer agreement with a local hospital and medical director agreement. DaVita provided these required documents. Furthermore, DaVita has a history of operating within Washington State and has demonstrated their ability to successfully operate a dialysis facility – including required ancillary relationships.

If DaVita's project is approved, the department would include two conditions. One would require DaVita to provide a copy of the executed Medical Director agreement, and a second condition would require DaVita to provide a copy of the executed patient transfer agreement with a local hospital.

With the following two conditions, the department concludes DaVita's project **meets this sub-criterion**.

- Prior to providing services, DaVita HealthCare Partners, Inc. will provide to the department for review and approval a copy of an executed medical director agreement. The executed agreement must be consistent with the draft agreement provided in the application.
- Prior to providing services, DaVita HealthCare Partners, Inc. will provide to the department for review and approval a copy of an executed transfer agreement with a local hospital. The executed agreement must be consistent with the draft agreement provided in the application.

DaVita – Canyon Road

44 New Stations in Three Phases

DaVita provides dialysis services throughout Washington State and the Pierce County planning area #5. For its new Canyon Road facility, the following ancillary and support services would be provided on site: social services, nutrition, financial counseling, pharmacy access, patient and staff education, human resources, material management, administration and biomedical technical services.

Additional services are coordinated through DaVita’s corporate offices in Denver, Colorado and support offices in Federal Way and Tacoma, Washington; El Segundo, California; Nashville, Tennessee; Berwyn, Pennsylvania; and Deland, Florida. [source: Application, p26]

DaVita provided a copy of the draft medical director agreement among Total Renal Care, Inc. (DaVita), Pacific Nephrology Associates, PS (group), and Ho Won Lee, MD (physician). Pacific Nephrology Associates, PS is a company that employs physicians, including nephrologists. Dr. Lee is the physician specifically named in the agreement that would provide medical director services at the Towne Center facility. The agreement also identifies four additional pre-approved physicians that may provide services as necessary. [source: Application, Appendix 3]

DaVita provided a copy of the draft patient transfer agreement to be used at Canyon Road facility. The draft agreement does not identify a specific hospital. [source: Application, Appendix 12]

Public Comment

During the review of the Canyon Road project, FMC provided comments focusing on DaVita’s ability to establish ancillary and other support services for its Canyon Road site. The comments relate to the 44-station facility or a 33-station facility. The comments focusing on the Canyon Road project and DaVita’s rebuttal statements will be addressed below, but not repeated in the 36-station review.

Fresenius Medical Care

“Considering that, if approved, DVA’s facility will operate over half of all dialysis stations in Pierce Five, it will be the main and dominant driver of costs and reimbursements for patients, ancillary, and support services, and dialysis facilities. This reduces the ability for ancillary and other support services to negotiate reasonable rates because the majority of patients will be forced to receive care at a single facility. Further, as this facility will more than double the amount of dialysis stations in the planning area in under five (5) years, it is unknown if there are adequate support and ancillary services in existence in Lakewood, or the planning area as a whole, to fully meet facility and patient needs. DVA has not demonstrated any contact with existing providers of ancillary and support services to determine if a 44-station facility can be adequately supported in the service area.” [source: FMC public comment, p11]

Rebuttal

DaVita did not provide rebuttal comments that directly relate to the public comments provided by FMC above.

Department Evaluation

While DaVita would not be a new provider in Washington State, its proposed DaVita Canyon Road facility would be a new facility that would require its own ancillary and support agreements and

relationships. FMC expressed concerns about DaVita's ability to establish ancillary and support agreements because "[DaVita] has not demonstrated any contact with existing providers of ancillary and support services."

In the case of a new facility, the department's long-standing approach has been to require an applicant to provide draft agreements for a new facility. If the project is approved, the department attaches a condition requiring the applicant to provide executed contracts.

DaVita provided draft documentation that it would establish the required relationships under this sub-criterion. The department does not require that an applicant provide documentation of every exploratory meeting or effort to form relationships with every kind of ancillary or support vendor – merely the CMS required patient transfer agreement with a local hospital and medical director agreement. DaVita provided these required documents. Furthermore, DaVita has a history of operating within Washington State and has demonstrated their ability to successfully operate a dialysis facility – including required ancillary relationships.

If DaVita's project is approved, the department would include two conditions. One would require DaVita to provide a copy of the executed Medical Director agreement, and a second condition would require DaVita to provide a copy of the executed patient transfer agreement with a local hospital.

With the following two conditions, the department concludes DaVita's project **meets this sub-criterion**.

- Prior to providing services, DaVita HealthCare Partners, Inc. will provide to the department for review and approval a copy of an executed medical director agreement. The executed agreement must be consistent with the draft agreement provided in the application.
- Prior to providing services, DaVita HealthCare Partners, Inc. will provide to the department for review and approval a copy of an executed transfer agreement with a local hospital. The executed agreement must be consistent with the draft agreement provided in the application.

36 New Stations in Two Phases

DaVita provides dialysis services throughout Washington State and the Pierce County planning area #5. For its new Canyon Road facility, the following ancillary and support services would be provided on site: social services, nutrition, financial counseling, pharmacy access, patient and staff education, human resources, material management, administration and biomedical technical services.

Additional services are coordinated through DaVita's corporate offices in Denver, Colorado and support offices in Federal Way and Tacoma, Washington; El Segundo, California; Nashville, Tennessee; Berwyn, Pennsylvania; and Deland, Florida. [source: Application, p26]

DaVita provided a copy of the draft medical director agreement among Total Renal Care, Inc. (DaVita), Pacific Nephrology Associates, PS (group), and Ho Won Lee, MD (physician). Pacific Nephrology Associates, PS is a company that employs physicians, including nephrologists. Dr. Lee is the physician specifically named in the agreement that would provide medical director services at the Towne Center facility. The agreement also identifies four additional pre-approved physicians that may provide services as necessary. [source: Application, Appendix 3]

DaVita provided a copy of the draft patient transfer agreement to be used at Canyon Road facility. The draft agreement does not identify a specific hospital. [source: Application, Appendix 12]

Public Comment

See above.

Rebuttal

See above.

Department Evaluation

While DaVita would not be a new provider in Washington State, its proposed DaVita Canyon Road facility would be a new facility that would require its own ancillary and support agreements and relationships. FMC expressed concerns about DaVita’s ability to establish ancillary and support agreements because “[DaVita] has not demonstrated any contact with existing providers of ancillary and support services.”

In the case of a new facility, the department’s long-standing approach has been to require an applicant to provide draft agreements for a new facility. If the project is approved, the department attaches a condition requiring the applicant to provide executed contracts.

DaVita provided draft documentation that it would establish the required relationships under this sub-criterion. The department does not require that an applicant provide documentation of every exploratory meeting or effort to form relationships with every kind of ancillary or support vendor – merely the CMS required patient transfer agreement with a local hospital and medical director agreement. DaVita provided these required documents. Furthermore, DaVita has a history of operating within Washington State and has demonstrated their ability to successfully operate a dialysis facility – including required ancillary relationships.

If DaVita’s project is approved, the department would include two conditions. One would require DaVita to provide a copy of the executed Medical Director agreement, and a second condition would require DaVita to provide a copy of the executed patient transfer agreement with a local hospital.

With the following two conditions, the department concludes DaVita’s project **meets this sub-criterion**.

- Prior to providing services, DaVita HealthCare Partners, Inc. will provide to the department for review and approval a copy of an executed medical director agreement. The executed agreement must be consistent with the draft agreement provided in the application.
- Prior to providing services, DaVita HealthCare Partners, Inc. will provide to the department for review and approval a copy of an executed transfer agreement with a local hospital. The executed agreement must be consistent with the draft agreement provided in the application.

- (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 no 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.

The department reviews two different areas when evaluating this sub-criterion. One is the conformance with Medicare and Medicaid standards and the other is conformance with state standards. To accomplish this task for these two projects, the department first reviewed the quality of care compliance history for all healthcare facilities operated outside of Washington State using the 'star rating' assigned by Centers for Medicare & Medicaid Services (CMS). Then the department focused on the CMS 'star ratings' for Washington State facilities. Finally, the department focused on its own state survey data performed by the Department of Health's Investigations and Inspections Office. Below is an overview of the CMS star rating review. The department's Washington State survey data is include in each applicant's separate review under this sub-criterion.

Centers for Medicare & Medicaid Services (CMS) Star Ratings

On January 22, 2015, the Centers for Medicare & Medicaid Services (CMS) released a media statement with the following information related to its dialysis facility compare website.

"Today, the Centers for Medicare & Medicaid Services (CMS) added star ratings to the Dialysis Facility Compare (DFC) website. These ratings summarize performance data, making it easier for consumers to use the information on the website. These ratings also spotlight excellence in health care quality. In addition to posting the star ratings, CMS updated data on individual DFC quality measures to reflect the most recent data for the existing measures.

"Star ratings are simple to understand and are an excellent resource for patients, their families, and caregivers to use when talking to doctors about health care choices," said CMS Administrator Marilyn Tavenner. "CMS has taken another step in its continuous commitment to improve quality measures and transparency."

DFC joined Nursing Home Compare and Physician Compare in expanding the use of star ratings on CMS websites. The DFC rating gives a one to five-star rating based on information about the quality of care and services that a dialysis facility provides. Currently, nine DFC quality measures are being used collectively to comprise the DFC star ratings. In the future, CMS will add more measures.

In related news, CMS plans to add the Standardized Readmission Ratio (SRR) for dialysis facilities to the publicly reported quality outcome measures available on the Compare website. SRR is a measure of care coordination. SRR is not included in DFC's star rating at this time.

DFC quality measure data is either updated quarterly or annually. CMS plans to update the DFC's star rating on an annual basis beginning in October 2015."

CMS provided the following overview regarding its star rating for dialysis centers. [source: CMS website]

“The star ratings are part of Medicare's efforts to make data on dialysis centers easier to understand and use. The star ratings show whether your dialysis center provides quality dialysis care - that is, care known to get the best results for most dialysis patients. The rating ranges from 1 to 5 stars. A facility with a 5-star rating has quality of care that is considered 'much above average' compared to other dialysis facilities. A 1- or 2- star rating does not mean that you will receive poor care from a facility. It only indicates that measured outcomes were below average compared to those for other facilities. Star ratings on Dialysis Facility Compare are updated annually to align with the annual updates of the standardized measures.”

CMS assigns a one to five ‘star rating’ in two separate categories: best treatment practices and hospitalizations and deaths. The more stars, the better the rating. Below is a summary of the data within the two categories.

- Best Treatment Practices

This is a measure of the facility’s treatment practices in the areas of anemia management; dialysis adequacy, vascular access, and mineral & bone disorder. This category reviews both adult and child dialysis patients.

- Hospitalization and Deaths

This measure takes a facility's expected total number of hospital admissions and compares it to the actual total number of hospital admissions among its Medicare dialysis patients. It also takes a facility's expected patient death ratio and compares it to the actual patient death ratio taking into consideration the patient’s age, race, sex, diabetes, years on dialysis, and any co-morbidities.

The Dialysis Facility Compare website currently reports on 9 measures of quality of care for facilities. These measures are used to develop the star rating. Based on the star rating in each of the two categories, CMS then compiles an ‘overall rating’ for the facility. As with the separate categories: the more stars, the better the rating. The star rating is based on data collected from January 1, 2012 through December 31, 2015.²³

The measures used in the star rating are grouped into three domains by using a statistical method known as Factor Analysis. Each domain contains measures that are most correlated. This allows CMS to weight the domains rather than individual measures in the final score, limiting the possibility of overweighting quality measures that assess similar qualities of facility care. The three domains are as follows:

- "Standardized Outcomes (SHR, SMR, and STrR)" – This first domain combines the three outcome measures for hospitalization, mortality and transfusions (SHR, SMR, and STrR).
- "Other Outcomes 1 (AV fistula, tunneled catheter)" – The arteriovenous fistula and catheter measures forms the second domain.
- "Other Outcomes 2 (Kt/V, hypercalcemia)" – The All Kt/V and hypercalcemia measures forms the third domain.

Facilities are rated as long as they have at least one measure in each of the three domains. Because the vascular access measures in the “Other Outcomes 1 (AV fistula, tunneled catheter)” domain do

²³ The information or data on Dialysis Facility Compare comes from two key sources: 1) CMS Statistical Analytical Files (Medicare Claims); and 2) Consolidated Renal Operations in a Web-enabled Network (CROWN). Some ratios are calculated annually based on the information that facilities send Medicare each month; other ratios are calculated quarterly.

not apply to peritoneal dialysis patients, peritoneal dialysis-only facilities are rated based on the other two domains. They receive ratings as long as they have scores for at least one of the two domains not related to vascular access.

CHI Franciscan

CHI Franciscan provided the following statement related to this sub-criterion:

“CHI Franciscan operates all existing programs in conformance with applicable federal and state laws, rules and regulations.” [source Application p38]

Public Comment

None

Rebuttal

None

Department Evaluation

The department completed a review of CHI Franciscan’s quality and compliance with state and federal requirements, below.

CMS Star Rating for Out-of-State Centers

CHI Franciscan does not own or operate any dialysis centers outside of Washington State.

CMS Star Rating for Washington State Centers

The department reviewed the star rating for the following five operational dialysis centers owned and operated by CHI Franciscan:

**Table 73
CHI Franciscan Dialysis Facilities**

Facility Name	CMS Certification Number	CMS Star Rating
St Joseph Medical Center Nephrology Services	500108	2
Greater Puyallup Dialysis Center	503507	5
St Joseph Dialysis Center Gig Harbor	503510	5
Franciscan Dialysis Center Eastside	503511	5
St Joseph Medical Center South Dialysis	503512	4

[source: Dialysis Facility Compare Dataset]

As shown above, all but one of CHI Franciscan’s dialysis facilities show a three or better star rating.

Washington State Survey Data

The department reviewed the compliance history for all five centers above. In the most recent two years, the department has conducted and completed at least five surveys. All surveys resulted in no significant non-compliance issues. [source: DOH IIO survey data]

All CHI Franciscan dialysis centers are also licensed under the St Joseph Medical Center hospital license. Therefore, the department also completed a review of CHI Franciscan’s hospitals in Washington State. The eight hospitals owned or operated by CHI Franciscan in Washington State include Harrison Medical Center in Bremerton and Silverdale, Highline Medical Center in Burien,

Regional Hospital located in Burien, St Anthony Hospital located in Gig Harbor, St Clare Hospital located in Lakewood, St Elizabeth Hospital located in Enumclaw, St Francis Community Hospital located in Federal Way, and St Joseph Medical Center located in Tacoma.

Seven of the eight hospitals are accredited by the Joint Commission.²⁴

Using the department’s internal database, the department reviewed survey data for each of the hospitals listed above. In the last two years, a total of nine surveys have been conducted and completed by Washington State surveyors of these facilities. All nine surveys resulted in no significant non-compliance issues. [source: ILRS, DOH IIO survey data]

In addition to the facilities owned and operated by CHI, the department also reviewed the compliance history for the medical director identified for CHI. Using data from the Medical Quality Assurance Commission, the department found that Dr. Melissa Yeh Kaptik has no enforcement actions on her license. She is expected to continue employment if this project is approved.

In review of this sub-criterion, the department considered the total compliance history of the dialysis facilities owned and operated by CHI. The department also considered the compliance history of the medical director associated with the proposed facility. There is reasonable assurance that Franciscan Lakewood would be operated and managed in conformance with applicable state and federal licensing and certification requirements. The department concludes that CHI Franciscan’s project **meets this sub-criterion.**

Puget Sound Kidney Centers

PSKC does not own or operate any out-of-state healthcare facilities and only provides dialysis services in Snohomish, Island, and Skagit counties within Washington State. PSKC provided the following statement related to this sub-criterion:

“PSKC will operate all existing programs in conformance with applicable federal and state laws, rules and regulations.” [source Application p37]

Public Comment

FMC submitted comments related to this sub-criterion

FMC Public Comment

“A dialysis facility provides a significant number of treatments to its patients on a daily basis – one dialysis patient requires three (3) treatments a minimum of four (4) times per week, or approximately twelve (12) treatments per week. As such, a 44-station facility will not only have a tremendous number of patients, but will also provide an enormous amount of treatments on a daily, weekly, and annual basis.

In such a large facility, it is more likely that patients requiring special needs or considerations will have to jump through extra hoops or will be forced to go elsewhere for care because of the inability for a large facility to effectively and quickly respond to adjustments in care. It is also more likely that patient concerns will be overlooked or simply missed at a large facility, and will

²⁴ St Elizabeth Hospital does not hold Joint Commission accreditation.

reduce the ability for patients to receive care elsewhere because of the limited options.” [source: FMC public comment pp13-14]

Rebuttal

PSKC provided the following statements in response to FMC’s public comment:

“Again, while offering no evidence or data to support its baseless and incoherent claims, FMC also argues that a large PSKC facility cannot accommodate special needs or make adjustments to care. Again, this is not accurate. PSKC operates all of its facilities in conformance with all state and federal requirements. And, in fact, PSKC has some of the highest quality facilities (if not the highest) in the State of Washington. Once again, PSKC reminds the CN Program that PSKC’s first priority is its patients. And, as noted earlier, PSKC Lakewood will not be staffed any differently than any other PSKC facility. These staffing ratios allow PSKC to be able to respond to any changes in the acuity needs of each and every patient and to make any adjustments to an individual patient’s care needs. FMC’s arguments are groundless, unsubstantiated and must be disregarded.”
[source: PSKC rebuttal p8]

Department Evaluation

The department completed a review of PSKC’s quality and compliance with state and federal requirements, below.

CMS Star Rating for Out-of-State Centers

PSKC does not own or operate any dialysis centers outside of Washington State.

CMS Star Rating for Washington State Centers

The department reviewed the star rating for the following six operational dialysis centers owned and operated by PSKC:

Table 74
PSKC Dialysis Facilities

Facility Name	CMS Certification Number	CMS Star Rating
Puget Sound Kidney Center	502503	4
Puget Sound Kidney Center South	502521	5
Puget Sound Kidney Center Whidbey Island	502545	3
Puget Sound Kidney Center Smokey Pointe	502546	4
Puget Sound Kidney Centers Anacortes	502573	4
Puget Sound Kidney Center - Monroe	502576	4

[source: Dialysis Facility Compare Dataset]

As shown above, all PSKC dialysis facilities show a three or better star rating.

Washington State Survey Data

The department reviewed the compliance history for all six centers above. In the most recent two years, the department has conducted and completed at least three surveys. All surveys resulted in no significant non-compliance issues. [source: DOH IIO survey data]

In addition to the facilities owned and operated by PSKC, the department also reviewed the compliance history for the medical director identified for PSKC. Using data from the Medical

Quality Assurance Commission, the department found that Dr. Mark Gunning has no enforcement actions on his license. He is expected to continue employment if this project is approved.

In their public comment FMC expressed doubts that PSKC had the ability to adhere to state and federal requirements in a facility of that size. FMC did not express similar doubts relating to the DaVita and CHI Franciscan projects in this review, though the number of stations proposed in each of these projects are the same. FMC did not offer any data to support their concern regarding PSKC's adherence to state and federal requirements. As shown above, PSKC has demonstrated compliance with state and federal requirements at their existing dialysis centers, and the department has no reason to expect that they would not continue to do so at the proposed PSKC Lakewood facility, if it is approved.

In review of this sub-criterion, the department considered the total compliance history of the dialysis facilities owned and operated by PSKC. The department also considered the compliance history of the medical director associated with the proposed facility. There is reasonable assurance that PSKC Lakewood would be operated and managed in conformance with applicable state and federal licensing and certification requirements. The department concludes that PSKC's project **meets this sub-criterion.**

Fresenius Medical Care

FMC provided the following statement in response to this sub-criterion:

“Both RCG and Fresenius have proven track records in complying with applicable state and federal rules and regulations.” [source: Application p32]

Public Comment

None

Rebuttal

None

Department Evaluation

The department completed a review of FMC's quality and compliance with state and federal requirements, below.

CMS Star Rating for Out-of-State Centers

FMC operates or provides administrative services in approximately 2,276 outpatient dialysis centers in 48 states, the District of Columbia, and Puerto Rico.²⁵ For Washington State, FMC owns or operates 18 dialysis centers. The department obtained the star rating for all of the out-of-state centers.

Of 2,276 facilities operated by FMC, 183 facilities had no star rating. For the remaining 2,093 facilities with a star rating, 80% had a rating of three or better.

CMS Star Rating for Washington State Centers

The department reviewed the star rating for the following 18 operational dialysis centers owned and operated by FMC:

²⁵ The only two states in which FMC does not operate are North Dakota and South Dakota.

Table 75
FMC Dialysis Facilities

Facility Name	CMS Certification Number	CMS Star Rating
FMC Leah Layne Dialysis Center	502558	4
FMC Columbia Basin	502518	5
PNRS Ft Vancouver	502522	3
PNRS Salmon Creek	502524	4
PNRS Clark County Dialysis Clinic	502574	4
FMC Moses Lake Dialysis Clinic	502529	4
FMC Aberdeen	502531	5
FMC Chehalis	502539	5
FMC Shelton	502548	2
FMC Omak Dialysis Center	502533	4
FMC Spokane Kidney Center	502527	3
FMC Northpointe Dialysis Unit	502528	4
FMC Valley Dialysis Unit	502535	3
Panorama Dialysis	502567	5
FMC Colville	502557	5
FMC Lacey	502530	5
FMC Thurston County Dialysis Center	502575	5
Qualicenters – Walla Walla LLC	502517	5

[source: Dialysis Facility Compare Dataset]

As shown above, all but one of FMC’s Washington State dialysis facilities show a three or better star rating.

Washington State Survey Data

As shown above, FMC owns, operates, or manages 18 facilities in 12 separate counties in Washington State. For these facilities, the department has conducted and completed at least 16 surveys within the last two years. All surveys resulted in no significant non-compliance issues. [source: DOH IIO survey data]

In addition to the facilities owned and operated by FMC, the department also reviewed the compliance history for the medical director identified for FMC. Using data from the Medical Quality Assurance Commission, the department found that Dr. Seth Thaler has no enforcement actions on his license. He is expected to continue employment if this project is approved.

In review of this sub-criterion, the department considered the total compliance history of the dialysis facilities owned and operated by FMC. The department also considered the compliance history of the medical director associated with the proposed facility. There is reasonable assurance that FKC – Fredrickson would be operated and managed in conformance with applicable state and federal licensing and certification requirements. The department concludes that FMC’s project **meets this sub-criterion.**

DaVita HealthCare Partners, Inc.

For each of its three applications, DaVita provided the following statements related to this sub-criterion. [source: Lakewood Community Center Application, pp8-9, p25, & Appendix 4; Towne Center Application, pp8-9, p25, & Appendix 4; Canyon Road Application, pp8-9, p26, & Appendix 4]

“DaVita has no criminal convictions related to DaVita’s competency to exercise responsibility for the ownership or operation of its facilities. As previously reported, a DaVita facility in Tennessee was decertified and closed eight years ago (2007) and DaVita voluntarily temporarily shut down a facility in Texas seven years ago (2008). ...Although it is outside the scope of WAC 246-310-230(5)(a), DaVita also discloses that it entered into a settlement agreement that is described in the SEC Form 8K dated October 22, 2014, a copy of which is provided as Appendix 4 to this application.”

“The applicant has no adverse history of license revocation or decertification in Washington State.

This sub-section provides the review of DaVita HealthCare Partners for all three applications submitted.

Public Comment

None

Rebuttal

None

Department Evaluation

The department completed a review of DaVita’s quality and compliance with state and federal requirements below.

CMS Star Rating for Out-of-State Centers

DaVita reports dialysis services to CMS for 2,303 facilities in 45 states and the District of Columbia.²⁶ For Washington State, DaVita owns or operates 42 dialysis centers. The department obtained the star rating for all of the out-of-state centers.

Of the 2,303 facilities reporting to CMS by DaVita, 2,261 are out of state facilities. Of the 2,261 out of state facilities, 230 had no star rating. For the remaining 2,031 facilities with a star rating, 86.2% had a rating of three or better.

CMS Star Rating for Washington State Centers

DaVita owns, operates, or manages 42 facilities in 18 separate counties. Of the 42 centers, 37 of them are currently operating. Of the 37 centers, six do not have the necessary amount of data to compile a star rating.²⁷ The department reviewed the star rating for the remaining 31 centers.

²⁶ The five states where DaVita does not operate are: Alaska, Delaware, Mississippi, Vermont, and Wyoming.

²⁷ The six centers are: Battleground Dialysis Center, Belfair Dialysis Center, Cascade Dialysis Center, Echo Valley Dialysis Center, Rainier View Dialysis Center, and Tumwater Dialysis Center.

**Table 76
DaVita Washington State Dialysis Facilities**

Facility Name	CMS Certification Number	Five star
Bellevue Dialysis Center	502542	3
Chinook Kidney Center	502559	5
DaVita Mount Baker Kidney Center	502501	5
Downtown Spokane Renal Center	502547	3
East Wenatchee Dialysis Center	502569	5
Ellensburg Dialysis Center	502552	4
Everett Dialysis Center	502560	5
Federal Way Community Dialysis Center	502513	4
Graham Dialysis Center	502554	5
Kennewick Dialysis Center	502572	4
Kent Community Dialysis Center	502526	4
Lakewood Community Dialysis Center	502519	4
Mid-Columbia Dialysis Center	502504	4
Mill Creek Dialysis Center	502561	5
Mount Adams Dialysis Center	502514	5
North Spokane Renal Center	502538	3
Olympia Dialysis Center	502555	5
Olympic View Dialysis Center (managed)	502525	3
Parkland Dialysis Center	502566	3
Pilchuck Dialysis Center	502577	4
Puyallup Community Dialysis Center	502534	3
Seaview Dialysis Center	502562	5
Spokane Valley Renal Center	502537	5
Tacoma Dialysis Center	502551	3
Union Gap Dialysis Center	502543	5
Vancouver Dialysis Center	502550	3
Wenatchee Valley Dialysis Center	502568	5
Westwood Dialysis Center	502544	4
Whidbey Island Dialysis Center	502564	3
Yakima Dialysis Center	502541	4
Zillah Dialysis Center	502571	4

As shown above, all of DaVita’s Washington State dialysis facilities show a three or better star rating.

Washington State Survey Data

For Washington State, DaVita owns, operates, or manages 42 facilities in 18 separate counties. Four of the 42 are CN approved, but not yet state surveyed and operational. The department reviewed the compliance history for the 37 operational DaVita dialysis centers listed above. For the Washington State facilities, the department has conducted and completed at least 40 surveys in the most recent three years. All surveys resulted in no significant non-compliance issues. [source: DOH IIO survey data]

In addition to the facilities owned and operated by DaVita, the department also reviewed the compliance history for the current medical director of Lakewood Community Dialysis Center and all of the nephrologists associated with Pacific Nephrology Associates. Table 77 below identifies each physician and licensing status.

Table 77
Pacific Nephrology Associates, PS Physicians

Physician	Status
Zeng Ge	Active
Neil R. Hannigan	Active
Yajuan He	Active
Ho Won Lee	Active
Catherine Ann Richardson	Active
Di Zhao	Active

In this process, the Certificate of Need program used compliance data from the Medical Quality Assurance Commission (MQAC). This review found that the proposed medical director is licensed and in good standing.

DaVita is currently operating under a Corporate Integrity Agreement (CIA) with the Office of the Inspector General of the Department of Health and Human Services that was signed on October 22, 2014. DaVita provided a copy of the signed agreement. [source: Application, Appendix 4] The department notes that the agreement focuses on DaVita’s joint ventures with nephrologists to operate dialysis clinics; rather than patient care or billing practices.

DaVita’s CIA has 16 specific sections under ‘Term and Scope’ that requires DaVita to:

- establish and maintain a Compliance Program that includes a Chief Compliance Officer and Management Compliance Committee;
- establish written standards for covered persons (as defined in the CIA);
- establish training and education for covered persons;
- ensuring compliance with anti-kickback statute;
- provide notice to joint venture partners and medical directors of specific information related to patient referrals and ownership information;
- unwind specific joint venture clinics;
- retain an independent monitor selected by OIG;
- establish compliance audits;
- establishment of a risk assessment and mitigation process;
- establish a financial recoupment process;
- cooperate with all OIG investigations;
- maintain its disclosure program;
- removal of ‘ineligible persons’ as defined in the CIA;
- notify the OIG of government investigation or legal proceedings;
- repayment of overpayments; and
- report all reportable events as defined in the CIA.

Appendix B of the CIA identifies the eleven separate joint ventures that must be unwound, which includes a total of 26 dialysis clinics in five different states.²⁸ None of the joint ventures or dialysis clinics are located in Washington State.

For this specific CIA, DaVita would not be excluded from participation in Medicare, Medicaid or other Federal health care programs provided that DaVita complies with the obligations outlined in the CIA.

Given the compliance history of DaVita, which includes continued compliance with the CIA, the compliance history of the medical directors associated with Pacific Nephrology Associates, the department concludes that there is reasonable assurance that Lakewood Community Dialysis Center would continue to operate in compliance with state and federal regulations if an additional 15 stations are added to the facility. The department also concludes that both of DaVita’s new proposed dialysis centers would operate in compliance with state and federal regulations if approved.

The department concludes that DaVita’s three projects **meet this sub-criterion**.

Superiority Ranking

For this sub-criterion, the department used the average star ranking for an applicant’s existing in-state facilities. These serve as an indicator that the project would be in conformance with applicable conditions of participation for Medicare certification. The department used data already provided within this sub-criterion to perform this superiority review. The department completed this superiority review by ranking the applicants – not the projects or sub-projects. Using this format, each project proposed by a single applicant would be tied. The superiority review is shown below in Table 78.

**Table 78
Department Superiority Review of WAC 246-310-230(3)**

Applicant/Application	Average Star Rating in Washington State	Ranking
CHI Franciscan:	4.20	1
Puget Sound Kidney Centers	4.00	4
Fresenius	4.16	2
DaVita – Lakewood Community	4.10	3
DaVita – Towne Center	4.10	3
DaVita – Canyon Road	4.10	3

In the event that one or more applications meet all of the applicable review criteria, this superiority information may be used in the departments evaluation of WAC 246-310-240(1) Step 3. In the event that only one application meets all of the applicable review criteria, this superiority information will not be used.

²⁸ The five states are: California (9); Colorado (7); Florida (5); Kentucky (1); and Ohio (4).

- (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.

CHI Franciscan

CHI Franciscan provided the following statement related to this sub-criterion:

“CHI Franciscan has organized its nephrology program such that all services are contained in a single service line. This organizational structure integrates inpatient, outpatient and home services within a single continuum. This continuum is supported by an electronic medical record which provides appropriate patient and clinical data to care providers throughout the system. CHI Franciscan’s nephrology program also maintains well established working relationships with area nursing homes and provides in-service and training opportunities for nursing home staff and residents. Specific arrangements are made on a resident by resident basis; therefore, the list of nursing homes that CHI Franciscan works with varies. While we do not maintain formal working agreements with any party related specifically to dialysis, we have longstanding relationships in place with many Pierce 5 providers. In addition, CHI Franciscan has informal relationships with area colleges and universities. Included in Exhibit 11 is a draft transfer agreement between the St. Clare Hospital and Franciscan Lakewood.” [source: Application p38]

Public Comment

None

Rebuttal

None

Department Evaluation

Given that CHI Franciscan has been providing dialysis services for many years, and provides numerous healthcare services not limited to dialysis throughout Pierce, King, and Kitsap Counties, CHI Franciscan has demonstrated their ability to promote continuity in healthcare systems. Specific to this proposed new dialysis facility, CHI stated that they would create appropriate relationships with other healthcare facilities in the planning area, including hospitals and nursing homes. The addition of dialysis stations would continue to promote continuity in the provision of healthcare services in Pierce County planning area #5.

Under WAC 246-310-230(2), the department requires a signed transfer agreement that is consistent with the draft that was provided with this application.

While the draft agreements provided by CHI Franciscan could be reasonable under their own ownership and control, the department received no assurance that this facility would remain under CHI Franciscan ownership and control for the entire projection period. Information found in the PUI led the department to conclude that the facility would ultimately be sold. CHI did not provide any assurance throughout the PUI process that this subsequent transaction would not have an effect

on the viability of the draft medical director agreement or draft transfer agreement. The department cannot reasonably conclude that the proposed facility would have or maintain the required relationships and agreements outside of CHI Franciscan ownership and control. The department concludes CHI Franciscan's project **does not meet this sub-criterion**.

Puget Sound Kidney Centers

PSKC provided the following statement related to this sub-criterion. [source: Application p36]

“As with all PSKC facilities, PSKC - Lakewood will provide a collaborative, comprehensive, and patient-centered approach to the provision of dialysis services in the community. In addition, PSKC’s unrelenting focus on high-quality, compassionate care, coupled with respect for the patients, staff, and other providers has served the community well. Without dispute, PSKC’s quality is unparalleled as evidenced by several publicly available metrics. With the establishment of this new facility, PSKC will reach out, establish collegial relationships with all medical groups in the planning area, and work closely with the following types of providers in Pierce 5:

- *Existing Dialysis Providers*
- *Hospitals*
- *Transportation agencies (Paratransit)*
- *Long term care facilities*
- *Service Agencies (DSHS)”*

Public Comment

FMC submitted comments relating to this sub-criterion:

FMC Public Comment

“PSKC’s proposed facility clearly fails this criterion as it is requesting a facility with twice the number of dialysis stations currently in operation in the entire Pierce Five planning area. This will concentrate the overwhelming majority of dialysis stations at a single facility and will primarily serve just one city in the planning area. This negatively impacts existing facilities as well as ancillary and support services, because there is less bargaining leverage with such a large provider.

A facility operating the vast majority of dialysis stations will likely limit outside negotiation and influence as it will be the dominant driver in care in the planning area. Patients, payers, and other health care providers will be forced to conform to the standards set exclusively by this facility because of its dominance in dialysis care. This will not promote continuity within the existing health care system, instead effectively creating a very large provider with significant market power in the Pierce Five service area.” [source: FMC Public Comment p13]

Rebuttal

PSKC provided the following statements in response to FMC’s public comment:

“Without any data or analysis in support of its position, FMC also states that PSKC’s proposal will somehow charge too much for our ancillary and support services. PSKC does not understand the point being made by FMC. We are committed not to overcharge for our services. We provide reasonably priced services and our ancillary and support services are built into our charges.

PSKC is confident that our Lakewood operations will be successful and cost-conscious. FMC's criticisms are without merit." [source: PSKC rebuttal p7]

Department Evaluation

Given that PSKC has been providing dialysis services for many years, and successfully operates dialysis facilities in several counties, PSKC has demonstrated their ability to promote continuity in healthcare systems. Specific to this proposed new dialysis facility, PSKC provided assurance that they would create appropriate relationships with other healthcare facilities in the planning area, including hospitals, nursing homes, long-term care facilities, transportation agencies, and other dialysis providers. The addition of dialysis stations would continue to promote continuity in the provision of healthcare services in Pierce County planning area #5.

Under WAC 246-310-230(2), the department attached a condition requiring PSKC to provide a signed transfer agreement that is consistent with the draft that was provided with this application. This condition would also apply to this sub-criterion.

FMC suggests in their public comments that PSKC's project "*negatively impacts existing facilities as well as ancillary and support services because there is less bargaining leverage.*" No documentation was provided to support this claim. In addition to this, it is unclear who PSKC would be bargaining with, as many ancillary and support services will be provided on-site. FMC's comments are without merit.

PSKC has demonstrated their intent and ability to promote continuity in the provision of health care, and not result in an unwarranted fragmentation of services, and have an appropriate relationship to the service area's existing health care system.

The department concludes that PSKC's project **meets this sub-criterion.**

Fresenius Medical Care

FMC provided the following statement in response to this sub-criterion:

The establishment of a new facility in the Pierce Five Dialysis Planning Area in Fredrickson, owned and operated by RCG, will not only ensure timely access to dialysis services, but it will also realize efficiency, coordination and continuity of care through shared System-level staff, administration and other functions.

As RCG has done in the other communities in which we operate, prior to opening, FKC Fredrickson will establish relationships with area transit providers and nursing homes. We will also establish a transfer agreement with one or more local hospitals. [source: Application p32]

Public Comment

None

Rebuttal

None

Department Evaluation

FMC has been a provider of dialysis services in Washington State for many years. Though FMC has a history of establishing relationships with existing healthcare networks, this application for a

24-station facility in Pierce County planning area #5 did not include any documentation of their proposed relationships.

Consistent with FMC's failure to meet the sub-criterion under WAC 246-310-230(2), FMC cannot meet this sub-criterion. FMC has not sufficiently documented that they will be able to establish the required transfer agreement with a local hospital. **FMC does not meet this sub-criterion.**

If this sub-criterion was the only item that FMC failed to meet, and if this were not a concurrent review, failure to provide a draft transfer agreement would not be grounds for denial on its own. There would, instead, be two conditions. One would require FMC to provide a draft transfer agreement for review and approval prior to their receiving a Certificate of Need. The second would be for FMC to provide an executed version of the document, consistent with the draft, prior to completion of the project.

In the case of this concurrent review, though, the department would not allow this additional consideration. The kidney dialysis Certificate of Need application specifically asks for a draft transfer agreement in question 5 under Structure and Process of Care. It asks the applicant to document:

*“The specific means by which the proposed project will promote continuity in the provision of health care to the defined population and avoid unwarranted fragmentation of services. This section should include the identification of existing and proposed formal working relationships with **hospitals**, nursing homes, and other health service resources serving your primary service area. This description should include recent, current, and pending cooperative planning activities shared service agreements, and **transfer agreements**. **Copies of relevant agreements and other documents should be included.**” [emphasis added] [source: CN application p9]*

DaVita – Lakewood Community Dialysis Center

DaVita provided the following statements in response to this sub-criterion. [source: Application, p26 & Appendices 12, 17, &18]

“Appendix 17 provides a summary of quality and continuity of care indicators used in DaVita's quality improvement program. The DaVita Continuous Quality Improvement (CQI) program incorporates all areas of the dialysis program. The program monitors and evaluates all activities related to clinical outcomes, operations management, and process flow. Dialysis-specific statistical tools (developed by DaVita) are used for measurement, analysis, communication, and feedback. Continuing employee and patient education are integral parts of this program. Appendix 17 includes an example of DaVita Quality Index (DQI) data. Appendix 18 includes an example of DaVita's Physician, Community and Patient Services offered through DaVita's Kidney Smart Education Program. Appendix 12 includes a copy of the affiliation letter between St. Clare Hospital and Lakewood Dialysis. DaVita has been honored as one of the World's Most Admired Companies® by FORTUNE® magazine since 2006, confirming its excellence in working effectively with the communities it serves. (davita.com/about/awards)”

Public Comment

None

Rebuttal Comment

None

Department Evaluation

DaVita has been providing dialysis services in the planning area since approximately 1996 with its Lakewood Community Dialysis Center. This project proposes to add 15 dialysis stations to the planning area. DaVita’s project would promote continuity in the provision of healthcare services in Pierce County planning area #5 by operating a total of 57 stations in the planning area.

Since DaVita is in the process of updating its patient transfer agreements, even though Lakewood Community Dialysis Center has been operating in the planning area since 1996, DaVita provided a draft of the updated transfer agreement. If DaVita’s 15 station addition project is approved, the department would attach a condition requiring DaVita to provide a copy of the executed transfer agreement with a local hospital.

DaVita provided documentation in the application to demonstrate that the project would promote continuity in the provision of health care services in the community and not result in unwarranted fragmentation.

With the condition identified above, the department also concludes that DaVita’s project **meets this sub-criterion**.

DaVita – Towne Center

44 New Stations in Two Phases

DaVita provided the following statements in response to this sub-criterion. [source: Application, p26 & Appendices 12, 17, & 18]

“Appendix 17 provides a summary of quality and continuity of care indicators used in DaVita's quality improvement program. The DaVita Continuous Quality Improvement (CQI) program incorporates all areas of the dialysis program. The program monitors and evaluates all activities related to clinical outcomes, operations management, and process flow. Dialysis-specific statistical tools (developed by DaVita) are used for measurement, analysis, communication, and feedback. Continuing employee and patient education are integral parts of this program. Appendix 17 includes an example of DaVita Quality Index (DQI) data. Appendix 18 includes an example of DaVita's Physician, Community and Patient Services offered through DaVita's Kidney Smart Education Program. Appendix 12 includes a copy of the affiliation letter between St. Clare Hospital and Lakewood Dialysis. DaVita has been honored as one of the World's Most Admired Companies® by FORTUNE® magazine since 2006, confirming its excellence in working effectively with the communities it serves. (davita.com/aboutUawards)”

Public Comment

FMC provided comments related to this sub-criterion.

“DVA’s proposed facility clearly fails this criterion as it is requesting a facility with twice the number of dialysis stations currently in operation in the entire Pierce Five service area. This will concentrate the overwhelming majority of dialysis stations at a single facility and will primarily serve just one city in the planning area. This negatively impacts patients as well as ancillary and support services, because there is less bargaining leverage with such a large provider. A facility

operating the vast majority of dialysis stations will likely limit outside negotiation and influence as it will be the dominant driver in care in the planning area. Patients, payers, and other health care providers will be forced to conform to the standards set exclusively by this facility because of its dominance in dialysis care. This is of particular concern considering that DVA operates all existing dialysis facilities in Pierce Five. This does not promote continuity within the existing health care system, instead effectively creates a very large provider with significant market power in the Pierce Five service area.” [source: FMC public comment, p13]

Rebuttal

Fresenius implies a faulty definition of “continuity of care”. Having a greater number of stations actually reduces the per-square-foot cost of a dialysis station, as many fixed costs remain the same regardless of the facility size. This is demonstrated by the inefficiencies of Fresenius’s approach which proposed a higher capital budget than DaVita to meet half the need that DaVita would meet. Most importantly, however, providing care continuity is not a function of facility size, but rather of maintaining proper staffing and a well-designed floorplan that allows for optimal line-of-sight for the clinicians to patients. In this respect, DaVita is the only applicant that has a proposed a facility that will both meet the demonstrated need and maximize patient safety and continuity of care. [source: DaVita rebuttal comment, p6] [emphasis in original]

Department Evaluation

FMC suggests in their public comments that DaVita is unable to ensure that ancillary and support services are available. No documentation was provided to support this claim. DaVita has been providing dialysis services in the planning area since approximately 1996 with its Lakewood Community Dialysis Center. DaVita has demonstrated an intent and ability to promote continuity in the provision of health care, and not result in an unwarranted fragmentation of services, and have an appropriate relationship to the service area’s existing health care system. FMC’s comments are without merit.

This project proposes a new facility in the planning area. DaVita’s project would also promote continuity in the provision of healthcare services in Pierce County planning area #5 by adding a 44-station facility in the planning area. Given that its Towne Center facility would be new to the planning area, DaVita provided a draft transfer agreement that would be used at the facility. If DaVita’s project is approved, the department would attach a condition requiring DaVita to provide a copy of the executed transfer agreement with a local hospital.

DaVita provided documentation in the application to demonstrate that the project would promote continuity in the provision of health care services in the community and not result in unwarranted fragmentation.

With the condition identified above, the department also concludes that DaVita’s project **meets this sub-criterion.**

33 New Stations

DaVita provided the following statements in response to this sub-criterion. [source: Application, p26 & Appendices 12, 17, & 18]

“Appendix 17 provides a summary of quality and continuity of care indicators used in DaVita’s quality improvement program. The DaVita Continuous Quality Improvement (CQI) program incorporates all areas of the dialysis program. The program monitors and evaluates all activities related to clinical outcomes, operations management, and

process flow. Dialysis-specific statistical tools (developed by DaVita) are used for measurement, analysis, communication, and feedback. Continuing employee and patient education are integral parts of this program. Appendix 17 includes an example of DaVita Quality Index (DQI) data. Appendix 18 includes an example of DaVita's Physician, Community and Patient Services offered through DaVita's Kidney Smart Education Program. Appendix 12 includes a copy of the affiliation letter between St. Clare Hospital and Lakewood Dialysis. DaVita has been honored as one of the World's Most Admired Companies® by FORTUNE® magazine since 2006, confirming its excellence in working effectively with the communities it serves. (davita.com/about/awards)”

Public Comment

None

Rebuttal

None

Department Evaluation

DaVita has been providing dialysis services in the planning area since approximately 1996 with its Lakewood Community Dialysis Center. This project proposes a new facility in the planning area. DaVita's project would also promote continuity in the provision of healthcare services in Pierce County planning area #5 by adding a 33-station facility in the planning area. Given that its Towne Center facility would be new to the planning area, DaVita provided a draft transfer agreement that would be used at the facility. If DaVita's project is approved, the department would attach a condition requiring DaVita to provide a copy of the executed transfer agreement with a local hospital.

DaVita provided documentation in the application to demonstrate that the project would promote continuity in the provision of health care services in the community and not result in unwarranted fragmentation.

With the condition identified above, the department also concludes that DaVita's project **meets this sub-criterion.**

DaVita – Canyon Road

44 New Stations in Three Phases

DaVita provided the following statements in response to this sub-criterion. [source: Application, p26 & Appendices 12, 17, & 18]

“Appendix 17 provides a summary of quality and continuity of care indicators used in DaVita's quality improvement program. The DaVita Continuous Quality Improvement (CQI) program incorporates all areas of the dialysis program. The program monitors and evaluates all activities related to clinical outcomes, operations management, and process flow. Dialysis-specific statistical tools (developed by DaVita) are used for measurement, analysis, communication, and feedback. Continuing employee and patient education are integral parts of this program. Appendix 17 includes an example of DaVita Quality Index (DQI) data. Appendix 18 includes an example of DaVita's Physician, Community and Patient Services offered through DaVita's Kidney Smart Education Program. Appendix 12 includes a copy of the affiliation letter between St. Clare Hospital and Lakewood Dialysis. DaVita has been honored as one of the World's Most Admired

Companies® by FORTUNE® magazine since 2006, confirming its excellence in working effectively with the communities it serves. (davita.com/about/awards)”

Public Comment

FMC provided comments related to this sub-criterion.

“DVA’s proposed facility clearly fails this criterion as it is requesting a facility with twice the number of dialysis stations currently in operation in the entire Pierce Five service area. This will concentrate the overwhelming majority of dialysis stations at a single facility and will primarily serve just one city in the planning area. This negatively impacts patients as well as ancillary and support services, because there is less bargaining leverage with such a large provider. A facility operating the vast majority of dialysis stations will likely limit outside negotiation and influence as it will be the dominant driver in care in the planning area. Patients, payers, and other health care providers will be forced to conform to the standards set exclusively by this facility because of its dominance in dialysis care. This is of particular concern considering that DVA operates all existing dialysis facilities in Pierce Five. This does not promote continuity within the existing health care system, instead effectively creates a very large provider with significant market power in the Pierce Five service area.”

[source: FMC public comment, p11]

Rebuttal

Fresenius implies a faulty definition of “continuity of care”. Having a greater number of stations actually reduces the per-square-foot cost of a dialysis station, as many fixed costs remain the same regardless of the facility size. This is demonstrated by the inefficiencies of Fresenius’s approach which proposed a higher capital budget than DaVita to meet half the need that DaVita would meet. Most importantly, however, providing care continuity is not a function of facility size, but rather of maintaining proper staffing and a well-designed floorplan that allows for optimal line-of-sight for the clinicians to patients. In this respect, DaVita is the only applicant that has a proposed a facility that will both meet the demonstrated need and maximize patient safety and continuity of care.

[source: DaVita November 16, 2016, rebuttal, p6] [emphasis in original]

Department Evaluation

FMC suggests in their public comments that DaVita is unable to ensure that ancillary and support services are available. No documentation was provided to support this claim. DaVita has been providing dialysis services in the planning area since approximately 1996 with its Lakewood Community Dialysis Center. DaVita has demonstrated an intent and ability to promote continuity in the provision of health care, and not result in an unwarranted fragmentation of services, and have an appropriate relationship to the service area's existing health care system. FMC’s comments are without merit.

This project proposes a new facility in the planning area. DaVita’s project would also promote continuity in the provision of healthcare services in Pierce County planning area #5 by adding a 44-station facility in the planning area. Given that its Canyon Road center facility would be new to the planning area, DaVita provided a draft transfer agreement that would be used at the facility. If DaVita’s project is approved, the department would attach a condition requiring DaVita to provide a copy of the executed transfer agreement with a local hospital.

DaVita provided documentation in the application to demonstrate that the project would promote continuity in the provision of health care services in the community and not result in unwarranted fragmentation.

With the condition identified above, the department also concludes that DaVita’s project **meets this sub-criterion.**

36 New Stations in Two Phases

DaVita provided the following statements in response to this sub-criterion. [source: Application, p26 & Appendices 12, 17, & 18]

“Appendix 17 provides a summary of quality and continuity of care indicators used in DaVita's quality improvement program. The DaVita Continuous Quality Improvement (CQI) program incorporates all areas of the dialysis program. The program monitors and evaluates all activities related to clinical outcomes, operations management, and process flow. Dialysis-specific statistical tools (developed by DaVita) are used for measurement, analysis, communication, and feedback. Continuing employee and patient education are integral parts of this program. Appendix 17 includes an example of DaVita Quality Index (DQI) data. Appendix 18 includes an example of DaVita's Physician, Community and Patient Services offered through DaVita's Kidney Smart Education Program. Appendix 12 includes a copy of the affiliation letter between St. Clare Hospital and Lakewood Dialysis. DaVita has been honored as one of the World's Most Admired Companies® by FORTUNE® magazine since 2006, confirming its excellence in working effectively with the communities it serves. (davita.com/aboutUawards)”

Public Comment

None

Rebuttal

None

Department Evaluation

DaVita has been providing dialysis services in the planning area since approximately 1996 with its Lakewood Community Dialysis Center. This project proposes a new facility in the planning area. DaVita’s project would also promote continuity in the provision of healthcare services in Pierce County planning area #5 by adding a 36-station facility in the planning area. Given that its Canyon Road center facility would be new to the planning area, DaVita provided a draft transfer agreement that would be used at the facility. If DaVita’s project is approved, the department would attach a condition requiring DaVita to provide a copy of the executed transfer agreement with a local hospital.

DaVita provided documentation in the application to demonstrate that the project would promote continuity in the provision of health care services in the community and not result in unwarranted fragmentation.

With the condition identified above, the department also concludes that DaVita’s project **meets this sub-criterion.**

- (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. **This sub-criterion is met.**

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

CHI Franciscan

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department concludes that the CHI Franciscan project – whether as a 28-station facility in one phase or a 44-station facility in two phases – has not met the cost containment criteria in WAC 246-310-240.

Puget Sound Kidney Centers

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department concludes that the Puget Sound Kidney Centers project – whether as a 16-station, 20-station, 22-station, or 44-station (regardless of configuration) – has met the cost containment criteria in WAC 246-310-240.

Fresenius Medical Care

Based on the source information reviewed, the department concludes that the Fresenius Medical Care project has not met the cost containment criteria in WAC 246-310-240.

DaVita Healthcare Partners, Inc.

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department concludes that the DaVita Lakewood Community Dialysis Center project has met the cost containment criteria in WAC 246-310-240.

DaVita Healthcare Partners, Inc.

Based on the source information reviewed, the department concludes that the DaVita Towne Center project – whether as a new 33 or 44-station facility – has not met the cost containment criteria in WAC 246-310-240.

DaVita Healthcare Partners, Inc.

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department concludes that the DaVita Canyon Road project – whether as a new 36 or 44-station facility – has met the cost containment criteria in WAC 246-310-240.

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

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

If there are multiple applications, the department's assessment is to apply any service or facility superiority criteria contained throughout WAC 246-310 related to the specific project type in Step three. The superiority criteria are objective measures used to compare competing projects and

make the determination between two or more approvable projects which is the best alternative. If WAC 246-310 does not contain any service or facility type superiority criteria as directed by WAC 246-310-200(2) (a)(i), then the department would use WAC 246-310-240(2)(a)(ii) and (b) for criteria to make the assessment of the competing proposals. If there are no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b), then using its experience and expertise, the department would assess the competing projects and determine which project should be approved.

Step One

Step One for each of the applicants and their various projects is summarized below in the Table 79.

**Table 79
WAC 246-310-240(1) – Step One**

APPLICANT	246-310-210 Need	246-310-220 FF	246-310 230 SPOC	246-310-240 CC
<i>Franciscan Lakewood – 28 stations (1 phase)</i>	<i>No</i>	<i>No</i>	<i>No</i>	<i>No</i>
<i>Franciscan Lakewood – 44 stations (2 phase)</i>	<i>No</i>	<i>No</i>	<i>No</i>	<i>No</i>
PSKC Lakewood – 44 stations (2 phase, 16+28)	Yes	Yes	Yes	Yes
PSKC Lakewood – 44 stations (2 phase, 20+24)	Yes	Yes	Yes	Yes
PSKC Lakewood – 44 stations (2 phase, 22+22)	Yes	Yes	Yes	Yes
PSKC Lakewood – 16 stations (1 phase)	Yes	Yes	Yes	Yes
PSKC Lakewood – 20 stations (1 phase)	Yes	Yes	Yes	Yes
PSKC Lakewood – 22 stations (1 phase)	Yes	Yes	Yes	Yes
<i>FMC</i>	<i>Yes</i>	<i>No</i>	<i>No</i>	<i>No</i>
DaVita – LCDC 15 station addition	Yes	Yes	Yes	Yes
<i>DaVita – Towne Center 44-Station project</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
<i>DaVita – Towne Center 33-Station project</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
<i>DaVita – Towne Center 33 new stations and 11 stations relocated from LCDC</i>	<i>No</i>	<i>Not Evaluated</i>		
DaVita – Canyon Road 44-Station project	Yes	Yes	Yes	Yes
DaVita – Canyon Road 36-Station project	Yes	Yes	Yes	Yes
<i>DaVita – Canyon Road 24-Station project</i>	<i>No</i>	<i>Not Evaluated</i>		

As shown above the following projects did not meet the applicable review criteria outlined in WAC 246-310-210, -220, and -230.

- CHI Franciscan’s 28-station project established in one phase.
- CHI Franciscan’s 44-station project established in two phases.
- Fresenius Medical Care’s 24-dtation project
- DaVita – Towne Center 44-station project established in two phases.
- DaVita – Towne Center 33-station project established in one phase.
- DaVita – Towne Center 44-station project established in one phase with 33 new stations and 11 stations relocated from LCDC.
- DaVita – Canyon Road 24-Station project established in one phase.

The projects listed above that did not meet the applicable review criteria will not be evaluated further under Step Two or Step Three below.

For each remaining projects, Step Two will be evaluated below. It should be noted that Step Two will only include the alternatives considered by the applicants, and the departments evaluation of the alternatives considered.

Step Two

CHI Franciscan

As stated above, CHI Franciscan did not meet the applicable review criteria under WAC 246-310-210 and 220. Therefore, it will not be discussed under WAC 246-310-240(1).

Puget Sound Kidney Centers

Within their application, PSKC only identified two options: the requested project, and no project. As demonstrated throughout this evaluation, PSKC also provided alternative phasing within the proposed project. In the event that only phase 1 could be approved, the PSKC ranked their preference as follows: 22 stations, 20 stations, 16 stations. [source: Application p38, Screening Response p12]

Public Comment

FMC submitted related to this sub-criterion:

FMC Public Comment

“Although PSKC proposes a project that at face value meets patient need in Pierce Five, it does not improve patient access, as detailed above. Considering that patient access is closely tied with patient need, proposing a large facility to meet the number of stations needed does not necessarily equate to adequately fulfilling patient need. In other words, PSKC's project disproportionately benefits patients in the northernmost region of Pierce Five which is already served by the three existing DVA dialysis facilities. PSKC's project will not meet need for patients in other regions of Pierce Five, particularly Spanaway, which has the third highest concentration of patients in the service area and is not currently served by a reasonably close dialysis facility. Due to PSKC's failure to improve much needed patient access, PSKC's proposed project fails to adequately meet patient need in the entire Pierce Five service area.

PSKC's project is also inferior to FMC's proposed FKC Frederickson in terms of access and quality of care standards. PSKC proposes a facility more than twice the total number of existing dialysis stations in Pierce Five, which would locate over half of the entire planning area stations in a single facility. A large, concentrated facility such as PSKC is proposing is not an ideal choice for patients living in Pierce Five. A facility of this size, even in a planning area with significant current and future need for dialysis stations, will negatively impact patients, payers, and other existing healthcare providers in the Pierce Five planning area. The crucial problems with a 44-station facility can be summarized as follows:

- 1. No beneficial impact on patient access, which is a tremendous problem;*
- 2. Likely to be inefficient since it is 44 stations, costs over \$10.8 million, and may well have idle capacity for many years, and as a consequence, potentially negatively impact costs and charges; and*
- 3. Significant potential difficulties adequately staffing a facility as large as PSKC proposes.*

Most significantly, a large facility will have a zero or negative effect on patient access in Pierce Five. This is because a single facility caters exclusively to patients in just one city in the service

area. Due to the facility operating over half of the total planning area dialysis stations, it will effectively force more than half of all the dialysis patients in Pierce Five to receive dialysis care at a single, large facility.

Patients living in other cities of the planning area will not benefit from this facility, and in fact will likely face many challenges attempting to access dialysis care at the facility. While we agree that there are a large number of dialysis patients in the Lakewood and surrounding regions, there are also a large number of patients in and around Spanaway. As discussed thoroughly above, one-fifth (20%) of dialysis patients in Pierce Five are not currently served by a dialysis facility. These patients will be forced to receive care at inconvenient and/or overcrowded facilities in Lakewood or Parkland, increasing traffic and congestion in and around the location of PSKC's proposed facility as a result of the concentration of dialysis stations.

Patient choice is also of concern with a 44-station facility as it will take many years for PSKC's proposed facility to reach capacity, particularly since this facility will be phased in two (2) stages over the course of three (3) years. It will be impossible to address patient needs, including growth in other regions of Pierce Five, while the PSKC project is undergoing construction or if it fails to reach expected patient volumes due to its size.

Further, PSKC proposes to add an entire second floor during the first two years of operation, which requires a substantial amount of construction. This will likely negatively impact patients receiving dialysis care at the facility during the construction.

Due to the combination of negative factors resulting from a very large-sized dialysis facility and its failure to demonstrate conformance to Need (WAC 246-310-210), Financial Feasibility (WAC 246-310-220), and Structure and Process of Care (WAC 246-310-230), and Cost Containment (WAC 246-310-240), PSKC's proposed project is not the best option to meet current and future patient need in the Pierce Five dialysis planning area and its 44-station request should be denied.” [source: FMC Public Comment pp15-16]

Rebuttal

“As stated throughout this submittal, the comments submitted primarily by DV and FMC are weak attempts on their part to thwart our entry into the Pierce 5 market, and must be disregarded. In the end, we believe the CN Program will concur with our analysis. We are the superior alternative. When we take access to care, quality of care, and cost of care into consideration, it's not even close! PSKC is fully prepared to develop both phases (all 44 stations) of our application quickly, and with the utmost in quality and integrity. We improve quality of care, increase access to care, and reduce cost of care, all parts of the triple aim in health care.” [source: PSKC rebuttal p8]

Department Evaluation

The department's evaluation of PSKC's alternatives considered will be discussed below, concurrently with the CHI Franciscan and DaVita projects.

Fresenius Medical Care

As stated above, FMC did not meet the applicable review criteria under WAC 246-310-220 and 230. Therefore, it will not be discussed under WAC 246-310-240(1).

DaVita's Combined Step Two

Before submitting each of the three applications, DaVita considered and rejected the following five alternatives.

- 1) Do nothing
- 2) Add 15 dialysis stations to Rainier View Dialysis Center located in Pierce County planning area #5
- 3) Add 15 stations to Lakewood Community Dialysis Center in Lakewood
- 4) Establish a new two phase 44-station center in the Lakewood Towne Center
- 5) Establish a new three phase 44-station center on Canyon Road in Spanaway

Of these alternatives, number three above did not meet the applicable review criteria under 210-230. One of the options described in number five also did not meet the applicable review criteria. The alternative under number two above was not submitted for this review cycle.

Below is DaVita's discussion and ranking of each alternative that met the review criteria under 210-230, or were considered but not submitted within this concurrent review cycle. [source: Lakewood Community Dialysis Center Application pp26-28; Towne Center Application, pp28-29; & Canyon Road Application, pp28-29]

***Alternative 1:** Do nothing, that is do not apply for the full 44 station need in Pierce 5. It has been established that the Pierce 5 planning area is experiencing unprecedented need in Washington State. This need must be met in order to serve both current capacity constraints as well as future expected growth. At present, many patients are dialyzing on sub-optimal shifts or otherwise compelled to exit the planning area to seek treatment. This outcome reduces patient quality of life, particularly since the patient may be required to change physician providers in order to dialyze at a time that accommodates their work or transportation needs. DaVita does not view this as an acceptable alternative for its patients. As such, we have selected to apply for stations through multiple applications which we hope will give the Department ample choices to determine which option it believes will best meet the needs of this ESRD population. Moreover, DaVita has built strong, trusting relationships with our patients, as well as physicians, in Pierce 5 that we believe make us the best possible provider to expand existing services. The alternative to not apply was rejected.*

***Alternative 2:** Expand the DaVita Rainier View Dialysis Center. This option would provide fifteen (15) new stations to the planning area relatively quickly and cost-efficiently when compared to a forty-four (44) station facility. Rainier View reached 4.8 capacity as of the December 31, 2015 Network data and is expected to continue to thrive in a zip code experiencing continued yearly ESRD population growth. However, expanding Rainier View would require construction and total capital expenditure of \$1.24 million which, compared to expanding the existing Lakewood Dialysis Center, was ultimately determined to be less favorable. The alternative to expand DaVita Rainier View was rejected.*

***Alternative 3:** Expand the Lakewood Dialysis Facility by fifteen (15) stations. The existing Lakewood facility is operating at 6.64 utilization as of the December 31, 2015 ESRD Network data and, as such, has been forced to operate a 4th shift in order to accommodate the high demand in Pierce 5 and the Lakewood zip code, in particular. An expansion of 15 stations is the most cost-effective application under review as well as the most timely to execute. Every application, including DaVita's 44 station applications, proposes to establish a new facility which will require months to years to make operational for patients. The Lakewood expansion is the only option that*

will deliver patient services quickly and with the least amount of capital expense. As an existing center, Lakewood also has the benefit of having a proven track record in operational effectiveness, evidenced by its ability to staff and manage sub-optimal shifts due to the overwhelming patient demand.

Alternative 4: Apply for a forty-four (44) station facility in the Lakewood Towne Center.

Alternative 5: Apply for a forty-four (44) station facility on Canyon Road in Spanaway. This location is exceptionally unique in that more than 75% of the Spanaway area cannot service a dialysis facility, either due to zoning limitations or the property not being located on required sewage. DaVita believes it has secured the only viable property that could accommodate a need of this size. Moreover, we have secured highly favorable lease terms that will minimize both start-up capital costs as well as future operating expenses. Most importantly, the Spanaway zip code, 98387, has the second highest 3 and 5 Year CAGR of the entire planning area. This indicates that much of the planning area is saturated and, as such, the Spanaway area is expected to experience strong growth and ESRD presence.

DaVita believes that Alternative 4 is the best option, for the reasons discussed above, and accordingly has submitted th[ese] application[s] for the Department's consideration. But because DaVita recognizes that the Department may determine that the best option is Alternative 3 (due to its cost-effectiveness, and how quickly it could be completed) or Alternative 5 (due to its location), DaVita also has submitted applications consistent with these options."

Public Comment

FMC provided similar, but different, comments on each of DaVita's three applications. Below is FMC's comment under the related DaVita application.

DaVita – Lakewood Community Dialysis Center

"DVA stated it considered doing nothing rather than relocating stations from DVA Lakewood to Rainier View, but recognized the lack of patient access if it did nothing. As a result, DVA opted to relocate stations away from DVA Lakewood to a new facility. DVA was approved for this relocation, resulting in DVA Rainier View which is located in South Tacoma near Parkland. Importantly, DVA's primary argument for relocating stations away from DVA Lakewood was patient access-its current request does not improve patient geographic access in any regard. Based on DVA's own analysis of the Pierce Five service area, dialysis care is needed across the geographic region. Concentrating all existing stations in the northern region of Pierce Five will not improve patient access.

DVA's current proposal is poorly planned and contradicts its previous actions. ...Clearly, DVA's requested expansion is the inferior proposal in the concurrent review in terms of cost, efficiency, and effectiveness. This most important deficit to its proposal is the fact, it requests too fee stations to meet demand and does nothing to improve geographic access." [source: FMC public comment, p14]

DaVita – Towne Center

FMC provided comments relating to this sub-criterion for the DaVita Towne Center project. This project did not meet the applicable review criteria under WAC 246-310-210 and 220. As this project will not be considered under WAC 246-310-240(1), FMC's comments are not addressed.

DaVita – Canyon Road

“Although DVA’s Canyon Road facility request at face value meets patient need in Pierce Five, it does not improve patient access or patient choice, as detailed above. Considering that patient access is closely tied with patient need, proposing a large facility to meet the physical number of stations needed does not necessarily equate to adequately fulfilling patient need. Since DVA’s project will likely result in in-migration by patients from Pierce One due to the extremely close proximity of the site location, it does not improve access exclusively for Pierce Five patients. Due to DVA’s failure to improve much needed patient access, DVA’s proposed project fails to adequately meet patient need in the entire Pierce Five service area.

...A large, concentrated facility such as DVA is proposing is not an ideal choice for patients living in Pierce Five, particularly considering that DVA is the only provider of dialysis care in the entire service area. A facility of this size, even in a planning area with significant current and future need for dialysis stations, will negatively impact patients, payers, and other existing healthcare providers in the Pierce Five planning area. ...Most prominently a large facility will have a negative effect on patient access in Peirce Five. This is because a single facility caters exclusively to patients in just one city in the service area. Due to the facility operating over half of the total planning area dialysis stations, it will effectively force more than half of all the dialysis patients in Pierce Five to receive dialysis care at a single, large facility. Further, patients living in other cities of the planning area will not benefit from this facility.

Patient choice is also of concern with a 44-station facility operated by DVA, as it will take many years for DVA’s proposed facility to reach capacity, particularly since this facility will be phased in two stages over the course of 3 years. [sic] It will be impossible to address patient needs, including growth in other regions of Pierce Five, while the DVA project is undergoing construction or if it fails to reach expected patient volumes due to its size. Considering that DVA is currently the only provider of dialysis care in the entire service area, with three existing facilities and a fourth approved, adding yet another DVA-owned facility is a serious detriment to patient choice and thus patient quality of care in the Pierce Five service area.”

[source: FMC public comment, pp13-14]

CHI Franciscan also provided comments related to patient access and best available alternative for all three applications submitted by DaVita.

“Likely in an effort to attempt to monopolize Pierce 5, DV submitted multiple applications proposing to add dialysis stations to Pierce 5. As DV notes in all three applications: “the Pierce 5 planning area is experiencing unprecedented need in Washington State.” What it failed to state is the obvious: the need is so unprecedented because DV made moves over the past 7 years intended to thwart a competitive review process. Its Q2 2016 applications include a 15 station expansion of its existing DV Lakewood (doable only because it recently relocated stations 11 stations to its new facility known as Rainier View) and two other applications—each for a 44 station facility—to be made operational in either two or three phases.”

[source: CHI Franciscan public comment p2]

PSKC provided the following comments related to patient access and best available alternative for all three applications submitted by DaVita.

“DV should not be granted any new stations in Pierce 5 because it has manipulated its existing 42 stations in an effort to remain the sole provider and has caused significant patient access

problems. DV placed business profits ahead of patient needs. Its tactics have increased the net need in Pierce 5 to levels unprecedented in Washington State.

DV's three applications include: 1) a 15 station expansion of DV Lakewood, 2) a new 44 station facility to be made operational in three phases, and 3) a new 44 station facility to be made operational in two phases.

There has been unmet need for additional dialysis stations in Pierce 5 for more than seven years. Despite the unprecedented need in Pierce 5 for more stations, no applications for new stations were able to be submitted because at least one of DV's facilities was operating below the minimum threshold of 4.8 patients per station.

*As previously stated, DV is currently the only provider of dialysis services in Pierce 5. DV's Lakewood facility has been operational for two decades. In 2008, DV received Certificate of Need (CN) approval to establish a new 21 station dialysis facility (Parkland). The year after receiving approval, need increased to 9 stations above the 21 it had been awarded, but no one could apply to address the need because DV had not yet opened Parkland. In fact, DV did not open Parkland until November 2011, more than three years after securing CN approval. At the time it opened Parkland, there was a need for 40 **additional** stations in Pierce 5. [emphasis in original]*

Prior to Parkland attaining 80% occupancy (thereby allowing dialysis providers to submit CN applications to add new stations), DV filed two additional applications (one in 2013 and one in 2015) to relocate stations from its existing facilities to establish new facilities. Because of this, under the current dialysis rules, no applicant was able to submit for the large and growing number of new stations needed.

Table 1 incorporates data from a table contained in our CN application and provides some updates and additional information to demonstrate the effect of DV's efforts to keep census below 80% despite staggering numeric need.

[continued on the following page]

PSKC Table
Gross Station Need in Pierce 5

Year	Gross Station Need	CN Approved Stations	Net Station Need	# of CN Approved Stations	CN Summary
1997-2007		21			
2008	42	42	0	21	FHS and DV submit CN applications. DV approved. Its application noted that it would open in 2009. DV Lakewood was operating at 103% on 12/31/08.
2009	51	42	9	0	Lakewood operating at 103% on 12/31. Parkland fails to meet the opening date cited in the DV CN.
2010	64	42	22	0	Lakewood operating at 104% pts/station on 12/31. Parkland still not opened. DV secures CN extension, giving it until 1/2011 to commence.
2011	82	42	22	0	Parkland opens (10/2011); Lakewood operating at 93%.
2012	70	42	28	0	Lakewood operating at 91%; Parkland operating at 52%.
2013	69	42	27	030	DV submits application to establish Rainier View (8/2013) by relocating stations from Lakewood. Scheduled date of opening was 11/14. Parkland at 76% and Lakewood at 90%.
2014	72	42	30	0	Parkland below 80%; Lakewood at 95%. Rainier View not opened.
2015	77	42	35	0	Rainier View opens (8/15); Parkland at 88%; Rainier View at 80% and Lakewood at 111%.

PSKC has directly experienced DV facilities operating below 80% thereby prohibiting another provider from addressing community need. For example, PSKC and DV both operate in the Snohomish 3 Dialysis Planning Area (Snohomish 3). PSKC and DV recently completed a concurrent review process for 7 stations in the Snohomish 3. In that application, PSKC noted, “since 2011, it had operated at or above 90% occupancy and was forced to ‘wait’ while the DV facility took nearly six years to achieve 80% utilization” again, after opening much later than it should have, or its application projected. While we “waited,” PSKC was forced to send patients to facilities not of their choosing, and need continued to escalate. Patients are negatively affected by this manipulation. The same situation exists in Pierce 5. DV should not be granted any new stations based on its history of delay and its inability to open stations timely. Patients, residents, and the CN Program should expect reasonable and predictable access. RCW 70.38.015 declares that the public policy of Washington State is:

*(1) That strategic health planning efforts must be supported by appropriately tailored regulatory activities that can effectuate the goals and principles of the statewide health resources strategy developed pursuant to chapter 43.370 RCW. **The implementation of the strategy can promote, maintain, and assure the health of all citizens in the state, provide accessible health services, health manpower, health facilities, and other resources while controlling increases in costs, and recognize prevention** as a high priority in health programs. Involvement in health planning from both consumers and providers throughout the state should be encouraged; DV, as the sole provider, has failed to provide accessible health facilities. Residents deserve a second provider to offer choice and to assure better access.’” [emphasis in original]*

[source: PSKC public comment, pp2-4]

Rebuttal Comment

“Fresenius argues that approval of more DaVita stations in the planning area would not enhance patient choice. Fresenius is mistaken. The question of patient choice is about more than having competing providers. It also is about whom patients prefer to provide their lifesaving care. Patients choose to dialyze on evening and nocturnal shifts with DaVita in Pierce 5, despite having multiple Franciscan facilities within close proximity. This is due to excellent clinical outcomes, convenience, relationships with their nephrologists, and a host of other factors that affect patients’ decision to obtain care from DaVita.”

Footnote #6 in DaVita’s rebuttal:

“To the extent the Department defines patient choice in terms of different providers, we would note again that Fresenius and Franciscan would not increase patient choice vis-à-vis each other, and should be considered to be the same provider consistent with their recent agreement.”

[source: DaVita rebuttal comment, p5]

“Franciscan and PSKC criticize DaVita for relocating stations within the planning area, which they argue has delayed the projected need from being met. First, this is irrelevant to the Department’s analysis here. The issue is which applications satisfy the CN criteria and, of those, which is the superior alternative to meet the need. Whether stations should have been relocated previously is not at issue.

Second, there is no merit to this criticism, whether viewed from the perspective of ethical practice or basic statistics. DaVita did not add any new stations to the planning area with the relocation of stations from Parkland to Rainier View, nor did that relocation meaningfully delay the ability of other applicants to apply for additional capacity.

DaVita’s decision to build Rainier View was based on (a) increasing geographic access and (b) providing surge capacity in Pierce 5 in the event that either Lakewood or Parkland became inoperable. Neither of those existing facilities would have been able to accommodate emergency dialysis which puts all Pierce 5 patients at risk. Moreover, Parkland did not reach the 4.8 utilization requirement until June 2015, well after the time of the Rainier View application. And Rainier View reached 4.8 utilization in its first reportable data period of 12/31/15 after completing its first treatment on 8/13/15. To “suppress” need as alleged, a provider would have to compel patients to stay at an existing facility on a less favorable shift, which obviously did not occur here.

Similarly, DaVita’s decision to build Elk Plain was in recognition that the Spanaway area to the east of Joint Base Lewis McChord is growing in ESRD prevalence and largely unserviceable for dialysis due to lack of available sewage. DaVita identified a rare location that could accommodate patients in that area. The Department may reference DaVita’s screening response with respect to the Elk Plan relocation, which addressed this issue.

This Franciscan and PSKC argument is unfortunately typical of the hollow criticisms they have made of DaVita applications historically. It lacks any basis whatsoever. DaVita has always been fully committed to serving patient needs in Pierce 5.” [source: DaVita rebuttal comment, p3-4]

Department Evaluation

The department’s evaluation of DaVita’s alternatives considered is discussed below, concurrently with the PSKC projects.

Department Evaluation – All Projects

Each applicant provided a comprehensive discussion of alternatives considered before submitting their respective applications. All applicants rejected the ‘do nothing’ alternative because the numeric methodology shows need for stations in the planning area. Given that the numeric methodology is based on the historical number of patients dialyzing in the planning area, the methodology also demonstrates patient growth in the planning area. Both PSKC and DaVita appropriately rejected the ‘do nothing’ alternative.

Puget Sound Kidney Centers

The only two options presented by PSKC were “no project” and the requested project. They did, however, identify several configurations of their project, and ranked their preference. [source: Screening Response p12]

- 44 station facility – any configuration of Phase 1
- 22 station facility
- 20 station facility
- 16 station facility

PSKCs reasoning for ranking their projects is logical, as it ranges from the greatest possible award of stations to the least.

FMC argued that PSKCs project had no impact on patient access, that it is too expensive, and that staffing the facility would be difficult. FMC provided no data to substantiate these claims. DaVita is currently the only provider in the Pierce #5 planning area, and there is a 44 station need; therefore, the introduction of any new provider increases access and patient choice. PSKC demonstrated under WAC 246-310-220 that their project is financially feasible. FMC provided no data to support their claims surrounding PSKC’s ability to staff their facility, and PSKC provided information supporting that they have the ability to staff the facility appropriately. PSKC appropriately selected their preferred project(s), and FMC’s comments are without merit.

DaVita HealthCare Partners – All Projects

DaVita provided the same alternatives within each of its three applications.

The alternative of expanding the Rainier Dialysis Center was rejected by DaVita. DaVita states the capital costs to add 15 stations to Rainier Dialysis Center was determined to be \$1,240,000. When compared to the less than \$400,000 to add 15 stations at Lakewood Community Dialysis Center, the Rainer Dialysis Center expansion was rejected in favor of expanding Lakewood Community Dialysis Center. The department agrees that this alternative was appropriately rejected.

The Lakewood Community Dialysis Center expansion was an alternative considered by DaVita to be a cost effective project. DaVita submitted this application. However, the center could only accommodate 15 of the 44 stations projected to be needed in the planning area. Expansion of the Lakewood Community Dialysis Center leaves another 29 stations needed in the planning area.

DaVita also submitted two applications each proposing to add 44 stations in phases. One project located in Lakewood Towne Center and one located on Canyon Road. Towne Center did not meet the applicable review criteria. In its Canyon Road project, DaVita proposed a 44-station facility in three phases.

- 44-station facility in three phases (24 + 12 + 8). This project added 44 new stations to the planning area and would result in DaVita operating 82 dialysis stations in Pierce County planning area #5.
- 36-station facility in two phases (24 + 12). This project was approximately \$153,065 less in capital expenditure than adding 44 new stations to the planning area.
- 24-station facility (phase one only of the project). This option did not meet the utilization standard under WAC 246-310-286(4) that requires new dialysis stations to be operating at 4.8 patients per station at the end of the third year of operation. As a result, the department rejected this option within the Canyon Road application. This option was denied under WAC 246-310-210(1) and was not further evaluated in this review.

Under Alternative 4 above, DaVita suggested they could establish a 44-station center on Canyon Road with 33 new stations and relocating the 11-station Lakewood Community Dialysis Center. This option was not presented in the Canyon Road application. As a result, it is not evaluated in this review or ranked below.

DaVita ranked their three applications. Below is DaVita’s ranking of the remaining three potentially approvable projects.

- Lakewood Community Dialysis Center 15-station addition.
- DaVita Canyon Road project for 44 stations.
- DaVita Canyon Road project for 36 stations.

Step Two Superiority Review

The department does not have the data to measure which is more valuable—increasing access to dialysis services in an existing facility versus creating a new facility to increase geographic access to dialysis services. The statements provided by each applicant in relation to this sub-criterion can be substantiated. The department did not identify any alternative for consideration that was superior in terms of cost, efficiency, or effectiveness that is available or practicable for PSKC or DaVita.

When the department completed the numeric need methodology in March 2016, the Pierce County planning area #5 showed a need for 44 stations. Due to this unusually large numeric need, it was determined that the needs of patients in the planning area could be better served by more than one smaller facility, rather than a single 44-station facility. To achieve this, the department sent out a memo to dialysis providers in Washington State, indicating that the department would accept phased projects for Pierce #5. Within these phased projects, each applicant was instructed through screening to provide sufficient financial data to support the approval of just one or more phase.

For this sub-criterion, the department ranked projects requesting the full 44-station need below the smaller projects. The department did not identify that any particular number of stations below 44 would be superior; all projects proposing less than 44 stations were ranked equally. The superiority review is shown below in Table 80.

Table 80
Department Superiority Review of WAC 246-310-240(1) Step 2

Applicant	Project	44-Station Facility?	Rank
PSKC	PSKC Lakewood – 44 stations (2 phase, 22+22)	Yes	2
PSKC	PSKC Lakewood – 44 stations (2 phase, 20+24)	Yes	2
PSKC	PSKC Lakewood – 44 stations (2 phase, 16+28)	Yes	2
PSKC	PSKC Lakewood – 22 stations (1 phase)	No	1
PSKC	PSKC Lakewood – 20 stations (1 phase)	No	1
PSKC	PSKC Lakewood – 16 stations (1 phase)	No	1
DaVita	LCDC – 15 station addition	No	1
DaVita	Canyon Road – 44 stations (3 phase)	Yes	2
DaVita	Canyon Road – 36 stations (2 phase)	No	1

The department’s evaluation of Step Three for the remaining dialysis projects is below; it will rank each remaining project based on the superiority rankings conducted throughout this evaluation.

Step Three

Throughout this evaluation, the department ranked the applications under the following sub-criteria. The department assigned between 1-4 points to each application (1 being the highest), and the top three projects each received points that corresponded with their ranking (i.e. 1st gets one point, 2nd gets two points, 3rd gets three points). To ensure that a ranking below 3rd in any one criterion would not be an unfair barrier to a projects success, all remaining projects received 4 points. The project with the lowest score will be considered the best available project for the Pierce #5 planning area.

- WAC 246-310-210(2): Applicants with a higher projected percentage of Medicare and Medicaid patients are ranked better.
- WAC 246-310-220(2): Applicants with lower projected net revenue per treatment are ranked better.
- WAC 246-310-230(3): Applicants with higher average CMS star rating for all Washington State facilities are ranked better.
- WAC 246-310-240(1) Step Two: Projects that proposed to build a 44-station facility are ranked worse. Due to the higher than normal numeric need projected for the Pierce #5 planning area, the department has determined that the needs of patients in the planning area could be better served by more than one smaller project, rather than a single 44-station project.

The table below contains a summary of the remaining projects superiority ranking. A lower score indicates a superior project.

**Table 81
Superiority Ranking**

Applicant	Application	210(2)	220(2)	230(3)	240(1)	Total
PSKC	PSKC Lakewood – 44 stations (2 phase, any configuration)	2	1	4	2	9
PSKC	PSKC Lakewood – 16 stations (1 phase)	2	1	4	1	8
PSKC	PSKC Lakewood – 20 stations (1 phase)	2	1	4	1	8
PSKC	PSKC Lakewood – 22 stations (1 phase)	2	1	4	1	8
DaVita	LCDC – 15 station addition	4	3	3	1	11
DaVita	Canyon Road – 44 stations (3 phase)	3	4	3	2	12
DaVita	Canyon Road – 36 stations (2 phase)	3	4	3	1	11

As shown above, the project with the lowest – best – score is any one of PSKC’s first phase projects. The second lowest score is PSKC’s 44-station proposal. Consistent with the statements above, the department has determined that the needs of patients in the planning area could be better served by more than one smaller facility, rather than a single 44-station facility. Therefore, the department will first consider the second best-scoring applicant, DaVita, for the third best-scoring project. This DaVita application proposes to add 15 dialysis stations to an existing facility. The award of 15 stations to DaVita leaves 29 stations for PSKC. Again, the applicant with the best score is PSKC. With the approval of DaVita’s 15 station addition, the remaining 29 stations should be awarded to PSKC. The approvable projects and how they fill the net need are summarized in the Table below.

**Table 82
Distribution of Approved Stations**

Applicant	Number of Stations Awarded	Net Need Remaining
--	--	44
PSKC	29	15
DaVita LCDC	15	0
DaVita Canyon Road ²⁹	0	0

²⁹ DaVita’s Canyon Road facility was potentially approvable as a 36-station or 44-station facility. Though 7 stations were “left over” after being allocated to PSKC’s 22-station project and DaVita’s Lakewood Community Dialysis Center 15-station addition, the department could not offer these to the Canyon Road site. As noted under WAC 246-310-284(6), the Canyon Road facility did not reach 4.8 patients per station within three years as a 24-station facility (one phase). Therefore, the department could not assume that Canyon Road could meet this standard as a 7-station facility. No stations were awarded to the Canyon Road site.

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

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

CHI Franciscan

CHI Franciscan's proposed location is an existing building. Construction would be limited to tasks that would make the facility appropriate to provide dialysis services. CHI provided the following comment related to this sub-criterion:

"CHI Franciscan utilized our actual experience with our newer dialysis units as well as our extensive experience in health care program planning and development to calculate construction costs and other estimated capital expenditures." [source: Application p33]

Public Comment

None

Rebuttal

None

Department Evaluation

CHI Franciscan proposes to establish a new facility. These costs were evaluated in the financial feasibility section of this analysis. The department could not reasonably conclude that costs were reasonable outside of CHI Franciscan ownership and control. Therefore, the department concludes **this sub-criterion is not met.**

Puget Sound Kidney Centers

"The construction costs for this project have been based upon PSKC's experience in constructing dialysis facilities." [source: Application p30]

"PSKC designs and custom-builds every facility it operates. The Lakewood facility will be no different. We will provide the absolute best in care environments. We consider patient comfort and amenities, and quality and safety at every decision point. In addition to providing high quality patient care, the Lakewood facility will be architecturally and aesthetically pleasing to patients and staff." [source: Screening Response p12]

Public Comment

DaVita submitted comments relating to this sub-criterion.

DaVita Public Comment

"PSKC's facility design is dangerous to patients.

Dialysis facilities leak. It is inevitable. This is one of the reasons that dialysis centers are designed as 1-story facilities. Where space constraints necessitate a multi-story facility, an exception might be made. But when building a 1-story facility is an option, building a multistory facility makes no sense and can have serious consequences for both patients and staff.

Yet this is what PSKC proposes to do here. PSKC has applied to build what is referred to as a "podium style" layout, a 2-story facility that will accommodate 22 patient stations on the first level and 22 patient stations on the second level.

Dialysis facilities use city water that is pumped through an extensive water treatment and reverse osmosis water purification process system. Purified water is then pumped out to individual patient stations. When any portion of the system experiences a leak, the ramifications are, at a minimum, that drywall must be ripped out, and, at maximum, that it compromises electrical systems with total disruption to patient care. What PSKC has proposed absolutely guarantees that, at some point, one of its patient floors will become unserviceable. We know this because DaVita has experienced it in every single podium style facility it has ever operated. As such, DaVita has appropriately moved away from podium style design in which patients and staff members are split out over two stories.

In addition to guaranteed disruption of patient care, PSKC's proposal to split patients between floors will create a staffing and patient oversight issue, especially at the end of shifts and during shift changes. PSKC may argue that their staffing plan accounts for turnover throughout the treatment day, but reality is that this plan elevates the opportunity for human error as patient to caregiver ratios fluctuate between floors. As an example, PSKC failed in its design to place staff restrooms on each floor to ensure that clinical staff are staying on their respective treatment floor. They could correct this prior to breaking ground, but it will add to the cost of the project, which is already exorbitant compared to other applicants. We certainly do not believe that PSKC would intentionally place either its staff or patients in jeopardy, but are at a loss as to why PSKC would propose a plan that simply invites disaster.

Some geographies, including those in which DaVita has developed facilities, are constrained to podium style layouts due to limited real estate options. In fact, DaVita recently built a podium style facility in Boston-but did so with only a parking level beneath the patient treatment floor so that any leakage would fall on cars, not on patients. However, there are no such geographic limitations in Pierce 5. There are multiple viable locations for a 1-story, 44-station center, and each applicant, with the sole exception of PSKC, proposed a 1-story floorplan.

PSKC's description of its proposed facility in Pierce 5 is disconcerting to say the least. While emphasizing in both its application and its screening responses how "architecturally and aesthetically pleasing" its facility will be (Application, page 39; Screening Responses, page 13), PSKC apparently is completely oblivious to the risks to patient safety that would be created by this visually attractive design. PSKC does not even acknowledge, much less address, the problems with podium style dialysis facilities. In healthcare, patient safety obviously trumps architectural aesthetics.

PSKC has proposed a floorplan that would be dangerous to patients. Again, DaVita does not believe that PSKC would intentionally endanger its patients, so must therefore assume that PSKC's application simply reflects a lack of experience managing dialysis projects of this scale. That lack of experience has resulted in a very poor decision on PSKC's part to propose a 2-story facility instead of a 1-story facility as every other applicant has done. Developing and operating a facility this size is a tremendous responsibility, and PSKC's proposal makes very clear that it does not have the experience or expertise to ensure patient safety in a facility of this size.

PSKC undoubtedly will explain in its rebuttal comments that it was unaware of the risks created by its facility design and ask the Department to approve only Phase 1 of its project to be operated as a 1-story facility. But the fact that PSKC would even propose a 2-story facility in these circumstances reveals such a fundamental lack of knowledge and/ or judgment regarding how to ensure patient safety in large dialysis facilities that the Department should simply deny PSKC's application here-especially since there is another applicant, DaVita, that does have the experience and expertise required to operate large dialysis facilities." [source: DaVita Public Comments pp1-2]

Rebuttal

PSKC provided the following statements in response to DaVita's public comments:

“First and foremost, PSKC reminds the Certificate of Need Program (CN Program) what it already knows: as the provider in the State with the consistently highest quality ratings, our unwavering focus is our patients and their safety, and our experience demonstrates this to be the case. PSKC has a documented history of providing high quality and safe dialysis services in all of its centers and this history rebuts DV’s suggestion that a two-story dialysis center is unsafe. Since 1986, PSKC’s Everett facility has operated successfully as a two-story facility (dialysis services are provided on both floors). And, in fact, PSKC Everett has been surveyed many times by the Department of Health and it has not been cited for anything other than the “typical” citations received by all providers. Because of our quality pre-construction planning and design, we have experienced no operating problems. Again, DV’s confusion may come into play because it does not own its facilities. PSKC custom builds high quality buildings from the ground up; we do not attempt to remodel existing buildings that may not have had the initial infrastructure necessary to accommodate a 2nd story dialysis service.” [source: PSKC rebuttal p2]

Department Evaluation

PSKC proposes to establish a new facility. These costs were evaluated in the financial feasibility section of this analysis. Though higher than the other applications within this concurrent review, there is no information within the application that would cause the department to conclude that the costs of the project are unreasonable.

DaVita questions the safety of a two-story facility design and expressed concerns regarding potential leaks, staffing issues, and patient care. Though DaVita does raise these issues compellingly, PSKC's rebuttal correctly points out that they have safely operated a two-story facility for years without any safety issues. The department cannot reasonably conclude that a two-story facility is inferior to a one-story facility.

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

Fresenius Medical Care

“RCG has based the construction cost estimate for tenant improvements and other capital expenditures on its and its parent corporation's experience in developing dialysis facilities in Washington State. RCG's past experience and expertise, coupled with that of Fresenius should ensure that the proposed project is completed on time and within budget.” [source: Application p27]

Public Comment

None

Rebuttal

None

Department Evaluation

FMC proposes to establish a new facility. These costs were evaluated in the financial feasibility section of this analysis. Though the identified costs would be reasonable, land purchase costs could not be substantiated. Therefore, the department concludes **this sub-criterion is not met.**

DaVita – Lakewood Community Dialysis Center

DaVita states that only leasehold improvements are necessary to accommodate the additional 15 stations at Lakewood Community Dialysis Center. With minor remodel, and purchase of both fixed and moveable equipment, the facility could be operating with 26 dialysis stations. No planned modifications to the physical plant are required for this project. [source: Application, p29]

Public Comment

None

Rebuttal Comment

None

Department Evaluation

DaVita proposes to add stations to an existing center. These costs were evaluated in the financial feasibility section of this analysis. There is no information within the application that would cause the department to conclude that the costs of the project are unreasonable. The department concludes **this sub-criterion is met.**

DaVita – Towne Center

In response to this sub-criterion, DaVita provided the following statements. [source: Application, p30]

“Experience with operating or managing over 2,197 Medicare-certified dialysis centers throughout the country including many in the Northwest, provides the background for designing facilities that satisfy all patient requirements and provide the greatest value for the investment dollar. Lakewood Community will meet all current energy conservation standards. Lakewood Community is designed to meet current energy code requirements; therefore, additional energy costs associated with unused space does not substantially add to energy consumption.”

Public Comment

None

Rebuttal

None

Department Evaluation

DaVita proposes to establish a new facility. These costs were evaluated in the financial feasibility section of this analysis. The identified costs could not be substantiated. The department concludes **this sub-criterion is not met.**

DaVita – Canyon Road

In response to this sub-criterion, DaVita provided the following statements. [source: Application, p30]

“Experience with operating or managing over 2,197 Medicare-certified dialysis centers throughout the country including many in the Northwest, provides the background for designing facilities that satisfy all patient requirements and provide the greatest value for the investment dollar. Canyon Road will meet all current energy conservation standards. Canyon Road is

designed to meet current energy code requirements; therefore, additional energy costs associated with unused space does not substantially add to energy consumption.”

Public Comment

None

Rebuttal

None

Department Evaluation

DaVita proposes to establish a new facility. These costs were evaluated in the financial feasibility section of this analysis. There is no information within the application that would cause the department to conclude that the costs of the project are unreasonable. The department concludes **this sub-criterion is met.**

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

CHI Franciscan

“CHI Franciscan’s charges for dialysis services are not impacted by, nor established based on, a facility’s specific capital cost. In fact, we negotiate a global rate charge with insurers, which does not single out specific services, such as dialysis, or specific facilities such as Franciscan Lakewood. Thus, the costs and charges for dialysis paid by commercial insurers, as well as Medicare/Medicaid, would remain the same regardless of whether CHI Franciscan did nothing or undertakes the project described in this application.” [source: Application p33]

Public Comment

None

Rebuttal

None

Department Evaluation

CHI Franciscan’s project involves construction. This sub-criterion was evaluated under WAC 246-310-220(2). The department could not conclude whether the project would have an unreasonable impact on the costs and charges to the public as a result of establishing a new dialysis center in the planning area, and subsequently selling the facility. The department concludes that CHI Franciscan **does not meet this sub-criterion.**

Puget Sound Kidney Centers

“PSKC does not expect the project to affect the charges for its services, and will have no effect on billed rates to patients, providers, or payers. [source: Application p31]

Public Comment

None

Rebuttal

None

Department Evaluation

PSKC's project involves construction. With the need for additional stations in Pierce County planning area #5 and the assumptions related to the costs and charges discussed under the Financial Feasibility section of this evaluation, the department does not anticipate an unreasonable impact on the costs and charges to the public as a result of establishing a new dialysis center in the planning area. The department also concludes that PSKC **meets this sub-criterion**.

Fresenius Medical Care

"This project has no impact on either charges or payment, as reimbursement for kidney dialysis services is based on a prospective composite per diem rate. Further, it is important to understand the basis for FKC reimbursement, given this Department question, which raises the issue of capital expenditures and their potential effect on costs and charges for health services.

In the case of government payers, reimbursement is based on CMS (Center for Medicaid and Medicare) fee schedules which have nothing to do with capital expenditures by providers such as FKC.

In the case of private sector payers, FKC negotiates national, state, and regional contracts with payers. These negotiated agreements include consideration/negotiation over a number of variables, including number of covered lives being negotiated; the provider's accessibility, including hours of operation; quality of care; the provider's patient education and outreach; its performance measures such as morbidity and/or mortality rates; and increasingly, consideration of more broad performance/quality measures, such as the CMS Quality Incentive Program ("QIP") Total Performance Score ("TPS").

FKC does not negotiate any of its contracts at the facility-level, thus, the proposed FKC Fredrickson facility's capital costs would have no impact on payer negotiations or levels of reimbursement. In this regard, facility-level activities, such as number of FTEs, operating expenses or capital expenditures have no effect on negotiated rates, since such negotiations do not consider facility-level operations. As such, the proposed FKC facility would have no effect on rates FKC would receive in the Pierce Five ESRD Planning Area." [source: Application pp27-28]

Public Comment

None

Rebuttal

None

Department Evaluation

FMC's project involves construction. This sub-criterion was evaluated under WAC 246-310-220(2), under which the department could not substantiate the costs of the proposed facility. Therefore, the department could not conclude whether the project would have an unreasonable impact on the costs and charges to the public as a result of establishing a new dialysis center in the planning area. The department concludes that FMC **does not meet this sub-criterion**.

DaVita – Lakewood Community Dialysis Center

DaVita provided the following statements related to costs and charges for health services. [source: Application, p23]

“The proposed facility will operate at utilization levels consistent with required utilization levels. Reimbursements for dialysis services are not subject to or affected by capital improvements and expenditures by providers; the proposed project will have no impact on increases in charges for services within the ESRD planning area.”

Public Comment

None

Rebuttal Comment

None

Department Evaluation

DaVita’s project involves construction. With the need for additional stations in Pierce County planning area #5 and the assumptions related to the costs and charges discussed under the Financial Feasibility section of this evaluation, the department does not anticipate an unreasonable impact on the costs and charges to the public as a result of establishing a new dialysis center in the planning area. The department also concludes that DaVita **meets this sub-criterion**.

DaVita – Towne Center

DaVita provided the following statements related to costs and charges for health services. [source: Application, p23]

“The proposed facility will operate at utilization levels consistent with required utilization levels. Reimbursements for dialysis services are not subject to or affected by capital improvements and expenditures by providers; the proposed project will have no impact on increases in charges for services within the ESRD planning area.”

Public Comment

None

Rebuttal Comment

None

Department Evaluation

DaVita’s project involves construction. This sub-criterion was evaluated under WAC 246-310-220(2), under which the department could not substantiate the costs of the proposed facility. Therefore, the department could not conclude whether the project would have an unreasonable impact on the costs and charges to the public as a result of establishing a new dialysis center in the planning area. The department also concludes that DaVita **does not meet this sub-criterion**.

DaVita – Canyon Road

DaVita provided the following statements related to costs and charges for health services. [source: Application, p23]

“The proposed facility will operate at utilization levels consistent with required utilization levels. Reimbursements for dialysis services are not subject to or affected by capital improvements and expenditures by providers; the proposed project will have no impact on increases in charges for services within the ESRD planning area.”

Public Comment

None

Rebuttal Comment

None

Department Evaluation

DaVita’s project involves construction. With the need for additional stations in Pierce County planning area #5 and the assumptions related to the costs and charges discussed under the Financial Feasibility section of this evaluation, the department does not anticipate an unreasonable impact on the costs and charges to the public as a result of establishing a new dialysis center in the planning area. The department also concludes that DaVita **meets this sub-criterion.**

- (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.*

CHI Franciscan

“The proposed facility will be designed and built to meet or exceed all applicable state and local codes and CMS conditions of coverage. In addition, the facility has been specifically designed to accommodate a nocturnal program (the lighting, noise dampening and bed stations will be configured to allow patients to be able to sleep while dialyzing), thus providing a superior care environment and making us unique among Pierce County dialysis providers. The proposed building will comply with the State Energy Code, latest edition.” [source: Application p40]

Public Comment

None

Rebuttal

None

Department Evaluation

CHI Franciscan’s project has the potential to improve delivery of dialysis services to the residents of Pierce County planning area #5 with the addition of dialysis stations in the planning area. **This sub-criterion is met.**

Puget Sound Kidney Centers

“PSKC – Lakewood will be designed to meet or exceed current energy code requirements. High efficiency systems, with lower life-cycle operating costs will be used wherever possible.” [source: Application p40]

Public Comment

None

Rebuttal

None

Department Evaluation

PSKC's project has the potential to improve delivery of dialysis services to the residents of Pierce County planning area #5 with the addition of dialysis stations in the planning area. The department is satisfied PSKC's project is appropriate and needed. **This sub-criterion is met.**

Fresenius Medical Care

"The construction proposed for the new facility will meet all RCG and Fresenius internal standards which have been engineered and tested to ensure that they support our high quality, efficient and patient-focused standards. Our standards also meet and or exceed all applicable state and local codes. The proposed site will comply with the State Energy Code, latest edition."
[source: Application pp37-38]

Public Comment

None

Rebuttal

None

Department Evaluation

FMC's project could have the potential to improve delivery of dialysis services to the residents of Pierce County planning area #5 with the addition of dialysis stations in the planning area. **This sub-criterion is met.**

DaVita – Lakewood Community Dialysis Center

DaVita provided the following statements related to this sub-criterion. [source: Application, 29]

"Lakewood Community will meet all current energy conservation standards. Lakewood Community is designed to meet current energy code requirements; therefore, additional energy costs associated with unused space does not substantially add to energy consumption."

Public Comment

None

Rebuttal

None

Department Evaluation

DaVita's project has the potential to improve delivery of dialysis services to the residents of Pierce County planning area #5 with the addition of dialysis stations in the planning area. **This sub-criterion is met.**

DaVita – Towne Center

DaVita provided the following statements related to this sub-criterion. [source: Application, 30]

“Lakewood Community will meet all current energy conservation standards. Lakewood Community is designed to meet current energy code requirements; therefore, additional energy costs associated with unused space does not substantially add to energy consumption.”

Public Comment

None

Rebuttal

None

Department Evaluation

DaVita’s project has the potential to improve delivery of dialysis services to the residents of Pierce County planning area #5 with the addition of a new dialysis center in the planning area. **This sub-criterion is met.**

DaVita – Canyon Road

DaVita provided the following statements related to this sub-criterion. [source: Application, 30]

“Canyon Road will meet all current energy conservation standards. Canyon Road is designed to meet current energy code requirements; therefore, additional energy costs associated with unused space does not substantially add to energy consumption.”

Public Comment

None

Rebuttal

None

Department Evaluation

DaVita’s project has the potential to improve delivery of dialysis services to the residents of Pierce County planning area #5 with the addition of a new dialysis center in the planning area. **This sub-criterion is met.**

APPENDIX A

CHRONOLOGIC SUMMARY OF REVIEW

Action	CHI Franciscan Health	Puget Sound Kidney Centers	Fresenius Medical Care	DaVita Lakewood	DaVita Towne Center	DaVita Canyon Road
Letter of Intent Submitted	April 29, 2016	April 29, 2016	April 29, 2016	April 29, 2016	April 29, 2016	April 29, 2016
Application Submitted	May 31, 2016	May 31, 2016	May 31, 2016	May 31, 2016	May 31, 2016	May 31, 2016
1 st Amendment Application Submitted	N/A	N/A	N/A	N/A	N/A	N/A
Department's pre-review Activities						
• Department screening letter sent	June 30, 2016	June 30, 2016	June 30, 2016	June 30, 2016	June 30, 2016	June 30, 2016
• Screening responses received	July 29, 2016	July 29, 2016	July 29, 2016	July 29, 2016	July 29, 2016	July 29, 2016
Beginning of Review	August 16, 2016					
End of Public Comment						
• No public hearing conducted						
• Public comments accepted through the end of public comment	October 17, 2016					
Rebuttal Comments Received	November 16, 2016					
Department's Anticipated Decision Date	January 3, 2017					
Department Declares Pivotal Unresolved Issue (PUI) on CHI Franciscan Application	December 19, 2016					
CHI Franciscan Submits PUI Documents	January 13, 2017					
End of Public Comment on PUI Documents	January 30, 2017					
Rebuttal Comments on PUI Documents	February 10, 2017*					
Department's Anticipated Decision	March 30, 2017					
Department's Actual Decision Date	March 30, 2017					

*The due date for CHI Franciscan's rebuttal comments was February 13, 2017. The comments were received on February 10, 2017.

APPENDIX B

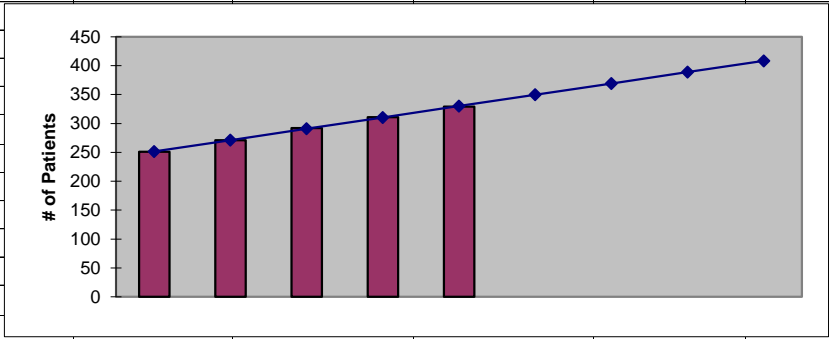


**2016
Pierce County 5
ESRD Need Projection Methodology**

Planning Area		6 Year Utilization Data - Resident Incenter Patients					
Pierce Five		2010	2011	2012	2013	2014	2015
98303		0	0	1	1	0	0
98327		3	4	2	0	0	0
98387		38	42	39	44	47	59
98388		5	6	8	7	7	8
98430		0	0	0	0	0	0
98433		1	2	1	2	1	0
98438		0	0	0	0	0	0
98439		6	5	6	7	0	1
98444		58	55	62	68	73	75
98445		28	28	34	34	37	38
98446		6	7	15	12	15	15
98447		0	0	0	0	0	0
98467		20	19	19	19	19	17
98498		30	23	25	32	39	45
98499		54	55	54	54	66	69
98580		6	5	5	12	7	2
TOTALS		255	251	271	292	311	329
246-310-284(4)(a)	Rate of Change		-1.57%	7.97%	7.75%	6.51%	5.79%
	6% Growth or Greater?		FALSE	TRUE	TRUE	TRUE	FALSE
	Regression Method:	Linear					
246-310-284(4)(c)				Year 1	Year 2	Year 3	Year 4
				2016	2017	2018	2019
Projected Resident Incenter Patients	from 246-310-284(4)(b)			349.60	369.20	388.80	408.40
Station Need for Patients	Divide Resident Incenter Patients by 4.8			72.8333	76.9167	81.0000	85.0833
	Rounded to next whole number			73	77	82	86
246-310-284(4)(d)	subtract (4)(c) from approved stations						
Existing CN Approved Stations				42	42	42	42
Results of (4)(c) above				- 73	- 77	- 82	- 86
Net Station Need				-31	-35	-40	-44
Negative number indicates need for stations							
Planning Area Facilities							
Name of Center	# of Stations						
DaVita Lakewood Comm	11						
DaVita Parkland	21						
DaVita Rainier View	10						
Total	42						
Source: Northwest Renal Network data 2010-2015							
Most recent year-end data: 2015 posted 02/05/2016							

**2016
Pierce County 5
ESRD Need Projection Methodology**

x	y	Linear
2011	251	252
2012	271	271
2013	292	291
2014	311	310
2015	329	330
2016		349.600
2017		369.200
2018		388.800
2019		408.400



SUMMARY OUTPUT

Regression Statistics	
Multiple R	0.999583767
R Square	0.999167707
Adjusted R Square	0.998890276
Standard Error	1.032795559
Observations	5

ANOVA					
	df	SS	MS	F	Significance F
Regression	1	3841.6	3841.6	3601.5	1.01932E-05
Residual	3	3.2	1.066666667		
Total	4	3844.8			

	Coefficients	Standard Error	t Stat	P-value	Lower 95%	Upper 95%	Lower 95.0%	Upper 95.0%
Intercept	-39164	657.4432092	-59.57016431	1.04218E-05	-41256.27771	-37071.7223	-41256.27771	-37071.72229
X Variable 1	19.6	0.326598632	60.0124987	1.01932E-05	18.56061739	20.63938261	18.56061739	20.63938261

RESIDUAL OUTPUT

Observation	Predicted Y	Residuals
1	233	-1
2	246.6	8.4
3	260.2	-9.2
4	273.8	-2.8
5	287.4	4.6

APPENDIX C

**Pierce #5 Planning Area
Concurrent Review
Pass-Fail Tracking**

Project Number	Applicant	Project Identifier	WAC 246-310-210 (Need)				WAC 284-310-220					WAC 246-310-230					WAC 246-310-240					
			210(1)				210(2)	220(1)	220(2)	220(3)	230(1)	230(2)	230(3)	230(4)	230(5)	240(1)			240(2)		240(3)	
			284(4)	284(5)	284(6)	287 ⁽¹⁾										Step 1	Step 2	Step 3	240(2)(a)	240(2)(b)		
16-32	CHI Franciscan	FHS Lakewood - 28 stations (1 phase)	pass	pass	fail ⁽²⁾		pass	fail ⁽⁵⁾	fail ⁽⁷⁾	pass	pass	fail ⁽¹⁰⁾	pass	fail ⁽¹²⁾	pass	fail ⁽¹⁴⁾			fail ⁽¹⁷⁾	fail ⁽²⁰⁾	pass	
	CHI Franciscan	FHS Lakewood - 44 stations (2 phase)	pass	pass	fail ⁽²⁾		pass	fail ⁽⁵⁾	fail ⁽⁷⁾	pass	pass	fail ⁽¹⁰⁾	pass	fail ⁽¹²⁾	pass	fail ⁽¹⁴⁾			fail ⁽¹⁷⁾	fail ⁽²⁰⁾	pass	
16-33	PSKC	PSKC Lakewood - 44 stations (2 phase, 22+22)	pass	pass	pass		pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	
	PSKC	PSKC Lakewood - 44 stations (2 phase, 20+24)	pass	pass	pass		pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	
	PSKC	PSKC Lakewood - 44 stations (2 phase, 16+28)	pass	pass	pass		pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	
	PSKC	PSKC Lakewood - 22 stations (1 phase)	pass	pass	pass		pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	
	PSKC	PSKC Lakewood - 20 stations (1 phase)	pass	pass	pass		pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	
	PSKC	PSKC Lakewood - 16 stations (1 phase)	pass	pass	pass		pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	
16-37	Fresenius	FKC Fredrickson (1 phase)	pass	pass	pass		pass	fail ⁽⁶⁾	fail ⁽⁸⁾	pass	pass	fail ⁽¹¹⁾	pass	fail ⁽¹³⁾	pass	fail ⁽¹⁵⁾			fail ⁽¹⁸⁾	fail ⁽²¹⁾	pass	
16-34	DaVita (LCDC)	LCDC - 15 station addition	pass	pass	pass		pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	
16-35	DaVita	Towne Center - 44 stations (2 phase)	pass	pass	pass		pass	pass	fail ⁽⁹⁾	pass	pass	pass	pass	pass	pass	fail ⁽¹⁶⁾			fail ⁽¹⁹⁾	fail ⁽²²⁾	pass	
	DaVita	Towne Center - 33 stations + 11 relocated (1 phase)	pass	pass	fail ⁽³⁾																	
	DaVita	Towne Center - 33 stations (1 phase)	pass	pass	pass		pass	pass	fail ⁽⁹⁾	pass	pass	pass	pass	pass	pass	fail ⁽¹⁶⁾			fail ⁽¹⁹⁾	fail ⁽²²⁾	pass	
16-36	DaVita	Canyon Road - 44 stations (3 phase)	pass	pass	pass		pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	
	DaVita	Canyon Road - 36 stations (2 phase)	pass	pass	pass		pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	pass	
	DaVita	Canyon Road - 24 stations (1 phase)	pass	pass	fail ⁽⁴⁾																	

- (1) None of the applicants requested station approvals beyond the 44 identified by the numeric need methodology under WAC 246-310-284(4).
- (2) CHI Franciscan (28 or 44 stations) failed under WAC 246-310-284(6) because the volume projections could not be deemed reliable.
- (3) DaVita - Towne Center (33 new + 11 relocated stations) failed under WAC 246-310-284(6). It did not meet the 4.8 standard. It was not evaluated any further within the evaluation.
- (4) DaVita - Canyon Road (24 stations) failed under WAC 246-310-284(6). It did not meet the 4.8 standard. It was not evaluated any further within the evaluation.
- (5) CHI Franciscan (28 or 44 stations) failed under WAC 246-310-220(1) because the projected revenues and expenses could no be deemed reliable.
- (6) Fresenius failed under WAC 246-310-220(1). They did not demonstrate site control; therefore, their expenses could not be substantiated.
- (7) CHI Franciscan (28 or 44 stations) failed under WAC 246-310-220(2). Their construction costs could not be substantiated.
- (8) Fresenius failed under WAC 246-310(220)(2). The costs for their site could not be substantiated.
- (9) DaVita - Towne Center (44 or 33 stations) failed under WAC 246-310-220(2). Their construction costs could not be substantiated.
- (10) CHI Franciscan (28 or 44 stations) failed under WAC 246-310-230(2). They did not demonstrate that they had the ability to create the necessary relationships with ancillary and support services
- (11) Fresenius failed under WAC 246-310-230(2). They did not demonstrate that they had the ability to create the necessary relationships with ancillary and support services
- (12) CHI Franciscan (28 or 44 stations) failed under WAC 246-310-230(4). They did not demonstrate that the facility would have an appropriate relationship to the service area's existing health care system.
- (13) Fresenius failed under WAC 246-310-230(4). They did not demonstrate that the facility would have an appropriate relationship to the service area's existing health care system.
- (14) CHI Franciscan (28 or 44 stations) failed under WAC 246-310-240(1). It did not meet the applicable review criteria in WAC 246-310-210 through 230.
- (15) Fresenius failed under WAC 246-310-240(1). It did not meet the applicable review criteria in WAC 246-310-210 through 230.
- (16) DaVita - Towne Center (44 or 33 stations) failed under WAC 246-310-240(1). It did not meet the applicable review criteria in WAC 246-310-210 through 230.
- (17) CHI Franciscan (28 or 44 stations) failed under WAC 246-310-240(2)(a). Because the application failed under WAC 246-310-220(2), it could not pass WAC 246-310-240(2)(a).
- (18) Fresenius failed under WAC 246-310-240(2)(a). Because the application failed under WAC 246-310-220(2), it could not pass WAC 246-310-240(2)(a).
- (19) DaVita - Towne Center (44 or 33 stations) failed under WAC 246-310-240(2)(a). Because the application failed under WAC 246-310-220(2), it could not pass WAC 246-310-240(2)(a).
- (20) CHI Franciscan (28 or 44 stations) failed under WAC 246-310-240(2)(b). Because the application failed under WAC 246-310-220(2), it could not pass WAC 246-310-240(2)(b).
- (21) Fresenius failed under WAC 246-310-240(2)(b). Because the application failed under WAC 246-310-220(2), it could not pass WAC 246-310-240(2)(b).
- (22) DaVita - Towne Center (44 or 33 stations) failed under WAC 246-310-240(2)(b). Because the application failed under WAC 246-310-220(2), it could not pass WAC 246-310-240(2)(b).