STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

October 13, 2014

CERTIFIED MAIL # 7011 1570 0002 7808 8317

Richard Petrich, Vice President
Planning and Business Development
Franciscan Health System
Post Office Box 2197
Tacoma, Washington 98401

RE: CN 14-22A

Dear Mr. Petrich:

We have completed review of the Certificate of Need (CN) application submitted by Franciscan Health System proposing add 43 beds at Highline Medical Center. For the reasons stated in the enclosed decision, the application is consistent with the applicable criteria of the Certificate of Need Program, provided Franciscan Health System agrees to the following in its entirety.

Project Description:

This certificate approves the addition of 43 acute care beds to Highline Medical Center located in southwest King County. Of the 43 additional beds, 12 are dedicated to level II rehabilitation services and 31 are dedicated to medical/surgical services. At project completion, Highline Medical Center will be licensed for 171 acute care beds with the following breakdown.

Service Type	Project Completion
General Medical/Surgical	154
Level II Intermediate Care Nursery	5
Level II Rehabilitation	12
Total	**171**

Conditions:

1. Approval of the project description as stated above. Franciscan Health System 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. Franciscan Health System expects the medical surgical space to be complete and ready for occupancy by the end of year 2017. Franciscan Health System shall add the 31 medical surgical beds by June 30, 2018. Any remaining medical surgical

bed authorization not meeting licensing requirements by June 30, 2018, shall be forfeited.

3. Franciscan Health System expects the level II rehabilitation space to be complete and ready for occupancy by the end of year 2017. Franciscan Health System shall add the 12 level II rehabilitation beds by June 30, 2018. Any remaining bed level II rehabilitation bed authorization not meeting licensing requirements by June 30, 2018, shall be forfeited.

Approved Costs:
The approved capital expenditure associated with the relocation is $53,327,429.

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

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

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

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

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

Sincerely,

Steven M. Saxe, FACHE
Director, Community Health Systems

Enclosure

EVALUATION DATED OCTOBER 13, 2014, OF THE CERTIFICATE OF NEED APPLICATION SUBMITTED BY FRANCISCAN HEALTH SYSTEM PROPOSING TO ADD 43 ACUTE CARE BEDS TO HIGHLINE MEDICAL CENTER LOCATED IN SOUTHWEST KING COUNTY

GENERAL INFORMATION

There are three main entities associated with this project. They are: Franciscan Health System, Highline Medical Center, and Regional Hospital for Respiratory and Complex Care. Below is a brief description of all three.

Franciscan Health System

Franciscan Health System (FHS) is part of Catholic Health Initiatives, one of the largest not-for-profit health care systems in the United States. Through one of its subsidiaries, Catholic Health Initiatives operates 118 health care facilities in 22 states. For Washington State, FHS is the subsidiary that owns or operates a variety of health care facilities including hospitals, dialysis centers, a skilled nursing facility, ambulatory surgery centers, a Medicare certified hospice agency, and a hospice care center. The eight Washington State hospitals are listed below. [source: CN historical files]

- Highline Medical Center
- Harrison Medical Center
- Regional Hospital for Respiratory and Complex Care
- St. Elizabeth Hospital, Enumclaw
- St. Anthony Hospital, Gig Harbor
- St. Joseph Medical Center, Tacoma
- St. Clare Hospital, Lakewood
- St. Francis Hospital, Federal Way

Highline Medical Center

Highline Medical Center (Highline) is an acute care hospital located in southwest King County. Highline is a recognized level IV trauma hospital and holds a three year accreditation with the Joint Commission.[1] Prior to September 20, 2013, Highline operated a 239 bed hospital on the two separate campuses. On September 20, 2013, Certificate of Need #1513 was issued to Acadia Healthcare approving an Asset Purchase Agreement for the purchase of Highline's Specialty campus. Once Highline entered into the Asset Purchase Agreement with Acadia, it no longer operated on two separate campuses. As of the writing of this evaluation, Highline is a 154-bed acute care hospital located on one campus at 16251 Sylvester Road in Burien [98166]. [source: CN historical files]

Regional Hospital for Respiratory and Complex Care

Regional Hospital for Respiratory and Complex Care (RHRCC) is a non-profit long-term acute care hospital located in southwest King County. RHRCC is licensed for 40 acute care beds and all 40 beds are used solely for long-term acute care patients. RHRCC provides long term acute care services to residents of Southwest King County and surrounding counties and is accredited by the Joint Commission.

Long-term acute care hospitals (LTACHs) differ from general acute care hospitals in that they furnish extended medical and rehabilitative care to individuals who are clinically complex and have multiple

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

acute or chronic conditions. An LTACH must be certified as an acute care hospital that meets criteria to participate in the Medicare program and has an average inpatient length of stay greater than 25 days. [source: American Hospital Association Long Term Care Hospital home page]

LTACHs also differ from nursing homes and rehabilitation hospitals in that their patients generally require a higher level of medical attention. The LTACH is designed to provide extended medical and rehabilitative care for patients who are clinically complex and have multiple acute or chronic conditions. Most patients in LTACHs have several diagnosis codes on their Medicare claim, which indicates that they have multiple co-morbidities and are less stable on admission than patients admitted to other post-acute care settings. Approximately one half of the patients in an LTACH have five or more diagnoses noted on their claims. [source: Prospective Payment Assessment Commission, 1996]

Under the current Medicare payment system, LTACH reimbursement is structured to compensate hospitals for the care of patients whose average length of stay exceeds 25 days. The reimbursement model for general acute care hospitals is not designed to compensate hospitals for this population. As a result, the LTACH is a model of care that provides an environment tailored to medically complex patients and is able to serve those patients under a reimbursement model that adequately covers the costs of treatment. LTACHs in a community enable existing hospitals to improve facility utilization by discharging patients to the LTACH who would otherwise be occupying intensive care or critical care units or other acute care beds for long periods of time and place them in a suitable clinical setting. As a result, the existing hospitals are able to free space to more effectively manage their daily caseload, particularly in intensive care and critical care unit settings, which are often subjected to highly fluctuating occupancy rates. Referral of suitable patients to an LTACH improves hospitals' ability to ensure that intensive care and critical care beds are available. [source: American Hospital Association Long Term Care Hospital home page]

APPLICANT DESCRIPTION

For this project, Franciscan Health System is the applicant and the focus facility is Highline. This evaluation will also discuss RHRCC because it is a tenant of Highline.

PROJECT DESCRIPTION

On November 7, 2013, FHS submitted an application to relocate the 40-bed LTACH of RHRCC to space within Highline.[2] In order to accommodate RHRCC, Highline must reduce its acute care bed license by 26 beds, from 154 to 128. The bed reduction is due to space constraints while portions of the hospital are under construction. The construction for this project consists of completing two patient floors [8 and 9] of the recently constructed Birch Tower and shelling in space on floor 10 of the tower. Once the construction at Highline is complete in year 2017, Highline will have the space to bring the 26 beds back on line. [source: Application, p9]

With this project, FHS requests to add 43 beds to Highline, thereby increasing the total number of beds from 128 to 171. The table below shows the current and proposed configuration of beds for Highline. [source: Application, p9]

[2] CN application #14-14A2. The application proposes a two-phase project with 26 beds in phase one and 14 beds in phase two.

Table 1
Highline Medical Center Current and Proposed Breakdown of Beds

Service Type	Current	During Construction	This Project
General Medical/Surgical	137	123	154
Level II Intermediate Care Nursery	5	5	5
Level II Rehabilitation	12	0	12
License Total	**154**	**128**	**171**

As shown in the table above, once RHRCC is located at Highline, 12 dedicated level II rehabilitation bed and services and 14 general medical surgical beds must be taken off line. After the construction is completed, RHRCC will set up its remaining 14 beds, to meet its licensed capacity of 40. There will also be space for Highline to increase its beds by 43, from 128 to 171. [source: Application, p9]

The capital expenditure associated with this project is $53,327,469. Of that amount, 66% is associated with construction and fixed equipment; 16% is associated with moveable equipment; and the remaining 18% is associated with fees, taxes, permits, and supervision/management costs. [source: Application, p31]

If approved, FHS expects the space to be complete and ready for occupancy by the end of year 2017. Under this timeline, year 2018 would be the Highline's first full calendar year of operation as a 171 bed hospital and 2020 would be year three. [source: March 10, 2014, supplemental information, Attachment 3]

APPLICABILITY OF CERTIFICATE OF NEED LAW

This project is subject to review as a change of bed capacity of a healthcare facility under Revised Code of Washington 70.38.105(4)(e) and Washington Administrative Code 246-310-020(1)(c).

EVALUATION CRITERIA

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

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

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

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

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

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

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

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

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

The review for this project will focus on applicable portions of need (WAC 246-310-210), financial feasibility (WAC 246-310-220), structure and process of care (WAC 246-310-230), cost containment (WAC 246-310-240); and portions of the 1987 Washington State Health Plan as it relates to the acute care bed methodology.[3]

TYPE OF REVIEW

This application was reviewed under the regular review timeline outlined in WAC 246-310-160, which is summarized below. During the review of this project, FHS submitted an initial application and an amendment application. The review timeline below shows the initial and amendment application timelines.

APPLICATION CHRONOLOGY

Action	Franciscan Health System
Letter of Intent Submitted	October 2, 2013
Initial Application Submitted	December 3, 2013
Department's pre-review activities • DOH 1st Screening Letter • FHS Responses Received[4]	 December 23, 2013 March 10, 2014
FHS Requests Suspension of Action on the Application	March 13, 2014
First Amendment Application Submitted	June 9, 2014
Department's pre-review activities • DOH 1st Screening Letter • FHS Responses Received	 June 12, 2014 June 16, 2014
Beginning of Review	June 19, 2014
Public comments accepted through end of public comment	July 24, 2014
Public hearing conducted	None
End of Public Comment	July 24, 2014

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

[4] After FHS submitted its screening responses, FHS changed the project that resulted in submission of an amendment application.

Action	Franciscan Health System
Rebuttal Comments Submitted[5]	August 8, 2014
Department's Anticipated Decision Date	September 22, 2014
Department's Anticipated Decision Date with 30 day extension	October 22, 2014
Department's Actual Decision Date	October 13, 2014

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."

During the review of this project, two entities sought interested person status, but did not provide comments on the application to qualify for affected person status. The two entities are MultiCare Health System and Swedish Health Services.

SOURCE INFORMATION REVIEWED

- Franciscan Health System's Certificate of Need application submitted December 3, 2013
- Franciscan Health System's supplemental information received March 10, 2014
- Franciscan Health System's first amendment application received June 9, 2014
- Franciscan Health System's supplemental information received June 16, 2014
- Public comments submitted by 5:00pm on July 24, 2014
- Department of Health Hospital and Patient Data Systems Analysis received September 15, 2014
- Licensing and/or survey data provided by the Department of Health's Investigations and Inspections Office
- Licensing data provided by the Medical Quality Assurance Commission
- Regional Hospital for Respiratory and Complex Care website at www.regionalhospital.org
- Franciscan Health System website at www.fhshealth.org
- Highline Medical Center website at www.highlinemedicalcenter.org
- MultiCare Health System website at www.multicare.org
- Swedish Health Services website at www.swedish.org
- Joint Commission website at www.jointcommission.org
- Joint Commission quality check website at www.qualitycheck.org
- Washington State Secretary of State website at www.sos.wa.gov
- Washington State Department of Revenue website at www.dor.wa.gov
- 1987 State Health Plan
- Claritas population data used for partial county populations
- Office of Financial Management population data used for health service areas (HSAs) and statewide populations

[5] Public comments for this project included three letters of support and no letters of opposition. FHS elected not to provide rebuttal comments to the public comment.

- Year 2013 Comprehensive Hospital Abstract Reporting System (CHARS) data obtained from the Department of Health's Hospital and Patient Data Systems office
- Certificate of Need historical files

CONCLUSION

For the reasons stated in this evaluation, the application submitted by Franciscan Health System proposing the addition of 43 acute care beds to Highline Medical Center is consistent with applicable criteria of the Certificate of Need Program, provided Franciscan Health System agrees to the following in its entirety.

Project Description:

This certificate approves the addition of 43 acute care beds to Highline Medical Center located in southwest King County. Of the 43 additional beds, 12 are dedicated to level II rehabilitation services and 31 are dedicated to medical/surgical services. At project completion, Highline Medical Center will be licensed for 171 acute care beds with the following breakdown.

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Total	**171**

Conditions:

1. Approval of the project description as stated above. Franciscan Health System 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. Franciscan Health System expects the medical surgical space to be complete and ready for occupancy by the end of year 2017. Franciscan Health System shall add the 31 medical surgical beds by June 30, 2018. Any remaining medical surgical bed authorization not meeting licensing requirements by June 30, 2018, shall be forfeited.
3. Franciscan Health System expects the level II rehabilitation space to be complete and ready for occupancy by the end of year 2017. Franciscan Health System shall add the 12 level II rehabilitation beds by June 30, 2018. Any remaining bed level II rehabilitation bed authorization not meeting licensing requirements by June 30, 2018, shall be forfeited.

Approved Costs:

The approved capital expenditure associated with the relocation is $53,327,429.

CRITERIA DETERMINATIONS

A. Need (WAC 246-310-210)

Based on the source information reviewed and the applicant's agreement to the conditions identified in the conclusion section of this evaluation, the department concludes that Franciscan Health System has met the applicable need criteria in WAC 246-310-210.

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

As previously stated in the project description portion of this evaluation, Highline is currently licensed for 154 acute care beds. Of the bed complement, 137 are classified as general medical surgical beds, 5 are dedicated to the level II intermediate care nursery, and 12 are dedicated to the level II rehabilitation unit.

On September 22, 2014, the department released its conditional approval to FHS for the relocation of RHRCC into space at Highline.[6] To accommodate the first phase of RHRCC's relocation, Highline must delicensed 26 of its acute care beds. After an internal review of historical occupancy and bed use of the hospital, FHS elected to delicense 14 general medical surgical beds and 12 dedicated level II rehabilitation beds. This action decreased Highline's total licensed beds from 154 to 128. Of the 128 beds, 5 continue to be dedicated to the level II intermediate care nursery, leaving 123 for general medical surgical use.

This project requests to add 43 acute care beds to the hospital. Of the 43 beds, 31 would be general medical surgical beds and 12 would be dedicated to level II rehabilitation services. All 43 beds would be added once floors 8 and 9 of the Birch Tower are completed.

To demonstrate compliance with this sub-criterion, FHS provided two separate numeric bed need methodologies. One for its general medical surgical beds and one dedicated to its rehabilitation beds. For reader ease, each methodology will be discussed separately, beginning with the general medical surgical methodology.

Summary of General Medical Surgical Methodology submitted for Highline Medical Center
[source: Application, pp27-29, Exhibit 8, and March 10, 2014, supplemental information, p8]

Highline is located in the southwest King hospital planning area. For its numeric methodology, FHS included the following zip codes.

Zip	City	Zip	City	Zip	City
98013	Burton/Vashon	98131	Seattle	98158	Seattle/SeaTac
98062	Seahurst/Burien	98132	Seattle	98166	Seattle/Burien
98070	Vashon	98136	Seattle	98168	Seattle/Burien
98106	Seattle	98138	Seattle/Tukwila	98188	Seattle/SeaTac
98116	Seattle	98146	Seattle/Burien	98190	Seattle
98126	Seattle	98148	Seattle/Burien	98198	Des Moines

[6] Certificate of Need application #14-14A2. A Certificate of Need has not yet been issued.

FHS submitted this application in December 2013 and relied on historical data from years 2003 through 2012 for its numeric demonstration of need for the general medical surgical beds. Based on the historical data available, FHS projected for years 2013 through 2021.[7] Using a seven-year horizon for forecasting acute care bed projections as recommended by the state health plan, FHS projected to year 2019.

Highline is the only acute care hospital located in the planning area of southwest King County. The table below shows a summary of the final step of FHS's general medical surgical bed need projections for years 2013 through 2019. [source: Application, p29]

Table 2
Summary of Highline Medical Center General Medical Surgical Bed Need Methodology for Southwest King County Planning area

	2013	2014	2015	2016	2017	2018	2019
Patient Days	29,462	29,673	30,483	31,340	32,232	33,160	34,126
Adjusted Gross Bed Need	124	125	128	132	136	140	144
Minus Planning Area Beds	111	111	111	111	111	111	111
Adjusted Net Need / (Surplus)	13	14	17	21	25	29	33

[All numbers are rounded]

As shown in Table 2 above, FHS projected need for additional general medical surgical beds in all seven years shown. However, FHS subtracted 111 beds at the hospital beginning in year 2013. This miscalculation is due to FHS's submission of its amendment application, which proposed to include 12 rehabilitation beds in the 26 beds that would be delicensed. FHS did not provide a revised numeric methodology for its general medical surgical beds.

Relying on FHS's numbers, the department recalculated FHS's bed need methodology by subtracting 123 general medical surgical beds from the gross bed need beginning in year 2015 and continuing through 2019. The department's recalculations are shown in the table below.

Table 3
Department's Recalculation of
Highline Medical Center General Medical Surgical Bed Need Methodology

	2013	2014	2015	2016	2017	2018	2019
Adjusted Gross Bed Need	124	125	128	132	136	140	144
Minus Planning Area Beds	137	137	123	123	123	123	123
Adjusted Net Need / (Surplus)	(13)	(12)	5	9	13	17	21

[All numbers are rounded]

Using the department's recalculations of the applicant's methodology shown in Table 3, need for an additional 5 beds materializes in year 2015 when FHS reduces the number of beds by 14 at Highline, and need for all 14 beds materializes in year 2017.

[7] At the time this application was submitted, historical year 2013 CHARS data was unavailable. Year 2013 data was released in mid-May 2014, which is approximately 30 days prior to the Beginning of Review for this project. Based on this timing, the applicant was not afforded an opportunity to revise its numeric methodology.

To further support its need for additional beds in the planning area, FHS included an adjustment to the methodology after completion of Step 10A. FHS's rationale for the adjustment is stated below. [source: Application, p28]

> *"Highline made an adjustment…to account for the expanded relationship with the Franciscan Health System. For the non-tertiary, patient days occurring at FHS hospitals, Highline has assumed that 75% of those will occur at Highline going forward. …while Highline excluded MDC 20 patient days in the earlier steps of the methodology, a review of CHARS data indicates that most of the community hospitals, without a chemical dependency program, still have about 1% of their patient days attributable to MDC 20. Therefore, a 1% adjustment each year has been assumed to account for this patient population."*

With the two adjustments described above, FHS provided the following projections for years 2013 through 2019. [source: Application, p29]

Table 4
Department's Recalculation of
Highline Medical Center General Medical Surgical Bed Need Methodology

	2013	2014	2015	2016	2017	2018	2019
Adjusted Patient Days	31,570	31,797	32,664	33,583	34,539	35,534	36,569
Adjusted Gross Bed Need	133	134	138	142	146	150	154
Minus Planning Area Beds	137	137	123	123	123	123	123
Adjusted Net Need / (Surplus)	(4)	(3)	15	19	23	27	31

[All numbers are rounded]

Based on FHS's numeric methodology, need for an additional 15 beds materializes in year 2015 when FHS reduces the number of beds by 14 at Highline. Need for all 31 medical surgical beds requested in this project is demonstrated in year 2019.

The Department's Determination of Numeric Need:

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

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

The 1987 methodology is a twelve-step process of information gathering and mathematical computation. The first four steps develop trend information on hospital utilization. The next six steps calculate baseline non-psychiatric bed need forecasts. The final two steps are intended to determine the total baseline hospital bed need forecasts, including need for short-stay psychiatric services: step

11 projects short-stay psychiatric bed need, and step 12 is the adjustment phase, in which any necessary changes are made to the calculations in the prior steps to reflect conditions which might cause the pure application of the methodology to under- or over-state the need for acute care beds.

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

At the time this application was submitted, historical year 2013 CHARS data was unavailable. Year 2013 data was released in mid-May 2014, which is approximately 30 days prior to the Beginning of Review for this project. Since 2013 data is available, the department will use it for historical trend information as referenced above.

The state health plan provides the following recommendation related to projection years. It states, "*For most purposes, bed projections should not be made for more than seven years into the future*."

Further, a seven year forecast is consistent with most projects for hospital bed additions reviewed by the department. At the time this application was submitted, the seven-year projection year was 2019. Incorporating historical year 2013, results in a projection year of 2020. As a result, the department will set the target year as 2020, which is seven years after the most recent data that was available during the review of this application.

The southwest King planning area is described in State Health Coordinating Council documents from 1987 as selected zip codes within King County[9]. Zip codes are assigned by the US Postal Service for mail delivery purposes and do not necessarily correspond to fixed areas over long periods of time. Zip codes may also be added or deleted in an area as necessary. Because some zip codes have been added in King County in the intervening years and some zip code boundaries have changed, the 1987 list of zip codes no longer corresponds with the geographic area intended to be considered the King planning area. Changes and updates were considered in the compilation of the patient day and population totals.

When preparing acute care bed need projections, the department relies upon population forecasts published by the Washington State Office of Financial Management (OFM). OFM publishes a set of forecasts known as the "intermediate-series" county population projections, based on the 2010 census,

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

[9] Described in 1987 State Health Coordinating Council documents, select zip codes from King County including—98013, 98018, 98062, 98070, 98106, 98116, 98126, 98136, 98146, 98148, 98158, 98166, 98168, and 98188. Zip code 98018 is no longer a valid zip code. [source: USPS website]

updated May 2012[10]. However, OFM figures are not available for any area smaller than an entire county. Because OFM does not provide population estimates at the level necessary for the zip code areas of the southwest King planning area, the department relied upon estimates and projections developed by Claritas, Inc. for the applicable zip code populations in King County.

This portion of the evaluation will describe, in summary, the calculations made at each step and the assumptions and adjustments made in that process. It will also include a review of any deviations related to the assumptions or adjustments made by FHS in its application of the methodology.

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

For this step, attached as Appendix 1, the department obtained planning area resident utilization data for 2004 through 2013 from the Department of Health Office of Hospital and Patient Data Systems' CHARS (Comprehensive Hospital Abstract Reporting System) database. Total resident patient days were identified for the southwest King Planning Area, HSA 1, and the State of Washington as a whole, excluding psychiatric patient days (Major Diagnostic Category (MDC) 19), normal newborns (Diagnostic Related Group (DRG) 391), and rehabilitation (MDC 15) according to the county in which care was provided.

FHS followed this step as described above with no deviations using 2003 through 2012 historical data.

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

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

FHS followed this step as described above with no deviations using 2003 through 2012 historical data. The nominal number of psychiatric patients, included in this step is psychiatric patients from the psychiatric hospitals not removed when the MDC 19 is applied in the query of the CHARS data base.

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

The average use rate (defined as the number of patient days per 1,000 population) was derived by dividing the total number of patient days in each HSA by that HSA's population and multiplied by 1,000. For the purposes of this application, the average use rate was also determined for the state and the southwest King planning area and is attached as Appendix 3. Actual and projected population figures for this analysis were derived from the combination of State of Washington Office of Financial Management (OFM) "medium-series" county population projections and Claritas data as described above.

FHS followed this step as described above using 2003 through 2012 historical data. While FHS did not deviate from the methodology as described, the department notes slight differences in population data used for both HSA #1 and statewide.

[10] The May 2012 series is the most current data set available during the production of the state acute care methodology and can be found at http://www.ofm.wa.gov/pop/estimates.asp and compiled internally by DOH

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

The department has computed trend lines for the state, HSA 1, and the southwest King planning area based upon the trends in use rates from these ten years and has included them as Appendix 4. The resulting trend lines uniformly exhibit a mild upward slope for both HSA 1 and statewide and a mild downward slope for southwest King. The HSA 1 and statewide trends can be related to overall population growth and the fact that the state's population is growing older as the large number of "baby boomers" (those born from 1946 to 1964) age and begin to demand more health services. Utilization of hospital beds by patients aged 65 and older is significantly higher than bed utilization by younger patients, as demonstrated in subsequent calculations.

FHS followed this step as described above with no deviations. While the HSA and statewide trend lines showed a mild upward slope, the trend line for southwest King County showed a mile downward slope. Use of differing population values and patient days and historical data produces slightly different, but comparable, results.

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

This step calculates the patient days of residents in the four HSAs and the state as a whole. The previous four steps of the methodology use data particular to the residents of the southwest King planning area to calculate the use rate in step 6. In order to forecast the availability of services for the residents of a given region, patient days must also be identified for the facilities available within the planning area. Step 5, included as Appendix 5, identifies referral patterns in and out of the southwest King planning area and illustrates where residents of the planning area currently receive care. For this calculation, the department separated patient days by age group (0-64 and 65 and older), and subtracted patient days for residents of other states. The department also used discharge data for Washington residents that receive health care in Oregon. The most recent data was obtained from the Oregon Department of Human Services in 2008.

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

FHS followed this step as described above. The out of state patient days varied slightly from those used by the department. This will effect comparable computations explained further in step 9.

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

Appendix 6 illustrates the age-specific use rates for the year 2013, as defined in Step 6, for the southwest King planning area and for the rest of the state. The department used Claritas 2012 population data that was available in August 2012 and based on 2010 census data to determine age-specific use rates for year 2013.

FHS followed this step as described above with no deviations, with the exception of focusing on base year 2012. FHS used Claritas 2012 population data to determine age-specific use rates for year 2012. The differences in the ten-year historical data used—2003 through 2012 for FHS and 2004 through 2013 for DOH—will impact the results in future steps within the methodology.

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

As discussed in Step 4, the department used the ten-year use rate trends for 2004-2013 to reflect the use patterns of Washington residents. The 2013 use rates determined in Step 6 were multiplied by the slopes of both the Health Service Area's ten-year use rate trend line and by the slope of the statewide ten-year use rate trend line for comparison purposes.

The HSA has a lower projected rate (an annual increase of 0.6064) than the statewide trend rate of 1.1269. As directed in Step 7A, the department applied the HSA trend to project future use rates.

The methodology is designed to project bed need in a specified "target year." It is the practice of the department to evaluate need for a given project through at least seven years from the last full year of available CHARS data, or 2013 for purposes of this analysis. Therefore, although some projections are shown through 2022, the target year for this evaluation is 2020.

FHS followed this step as described above with no deviations. However, since FHS relied on CHARS data from 2003 through 2012, its projected 7-year target is 2019. [source: Application, Exhibit 8]

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

Using the forecasted use rate for the target year 2020 and population projections, projected patient days for southwest King planning area residents are illustrated in Appendix 8. As noted in Step 7, above, forecasts have been prepared for a series of years and are presented in summary in Appendix 10 as "Total Southwest King Res Days."

FHS applied this step with projections through 2022 and focused on year 2019.

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

Using the patient origin study developed for Step 5, Appendix 9 illustrates how the projected patient days for the southwest King planning area and the remainder of the state were allocated from county of residence to the area where the care is projected to be delivered in the target year 2020. The results of these calculations are presented in Appendix 10 as "*Total Days in SWKing Hospitals*."

FHS applied this step with no deviations and with slightly differing in-migration percentages. [source: Application, Exhibit 8]

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

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

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

The State Health Plan determines the number of available beds in each Planning Area, by including only those beds that meet the definition of #1 and #2 above, plus any CN approved beds. Highline is the only acute care hospital located in the planning area of southwest King County.

The weighted occupancy standard for a planning area is defined by the State Health Plan as the sum, across all hospitals in the planning area, of each hospital's expected occupancy rate times that hospital's percentage of total beds in the area. In previous evaluations, the department determined that the occupancy standards reflected in the 1987 State Health Plan are higher than can be maintained by hospitals under the current models for provision of care. As a result, the department adjusted the occupancy standards presented in the State Health Plan downward by 5% for all but the smallest hospitals (1 through 49 beds). As a result of this change, the southwest King planning area's weighted occupancy is reflected in the line "*Wtd Occ Std*" in Appendices 10a and 10b.

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

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

FHS also did not provide psychiatric forecasts within its methodology.

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

Within the department's application of the methodology, adjustments have been made where applicable and described above. FHS's adjustments were all described within its methodology.

The results of the department's methodology are available in Exhibit A as Appendices 10A and 10B attached to this evaluation. Appendix 10A calculates the southwest King planning area bed need

without the proposed project for years 2014 through 2020. Appendix 10B demonstrates the impact of adding 31 additional general medical/surgical beds to Highline beginning in year 2018. A summary of those appendices is shown in Table 5 below. [source: Exhibit A, Appendices 10A &10B]

Table 5
Department Methodology
Appendix 10A – Without Project - Summary

	2013	2014	2015	2016	2017	2018	2019	2020
Gross Bed Need	173	177	181	186	190	195	199	204
Planning Area # of Beds	137	137	123	123	123	123	123	123
Need or (Surplus) w/o Project	36	40	58	63	67	72	76	81

As shown in Table 5, for base year 2013, Appendix 10A illustrates a planning area net need of 36 beds. In year 2015, Highline must reduce its medical/surgical beds from 137 to 123 to accommodate the relocation of RHRCC, at that time, the net need increases by another 18 beds. Step 10A indicates that without the addition of new beds to the planning area, the need would continue to grow in each subsequent year.

Step 10B calculates the impact of a 31 bed addition at Highline beginning in year 2018. A summary of those results are shown in Table 6 below.

Table 6
Department Methodology
Appendix 10B – With the Project - Summary

	2013	2014	2015	2016	2017	2018	2019	2020
Gross Bed Need	173	177	181	186	190	195	199	204
Planning Area # of Beds	137	137	123	123	123	154	154	154
Need or (Surplus) w/o Project	36	40	58	63	67	41	45	50

Step 10B illustrates the effect on the planning area if Highline recaptures the 14 beds that were reduced in year 2015 and adds another 17 medical surgical beds, bringing the hospital to 154 for medical/surgical bed capacity. Even with the additional 31 beds added in year 2018, year 2020 shows a projected need for 50 medical/surgical beds.

In summary, FHS's methodology only supports this project if the adjustments to the methodology following step 10A is applied. However, based on the department's need methodology, using year 2004 through 2013 CHARS data, need for this project is demonstrated.

During the review of this application, the department received three letters of support for the project and no letters of opposition. All three letters of support were submitted by an FHS-Highline entity. [source: Public comment provided during the review]

Based on the department's methodology using most current CHARS data, the department concludes that numeric need for the 31 medical/surgical beds has been demonstrated.

The Department's Determination of Numeric Need for Rehabilitation Beds

Since the department does not have a numeric bed methodology that focuses only on rehabilitation beds, the first step in evaluating the need for 12 rehabilitation beds requested by FHS is an evaluation of the numeric methodology provided by FHS.

Summary of Rehabilitation Methodology submitted for Highline Medical Center
[source: Amendment Application, Exhibit 1]

For its rehabilitation numeric methodology, FHS used a similar methodology as described in the general medical surgical methodology, with some modifications. Below is a description of the assumptions and data used in the rehabilitation methodology.

- Used historical CHARS data for years 2003 through 2012.
- Used the same zip codes for southwest King County as described above.
- Planning area populations were based on 2014 Claritas data.
- Focused on southwest King hospital planning area, HSA #1, and statewide data.
- Focused on rehabilitation days, patients, and beds only.
- Determined use rates per 1,000 population for rehabilitation only.
- Projected for years 2013 to 2020.[11]
- A weighted occupancy standard of 75% was used for the projection years.
- Projected the gross number of rehabilitation beds needed in the planning area for the projection years.
- To determine the net bed need [gross need minus current supply], FHS subtracted the number of existing beds in the planning area. Highline is the only hospital in the planning area. FHS counted all 12 of Highline's rehabilitation beds for the projection years.

Steps 1 through 4 of the methodology develop trend information on hospital utilization.

In steps 1 through 4, FHS appropriately focused on historical data to determine the health service area [HSA], planning area, and use trends for level II rehabilitation services. FHS computed a use trend line for the HSA, planning area, and statewide. The use trend line projected a mild decline in level II rehabilitation use for the HSA, planning area, and statewide. FHS determined that the statewide trend line was most statistically reliable and applied the data derived from those calculations to the projection years in the following steps.

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

For these steps, FHS applied its use trend line to the projected population to determine a use rate broken down by population ages 15-64 and ages 65 and older. FHS multiplied the use rates derived from step 6 by the slopes of the HSA, planning area, and statewide ten-year use rate trend line. This step is completed for comparison purposes, and showed the statewide use rate to be statistically most reliable. FHS also determined the in-migration for residents who do not live within southwest King County planning area, but need level II rehabilitation services at Highline.

[11] In its bed need methodology, FHS's projection table show years 2012 through 2020. The department assumes this to be a typographical error for the table headings since the most recent CHARS data used is 2012 and projection years should be 2013 through 2021.

The use rates, broken down by age group, and the in-migration ratio are each applied in future steps of this methodology.

When the use rates are applied to the projected population, the result is the projected number of level II rehabilitation patient days for the planning area. The numeric methodology is designed to project bed need in a specified "target year." It is the practice of the department to evaluate need for a given project through at least seven years from the last full year of available CHARS data. FHS relied on CHARS data for years 2003 through 2012 and projected to year 2019.

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

Step 11 projects short-stay psychiatric bed need. Step 12 is the adjustment phase where any necessary changes are made to the calculations in the prior steps to reflect conditions which might cause the pure application of the methodology to under-or over-state the need for acute care beds.

In steps 10 through 12, FHS projected the number of level II rehabilitation beds needed in the planning area, subtracted the existing capacity, resulting in a net need for level II rehabilitation beds. Since Highline is the only acute care hospital in the planning area that provides any rehabilitation services, existing capacity is its own 12 rehabilitation beds.

These steps also allow psychiatric projections, which FHS appropriately did not compute [step 11], and allow for other adjustments in population, use rates, market shares, out-of-area use and occupancy rates [step 12]. FHS did not include any other adjustments than those described in the previous steps.

Table 7 below shows a summary of FHS's rehabilitation bed need projections up to year 2019.

Table 7
Summary of Highline Medical Center Rehabilitation Bed Need Methodology
for Southwest King County Planning area

	2013	2014	2015	2016	2017	2018	2019
Patient Days	2,892	2,936	2,944	2,998	3,058	3,121	3,187
Gross Bed Need	11	11	11	11	11	11	12
Minus Planning Area Beds	12	12	12	12	12	12	12
Adjusted Net Need / (Surplus)	(1)	(1)	(1)	(1)	(1)	(1)	0

[All numbers are rounded]

As noted in Table 7 above, FHS's rehabilitation methodology shows no need for beds through year 2019. It is also noted that FHS counted 12 rehabilitation beds in years 2015 through 2017 even though the rehabilitation beds at Highline will be reduced from 12 to 0 in late year 2014 through year 2017.

As with the general medical/surgical methodology, the department recalculated FHS's level II rehabilitation methodology and reduced the number of planning area beds from 12 to 0 beginning in year 2015.

Table 8
Department's Recalculation of
Highline Medical Center Level II Rehabilitation Bed Need Methodology

	2013	2014	2015	2016	2017	2018	2019
Patient Days	2,892	2,936	2,944	2,998	3,058	3,121	3,187
Gross Bed Need	11	11	11	11	11	11	12
Minus Planning Area Beds	12	12	0	0	0	0	0
Adjusted Net Need / (Surplus)	(1)	(1)	11	11	11	11	12

[All numbers are rounded]

In the department's recalculated methodology shown in Table 8, need for all 12 rehabilitation beds that Highline would remove from service in year 2015 is demonstrated in year 2019. Need for level II rehabilitation beds beyond the 12 at Highline does not materialize in the applicant's methodology that projected to year 2020. [source: Amendment Application, Exhibit 1]

In conclusion, FHS demonstrated continuing need for 12 level II rehabilitation beds at Highline. If FHS agrees that these 12 beds are limited to providing level II rehabilitation services at Highline, **this sub-criterion is met.**

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

Highline has been an acute care hospital in King County for many years and currently provides health care services to the residents of Washington State, including low-income, racial and ethnic minorities, handicapped and other underserved groups. Highline currently participates in the Medicare and Medicaid programs. For this project, FHS must demonstrate a commitment to be available to the residents of the community, maintain its Medicare and Medicaid participation, and provide a percentage of charity care in the planning area.

Admission Policy

To determine whether all residents of the service area would continue to have access to a hospital's proposed services, the department requires applicants to provide a copy of its current or proposed admission policy. The admission policy provides the overall guiding principles of the facility as to the types of patients that are appropriate candidates to use the facility and any assurances regarding access to treatment. 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.

To demonstrate compliance with this sub-criterion, FHS provided a copy of the Admission Policy used at Highline. The policy completed its most recent administrative review in March 2014. The policy outlines the process/criteria that the hospital uses to admit patients for acute care services. The policy also includes the necessary language to ensure all residents of the service area would have access to services at Highline. [source: Application, Exhibit 6]

FHS also submitted the following three policies to the Department of Health for Highline that are posted on the department's website as required under WAC 246-320-141(5).

- Non-Discrimination Policy ensuring that Highline does not exclude or deny benefits, or otherwise discriminate against any person for any reason. The policy includes the appropriate non-discrimination language required under this sub-criterion. The policy was updated in November 2011.
- Reproductive Health Policy ensuring that Highline provides reproductive health services and outlining the specific procedures/process to obtain the services. This policy was updated in March 2014.
- Death with Dignity Act [End of Life Policy] clarifies that Highline provides hospice care to patients requiring the services, however, it also clarifies that Highline does not participate in the death with dignity process for any patient. The policy provides guidance and procedures for hospital staff when a patient requests these services. The policy was updated July 2013.

Medicare and Medicaid Programs

The department uses Medicare certification to determine whether the elderly would have access or continue to have access to the proposed services. To demonstrate compliance with this sub-criterion FHS provided the current and projected source of revenues by payer at Highline. Medicare revenues are, and would continue to be, 38.0% of total revenues at the hospital. Additionally, the financial data provided in the application shows Medicare revenues. [source: Amendment Application, Exhibit 2]

The department uses the facility's Medicaid eligibility or contracting with Medicaid to determine whether low-income residents would have access to the proposed services. To demonstrate compliance with this sub-criterion, FHS also provided the current and projected percentage of Medicaid revenues at 17.0% for Highline. Additionally, the financial data provided in the application shows Medicaid revenues. [source: Amendment Application, Exhibit 2]

Charity Care Policy

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

To demonstrate compliance with this sub-criterion, FHS submitted the charity care policy currently used at Highline. The policy submitted by FHS is the same policy that FHS submitted to the department for posting on its website. The charity care policy outlines the process a patient uses to access this service. The policy was updated in September 2004. Further, FHS included a 'charity care' line item as a deduction from revenue within historical and projected financial documents for Highline. [source: Application, Exhibit 6 and Amendment Application, Exhibit 2]

For charity care reporting purposes, the Department of Health's Hospital and Patient Data Systems program (HPDS), divides Washington State into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. Highline is one of 21 hospitals located in the King County Region. According to 2009 - 2011[12] charity care data obtained from HPDS, Highline has historically

[12] Charity care data for years 2012 and 2013 is not available as of the writing of this evaluation.

provided more than the average charity care provided in the region.[13] The table below is a comparison of the average charity care for the King County Region, and the historical and projected percentages of charity care for Highline. [source: Amendment Application, Exhibit 2 and HPDS 2009-2011 charity care summaries**]**

Table 9
Charity Care Percentage Comparisons

	% of Total Revenue	% of Adjusted Revenue
King County Region	1.67%	3.05%
Highline Historical	2.06%	4.97%
Highline Projected	2.00%	4.44%

The pro forma revenue and expense statements submitted by FHS for Highline indicate that the hospital will provide charity care above the regional average. Historical charity care data demonstrates that Highline has consistently provided charity care above the regional average.

On April 1, 2013, FHS became the sole member of, and the parent entity to Highline. FHS is fully aware of Washington State charity care requirements. Given that Highline's historical charity care percentages have been more than the regional average, the department concludes a charity care condition is not necessary for this project.

No public comments were submitted for this sub-criterion. Based on the source documents evaluated, the department concludes that all residents, including low income, racial and ethnic minorities, handicapped, and other under-served groups would continue to have access to the services provided by Highline. **This sub-criterion is met.**

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

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

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

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

To evaluate this sub-criterion, the department first reviewed the assumptions used by FHS to determine the projected number of admissions, patient days, and occupancy of Highline. RHRCC is

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

expected to relocate into Highline by the end of year 2014. At that time, Highline must reduce its beds from 154 to 128 and discontinue rehabilitation services through year 2017. Within this application, FHS projects that Highline will resume providing rehabilitation services and its beds will increase by 43 to a total of 171. Year 2020 is the third year following completion of the bed addition project. The assumptions used by FHS are summarized below. [source Amendment Application, Exhibit 1]

- As of September 20, 2013, Highline is licensed for a total of 154 acute care beds.
- Highline must delicense 26 of its total beds to accommodate relocation of RHRCC by the end of year 2014.
- From 2010 through 2013, Highline experienced a 12% growth in medical surgical census. In the first quarter of year 2014, Highline's medical/surgical census was 94 patients, calculating to 68.6% of 137 general medical/surgical beds.
- The reduction in 26 general medical/surgical beds at Highline, would result in 111 general medical/surgical beds. Assuming a year 2013 average census of 88 patients, Highline would be operating at 79.2% occupancy of general medical/surgical bed capacity. This occupancy is 21% higher than the 1987 State Health Plan standard of 65% for a hospital of Highline's size.
- Rehabilitation census growth has not experienced the same high growth as medical/surgical. Highline's 12-bed rehabilitation unit averaged 65% and 69% in years 2012 and 2013, respectively.
- Highline elected to discontinue its level II rehabilitation services and delicense the 12 dedicated beds, resulting in a reduction of 12 dedicated level II rehabilitation beds and 14 general medical/surgical beds.
- For years 2015 through 2017, Highline will be operating with 123 general medical surgical beds and 5 level II intermediate care nursery beds.
- In year 2018, Highline will add 43 new beds to the hospital. The breakdown of the 43 new beds is 12 level II rehabilitation beds and 31 general medical/surgical beds.
- With 43 additional beds, Highline's total acute care beds would be 171. The breakdown will be 154 general medical/surgical; 12 level II rehabilitation; and 5 level II intermediate care nursery.

Using the assumptions stated above, FHS projected the number of admissions and patient days for Highline for years 2015 through 2020. The projections are shown in the table below. [source: Amendment Application, p5]

Table 10
Highline Medical Center
Projected Years 2015 through 2020

Highline without Level II Rehabilitation Services	**CY 2015 Full Year 1**	**CY 2016 Full Year 2**	**CY 2017 Full Year 3**
Number of Licensed Beds	128	128	128
Projected Number of Acute Patient Days	32,984	33,906	38,297
Projected Number of Level II Patient Days	320	323	327
Projected Number of Rehabilitation Patient Days	0	0	3,431
Calculated Occupancy of All Licensed Beds	70.6%	72.6%	61.4%

Highline with Level II Rehabilitation Services	CY 2018 Full Year 1	CY 2019 Full Year 2	CY 2020 Full Year 3
Number of Licensed Beds	171	171	171
Projected Number of Acute Patient Days	39,381	40,507	41,678
Projected Number of Level II Patient Days	330	333	337
Projected Number of Rehabilitation Patient Days	3,517	3,605	3,695
Calculated Occupancy of All Licensed Beds	63.1%	64.9%	66.8%

As show in the tables above, FHS expects to resume providing level II rehabilitation services near the end of year 2017, with full services in year 2018. After reviewing the assumptions and projections above, the department concludes they are reasonable.

FHS also provided its assumptions used to project revenue, expenses, and net income for Highline. Those assumptions are summarized below. [source: Application, p13 and p36; March 10, 2014, supplemental information, Attachment 7; and Amendment application, Exhibit 2]

- All 171 beds will be operational in year 2018.
- Level II rehabilitation services should resume in late year 2017.
- Once RHRCC is located within space at Highline, revenue for ancillary services provided to RHRCC by Highline is included in the 'other operating revenue' line item.
- From year 2018 through 2020, a total of 30.0 additional FTEs will be needed to accommodate the additional patients and patient days.
- Charity care is expected to remain at 2.0% gross revenue and 4.4% adjusted revenue for years 2014 through 2020.
- Bad debt is held constant at 3.6% of gross revenues for years 2014 through 2020.
- Contractual allowances average 60.6% of gross revenue for years 2014 through 2020.
- Percentage of revenue by source is expected to remain the same. 38.0% Medicare; 17.0% Medicaid, and the remaining 45% from other insurance, workers compensation, HMO, etc.
- Purchase services are projected to be consistent with year 2014 at $654 per patient day.
- Professional fees/staff licenses are projected to be consistent with year 2014 at $212 per patient day.
- System Office allocations are included in expenses and are projected to be 1.8% of total operating expenses
- Salaries/wages are based on contracts in place; benefits are constant at 28%, which is the current CHI rate,
- Rents and leases are based on existing agreements.
- Supplies are based on year to date financials, and projected at $782 per patient day.

Using the assumptions stated above, FHS projected revenues and expenses for Highline, which is summarized in the table below. [source: Amendment Application, Exhibit 2]

Table 11
Highline Medical Center
Projected Years 2015 through 2020

	CY 2015 Full Year 1	CY 2016 Full Year 2	CY 2017 Transition Year
Total Acute Beds	128	128	128
Net Revenue	$ 210,519,746	$ 220,693,520	$ 240,158,349
Total Expenses	$ 209,251,399	$ 217,309,728	$ 232,424,522
Net Profit /(Loss)	**$ 1,268,347**	**$ 3,383,792**	**$ 7,733,827**

	CY 2018 Full Year 1	CY 2019 Full Year 3	CY 2020 Full Year 3
Total Acute Beds	171	171	171
Net Revenue	$ 251,049,537	$ 255,688,428	$ 260,466,041
Total Expenses	$ 236,760,373	$ 240,750,436	$ 244,957,401
Net Profit /(Loss)	**$ 14,289,164**	**$ 14,937,992**	**$ 15,508,640**

The 'Net Revenue' line item is gross inpatient and outpatient revenue, plus 'other operating revenue' expected from the relocation of RHRCC into space at Highline. Other operating revenue includes lease revenue and revenue for ancillary services provided to RHRCC by Highline. The 'Net Revenue' line item also includes any deductions for contractual allowances, charity care, and bad debt.

The 'Total Expenses' line item includes salaries and wages, amortization/depreciation, and all allocated costs for FHS and CHI. As shown above, FHS projected net profits in all years shown for Highline, even with a reduction in acute care beds in years 2015 through 2017.

To determine whether Highline would meet its immediate and long range capital costs, the department's Hospital and Patient Data Systems (HPDS) reviewed 2012 historical balance sheets for Highline and 2013 historical balance sheets for CHI. The information is shown in the table below. [source: HPDS analysis, p2]

Table 12
Highline Medical Center
Historical Balance Sheet for Year 2012

Assets		**Liabilities**	
Current Assets	$ 54,345,467	Current Liabilities	$ 38,217,647
Fixed Assets	$ 110,284,245	Long Term Debt	$ 119,389,899
Board Designated Assets	$ 25,344,318	Other Liabilities	$ 16,660,837
Other Assets	$ 31,921,688	**Equity**	**$ 47,627,335**
Total Assets	**$ 221,895,718**	**Total Liabilities and Equity**	**$ 221,895,718**

Catholic Health Initiatives
Historical Balance Sheet for Year 2013

Assets		Liabilities	
Current Assets	$ 3,175,461,000	Current Liabilities	$ 2,940,822,000
Fixed Assets	$ 7,786,240,000	Long Term Debt	$ 6,334,985,000
Board Designated Assets	$ 7,099,006,000	Other Liabilities	$ 1,787,787,000
Other Assets	$ 1,249,012,000	**Equity**	**$ 8,246,125,000**
Total Assets	**$ 19,309,719,000**	**Total Liabilities and Equity**	**$ 19,309,719,000**

After reviewing the balance sheet above, HPDS provided the following statements.

"Franciscan/Highline capital expenditure for the certificate of need is projected to be $53,327,469. Catholic Health Initiatives (CHI,) parent of Franciscan, who is the parent of Highline, will contribute the entire amount from pooled debt reserves. [The]balance sheets of Highline as reported in the application and for CHI in audited reports from the CHI website [show] Highline's Long Term Debt in 2012 is over $119 million, which is over half of the assets of the hospital for that year. This is a significant burden and will take many years of profits to make this debt more reasonable. The CHI/Franciscan has the funds for this project. The debt from this project will not be assigned to Highline."

To assist the department in its evaluation of this sub-criterion, HPDS also provided a financial ratio analysis. The analysis assesses the financial position of an applicant, both historically and prospectively. The financial ratios typically analyzed are **1)** long-term debt to equity; **2)** current assets to current liabilities; **3)** assets financed by liabilities; **4)** total operating expense to total operating revenue; and **5)** debt service coverage. If a project's ratios are within the expected value range, the project can be expected to be financially feasible. Additionally, HPDS reviews a project's projected statement of operations to evaluate the applicant's immediate ability to finance the service and long term ability to sustain the service.

For Certificate of Need applications, HPDS compares the projected ratios with the most recent year financial ratio guidelines for hospital operations. For this project, HPDS used 2012 data for comparison with historical year 2012 for Highline. Year 2012 data was also used as comparison for projected years 2014 through 2018 for Highline. The ratio comparisons are shown in the table below. [source: HPDS analysis, pp3]

Table 13
Highline Medical Center
Current and Projected HPDS Debt Ratios

Category	Trend *	State 2012	Highline 2012	Highline 2014	Highline 2015	Highline 2016
Long Term Debt to Equity	B	0.586	2.507	1.986	2.020	1.861
Current Assets/Current Liabilities	A	1.797	1.422	1.402	4.425	1.313
Assets Funded by Liabilities	B	0.468	0.710	0.669	0.675	0.665
Operating Expense/Operating Revenue	B	0.945	1.066	0.986	0.994	0.985
Debt Service Coverage	A	5.362	0.820	3.792	2.862	3.009

Category	Trend *	State 2012	Highline 2017	Highline 2018	Highline 2019	Highline 2020
Long Term Debt to Equity	B	0.586	1.609	1.157	0.957	0.805
Current Assets/Current Liabilities	A	1.797	1.295	1.365	1.872	2.370
Assets Funded by Liabilities	B	0.468	0.643	0.588	0.551	0.517
Operating Expense/Operating Revenue	B	0.945	0.968	0.943	0.942	0.940
Debt Service Coverage	A	5.362	3.446	4.060	4.204	4.347

Definitions:	Formula
Long Term Debt to Equity	Long Term Debt/Equity
Current Assets/Current Liabilities	Current Assets/Current Liabilities
Assets Funded by Liabilities	Current Liabilities + Long term Debt/Assets
Operating Expense/Operating Revenue	Operating expenses / operating revenue
Debt Service Coverage	Net Profit+Depr and Interest Exp/Current Mat. LTD and Interest Exp

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

Comparing Highline's year 2012 ratios with the most current statewide ratios reveal that all ratios are out of range. HPDS attributed this to Highline's long term debt of more than $119 million in year 2012 and the extended time needed to reduce the debt. [source: HPDS analysis, p2]

HPDS also focuses on Highline's projected ratios for years 2014 through 2020. HPDS provided the following analysis. [source: HPDS analysis, p3]

> *"Review shows that this project will have a significant impact however this project will not adversely impact the financial health of the hospital if the patient volume is realized. For the year 2020 or CN year 7, the hospital itself is out of range on several ratios. Long Term Debt to Equity, Assets Funded by Liability and Debt Service Coverage are improving during the seven years but still out of range in 2020. While the hospital is not adding long term debt, the debt [it] has is slowly being paid off. This affects all three ratios. As the hospital is breaking even by the end of the first year, the out of range ratios are acceptable."*

No public comments were submitted for this sub-criterion. Based on the source documents evaluated, the department concludes that the immediate and long-range operating costs of the project can be met. **This sub-criterion is met.**

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

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

As stated in the project description section of this evaluation, once the additional 43 beds are operational at Highline, FHS intends to continue to provide medical/surgical, rehabilitation, and level II intermediate care nursery services. As indicated in the pro forma projections and further

demonstrated within the application, FHS does not intend to increase charges for health services or change the payer mix to make a net profit at Highline. [source: Application, p13 and p36]

No public comments were submitted for this sub-criterion. Based on the source documents evaluated, the department concludes that the cost of the project will not result in an unreasonable impact on the costs and charges for health services within the service area. **This sub-criterion is met.**

(3) The project can be appropriately financed.

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

The total capital expenditure for the project is $53,327,469, which includes completion of floors 8 and 9 and shelling in space on floor 10 of the Birch Tower. The majority of the costs, approximately 66%, is related to building construction and fixed equipment. The remaining costs are for moveable equipment, fees, supervision/inspections, permits, and sales tax. [source: Application, p31]

The project will be funded from bond financing accessed through FHS's parent company, Catholic Health Initiatives (CHI). To demonstrate a financial commitment to the project, FHS provided the following two documents:

- a non-binding cost estimate for the construction costs of the project; and
- a letter from FHS's Chief Financial Officer acknowledging financial commitment.

FHS determined this was the preferred financing option because the interest rate under CHI is much lower than the type of financing that Highline could obtain as a stand-alone hospital. If Highline were using HUD financing, the interest rate would be about 6%, compared to the 4% interest rate under the CHI bonds. [source: Application, pp32-33; Exhibit 9; and March 10, 2014, supplemental information, Attachment 1]

Further, HPDS staff reviewed the historical and projected financial data for CHI and concluded that the short- and long-range costs of the project could be met with approval of this project. Even with the more than $119 million in long-term debt attributed to Highline, HPDS concluded that CHI continues to be in strong financial health.

No public comments were submitted for this sub-criterion. Based on the source documents evaluated, the department concludes **this sub-criterion is met**.

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

Based on the source information reviewed and the applicant's agreement to the conditions identified in the conclusion section of this evaluation, the department concludes that Franciscan Health System 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 FTEs that should be employed for projects of this type or size. Therefore, using its experience and expertise the department concludes that the planning would allow for the required coverage.

As stated throughout this evaluation, to accommodate RHRCC by the end of year 2014, Highline must reduce its licensed beds by 26 for approximately three years—the end of year 2017. The reduction in acute care beds and services equates to a reduction in admissions, patient days, and staff. Once the 43 beds are added in year 2018, Highline expects increases in admissions and patient days, resulting in increases in staff through year 2020. FHS provided current and projected FTEs [full time equivalents] for Highline for years 2014 through 2020. The table below shows the breakdown of FTEs. [source: June 16, 2014, supplemental information, p2]

Table 14
Highline Medical Center
Current Year 2014 through Projected Year 2020

FTE by Type	CY 2014 Current	CY 2015 Full Year 1	CY 2016 Increase	CY 2017 Increase	4-Year Total
Management	66.0	2.0	3.0	2.0	73.0
Nursing	259.0	4.0	12.0	10.0	285.0
Technical/Professional	317.0	10.0	15.0	8.0	350.0
Support Staff	234.0	4.0	11.0	10.0	259.0
Contracted Staff	5.0	0.0	0.0	1.0	6.0
Other	10.0	0.0	0.0	0.0	11.0
Total FTEs	**891.0**	**21.0**	**41.0**	**31.0**	**984.0**

FTE by Type	CY 2018 Increase	CY 2019 Increase	CY 2020 Increase	7-Year Total
Management	1.0	1.0	1.0	76.0
Nursing	5.0	4.0	5.0	299.0
Technical/Professional	5.0	5.0	6.0	366.0
Support Staff	4.0	4.0	4.0	271.0
Contracted Staff	0.0	0.0	0.0	6.0
Other	1.0	0.0	0.0	12.0
Total FTEs	**16.0**	**14.0**	**16.0**	**1,030.0**

As shown in the table above, the majority of key staff is already in place and FHS projects most of the increases to occur in the areas of nursing and technical/professional staff. Information provided in the application, but not shown in Table 14 above is the decrease in overall staff from historical year 2013 to current year 2014. In anticipation of reducing its licensed beds by 26, Highline reduced its overall FTEs by 66—from 957 to 891. The reduction in FTEs occurred in the areas of nursing and technical/professional. In year 2016, FHS expects FTEs at Highline to be near the year 2013 staffing level. In anticipation of increased patient days beginning in year 2018 with 43 additional beds, the

table shows an increase in FTEs through year 2020. This information is consistent with the assumptions identified for the financial projections. [source: June 16, 2014, supplemental information, p2]

Included in the table above is the following key staff employed by Highline: directors for critical care services, patient care services, emergency department, and surgical services; the medical director and the vice president of patient care services. [source: March 10, 2014, supplemental information, pp4-5]

FHS does not expect any difficulty recruiting the FTEs projected to be needed through year 2020. Highline has been at its current location in Burien for many years and has been a longstanding employer of healthcare workers. FHS is also a long-standing healthcare system located in Pierce County and providing services through a variety of healthcare facilities in both Pierce and King counties. FHS is also one of the larger employers of healthcare workers. FHS offers competitive salaries comparable wages to its employees. [source: Application, p38-39]

No public comments were submitted for this sub-criterion. Based on the source documents evaluated, the department concludes that FHS provided documentation to demonstrate that it would recruit and retain the necessary staff to provide the services at the hospital. **This sub-criterion is met**.

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

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

FHS states that all existing relationships will continue and, if necessary, may expand. To comply with this sub-criterion, FHS provided a listing of the current ancillary and support relationships in place for Highline. The listing includes healthcare providers, such as home health agencies, skilled nursing facilities, dialysis facilities, home infusion agencies, and medical equipment suppliers. [source: March 10, 2014, supplemental information, p5]

Documentation provided in the application demonstrates that FHS intends to continue working with existing providers to the betterment of the community. FHS does not intend to change the existing service area, community support partnerships, or ancillary relationships as a result of the bed addition, but may consider additional relationships as opportunities arise.

No public comments were submitted for this sub-criterion. Based on the source documents evaluated, the department concludes that there is reasonable assurance that FHS will continue to maintain the necessary relationships with ancillary and support services to provide healthcare in the communities. Approval of this project would not negatively affect these relationships. **This sub-criterion is met.**

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

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

FHS is a provider of a variety of health care services in Washington State. Currently FHS owns or operates healthcare facilities in Pierce and King counties, including both RHRCC and Highline. During review of this application, the department conducted a review of the quality of care history for Highline and healthcare facilities either owned or operated by FHS. This updated review revealed no substantial non-compliance issues for either Highline or FHS facilities.[14] [source: DOH Office of Investigations and Inspections]

FHS also provided the names and professional license numbers for key staff currently employed by Highline. Key staff includes directors for critical care services, patient care services, emergency department, and surgical services; the medical director and the vice president of patient care services. The department's compliance history for key staff shows no recorded sanctions. [source: Medical Quality Assurance Commission]

No public comments were submitted for this sub-criterion. Based on the compliance history of Highline and FHS owned and/or operated healthcare facilities, there is reasonable assurance that FHS would continue to operate Highline in conformance with applicable state and federal licensing and certification requirements. **This sub-criterion is met.**

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

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

FHS states that Highline currently promotes continuity in the provision of healthcare services under its current practices. Highline's policies direct that all patient care requirements be assessed on a daily basis and orders written, as appropriate, to increase or decrease level of care for each patient. Additionally, Highline's admission and discharge planning process assures that care is provided to patients in the least intensive and restrictive level possible. Discharge planning begins with admission, and Highline works closely with patients, families and all post-acute service providers in

[14] Compliance surveys were conducted for Highline in November 2010 and December 2011. Compliance surveys for FHS facilities include in-home services in April 2014. For specific FHS affiliated hospitals, St. Anthony Hospital was surveyed in October 2012 and April 2014. St. Clare Hospital was surveyed in April 2010, June 2011, and January 2013. Enumclaw Regional Hospital was surveyed in February 2010 and January 2014. RHRCC was surveyed in February 2010, January 2012, and December 2012. St. Joseph Medical Center was surveyed in August 2011 and May 2014.

the area to ensure efficient and quality discharge for each patient. Highline also works closely with existing healthcare providers in the community to achieve this continuity. [source: Application, pp40-41]

In order to accommodate RHRCC and 26 of its 40 beds, FHS elected to reduce Highline's acute care license by 26 for approximately three years—12 beds within the level II rehabilitation unit and 14 general medical/surgical beds. [source: Amendment application, p3] This reduction means that for years 2014 through 2017, Highline would be operating 123 medical/surgical beds and no rehabilitation beds.

To demonstrate compliance with this sub-criterion, FHS evaluated its options and determined that the short-term impact of closing the rehabilitation unit would be mitigated by the available general medical/surgical bed capacity in King County. For years 2010 through 2013, Highline's medical /surgical inpatient census grew by 12%. If Highline's medical/surgical bed capacity was 111, rather than 123, Highline's average occupancy would be almost 80%, which is well above the standard of 65% for a hospital of its size. FHS states that continuity in the provision of health care will also be accomplished with the additional 43 beds at Highline because the additional capacity will allow the Highline to operate at a consistently lower occupancy. [source: Amendment Application, p3-7]

No public comments were submitted for this sub-criterion. Based on the source documents evaluated, the department concludes that Highline will continue to promote continuity in the provision of health care services in the community with additional bed capacity. The department also concludes that the reduction in acute care beds and services at Highline will not result in an unwarranted fragmentation of services for the populations served by Highline. **This sub-criterion is met.**

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

D. Cost Containment (WAC 246-310-240)
Based on the source information reviewed and the applicant's agreement to the conditions identified in the conclusion section of this evaluation, the department concludes that Franciscan Health System has met the cost containment criteria in WAC 246-310-240.

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

If the project has met the applicable criteria in WAC 246-310-210 through 230 criteria, the department then assesses the other options considered by the applicant. If the department determines the proposed project is better or equal to other options considered by the applicant and the department has not

identified any other better options this criterion is determined to be met unless there are multiple applications.

If there are multiple applications, the department's assessment is to apply any service or facility superiority criteria contained throughout WAC 246-310 related to the specific project type. The 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.

This application is not competing with any other applications. For this project, FHS met the applicable review criteria under WAC 246-310-210, 220, and 230.

Before submitting this application, FHS states it considered only the option of status quo or 'do nothing.' The option was rejected because Highline must reduce its licensed bed capacity from 154 to 128 to accommodate the relocation of RHRCC into space at the hospital. For this reason, FHS considered relocating RHRCC somewhere other than Highline. FHS contends that LTACHs are most effective when located within close proximity of an acute care hospital. Highline is the only acute care hospital located in southwest King County planning area and both Highline and RHRCC have been located in the southwest King County planning area for many years. Since 79% of RHRCC's patients are from either southwest King County or adjacent Pierce County, relocating the LTACH outside the planning area did not seem practical. Once FHS committed to allowing relocation of RHRCC into space at Highline, the only option for Highline is to reduce its licensed bed capacity.

Department's Review of Alternatives

Once Highline's acute care bed capacity is reduced, the only option for increasing the beds is submission of a Certificate of Need application. Initially, FHS intended to reduce the general medical surgical beds by 26 and continue providing level II rehabilitation services at Highline. However, after submission of this application, FHS determined residents of the planning area would be better served if FHS reduced only 14 general medical surgical beds and discontinued providing level II rehabilitation services in the 12 beds. Within its amendment application, FHS provided information to demonstrate that the temporary reduction in level II services was ultimately the better option for the residents of the community.

This application proposes to add general medical surgical bed capacity to the southwest King planning area. Need for the beds was demonstrated using 2004 through 2013 CHARS data and the numeric methodology. The application also proposes Highline would resume providing level II rehabilitation services at the hospital near the end of year 2017 and continue to provide the services. FHS demonstrated that the 12 level II rehabilitation beds currently in use at Highline are needed for the planning area. The numeric methodology demonstrated that the 12 beds would also be needed through at least year 2020.

No public comments were submitted for this sub-criterion. Based on the source documents evaluated, the department concludes this project is the best available alternative for the residents King County and surrounding communities. **This sub-criterion is met**.

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

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

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

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

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

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

This project has the potential to improve delivery of both acute care and level II rehabilitation services to the residents of southwest King County and surrounding communities. The department is satisfied the project is appropriate and needed. **This sub-criterion is met**.

APPENDIX 1

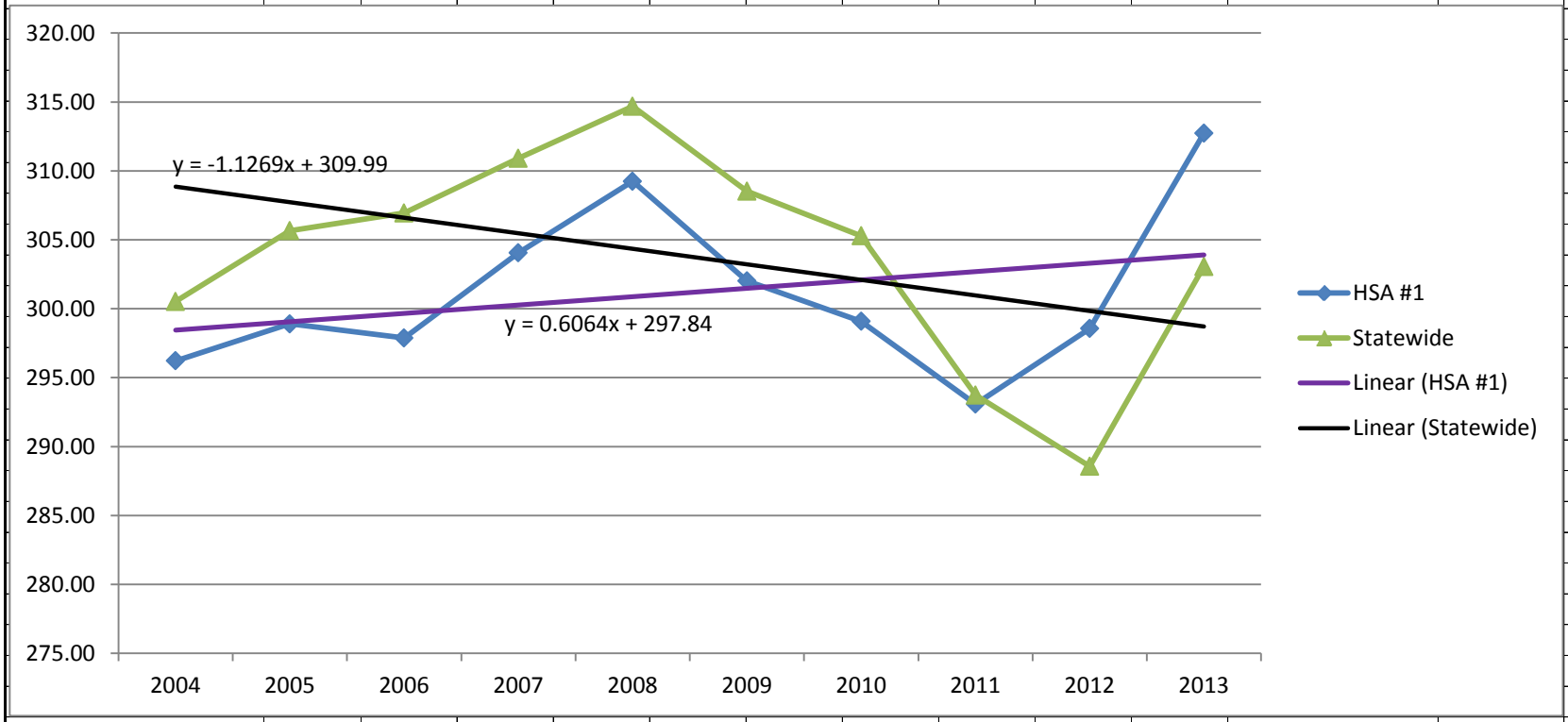
2004-2013 HSA TOTAL NUMBER OF RESIDENT PATIENT DAYS											
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**10-YEAR TOTAL**
HSA #1	1,194,260	1,223,414	1,235,319	1,282,804	1,328,827	1,321,575	1,313,342	1,295,164	1,346,550	1,415,214	**12,956,469**
SWKing	74,685	75,183	77,182	83,749	82,817	78,920	77,452	81,101	77,936	82,120	**791,145**
STATEWIDE TOTAL	**1,906,739**	**1,969,331**	**2,007,868**	**2,068,766**	**2,135,745**	**2,130,225**	**2,118,577**	**2,058,360**	**2,045,526**	**2,159,060**	**20,600,197**
2004-2013 CHARS wo all MDC19 and MDC15.xlsx											
HSA 1	42578	45672	42292	45029	49575	51880	49906	50383	63762	63186	
SWKing	223	545	412	419	429	481	480	490	415	0	
STATEWIDE	52291	56162	53850	56005	64577	65715	64090	63685	63913	63415	
Total Pt. Days											
HSA #1	1,151,682	1,177,742	1,193,027	1,237,775	1,279,252	1,269,695	1,263,436	1,244,781	1,282,788	1,352,028	
SWKing	74,462	74,638	76,770	83,330	82,388	78,439	76,972	80,611	77,521	82,120	
STATEWIDE TOTAL	1,854,448	1,913,169	1,954,018	2,012,761	2,071,168	2,064,510	2,054,487	1,994,675	1,981,613	2,095,645	

2004-2013 HSA TOTAL NUMBER OF RESIDENT PATIENT DAYS											
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**10-YEAR TOTAL**
HSA #1	1,151,682	1,177,742	1,193,027	1,237,775	1,279,252	1,269,695	1,263,436	1,244,781	1,282,788	1,352,028	**12,452,206**
SWKing	74,462	74,638	76,770	83,330	82,388	78,439	76,972	80,611	77,521	82,120	**787,251**
STATEWIDE TOTAL	1,854,448	1,913,169	1,954,018	2,012,761	2,071,168	2,064,510	2,054,487	1,994,675	1,981,613	2,095,645	**19,996,494**
2004-2013 HSA TOTAL NUMBER OF PSYCHIATRIC PATIENT DAYS											
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**10-YEAR TOTAL**
HSA #1	717	662	616	805	1067	1713	1404	1758	2911	2807	**14,460**
SWKing	115	89	107	21	39	62	66	62	121	0	**682**
STATEWIDE TOTAL	**898**	**799**	**716**	**954**	**1,152**	**2,006**	**1,527**	**1,939**	**3,189**	**3,509**	**16,689**
2004-2013 HSA TOTAL NUMBER OF PATIENT DAYS MINUS PSYCH DAYS											
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**10-YEAR TOTAL**
HSA #1	1,150,965	1,177,080	1,192,411	1,236,970	1,278,185	1,267,982	1,262,032	1,243,023	1,279,877	1,349,221	**11,286,781**
SWKing	74,347	74,549	76,663	83,309	82,349	78,377	76,906	80,549	77,400	82,120	**786,569**
STATEWIDE TOTAL	**1,853,550**	**1,912,370**	**1,953,302**	**2,011,807**	**2,070,016**	**2,062,504**	**2,052,960**	**1,992,736**	**1,978,424**	**2,092,136**	**19,979,805**

2004-2013 HSA TOTAL NUMBER OF RESIDENT PATIENT DAYS MINUS PSYCH DAYS												
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**10-YEAR TOTAL**	
HSA #1	1,150,965	1,177,080	1,192,411	1,236,970	1,278,185	1,267,982	1,262,032	1,243,023	1,279,877	1,349,221	**12,437,746**	
SWKing	74,347	74,549	74,549	83,309	82,349	78,377	76,906	80,549	77,400	82,120	**784,455**	
STATEWIDE TOTAL	**1,853,550**	**1,912,370**	**1,953,302**	**2,011,807**	**2,070,016**	**2,062,504**	**2,052,960**	**1,992,736**	**1,978,424**	**2,092,136**	**19,979,805**	
TOTAL POPULATIONS												
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**10-YEAR TOTAL**	
HSA #1	3,885,500	3,938,000	4,003,059	4,068,118	4,133,178	4,198,237	4,219,632	4,241,101	4,286,855	4,314,372	**41,288,052**	
SWKing	211,500	212,653	213,806	214,958	216,111	217,264	218,416	219,569	220,721	221,874	**2,166,872**	
STATEWIDE TOTAL	**6,167,800**	**6,256,400**	**6,363,584**	**6,470,767**	**6,577,951**	**6,685,134**	**6,724,540**	**6,784,072**	**6,856,239**	**6,903,272**	**65,789,759**	
USE RATE PER 1,000												
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**10-YEAR TOTAL**	
HSA #1	296.22	298.90	297.87	304.06	309.25	302.03	299.09	293.09	298.56	312.73	**3,012**	
SWKing	351.52	350.57	348.68	387.56	381.05	360.75	352.11	366.85	350.67	370.12	**3,620**	
STATEWIDE	**300.52**	**305.67**	**306.95**	**310.91**	**314.69**	**308.52**	**305.29**	**293.74**	**288.56**	**303.06**	**3,038**	

Southwest King Acute Care Bed Need
Appendix 4

RESIDENT USE RATE PER 1,000													
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**10-YEAR TOTAL**		**Trendline**
HSA #1	296.22	298.90	297.87	304.06	309.25	302.03	299.09	293.09	298.56	312.73	**3,011.80**		0.6064
SWKing											**0.00**		
STATEWIDE	**300.52**	**305.67**	**306.95**	**310.91**	**314.69**	**308.52**	**305.29**	**293.74**	**288.56**	**303.06**	**3,037.91**		**1.1269**



STEP #5													
2013 DATA													
	# of Pat days	Less OOS	TOTAL LESS OOS										
SWKing Hospitals													
0-64	23,323	507	**22,816**	2.17%									
65+	16,575	325	**16,250**	1.96%									
TOTAL	**39,898**	**832**	**39,066**	2.09%									
WA - SWKing													
0-64	1,109,585	52,279	**1,057,306**	4.71%									
65+	843,253	33,994	**809,259**	4.03%									
TOTAL	**1,952,838**	**86,273**	**1,866,565**	4.42%									
	TO SWKing	**TO WA**				**TOTAL # OF DAYS FOR RESIDENTS BY HSA**	**ADD DAYS PROVIDED IN**	**TOTAL # OF DAYS FOR RESIDENTS BY HSA**					
						(LESS PATS FROM OOS)	**OREGON ****						
FROM SWKing													
0-64	12,333	23,989	check w CHARS			36,322	108	36,430					
65+	13,333	19,218				32,551	83	32,634					
TOTAL	**25,666**	**43,207**				**68,873**	**191**	**69,064**					
FROM WA													
0-64	10,483	1,033,317				1,043,800	39,964	1,083,764					
65+	2,917	790,041				792,958	19,864	812,822					
TOTAL	**13,400**	**1,823,358**				**1,836,758**	**59,828**	**1,896,586**					
	39,066	**1,866,565**					** Patient Days as reported by 2008 HCUP data for Oregon CHARS						
MARKET SHARE													
PERCENTAGE OF PATIENT DAYS													
	TO SWKing	**TO WA**		**TO OREGON**									
% OF SWKing RESIDENTS													
0-64	33.85%	65.85%		0.30%									
65+	40.86%	58.89%		0.25%									
TOTAL													
% OF WA - SWKing RESIDENTS													
0-64	0.97%	95.35%		3.69%									
65+	0.36%	97.20%		2.44%									
TOTAL													
2013 POPULATIONS BY PLANNING AREA													
		WA-SWKING											
	SWKing	**TO WA**											
0-64	192,275	5,978,591											
65+	29,599	924,545											
TOTAL	**221,874**	**6,903,136**											
STEP #6													
USE RATE BY PLANNING AREA													
	SWKing	**TO WA**											
USE RATES													
0-64	189.47	181.27											
65+	1,102.54	879.16											

USE RATE BY PLANNING AREA FROM STEP 6							
	SWKing						
YEAR 2013 USE RATES							
0-64	189.47						
65+	1,102.54						
PROJECTED POPULATION	YEAR 2020						
	SWKing						
0-64	198,558						
65+	38,815						
TOTALS	**237,373**						
PROJECTED 2020 USE RATE							
	SWKing						
USE RATES*							
0-64 using HSA Trend	**193.71**						
0-64 using Statewide Trend	197.36						
65+ using HSA Trend	**1,106.78**						
65+ using Statewide Trend	1,110.43						
* Projected by applying either HSA trend or Statewide trend, whichever trend would result in the smaller adjustment							
Bold Print indicates use rate closest to current value							

USE RATE BY HSA FROM STEP 7A	
PROJECTED USE RATE - 2020	**SWKing**
USE RATES	
0-64	193.71
65+	**1,106.78**
PROJECTED POPULATION - 2020	
	SWKing
0-64	198,558
65+	38,815
TOTALS	**237,373**
PROJECTED # OF PATIENT DAYS	YEAR 2020
	SWKing
0-64	38,463
65+	42,960
TOTALS	**81,423**

PROJECTED # OF PATIENT DAYS					
YEAR 2020	**SWKing**	**WA - SWKing**		**TOTAL**	
0-64	38,463	1,251,304		1,289,767	
65+	42,960	1,134,961		1,177,921	
TOTALS	**81,423**	**2,386,265**		**2,467,688**	
MARKET SHARE % OF PATIENT DAYS FROM STEP 5					
% OF SWKing RESIDENTS	**SWKing**	**WA - SWKing**		**TO OREGON**	
0-64	33.85%	65.85%		0.30%	
65+	40.86%	58.89%		0.25%	
% OF WA - SWKing RESIDENTS	**SWKing**	**WA - SWKing**		**TO OREGON**	
0-64	0.97%	95.35%		3.69%	
65+	0.36%	97.20%		2.44%	
# OF SWKing RESIDENTS	**SWKing**	**WA - SWKing**		**TO OREGON**	**Total**
0-64	13,021	25,328		114	38,463
65+	17,552	25,299		109	42,960
					81,423
# OF WA - SWKing RESIDENTS	**SWKing**	**WA - SWKing**		**TO OREGON**	**Total**
0-64	12,104	1,193,058		46,142	1,251,304
65+	4,073	1,103,152		27,737	1,134,961
					2,386,265
# OF RESIDENT PAT DAYS PROJECTED IN SWKing					
0-64	25,125				
65+	21,625				
# OF RESIDENT PAT DAYS PROJECTED IN WA - SWKing					
0-64	1,218,386				
65+	1,128,450				
# OF WA RESIDENT PAT DAYS PROJECTED IN OREGON					
0-64	46,256				
65+	27,846				
OUT OF STATE % OF PATIENT DAYS FROM STEP 5					
SWKing	%				
0-64	2.22%				
65+	2.00%				
WA - SWKinging					
0-64	4.94%				
65+	4.20%				
PROJECTED # OF PATIENT DAYS 2020					
PLUS OUT OF STATE RESIDENTS					
SWKing					
0-64	25,683	0.667733751			
65+	22,057	0.51344043			
TOTAL	**47,740**				

Southwest King Acute Care Bed Need
Appendix 10a

	2012	2013	2014	2015	2016	2017	2018	2019	2020
SWKing Planning Area									
Population 0-64(1)	191,365	192,275	193,173	194,070	194,968	195,865	196,763	197,661	198,558
0-64 Use Rate	189.47	190.07	190.68	191.29	191.89	192.50	193.11	193.71	194.32
Population 65+(1)	29,356	29,599	30,916	32,232	33,549	34,865	36,182	37,499	38,815
65+ Use Rate	1,102.54	1103.14	1103.14	1103.75	1104.36	1104.96	1105.57	1106.18	1106.78
Total Population	220,721	221,874	224,088	226,302	228,517	230,731	232,945	235,159	237,373
Total SWKing Res Days	68,624	69,199	70,939	72,699	74,463	76,229	77,998	79,769	81,544
Total Days in SWKing Hospitals (2)	40,828	41,168	42,106	43,055	44,005	44,957	45,910	46,865	47,821
Available Beds (3)									
Highline	137	137	137	123	123	123	123	123	123
Total	**137**	**137**	**137**	**123**	**123**	**123**	**123**	**123**	**123**
Wtd Occ Std(5)	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%
	172	**174**	**177**	**181**	**185**	**189**	**194**	**198**	**202**
Net Bed Need/(Surplus)	**35**	**37**	**40**	**58**	**62**	**66**	**71**	**75**	**79**
									7 yr
(1) Source: Claritas 2013									
(2) Adjusted to reflect referral patterns into and out of SWKing Planning Area to other planning areas and Oregon									
(3) Source: Fall 2013 Hospital Survey returns									

Southwest King Acute Care Bed Need
Appendix 10b

	2012	2013	2014	2015	2016	2017	2018	2019	2020
SWKing Planning Area									
Population 0-64(1)	191,365	192,275	193,173	194,070	194,968	195,865	196,763	197,661	198,558
0-64 Use Rate	189.47	190.07	190.68	191.29	191.89	192.50	193.11	193.71	194.32
Population 65+(1)	29,356	29,599	30,916	32,232	33,549	34,865	36,182	37,499	38,815
65+ Use Rate	1,102.54	1103.14	1103.14	1103.75	1104.36	1104.96	1105.57	1106.18	1106.78
Total Population	220,721	221,874	224,088	226,302	228,517	230,731	232,945	235,159	237,373
Total SWKing Res Days	68,624	69,199	70,939	72,699	74,463	76,229	77,998	79,769	81,544
Total Days in SWKing Hospitals (2)	40,828	41,168	42,106	43,055	44,005	44,957	45,910	46,865	47,821
Available Beds (3)									
Highline	137	137	137	154	154	154	154	154	154
Total	**137**	**137**	**137**	**154**	**154**	**154**	**154**	**154**	**154**
Wtd Occ Std(4)	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%
	172	**174**	**177**	**181**	**185**	**189**	**194**	**198**	**202**
Net Bed Need/(Surplus)	**35**	**37**	**40**	**27**	**31**	**35**	**40**	**44**	**48**
									7 yr

(1) Source: Claritas 2013
(2) Adjusted to reflect referral patterns into and out of SWKing Planning Area to other planning areas and Oregon
(3) Source: Fall 2013 Hospital Survey returns
(4) Calculated per 1987 Washington State Health Plan as the sum , across all hospitals in the planning area,