STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

April 3, 2017

CERTIFIED MAIL # 7016 0910 0000 3454 9245

Sanford Melzer, MD MBA
Executive Vice President, Networks and Population Health
Seattle Children's Hospital
4800 Sand Point Way NE
PO Box 5371
Seattle, Washington 98105-0371

RE: Certificate of Need Application #16-29

Dear Dr. Melzer:

We have completed review of the Certificate of Need application submitted by Seattle Children's Hospital proposing to add 40 acute care beds to Seattle Children's Hospital in Seattle within King County. Enclosed is a written evaluation of the application.

For the reasons stated in this evaluation, the application submitted by Seattle Children's proposing to add 40 acute care beds of which 27 would be general acute care and 13 would be dedicated to NICU Level IV care is not consistent with applicable criteria. However, the addition of 23 general acute care beds and 13 NICU beds is consistent with the applicable criteria provided Seattle Children's agrees with the following project description and conditions in its entirety.

Project Description:

This certificate approves 23 new general acute care beds and 13 NICU Level IV NICU beds. At project completion, Seattle Children's Hospital is approved to license and operate a total of 407 total licensed beds with the following distribution.

Seattle Children's Hospital

	Number of Beds
Acute Care	318
Level IV NICU	32
Psychiatric	41
Rehabilitation	16
Total Licensed Beds	**407**

Conditions:

1. Approval of the project description as stated above. Seattle Children's Hospital further agrees that any change to the project as described in the project description is a new project that requires a new Certificate of Need.
2. Prior to providing services in the 29 non-operational beds, Seattle Children's will provide a copy of its revised Charity Care policy. The revised Charity Care policy must not be any more restrictive than the Charity Care policy submitted as part of this application.
3. Seattle Children's must provide least 1.50% of total revenue in charity care in future years as stated in the application.

Approved Costs:

The estimated capital expenditure for this project $19,564,561.

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,

Steve Bowman, Director
Office of Community Health Systems

Enclosure

EVALUATION DATED APRIL 3, 2017, OF THE CERTIFICATE OF NEED APPLICATION SUBMITTED BY SEATTLE CHILDREN'S HOSPITAL PROPOSING TO ADD FORTY ACUTE CARE BEDS TO SEATTLE CHILDREN'S HOSPITAL IN KING COUNTY

APPLICANT DESCRIPTION

Seattle Children's Hospital (Seattle Children's) is a not for profit organization exempt from federal taxation under IRC Section 501(c) (3). Seattle Children's is controlled by the parent corporation Seattle Children's Healthcare Systems. Seattle Children's does not operate any other separately licensed health care facilities. [Source: Application, pg. 2] Seattle Children's is licensed by Washington State as an acute care hospital and is accredited by DNV GL Healthcare.

PROJECT DESCRIPTION

Seattle Children's is proposing to add 40 acute care beds to its existing acute bed supply at its King County Hospital. In 2015 Seattle Children's reassigned seven of its acute care beds to their Neonatal Intensive Care Unit (NICU). Consequently, they currently operate 288 acute care beds for medical/surgical patients and 26 NICU beds. This project is proposed to be undertaken in two phases.

- Phase 1 will add 20 acute care beds in October 2016. Thirteen of these beds will be located on a medical/surgical unit and seven beds, while acute care beds, will be co-located within and operated as Level IV NICU beds. Formally increasing the number of Level IV NICU beds from 19 to 26 will allow Seattle Children's to return the seven previously reassigned beds to the medical/surgical units. At the completion of phase 1 Seattle Children's will have 391 licensed beds, of which 26 beds will be Level IV NICU and 308 beds will be used for acute medical/surgical patients. The 391 beds include their existing 41 psychiatric and 16 acute rehabilitation beds.

- Phase 2 will add another 20 acute care beds in October 2019. Fourteen of these beds will be located on a medical/surgical unit and the remaining six, while acute care beds, will be co-located within and operated and operated as Level IV NICU beds. At the completion of phase 2, Seattle Children's will have 411 licensed beds, of which 32 beds will be Level IV NICU beds and 322 beds will be used for acute medical/surgical patients. [Source: Application, pg. 10]

Unit	Current Beds	Phase 1 (completed 2016)	Phase 2 (completed 2019	Total Beds at Project Completion
Acute Care	288	Add 20	Add 14	322
Level IV NICU	26	0	Add 6	32
Psychiatric	41	0	0	41
Rehabilitation	16	0	0	16
Total	**371**	**Add 20**	**Add 20**	**411**

The capital expenditure associated with this project is $19,564,561. Of that amount 72.2% is related to construction costs and fixed equipment; 17.2% for moveable equipment; and the remaining 10.6% is related to fees, permits, and state taxes. [Source: Application, pg. 31]

Children's anticipates phase 1 will become operational in October 2016. Under this timeline, year 2017 is full year one and year 2019 is full year three[1] for phase 1. Phase 2 will add another 20 beds in 2019. [Source: Application, pg. 45]

APPLICABILITY OF CERTIFICATE OF NEED LAW

Seattle Children's application is subject to review as a change in the bed capacity of a health care facility which increases the total number of licensed beds under Revised Code of Washington (RCW) 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 WAC 246-310 does not contain service or facility standards in sufficient detail to make the required determinations, WAC 246-310-200(2)(b) identifies the types of standards the department may consider in making its required determinations. Specifically WAC 246-310-200(2)(b) states:

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

(i) Nationally recognized standards from professional organizations;

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

(iii) Federal Medicare and Medicaid certification requirements;

(iv) State licensing requirements;

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

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

To obtain Certificate of Need approval, the applicant must demonstrate compliance with the criteria found in WAC 246-310-210 (need) including applicable portions of the 1987 Washington State Health Plan; 246-310-220 (financial feasibility); 246-310-230 (structure and process of care); and 246-310-240 (cost containment).

[1] This timeline assumes the project, if approved, is not delayed by 3rd party challenges.

TYPE OF REVIEW

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

APPLICATION CHRONOLOGY

Action	Seattle Children's
Letter of Intent Submitted	January 15, 2016
Application Submitted	April 15, 2016
Department's Pre-review Activities	
• Department's 1st Screening Letter	May 6, 2016
• Applicant's Responses Received to 1st Screening Letter	June 20, 2016
• Department's 2nd Screening Letter	June 29, 2016
• Applicant's Responses Received to 2nd Screening Letter	July 7, 2016
Beginning of Review	June 27, 2016[2]
End of Public Comment	
• Public comments accepted through the end of Public comment period	August 1, 2016
• Public hearing conducted	N/A
Rebuttal Comments Received	August 16, 2016
Department's Anticipated Decision Date	September 30, 2016
Department's Actual Decision Date	April 3, 2017

AFFECTED PERSONS

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

"...an "interested person" who:

(a) Is located or resides in the applicant's health service area;

(b) Testified at a public hearing or submitted written evidence; and

(c) Requested in writing to be informed of the department's decision."

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

(a) The applicant;

(b) Health care facilities and health maintenance organizations providing services similar to the services under review and located in the health service area;

(c) Third-party payers reimbursing health care facilities in the health service area;

(d) Any agency establishing rates for health care facilities and health maintenance organizations in the health service area where the proposed project is to be located;

[2] In its June 20, 2016 screening response, Seattle Children's Hospital requested the department begin review. (WAC 246-310-090(2)(c)(ii). The department began the review of this application in accordance with WAC 246-310-170(2)(a)(ii). Although Children's requested the department to begin the review based on the information provided in its application and screening responses, the department made a second request for information from Seattle Children's after the beginning of review. This was a technical error. However, Seattle Children's response to this second request was received within ten days after the "notification of beginning of review" in accordance with WAC 246-310-090(2)(e) and were included as part of the public comment distributed to "interested persons" so it did not impact the public's ability to provide comments the department.

(e) Health care facilities and health maintenance organizations which, in the twelve months prior to receipt of the application, have submitted a letter of intent to provide similar services in the same planning area;]
(f) Any person residing within the geographic area to be served by the applicant; and
(g) Any person regularly using health care facilities within the geographic area to be served by the applicant.

For this application six individuals or entities sought interested person status. Of those, five also requested affected person status. The following individuals or entities asked for "interested" and/or "affected person" status.

- Providence Sacred Heart Medical Center & Children's Hospital
- Providence Regional Medical Center
- Swedish First Hill Campus
- MultiCare Health System
- Providence Health & Services
- Frank Fox, PHD

Providence Sacred Heart Medical Center & Children's Hospital -Spokane Washington

Providence Sacred Heart Medical Center & Children's Hospital (PSHMC) requested interested person status and to be informed of the department's decision. PSHMC is a 644-bed licensed acute care hospital located in Spokane, within Spokane County[3]. It is located in Children's stated health service area. PSHMC provides adult and pediatric inpatient services including the following tertiary health services heart and kidney transplants, open heart surgery, elective percutaneous coronary interventions, NICU level II, level III, and level IV. PSHMC meets the definition of an "interested person" under WAC 246-310-010(34)(b). Providence Health & Services d/b/a Providence Sacred Heart Medical Center & Children's Hospital, provided written comments regarding the Seattle Children's proposal to add 40 acute care beds. Therefore, PSHMC qualifies as an "affected person".

Providence Regional Medical Center-Everett, Washington

Providence Regional Medical Center-Everett (PRMC-E) requested interested person status and to be informed of the department's decision. PRMC-E is a 501-bed licensed acute care hospital located in Everett, within Snohomish County. It is located in Children's stated health service area. PRMC-E provides adult and pediatric inpatient services including the following tertiary health services NICU level II and level III. PSHMC meets the definition of an "interested person" under WAC 246-310-010(34)(b). PRMC-E did not provide written comments regarding the Seattle Children's proposal to add 40 acute care beds. Therefore, PRMC-E does not qualify as an "affected person".

Swedish Medical Center-Seattle Washington

Swedish Medical Center (Swedish) requested interested person status and to be informed of the department's decision. Swedish Medical Center-First Hill is an 830 bed licensed acute care hospital with two campuses located in Seattle, within King County. It is located in Children's stated health service area. Swedish provides adult and pediatric inpatient services including the following tertiary health services NICU level II, level III, and level IV. Swedish meets the definition of an "interested

[3] CN#1442RE issued December 13, 2013 approved the addition of 75 new beds at Sacred Heart. At project completion the licensed bed capacity at Sacred Heart will be 719. Of those 586 beds will be medical/surgical, 72 beds are psychiatric, 21 beds are NICU Level II bassinettes, and 40 beds are NICU Level III/IV bassinettes.

person" under WAC 246-310-010(34)(b). Swedish did not provide written comments regarding the Seattle Children's proposal to add 40 acute care beds. Therefore, Swedish does not qualify as an "affected person".

MultiCare Health Systems-Tacoma Washington

MultiCare Health Systems requested interested person status and to be informed of the department's decision. MultiCare Health Systems is the parent corporation for MultiCare Mary Bridge Children's Hospital and Health Center (Mary Bridge) and MultiCare Tacoma General Hospital (TG), both located in Tacoma within Pierce County. The two hospitals are located in Children's stated health service area. Mary Bridge is an 82-bed licensed acute care hospital serving pediatric inpatients. Its services include open heart surgery and elective PCI. Tacoma General is a 567-bed hospital with two campuses. TG provides adult and pediatric inpatient services including the following tertiary health services open heart surgery, elective percutaneous coronary interventions, NICU level II, level III, and level IV. Both Mary Bridge and TG collectively referred to as MultiCare meet the definition of an "interested person" under WAC 246-310-010(34)(b). MultiCare provided written comments regarding the Seattle Children's proposal to add 40 acute care beds. Therefore, MultiCare also qualifies as an "affected person".

Frank Fox, PHD

Frank Fox is a health care consultant located in Shoreline within King County and requested copies all materials related to the review. Mr. Fox resides in Children's stated health service area. Therefore, he does meet the definition of an "interested person" under WAC 246-310-010(34). Mr. Fox did not provide written comments regarding the Seattle Children's proposal to add 40 acute care beds. Therefore, he does not qualify as an "affected person".

SOURCE INFORMATION CONSIDERED

- Seattle Children's Certificate of Need application submitted April 15, 2016
- Seattle Children's Screening Responses received June 20, 2016
- Seattle Children's Screening Responses received July 7, 2016
- Public comments received by the department through the close of business August 1, 2016
- Seattle Children's rebuttal documents received August 16, 2016
- MultiCare Health Systems rebuttal documents received August 1, 2016
- Seattle Children's Research Institute website [http://www.seattlechildrens.org/research/about/]
- University of Washington Pediatric Residency Program website [http://www.seattlechildrens.org/healthcare-professionals/education/uw-peds/about/]
- Licensing and/or survey data provided by the Department of Health's Investigations and Inspections Office
- Comprehensive Hospital Abstract Reporting System (CHARS) data obtained from the Department of Health's Office of Hospital and Patient Data Systems
- Department of Health's Charity Care Program financial feasibility and cost containment analysis received September 8, 2016[4]

[4]The hospital financial analysis previously performed by Hospital Patient Data Section (HPDS) is now performed by staff from the Charity Care Program (CCP) within the Office of Community Health Systems.

- Historical charity care data for years 2013, 2014, and 2015 obtained from the Department of Health Charity Care Program (CCP)
- Department of Health internal database-Integrated Licensing & Regulatory System (ILRS)
- Joint Commission quality check website at [www.qualitycheck.org]
- Det Norske Veritas Germanischer Lloyd Healthcare web site dnvglhealthcare.com
- National Uniform Billing Committee website [http://www.nubc.org/aboutus/index.dhtml]
- Certificate of Need historical files

CONCLUSIONS

For the reasons stated in this evaluation, the application submitted by Seattle Children's proposing to add 40 acute care beds of which 27 would be general acute care and 13 would be dedicated to NICU Level IV care is not consistent with applicable criteria. However, the addition of 23 general acute care beds and 13 NICU beds is consistent with the applicable criteria provided Seattle Children's agrees with the following project description and conditions in its entirety

Project Description:

This certificate approves 23 new general acute care beds and 13 NICU Level IV NICU beds. At project completion, Seattle Children's Hospital is approved to license and operate a total of 407 total licensed beds with the following distribution.

Seattle Children's Hospital

	Number of Beds
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Total Licensed Beds	**407**

Conditions:

1. Approval of the project description as stated above. Seattle Children's Hospital further agrees that any change to the project as described in the project description is a new project that requires a new Certificate of Need.
2. Prior to providing services in the 29 non-operational beds, Seattle Children's will provide a copy of its revised Charity Care policy. The revised Charity Care policy must not be any more restrictive than the Charity Care policy submitted as part of this application.
3. Seattle Children's must provide least 1.50% of total revenue in charity care in future years as stated in the application.

Approved Costs:

The estimated capital expenditure for this project $19,564,561.

CRITERIA DETERMINATIONS

A. Need (WAC 246-310-210)

Based on the source information reviewed and Seattle Children's, the department concludes:

- Seattle Children's has met the need criteria in WAC 246-310-210 for 13 Level IV Neonatal Intensive Care Unit beds.
- Seattle Children's has met the need criteria in WAC 245-310-210 for the 23 general acute care beds.

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

WAC 246-310 does not contain an acute care bed forecasting method. The determination of numeric need for acute care hospital beds is performed using the Hospital Bed Need Forecasting method contained in the 1987 Washington State Health Plan (SHP). Though the SHP was "sunset" in 1989, the department has concluded that this methodology remains a reliable tool for predicting baseline need for acute care beds.

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

Seattle Children's Numeric Methodology

- *"This CN application is proposing to return the seven (7) acute care beds that have been assigned to the NICU, back to acute care and that 13 new beds be approved as Level IV NICU beds. As explained later in this application, we are asking that these 13 beds be evaluated within the CN Program's acute bed need methodology and not within its historic NICU methodologies. We are also requesting 27 new acute care beds for medical/surgical patients. At project completion we will operate 322 acute care beds and 32 Level IV NICU beds (of which 13 will be from the "acute care supply" but dedicated exclusively to the NICU). Including our psychiatric and acute rehabilitation inpatient beds, our total licensed bed capacity will increase from 371 beds to 411 beds."* [Source: Application, pg. 10]
- *"Seattle Children's applied the CN Program's Acute Care Bed Need Projection Methodology (Methodology) to the Children's Hospital Planning Area and found that the majority of the beds requested are needed within a 7-10 year timeframe."* [Source: Application, pg. 12]
- *"If observation days are included, 100% of the beds we are requesting are supported under the Methodology within an 8 year horizon, or by 2022."* [Source: Application, pg. 12]
- *"Specific to NICU, Seattle Children's closely reviewed the methodologies that the CN Program has used in the past to approve NICU beds. These methodologies have consistently and exclusively used MDC 15 as the input. Due in large part to the surgical nature of our NICU service, only 60% of the days occurring in Seattle Children's Level IV NICU fall into MDC 15."* [Source: Application, pg. 12]
- *"Seattle Children's has 295 acute care beds, of which seven (7) have been reassigned to the NICU to address growing demand for NICU care. This CN seeks to align CN requirements with the actual distribution."* [Source: Application, Footnote 12, pg. 13]

- For its project, Seattle Children's identified its assumptions and factors used in its numeric methodology:
  - Hospital Planning Area – Washington State
  - CHARS data – Historical years 2005 through 2014
  - Projected Population –OFM Forecast of the State population by age (one year age cohorts) and sex, November 2015 (The forecast period is 2016-2040). Decennial census values and intercensal estimates through 2010. Post censal estimates 2011-2015.
  - Excluded MDCs and DRGs:
    - MDC[5] 19 – patients, patient days, and DRGs for psychiatric.
    - MDC 15 – patients, patient days, and DRGs for neonates
    - DRG[6] 945-946 – patients, patient days, and DRGs for rehabilitation.
  - Weighted Occupancy – Calculated consistent with the State Health Plan as the sum, across all hospitals in the planning area, of each hospital's occupancy rate times that hospital's percentage of total beds in the area. For hospitals with 200 – 299 acute care beds the weighted occupancy is 70%.
  - Existing Acute Care Bed Capacity – Seattle Children's only children's hospital in their defined hospital planning area. A total of 295 beds were counted. The 295 beds represent only medical/surgical acute care beds. Seattle Children's 26 beds dedicated to level IV NICU, 16 rehabilitation beds and 41 psychiatric beds were excluded. [Source: Application, pg. 13, and Exhibit 7]

- Seattle Children's provided two separate versions of the acute care bed methodology. One version is based on historical CHARS[7] data for years 2005 through 2014 and does not include observation days. The second version is based on historical CHARS data for years 2005 through 2014 and also includes observation days.

Table 12 (Reproduced)
Summary of Seattle Children's Bed Need Methodology
Without Observation Days Included

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Planning Area Available Beds	295	295	295	295	295	295	295	295	295	295	295
Weighted Occupancy Standard	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%
Gross Bed Need	262	268	275	283	290	298	305	312	319	326	333
Net Bed Need/Surplus	**-33**	**-27**	**-20**	**-12**	**-5**	**3**	**10**	**17**	**24**	**31**	**38**

[Source: Application, pg. 41]

[5] MDC=Major Diagnostic Category
[6] DRG=Diagnosis Related Group
[7] CHARS=Comprehensive Hospital Abstract Reporting System.

Table 13 (Reproduced)
Summary of Seattle Children's Bed Need Methodology
With Observation Days Included

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Planning Area Available Beds	295	295	295	295	295	295	295	295	295	295	295
Weighted Occupancy Standard	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%
Gross Bed Need	278	285	292	299	307	314	322	329	336	343	351
Net Bed Need/Surplus	**-17**	**-10**	**-3**	**4**	**12**	**19**	**27**	**34**	**41**	**48**	**56**

[Source: Application, pg. 42]

Public Comment

Providence Health & Services (PH&S) and MultiCare Health Systems (MHS) each submitted nearly identical public comment on the Seattle Children's application. For ease, the department will use PH&S as the reference when the same information is contained in PH&S and MHS letters.

- *"Seattle Children's Hospital provides valuable and necessary general and specialty pediatric services and should be commended for its dedication and excellence in doing so. However, we respectfully identify that significant methodological flaws exist within its application."* [Source: MHS August 1, 2016 letter, pg. 1]

- *"There are numerous issues related to Children's request that require further clarification and analysis before the Department evaluates the proposed project.*
  - *Based on our review, the Seattle Children's bed need methodology is flawed. When corrected, it does not demonstrate net need for acute care beds.*
  - *Our analysis, based on public data, also demonstrates Children's is not "full" or facing occupancy constraints, as it asserts.*
  - *Seattle Children's use of Observation Days within the acute care bed methodology is incorrect and should not be allowed.*
  - *Seattle Children's also states Criterion 2, from the State Health Plan, which was sunset in 1989, should be used by the Department, if it finds, as we did, there is no numeric need. However, its use of Criterion 2 is not well explained or defended.*
  - *Additionally, Seattle Children's should have submitted two CN requests, not one, since the Department rules are very clear that Level IV NICU bassinets are a tertiary service and as such, require a CN separate approval before additional Level IV bassinets are added. Seattle Children's knew this, but ignored it.*
  - *Finally, Seattle Children's stated it has been reallocating beds and bassinets without Department authorization and approval. This, too, is not an activity other hospital providers would be allowed to undertake. Seattle Children's should be held to the same standards as all other providers."* [Source: PH&S and MHS August 1, 2016 letters, pg. 3]

- *"We are also troubled by the Department's willingness to accept an application which explicitly requests both acute care (med/surg) and tertiary NICU beds in a single application. This co-bundling should have been identified immediately upon initial review and the application declined with direction to apply separately."* [Source: MHS August 1, 2016 letter, pg. 1]

- *"It is evident based on the text above and throughout Seattle Children's application and screening responses that its 40 bed request is split between 27 acute care medical/surgical beds and 13 Level IV NICU beds. It is important to acknowledge that Level IV NICU beds are classified as a tertiary service as defined by WAC 246-310-010. A 2015 health service review assessment by the Department concluded that Level IV NICU should be added to the list of tertiary services:*

  > *The services and procedures that fall under NICU Level IV fit all of the Department's criteria for tertiary services. Additionally, the Department adopted Level of Care Guidelines in 2013 that recommended the addition of Level IV to the pre-existing levels. Finally, there was no external opposition to the addition of Level IV to the List. [3]*

  The classification as a tertiary service for Level IV NICU is relevant to the Seattle Children's application as any expansion in Level IV bed capacity requires a request that is distinct from a general acute care bed request. In fact, the Department clearly states the following in its 2013 Determination of Reviewability ("DOR") that recognized Seattle Children's Hospital as a level IV provider with 19 licensed beds: "Please note that any increase in level IV pediatric beds beyond 19 requires prior Certificate of Need review and approval."[4] [Source: PH&S August 1, 2016 letter, pg. 5]

- *"Seattle Children's acknowledges within its application that it is deviating from the historical NICU methodology.[5] It states the traditional application of the NICU bed need of analyzing MDC ("Major Diagnostic Category") 15 accounts for only 60% of its NICU days. 6 However, Seattle Children's objections to use of the MDC 15 classification approach for defining NICU does not require the overall abandonment of the NICU methodology, which, to our knowledge, the Department has used every time an applicant requests additional NICU capacity, and adopting the general acute care need methodology as a substitute, instead. In doing so, Seattle Children's ignores the documented and formalized clinical difference between NICU bassinets and general acute care beds. Again, the entire purpose of a 'tertiary service' designation is to recognize such specialized services. In turn, the need methodologies for these tertiary services should reflect such specialized needs."* [Source: PH&S August 1, 2016 letter, pg. 6]

- *"As discussed above, the Department's 2013 DOR explicitly states that a Certificate of Need review and approval is needed for any increase in Children's Level IV beds from its licensed bed count of 19. Yet Table 3 in Seattle Children's application shows an increase in Level IV NICU beds of 19 to 26 between 2014 and 2015.[7] This prompted a screening question from the Department asking Seattle Children's to provide documentation from the Department where it had approved the transfer of 7 acute care beds to the NICU. In its screening responses, Seattle Children's stated:*

  > *While the Department has not "approved" the transfer, in Seattle Children's 2015 year-end report filed with the Department, we showed an increase in ICU beds (which includes NICU) by 10 beds as compared to the 2014 year-end report ...*
  >
  > *... Furthermore, on two separate dates (June 1, 2015 and November 23, 2015), Seattle Children's filed license amendment notifications, both of which showed an increase in our NICU bed count...*
  >
  > *... We first notified the CN Program of the reallocation of beds we met in late 2015 to discuss this application.[8]*

Of course, none of the Seattle Children's statements above provide any documentation of Department approval. In accordance with the Department's 2013 DOR Decision, Seattle Children's should have sought CN approval ***before*** *transferring beds from acute care to its NICU. None of the statements provided by Seattle Children's in its screening response substitutes for Certificate of Need review and approval."* [Source: PH&S August 1, 2016 letter, pgs. 6 and 7]

- *"Table 2 above clearly shows that HSA 1 and Washington State resident days for pediatrics are constant and declining, respectively, viewed either over 2006-2015 or more narrowly, over 2011-2015. Over either of these two time periods, Seattle Children's has experienced significant average annual growth in its resident days (Table 2). As a result, Children's market share figures in either the HSA 1 or state have increased rapidly. For example, Table 2 shows that Children's share of resident days for pediatric inpatients in the state has increased to 61.7% in 2015, an annual increase of 5.5% over 2011-2015. The important point is that, while Seattle Children's may have a growing 'slice of the pie' (i.e. market share) year-over-year, the pie itself (i.e. overall pediatric days by residents) is remaining virtually the same in HSA 1 since 2006, and it has fallen in Washington State, despite population growth."* [Source: PH&S August 1, 2016 letter, pg. 9]

- *"Subsection B contains* a *step-by-step review of the methodology Seattle Children's included within its application,* as *well* as *suggested revisions that should be made to the methodology* so *it is consistent with the correct application.* [11] *The summary at the end of subsection B then compares net need projected by Seattle Children's model with* a *revised model that incorporates the aforementioned revisions and CY2015 CHARS data.*[12]*"* [Source: PH&S August 1, 2016 letter, pg. 9]

- ***"Summary: Net Need Comparison with Alternative Model Incorporating Suggested Revisions***
  Below is a summary of the primary revisions suggested above.
  • Define planning area as Washington State residents 0 to 14 in Steps 1-4 and 0-14 & 15-21 in Steps 5-10.
  • Define Seattle Children's as the planning area hospital.
  • Apply the HSA 1 trend to project planning area use-rates each year over the forecast period.
  • Given the revision in the planning area designation, include 'Other WA' hospital utilization in Step 5.

  An additional revision would be to update the entire acute care bed model with CY2015 CHARS which has recently been made available. A revised model incorporating all of the suggested revisions above, including 2015 CHARS, making 2015 as the base year, is provided in Exhibit 1 and includes the full 10-step methodology. Table 4 below provides summary findings and net need from step 10 of the revised model.

Table 4. Planning Area Acute Care Bed Need Forecast, 2015-2022 (Reproduced)

	2015	*2016*	*2017*	*2018*	*2019*	*2020*	*2021*	*2022*
Model 1	*Forecasts based on Step 4 trendline*							*7-Years*
Population 0-14 (1)	*1,333,992*	*1,346,082*	*1,360,893*	*1,374,664*	*1,386,508*	*1,396,983*	*1,406,762*	*1,413,616*
0-14 Use Rate (2)	*67.11*	*66.63*	*66.14*	*65.66*	*65.18*	*64.69*	*64.21*	*63.72*
Population 15-21 (1)	*634,691*	*636,801*	*637,589*	*639,019*	*641,453*	*644,610*	*647,853*	*653,863*
15-21 Use Rate (2)	*93.77*	*93.28*	*92.80*	*92.31*	*91.83*	*91.35*	*90.86*	*90.38*
Total Population	*1,968,683*	*1,982,883*	*1,998,482*	*2,013,683*	*2,027,959*	*2,041,593*	*2,054,615*	*2,067,479*
Total WA State Resident Days (0-12 Years Old)	*149,039*	*149,089*	*149,182*	*149,251*	*149,272*	*149,256*	*149,191*	*149,176*

	2015	2016	2017	2018	2019	2020	2021	2022
Total Days in Seattle Children's (3)	*67,809*	*67,892*	*68,059*	*68,185*	*68,238*	*68,238*	*68,204*	*68,089*
Available Beds (4)								
Seattle Children's	*295*	*295*	*295*	*295*	*295*	*295*	*295*	*295*
TOTAL	***295***	***295***	***295***	***295***	***295***	***295***	***295***	***295***
Wtd Occ Std (5)	*70.00%*	*70.00%*	*70.00%*	*70.00%*	*70.00%*	*70.00%*	*70.00%*	*70.00%*
Gross Bed Need (TPD/365/Occupancy)--Demand	*265.40*	*265.72*	*266.38*	*266.87*	*267.07*	*267.08*	*266.94*	*266.49*
Bed Supply	*295.00*	*295.00*	*295.00*	*295.00*	*295.00*	*295.00*	*295.00*	*295.00*
Net Bed Need/Surplus (Demand-Supply)	*-29.60*	*-29.28*	*-28.62*	*28.13*	*-27.93*	*-27.92*	*-28.06*	*-28.51*

(1) Washington State projections-OFM Forecast of the State Population by Age and Sex: 2010-2040 (November 2015 Release)
(2) Use Rate Data Source: CHARS. See Step 5 & 6. Future use rates adjusted per slope trends from Step 4.
(3) Total patient days adjusted to reflect referral into and out of Planning Area to other WA State planning areas. See Steps 5 & 6
(4) 2016 DOH Acute Care Bed Survey
(5) Weighted Occupancy: Calculated per 1987 Washington State Health Plan as the sum, across all hospitals in the planning area, of each hospital's occupancy rate times that hospital's percentage of total beds in the area.

As shown in Table 4 above, there is a current (2015) surplus of approximately 30 beds that continues to be a surplus of 28.5 beds by year 7 (2022). The bed need figures are considerably different than those projected by Seattle Children's." [Source: PH&S August 1, 2016 letter, pgs. 14-15]

- *"Table 5 below shows the difference between the Seattle Children's and revised model's net need projections for acute care beds.*

Table 5. Acute Care Net Need Bed Comparison between Seattle Children's and Revised Model, 2015-2022 (Reproduced)

	2015	2016	2017	2018	2019	2020	2021	2022
Seattle Children's Model	*-27.00*	*-20.00*	*-12.00*	*-5.00*	*3.00*	*10.00*	*17.00*	*24.00*
Revised Model	*-29.60*	*-29.28*	*-28.62*	*-28.13*	*-27.93*	*-27.92*	*-28.06*	*-28.51*

Seattle Children's Model Source: Seattle Children's April 2016 Application. Page 142
Revised Model: Please see Exhibit 1 of this document" [Source: PH&S August 1, 2016 letter, pg. 15]

- *"In summary, the revised bed need forecast does not support the request for 40 additional acute care beds. Further, as Table 5 demonstrates, even Seattle Children's own model, itself, does not demonstrate need for either its 27 acute care beds or full 40-bed request, even when it: (1) includes a variety of modeling deviations that inflate demand; and (2) is inconsistent with the acute care bed need methodology as utilized by the Department."* [Source: PH&S August 1, 2016 letter, pg. 17]
- *"The acute care bed need model, as discussed in depth above, takes into account the 70% occupancy target within its bed need forecast in Step 10. Seattle Children's model does not support its full 27 acute care bed request when the 70% occupancy standard is applied. When the revisions are made to Children's model, the revised model calculates a surplus of beds at Seattle Children's over the 7-year forecast horizon. Table 4 demonstrates there is no need for additional acute care beds.*

Further, going above the occupancy rate does not imply that an applicant should receive any number of beds they request. There must be justification for the specific number of beds that the applicant wishes to add. Neither the Seattle Children's nor revised model calculates net need that is consistent with Seattle Children's request. As Table 2 above illustrated, Seattle Children's patient day increase is not a result of a general increase in pediatric acute days, but rather increased market share capture. This implies that overall, the number of pediatric patient days will be stagnant (in HSA1) or falling (in the state). In other words, it is reasonable to expect there are limits to how much further market share increases Seattle Children's can sustain." [Source: PH&S August 1, 2016 letter, pg. 17]

- *"Seattle Children's placed emphasis on providing supplemental census data in its screening response to highlight recent issues with occupancy constraints placed on its NICU, stating; "The NICU has continued to experience high census as well, exceeding 90% occupancy at midnight on 20% of the days." [20]*

  Again, this is an issue of co-bundling general acute and NICU. There is a fundamental difference between the two types of care that warrant independent review of both projects. Instead, there is a mix of statistics going back and forth between bed types. The general acute and NICU bed requests should be separated, including their own independent bed need projections and occupancy statistics for review by the Department." [Source: PH&S August 1, 2016 letter, pg. 18]

- *"In response to its own documented failure to demonstrate need, Seattle Children's chooses to deviate further from Department's rules pertaining to the bed need methodology by producing a model that includes observation days. The text below highlights Seattle Children's rationale for why it included observation days in an inpatient, acute care bed model:*

  > *Observation status is a billing designation, not a care designation. Since 2010 alone, observation days at Seattle Children's have grown by 31 % (5. 7% annually), about 60% faster, than our inpatient days (2.5% annually); and we estimate that these days will grow at an even faster rate than our inpatient days in the coming years ...*
  >
  > *... Seattle Children's closed our dedicated seven (7) bed observation unit in 2014 because we determined that it was inefficient; clinically, we were underutilizing the observation area because we were placing patients on the inpatient units where the clinical expertise, staffing and equipment existed to best address patient need.[24]*

  Once again, Seattle Children's incorporates a novel adjustment to the bed need model in an attempt to justify its bed request. To our knowledge, observation days have never been used by the Department to determine inpatient acute care bed need. The 'observation model' is unprecedented. To allow Seattle Children's to arbitrarily decide to include these days would be unfair to all other Washington State hospitals that are expected and have been reviewed under the standard that observation days are excluded. [emphasis in original]

  Observation days are not unique to Seattle Children's. While Seattle Children's cites varying growth statistics related to observation days, nowhere does it conduct a comparative analysis of Seattle Children's with other Washington State hospitals to demonstrate that special rules should be adopted in its case. 25 Seattle Children's is one among many hospitals in Washington State to provide observation days and has not included statistics to show that it has uniquely

pressing demand pressures in its facility versus others' experience." [Source: PH&S August 1, 2016 letter, pgs. 18-19]

- *"There were no questions by the Department in screening regarding the issue of observation days. We would certainly expect the Department to continue to exclude such days from the acute care bed need methodology. There is no precedent for including observation days or any unique reason why it should be adopted in favor of Seattle Children's when no other Washington hospital has received similar treatment. To do so would be both unfair and illogical, since "observation" beds do not require certificate of need approval.*" [Source: PH&S August 1, 2016 letter, pgs. 20]

- *"Seattle Children's has provided very little in terms of data and examples to prove it deserving of approval under the standards cited above relevant to Criterion 2. .....*

  Specifically, one of the key standards for the potential applicability of Criterion 2 is the extent a requested project will improve the access and quality of care for the underserved, as noted above. Seattle Children's largely backs this up using Table 9 of its application[32] that showed its Medicaid percentages compared to the King County hospital average and the overall Washington State average. However, these figures ignore the fact that Seattle Children's age mix of patients is significantly different than the average King County or Washington State hospital, and that the substantially younger pediatric cohort is far more likely to have Medicaid insurance status than other age cohorts." [Source: PH&S August 1, 2016 letter, pgs. 21-22]

- *"There was little further discussion of Criterion 2 other than statements by Seattle Children's regarding its range of services and its outcomes.[33] As stated above, we appreciate Seattle Children's place in the provision of complex, high quality pediatric care, but as we also stated above, there are other high quality pediatric hospitals in the state, specifically MultiCare Mary Bridge Children's Hospital and Providence Sacred Heart Medical Center and Children's Hospital. Criterion 2 requires a comparison of care delivery, including analysis that demonstrates that: "The proposed development would allow expansion or maintenance of an institution which has staff who have greater training or skill, or which has a wider range of important services, or whose programs have evidence of better results than do neighboring and comparable institutions; or the proposed development would allow expansion of a crowded institution which has good cost, efficiency, or productivity measures of its performance while underutilized services are located in neighboring and comparable institutions with higher costs, less efficient operations or lower productivity."[34] There was no such comparison or analysis."* [Source: PH&S August 1, 2016 letter, pgs. 22-23]

<u>Rebuttal</u>

- *"The public comment submitted regarding our application was largely very supportive. Letters of support were provided by families and several hospital leaders."* [Source: Seattle Rebuttal, pg. 2]

- *"PHS and MultiCare acknowledge the high occupancy of our Level IV NICU beds and do not appear to oppose our need for additional beds. Rather, they have focused their comments on irrelevant procedural matters. ....While not concurring that an increase in Level IV NICU beds resulting from a reallocation of acute care beds automatically triggers CN review, Seattle Children's acknowledges that our Level IV determination of non-reviewability (dated June 10, 2013) indicated that we were to seek CN approval before increasing our Level IV*

NICU beds. However, CN rules do not state explicitly that an increase in NICU beds (without exceeding licensed bed capacity) is subject to prior CN review." [Source: Seattle Rebuttal, pg. 2].

- *"Second, PHS and MultiCare take issue that our CN application addresses both the need for additional medical/surgical and NICU beds. As noted in our application, we met with the CN Program on December 22, 2015, and had several follow-up phone conversations. The CN Program concurred that we should incorporate our Level IV NICU request into the application for new acute care beds. As noted in our application, we met with the CN Program on December 22, 2015, and had several follow-up phone conversations. The CN Program concurred that we should incorporate our Level IV NICU request into the application for new acute care beds. They based their rationale on the following:*
    - *The high percentage of days occurring in our NICU that are outside the CN Program's standard NICU definition (which the CN Program assumed was due in part to our lack of an in-born neonatal population and our unique scope of specialists and services); and*
    - *The inability of the CN Program or an interested or affected party to be able to validate our actual NICU census in CHARS."* [Source: Seattle Children's Rebuttal, pg. 3]

- *"For the record, we include as Attachment 1, the CN Program's widely accepted NICU bed need projection methodology. To project NICU bed need at Seattle Children's, we used our actual NICU patient days, not just the ones coded to DRGs (DRGs 789-795) as well as our actual 2015 use rate and a 65% occupancy target. We fully acknowledge that the CN Program cannot independently replicate the methodology because 40% of our actual NICU patients are coded with a DRG outside of the standard neonatal DRGs. The methodology documents the need for Seattle Children's to have 30 beds today (2016); four more than we are currently operating."* [Source: Seattle Children's Rebuttal, pg. 3]

- *"PHS and MultiCare are incorrect in their statement that pediatric days statewide are declining. Data captured in CHARS shows that with the inclusion of observation, pediatric days and use rates are largely flat, and in fact in the past few years have shown a mild upward trend. All current literature supports the regionalization of days at a preeminent institution such as Seattle Children's and CHARS substantiates that the growth in pediatric days is occurring in clinical conditions that only Seattle Children's provides care for."* [Source: Seattle Children's Rebuttal, pg. 4]

- *"Full year CHARS 2015 became available in June 2016, after the submittal of our CN application and after the commencement of formal review. Based on the CN Program's past operating practice, we understand that this full year data will be used in its evaluation of our CN application. As anticipated by Seattle Children's, the full year 2015 data shows strong continued growth. With the new 2015 data, the 7 year planning horizon is 2022. Included as Attachments 6 and 7 are updated methodologies."* [Source: Seattle Children's Rebuttal, pg. 12]

- *"At Section D of their respective public comments, PHS and MultiCare suggest that the inclusion of observation days is "wrong" and that other hospitals would somehow be harmed if the CN Program considered observation days in their analysis of our project. First and foremost, the inclusion of observation days for pediatric patients does not inflate the bed need estimates. Rather, if it is excluded, the resulting bed need projection understates the need. This is due to how neonates, children, and adolescents are cared for at Seattle Children's and at most pediatric hospitals nationwide. Furthermore, as noted in our CN application, we met with the CN Program in advance of submitting our application and they agreed that they*

would consider observation in our calculation of numeric bed need." [Source: Seattle Children's Rebuttal, pg. 16]

- *"The CN Program's willingness was based on both the actual experience of Seattle Children's and on published research. For example, an article published in the Journal of Hospital Medicine in 2012 found that for pediatric patients, the proportion of short-stays (including both observation and 1-day stays) increased from 37% to 41% between 2004 and 2009. Since 2007, observation stays have outnumbered 1-day stays. In 2009, more than half of admissions from the ED for 6 of the top 10 ranking discharge diagnoses were short-stays. Fewer than 25% of observation stays converted to inpatient status. Return visits and readmissions following observation were no more frequent than following 1-day stays. The conclusion of this study was that children admitted under observation status make up a substantial proportion of acute care hospitalizations and that analyses of inpatient administrative databases* ***that exclude observation stays likely result in an underestimation of hospital resource utilization for children.***[7] *A copy of this article, of which our Chief Medical Officer is a co-author, is in included as Attachment 8."* [Source: Seattle Children's Rebuttal, pg. 16]
- *"In addition, and in response to the parties concern about harm to other hospitals, to our knowledge****, no other hospital*** *has ever requested that the CN Program include the impact of observation. As such, there cannot be any harm."* [Source: Seattle Children's Rebuttal, pg. 16]

- *"Lastly, the point is moot: when full year 2015 CHARS data is employed and the methodology is run in the manner it has in the past, our requested 40 beds are fully supported within the projection timeframe."* [Source: Seattle Children's Rebuttal, pg. 16]

Attachment 1 (Reproduced)
Seattle Children's Hospital, NICU Bed Need

	2015 Actual	2016	2017	2018	2019	2020	2021	2022	2023	2024
NICU Patient Days (2015 actual; all other years projected)	7,002	7,055	7,116	7,182	7,250	7,307	7,367	7,431	7,494	7,556
Females 15-44 Pop (WA State)	1,381,770	1,392,185	1,404,297	1,417,297	1,430,777	1,441,938	1,453,725	1,466,477	1,478,792	1,491,090
Use Rate (2015 actual)	5.07	5.07	5.07	5.07	5.07	5.07	5.07	5.07	5.07	5.07
ADC	19.18	19.33	19.50	19.68	19.86	20.02	20.18	20.36	20.53	20.70
Bed Need at 65% Occupancy	**30**	**30**	**30**	**30**	**31**	**31**	**31**	**31**	**32**	**32**

[Source: Seattle Children's Rebuttal, pg. 23]

Attachment 6-Step 10(Reproduced)
Summary of Seattle Children's Bed Need Methodology
With Observation Days Included and Without Oregon

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Planning Area Available Beds	295	295	295	295	295	295	295	295	295	295	295	295
Weighted Occupancy Standard	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%
Gross Bed Need	283	292	301	309	318	327	336	345	354	363	373	382
Net Bed Need/Surplus	**-12**	**-3**	**6**	**14**	**23**	**32**	**41**	**50**	**59**	**68**	**78**	**87**

[Source: Seattle Children's Rebuttal, pg. 113]

Attachment 6-Step 10 (Reproduced)
Summary of Seattle Children's Bed Need Methodology
With Observation Days Included and With Oregon

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Planning Area Available Beds	295	295	295	295	295	295	295	295	295	295	295	295
Weighted Occupancy Standard	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%
Gross Bed Need	283	291	298	306	313	321	329	337	344	352	360	369
Net Bed Need/Surplus	**-12**	**-4**	**3**	**11**	**18**	**26**	**34**	**42**	**49**	**57**	**65**	**74**

[Source: Seattle Children's Rebuttal, pg. 123]

Attachment 7-Step 10 (Reproduced)
Summary of Seattle Children's Bed Need Methodology
Without Observation Days Included and Without Oregon

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Planning Area Available Beds	295	295	295	295	295	295	295	295	295	295	295	295
Weighted Occupancy Standard	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%
Gross Bed Need	268	276	285	294	302	311	320	329	338	347	356	366
Net Bed Need/Surplus	**-27**	**-19**	**-10**	**-1**	**7**	**16**	**25**	**34**	**43**	**52**	**61**	**71**

[Source: Seattle Children's Rebuttal, pg. 134]

Attachment 7-Step 10 (Reproduced)
Summary of Seattle Children's Bed Need Methodology
Without Observation Days Included and With Oregon

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Planning Area Available Beds	295	295	295	295	295	295	295	295	295	295	295	295
Weighted Occupancy Standard	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%
Gross Bed Need	268	275	282	289	296	304	311	318	326	333	341	349
Net Bed Need/Surplus	**-27**	**-20**	**-13**	**-6**	**1**	**9**	**16**	**23**	**31**	**38**	**46**	**54**

[Source: Seattle Children's Rebuttal, pg. 144]

Department Evaluation

There are three preliminary issues the department will address before evaluating the Seattle Children's proposed project.

Reassigning General Acute Care Beds to NICU Level IV Beds

Seattle Children's states that in 2015, it reassigned seven acute care beds to the NICU to address consistently high census in the NICU. These beds are stated to still be acute care, but temporarily located in the NICU. Emphasis added. [Source: Application, footnote No. 5, pg. 7] General acute care bed spaces and NICU spaces are not interchangeable. Each has specific physical space requirements that are relative to the type of care being provided in that space. NICU levels II, III, and IV each are specific specialized inpatient pediatric service and are identified as a tertiary health service that requires separate Certificates of Need. NICU CoNs, regardless of the level, are granted for a specific number of beds. Increasing the bed capacity for NICU levels II, III, and IV requires prior Certificate of Need review and approval. The department notified Seattle Children's in its June 10, 2013 Determination of Reviewability *"that any increase in level IV pediatric beds beyond 19 requires prior Certificate of Need review and approval*[8]*."* The department finds it troubling that this application now seeks to obtain the department's approval for the seven "reassigned" beds after the fact since Seattle Children's has known since at least 2013 that prior approval was necessary before increasing the number of NICU level IV beds. Seattle Children' attempts to explain away that the department knew of the increase when it submitted its year-end financial reports and annual license updates to the department. This explanation might have some merit if the two reports were required to be submitted to the Certificate of Need program but neither are. The remedy for Seattle Children's to come into compliance with Certificate of Need is either to stop providing NICU care in those seven beds or submit an application to increase the NICU bed capacity. Generally, the department does not require a facility to take one remedy course over another, but not choosing one of the two remedies is not an option. Seattle Children's chose to submit a CoN application.

Combining A General Acute Care Bed Addition With A NICU Level IV Bed Addition

PH&S and MHS are correct that the department generally does not accept a single application that contains two separate projects. That change in process was announced in May of 2011. On December 22, 2015 CoN program staff met with representatives of Seattle Children's to discuss their

[8] Determination of Reviewability (DoR) 13-34, dated June 10, 2013.

upcoming Certificate of Need application. During that meeting topics discussed were including observation days, the reassignment of general acute care beds to the NICU, NICU patient days that are not accounted for in the typical NICU DRGs, occupancy levels of the hospital and NICU, and submission of an application. With the exception of allowing Seattle Children's to submit a single application requesting both an increase in general acute care and NICU beds the department made no specific commitments how it would evaluate the issues, such as inclusion of observation days in the numeric bed need methodology once the application was submitted. Although Seattle Children's application materials state there were several additional conversations following the December meeting with the department, program staff didn't find any records relating to those conversations.

Inclusion Of Observation Days In The Numeric Need Methodology

In its application, Seattle Children's advocates for the inclusion of observation days as part of the calculating the numeric inpatient bed need methodology. Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. [Source: CMS, Regulations and Guidance Manual, 20.6 Outpatient Observation Services] This description is similar to others reviewed by CoN staff. To support this request Seattle Children's makes the following points:

- *"…observation volumes have grown substantially at Seattle Children's since 2010 and these patients are fully integrated onto the acute care inpatient units, where the staffing and clinical expertise best supports their conditions."* [Source: Application, pg. 11]
- *"At Seattle Children's, observation is a billing classification, not a clinical designation, and our clinical pathways – which for some conditions are now nationally recognized pediatric clinical pathways – call for the patient, to be cared for on the inpatient unit where their clinical needs can best be addressed regardless of whether they will be later classified as inpatient or observation."* [Source: Application, pg. 11]
- *"As noted later in this application, we believe that the Methodology should be adjusted to account for the very real clinical need we face on a daily basis regarding observation patients being placed on the inpatient units that best supports their conditions."* [Source: Application, pg. 12]
- *"Importantly, from our clinical perspective, care is indistinguishable between inpatient and observation. The length of stay of our patients classified as observation patients averages about 1.5 days."* [Source: Application, pg. 25]
- *"Seattle Children's closed our dedicated seven (7) bed observation unit in 2014 because we determined that it was inefficient; clinically, we were underutilizing the observation area because we were placing patients on the inpatient units where the clinical expertise, staffing and equipment existed to best address patient needs."* [Source: Application, pg. 25]
- *"On an average day in 2014, 11.5 patients were occupying medical/surgical inpatient bed at midnight that were later classified as observation. At 70% target occupancy, these 11.5 patients needed 16.4 beds. Importantly, these patients show up in CHARS as observation, not inpatient."* [Source: Application, pg. 25]
- *"The CN Program's Acute Care Bed Need Projection Methodology has historically not included observation days. However, since 2008, these days have been captured in the CHARS database, and it would be simple to include them in the Methodology."* [Source: Application, pg. 26]

Both PH&S and MHS objected to including observation days in the numeric inpatient bed methodology. They stated:

> *"To our knowledge, observation days have never been used by the Department to determine inpatient acute care bed need. The 'observation model' is unprecedented. To allow Seattle Children's to arbitrarily decide to include these days would be unfair to all other Washington State hospitals that are expected and have been reviewed under the standard that observation days are excluded. [emphasis in original]*
>
> *Observation days are not unique to Seattle Children's. While Seattle Children's cites varying growth statistics related to observation days, nowhere does it conduct a comparative analysis of Seattle Children's with other Washington State hospitals to demonstrate that special rules should be adopted in its case. [25] Seattle Children's is one among many hospitals in Washington State to provide observation days and has not included statistics to show that it has uniquely pressing demand pressures in its facility versus others' experience."* [Source: PH&S August 1, 2016 letter, pgs. 18-19]

In response Seattle Children's stated:
"At Section D of their respective public comments, PHS and MultiCare suggest that the inclusion of observation days is "wrong" and that other hospitals would somehow be harmed if the CN Program considered observation days in their analysis of our project. First and foremost, the inclusion of observation days for pediatric patients does not inflate the bed need estimates. Rather, if it is excluded, the resulting bed need projection understates the need. This is due to how neonates, children, and adolescents are cared for at Seattle Children's and at most pediatric hospitals nationwide. Furthermore, as noted in our CN application, we met with the CN Program in advance of submitting our application and they agreed that they would consider observation in our calculation of numeric bed need." [Source: Seattle Children's Rebuttal, pg. 16]

As part of its justification for including observation days in the numeric inpatient bed need methodology, Seattle Children's stated that DoH collects observation day data although it is in a different database than CHARS (Comprehensive Hospital Abstract Reporting System). CHARS only collected inpatient data from 1987 through 2007; the other category of data being outpatient, including emergency room services, was not collected. A third category of patients developed during the early 2000s and are known as "observation" patients. Some observation patients may be similar to outpatients in that their lengths of stay at the hospital can be measured in hours. Other observation patients are more like inpatients; their lengths of stay can be two days – or longer. Up until May 2007 CHARS only collected data on inpatients. Observation patients with lengths of stay exceeding a day or more were previously not reported to CHARS. This situation becomes even more concerning because the designation of a patient as either an inpatient or an observation patient is based upon each patient's payer's criteria. Hence, one patient may be deemed an inpatient by their payer and have their data reported to CHARS, while another patient with exactly the same clinic conditions and treatments – but with a different payer – may be deemed an observation patient and did not have their data reported to CHARS in the past. Medicare, as of October 1, 2015 has a Two Midnight rule to be an inpatient which seems to have increased the number of patients considered to be Observation. The data for inpatient and observation are available in separate files. A description of the file names is listed at the end of this document. Observation stays differ from inpatient in a few ways:

- HCPCS codes and day of service are reported in the revenue file.

Not Generated for Observation
- MS-DRG or MDC
- Case-Mix
- Outlier
- Excluded

The National Uniform Billing Committee (NUBC) has changed its definition of Admission Date so that it to be used only for Inpatient records. Any outpatient will only use the From date. As hospitals adjust their systems the number of Observation records CHARS receives without an Admission date is growing every month. Without this date our calculations for Age and LOS will not work. [Source: DoH Datanotes-Observation2015FY.doc, DoH website] The NUBC[9] classifies observation care as outpatient. As noted in the explanation from the department's website, observation data collected by the department is not a one to one comparison to the inpatient data reported to CHARS.

Another justification Seattle Children's advanced in its application for including these observation days is that these patients, while being classified as outpatients are using inpatient resources that are then not available to other hospital inpatients and often whether a patient is classified as an observation or inpatient does not occur until after discharge. Some hospitals have a special observation area or wing of the hospital for their observation patients. However, many choose to put their observation patients in the same rooms as their inpatients. As Seattle Children's stated in its application, it chose to close its observation area 2014 and started providing that care within its inpatient bed capacity. Seattle Children's use of its inpatient bed capacity for the provision of observation care is not unique to Seattle Children's. Nor is the timing of when a patient is classified as either observation vs inpatient.

PH&S and MultiCare are correct that the department has never included observation days in the numeric inpatient bed need methodology. Including these observation days in the hospital inpatient bed need numeric method would be a major departure from how the department has applied the inpatient bed numeric methodology. The impact of observation care is not a Seattle Children's only issue. Significant policy changes such as the one being requested by Seattle Children's should not be decided during the course of a single review. Rather, the appropriate forum for that type of change is through a rule making process where the merits of such a change can be fully debated by all interested organizations. Therefore, the department will not be including observation days in the evaluation of Seattle Children's acute care inpatient bed request.

General Acute Care Bed Request

Seattle Children's has requested a total of 40 acute care beds under the general acute care bed need method. If granted, the bed addition of only 27 beds would be used for general acute care and the

[9] The NUBC was formed in 1975 to develop and maintain a single billing form and standard data set to be used nationwide by institutional, private and public providers and payers for handling health care claims. In determining the data to be included, the NUBC strives to balance the need for the information against the burden of providing that information. The data specifications manual seeks to identify the national requirements for preparing Medicare, Medicaid, OCHAMPUS, Blue Cross/Blue Shield, and commercial insurance claims. One of the major roles of the NUBC is to maintain the integrity of the UB data set. Over the year, the UB data set has become more than a billing instrument. It is also used by many others, including public health and health researchers, as a tool to gauge the delivery of health care services to patients. Therefore, the data set has broad policy implications. [Source: National Uniform Billing Committee website]

remaining 13 would be located in the NICU. Seattle Children's states that a significant number of its NICU patient days are provided to patients that do show up in the typical MDC 15 for NICU IV and therefore it is appropriate to use the general acute care bed need method. The department does not find that reason compelling enough to apply the general acute care bed need method for beds to be dedicated to NICU Level IV. The department will consider each type of bed request separately. The department will start with the general acute care bed request.

For is application Seattle Children's states its planning area is state-wide. Seattle Children's cites the previous 1980 State Health Plan as documentation to support this position. PH&S and MHS argue that it should be less than state-wide. The department looked at 2015 patient county of origin for Seattle Children's, Mary Bridge, and Providence Sacred Heart. Table 1 shows that result.

Table 1
2015 Patient County of Origin

	Seattle Children's		Providence Sacred Heart		Mary Bridge	
	% of Total Discharges	% of Total Patient Days	% of Total Discharges	% of Total Patient Days	% of Total Discharges	% of Total Patient Days
Total from Western WA Counties	86.7%	86.1%	0.5%	0.4%	99.0%	99.1%
Total from Central WA Counties	6.7%	6.8%	1.6%	1.6%	0.0%	0.0%
Total from Eastern WA Counties	2.7%	3.0%	88.4%	88.6%	0.0%	0.0%
WA Total 0-14	96.0%	95.9%	90.6%	90.5%	99.0%	99.1%
Out-of-State	4.0%	4.1%	9.4%	9.5%	1.0%	0.9%

[Source: 2015 CHARS Data]

Seattle Children's had discharges from 31 of the 39 Washington counties. Providence Sacred Heart had discharges from 18 of Washington's 39 counties and Mary Bridge had discharges from 10 of Washington's 39 counties. Seattle Children's is correct that the 1980 State Health Plan recognized Seattle Children's (then named Children's Orthopedic-Seattle) as a specialty hospital. The department concludes use of a state-wide planning area is appropriate for Seattle Children's.

The department looked at its past application of the acute care bed need projection for Seattle Children's. The method approach submitted in this application is the same as the methodology used in 2010. There is no reason to change that approach. The department also looked at the methodology used for the Mary Bridge bed expansion. A similar approach was taken in that application. It focused on Mary Bridge's smaller planning area and excluded other facilities as well in the bed need projection used by Mary Bridge Children's Hospital.

In its rebuttal, Seattle Children's present two different projections updated to include 2015 CHARS data that exclude observation days and will be considered by the department. One projection includes Washington resident seeking care in Oregon and the other does not. Neither projection included observation days. A summary of the results of the two projections is presented in Table 2 below:

Table 2
Summary of Seattle Children's Bed Need Methodology
Without Observation Days Included and Without Oregon

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Planning Area Available Beds	295	295	295	295	295	295	295	295	295	295	295	295
Gross Bed Need w/o Oregon	268	276	285	294	302	311	320	329	338	347	356	366
Net Bed Need/Surplus w/o Oregon	**-27**	**-19**	**-10**	**-1**	**7**	**16**	**25**	**34**	**43**	**52**	**61**	**71**
Gross Bed Need w/ Oregon	268	275	282	289	296	304	311	318	326	333	341	349
Net Bed Need/Surplus w Oregon	**-27**	**-20**	**-13**	**-6**	**1**	**9**	**16**	**23**	**31**	**38**	**46**	**54**

The department concludes use of the methodology with Oregon is the most reasonable. It is consistent with the department's past application of the numeric need methodology used for Seattle Children's projects. Using this methodology, 23 new general acute care beds is justified.

The department notes that 295 beds have been used by Seattle Children's as the number of available general acute care beds throughout the projections. This number excludes beds dedicated to psychiatric, rehabilitation, and NICU care but does include non-NICU intensive care beds such as pediatric intensive care (PICU) beds. Seattle Children's has stated throughout this application only 288 are actually available because of Seattle Children's decision to "reassigned" seven of the 295 general acute care beds to NICU care. The department would agree that only 288 general acute care beds are available and as stated earlier NICU beds are not interchangeable with general acute beds. Further, changes from psychiatric or rehabilitation services to general acute care requires prior Certificate of Need review and approval. Therefore, once Seattle Children's "reassigned" the seven beds to the NICU, only 288 beds have been available for general acute care.[10]

Based on the department's analysis, a need for 23 new general acute care beds has been demonstrated. This 23 bed need was based on a total 295 available general acute care beds rather 288 (295 minus the 7 "reassigned" to NICU). Since 295 beds was used to demonstrate need for the 23 beds, no additional bed adjustments are necessary.

NICU

Seattle Children's as part of this application is requesting 13 Level IV Neonatal Intensive Care Unit (Level IV NICU) beds. If approved, seven of the beds would be to recognize the 7 beds Seattle Children's "reassigned" from general acute care to NICU in 2015. The remaining 6 beds would be new NICU level IV beds. As noted in the previous section on the general acute care bed need method,

[10] The department assumes the 295 beds reported in table D, in Seattle Children's rebuttal document was in error. Otherwise, Seattle Children's would be operating more general acute care beds than authorized.

Seattle Children's continued to count the 7 "reassigned" beds as part the general acute care capacity. Therefore, the department's evaluation related to NICU bed capacity will assess the need for both the 7 "reassigned" beds and the additional 6 beds.

In support of its NICU bed request, Seattle Children's provided the following:
"Specific to NICU, Seattle Children's closely reviewed the methodologies that the CN Program has used in the past to approve NICU beds. These methodologies have consistently and exclusively used MDC 15 as the input. Due in large part to the surgical nature of our NICU service, only 60% of the days occurring in Seattle Children's Level IV NICU fall into MDC 15." [Source: Application, pg. 12]

Seattle Children's also states that depending on the year, between 33-38% of its actual NICU days fall outside of MDC 15. Table 3 was included in the application to show this variation.

Table 3
Seattle Children's MDC 15 as a % of Total NICU Days

	CY 2014	CY 2015
Total NICU Days	5,648	7,002
Total MDC 15 including APR DRG 583 (Neonate with ECMO)	3,810	4,296
Percent of Total Days Coded to MDC 15	67%	61%

[Source: Application, pg. 27 using Applicant internal data, includes APR-DRG Neonate with ECMO[11]]

To further support its proposal for additional NICU beds, Seattle Children's provided projections using 2015 actual patient days provided in the NICU. These patient days include those not assigned to MDC 15 but provided in the NICU. Table 4 shows the results of those projections.

Table 4
Seattle Children's Projected NICU Bed Need

	2015	2016	2017	2018	2019	2020	2021	2022
NICU Patient Days (2015 Actual, all others years projected	7,002	7,055	7,116	7,182	7,250	7,307	7,367	7,431
Females 15-44 Pop (WA State)	1,381,770	1,392,185	1,404,297	1,417,297	1,430,777	1,441,938	1,453,725	1,466,477
Use Rate (2015 Actual)	5.07	5.07	5.07	5.07	5.07	5.07	5.07	5.07
ADC	19.18	19.33	19.50	19.68	19.86	20.02	20.18	20.36
Bed Need at 65% Occupancy	**30**	**30**	**30**	**30**	**31**	**31**	**31**	**31**

[Source: Seattle Children's Rebuttal, Attachment 1]

[11] APR-DRG (All Patient Refined Diagnostic Related Groups) is one of two DRG grouper software used to assign DRG numbers to patients. The other is MS DRG. There are differences between the two. The APR DRG includes a broader data source, includes all ages, has 4 levels of severity, all conditions have 4 levels of severity, and 4 levels of risk of mortality for every condition. It's used in reimbursement and quality performance measurement. MS DRG's data source is Medicare, includes 65+, 3 levels of severity, not all conditions contain 3 levels of severity, no risk categorization for risk of dying, and is intended for reimbursement only. The department only uses MS DRG.

As part of its evaluation the department looked also prepared a NICU projection using only 2015 CHARS reported MDC 15 NICU patient days. Table 5 shows the result of that projection.

Table 5
Department of Health NICU Bed Projection Using
2015 Reported MDC 15 NICU Patient Days

	2015	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
NICU Patient Dayes (2015 Actual, all others years projected based on DRGs 385-391/789-795 All ages	5,091	5,129	5,174	5,222	5,272	5,313	5,356	5,403
Females 15-44 Pop (WA State)	1,381,770	1,392,185	1,404,297	1,417,297	1,430,777	1,441,938	1,453,725	1,466,477
Use Rate (2015 Actual)	3.68	3.68	3.68	3.68	3.68	3.68	3.68	3.68
ADC	13.95	14.05	14.18	14.31	14.44	14.56	14.67	14.80
Bed Need at 65% Occupancy (DoH)	**21**	**22**	**22**	**22**	**22**	**22**	**23**	**23**
Bed Need at 75% Occupancy (DoH)	19	19	19	19	19	19	20	20
CHARS reported NICU days as % of Children's total Reported NICU days in Rebuttal comments	73%	73%	73%	73%	73%	73%	73%	73%

The department calculated the bed need on both a 65% occupancy standard and a 75% occupancy standard. The State Health Plan states the occupancy standard for NICUs of this size should be 75%. However, the department has applied the 65% standard since at least 2010. The department finds no basis to revert back to the 75% during this review. Historically, Seattle Children's has operated its 19 approved NICU beds at or above the 65% target occupancy standard. As shown in table 5, based only on CHARS MDC 15 2015 patient days, Seattle Children's has demonstrated a need for 23 NICU beds.

Criteria 2 of the State Health Plan

Seattle Children's requested that if the department did not find need for more beds under the numeric bed need methodology, that the department apply Criteria 2 under the State Health Plan to approve its request.

An evaluation of Seattle Children's reported historical available beds (set-up and staffed) would not support adding general acute care beds under this criteria. However, the department will evaluate whether additional NICU beds are justified under this criteria.

The department recognizes that Seattle Children's NICU is different from other NICU Level IVs in the state. Typically a portion of a hospital's NICU admits and patient days are the result of babies born at their facility and subsequently in need of that level of care. The 1987 State Health suggests that a hospital have a minimum of 1,200 births per year for a level II or level III NICU. Level III was the highest level of care at the time the 1987 State Health Plan was produced. The hospitals where these other level IVs are located have an active birthing program. Table 6 show the number

of births each of the department approved NICU Level IV facilities reported to the department in 2015.

Table 6
2015 Births Reported at
Department Approved NICU Level IV Facilities

	Seattle Children's	Tacoma General	Providence Sacred Heart	University of Washington	Swedish First Hill
2015 Reported Births	0	3,073	3,233	2,043	7,667

As shown in table 6 all the approved NICU Level IV facilities meet this birth standard except Seattle Children's. Since at least the 1980 State Health Plan, Seattle Children's has been recognized as a specialty hospital. Based on this factor alone, Seattle Children's with 5,091 MDC 15 patients days is different than the other approved NICU Level IV facilities.

As shown in Table 3 above, Children's reports that between 33-38% of its actual NICU days fall outside of MDC 15. The department calculated this figure to be 73% for 2015 based on Seattle Children's reported total NICU days compared to MDC 15 days reported through CHARS. This difference would equate to be about 8 NICU beds in 2015 increasing to 9 by 2022.

Seattle Children's is correct when it states that there are some services that only it provides. A listing of DRGs and Seattle Children's percentage of the market share was presented in Attachment 2 of its rebuttal comments. Based on the application materials reviewed the department concludes that additional NICU Level IV beds are justified under Criterion 2.

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

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

The admission policy provides the overall guiding principles of the facility as to the types of patients that are appropriate candidates to use the facility and 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.

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

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

A facility's charity care policy should show a willingness of a provider to provide services to patients who do not have private insurance, do not qualify for Medicare, do not qualify for Medicaid or are

under insured. With the passage of the Affordable Care Act (ACA), the amount of charity care is expected to decrease, but not disappear.

Seattle Children's

- "*Seattle Children's prohibits discrimination on the basis of race, income, ethnicity, sex, or handicap. Copies of the Seattle Children's policies related to admission and non-discrimination are included in Exhibit 6.*[26]" [Source: Application, pg. 32] [12]
- *"Seattle Children's bases our services on the patient's clinical needs and provides services to patients without regard to their financial resources. For hospital charity care reporting purposes, the Department of Health (Department) divides Washington State into five regions. Seattle Children's is located in the King County region. According to 2012-2014 charity care data (the latest data available) produced by the Department, the three-year charity care average for King County, excluding Harborview Medical Center, was 1.71% of gross revenue and 3.30% of adjusted revenue. Seattle Children's provided charity care at 1.74% of gross revenue and 3.28% of adjusted revenue during this period. For the pro forma financials, Seattle Children's has assumed charity to be 1.50% of gross revenue or slightly higher than Seattle Children's actual 2015 experience (which was 1.30%)."* [Source: Application, pg. 32]
- "*Copies of Seattle Children's requested policies are included as Exhibit 6.*[27]" [Source: Application, pg. 35] [13]
- *"Existing sources of revenue by payer are:*

Medicare	*1%*
Medicaid / Healthy Options	*48%*
Commercial	*45%*
Self-Pay	*2%*
Other	*4%*
Total	***100%"***

[Source: Application, pg. 16]

- *"The expected sources of revenue are:*

Medicare	*1%*
Medicaid / Healthy Options	*48%*
Commercial	*45%*
Self Pay	*2%*
Other	*4%*
Total	***100%"***

[Source: Application, pg. 53]

Public Comments

- None

[12] Footnote 26 from the application states: *"Please note that Seattle Children's does not have a separate non-discrimination policy. However, on the Department's website, our Financial Assistance policy is posted and identified as the non-discrimination policy."*

[13] Footnote 27 from the application states: *"Please note that Seattle Children's is in the process of reviewing and updating our Financial Assistance policy and are planning to submit it to the Department in the next several weeks for review and approval. The Financial Assistance policy that we are providing with our certificate of need application is our current version, which was reviewed and approved by the Department in 2013."* [Source: Application, pg. 35]

Rebuttal Comments

- None

Department Evaluation

Seattle Children's provided copies of the following policies used at their hospital.

- Admission Policy-Approved February 2014
- Advanced Directives -Approved October 2015
- Limitation of Resuscitation Documentation and Orders- Approved June 2015
- Financial Assistance Policy-Approved 2013

The adopted Admission policy states admission will be based upon clinical need. It also states *"All patients will be accepted for treatment without regard to race, color, creed, national origin, religion, sex (gender), gender identity, sexual orientation, or disability, consistent with requirements defined by the US Department of Health and Human Services Office for Civil Rights and the Washington State Department of Social and Health Services".* The policy also states *"All patients will be accepted regardless of ability to pay."* There is no expected change to the current adopted Admission Policy.

Seattle Children's currently provides care to Medicare patients. Table 7 shows the percentage of Medicare revenue Seattle Children's has reported to the department for fiscal years (FY) 2010 through 2015.

Table 7
Medicare Revenue
For FY 2010-2015

Year	Percent of Inpatient Revenue	Percent of Total Revenue
2010	1.02%	1.16%
2011	1.31%	1.49%
2012	1.77%	1.88%
2013	1.04%	1.40%
2014	1.53%	1.80%
2015	0.75%	1.12%

[Source: Hospital Year End Financial Reports Submitted to DoH]

While Seattle Children's provides services to Medicare patients the percentage is small. Approximately 1% of Seattle Children's revenue comes from Medicare. These percentages are comparable to those stated by the applicant within its application. [Source: Application, pgs. 16 and 53] This is expected since the target population, in general, is not eligible for Medicare funding. The department concludes Seattle Children's currently serves Medicare patients, if appropriate, and are expected to continue to provide care if this project is approved.

Seattle Children's currently provides care to Medicaid patients. Table 8 shows the percentage of Medicaid revenue Seattle Children's has reported to the department for fiscal years (FY) 2010 through 2015.

Table 8
Medicaid Revenue
For FY 2010-2015

Year	Percent of Inpatient Revenue	Percent of Total Revenue
2010	49.47%	46.31%
2011	47.92%	45.41%
2012	46.87%	44.02%
2013	47.94%	45.74%
2014	48.09%	46.03%
2015	49.21%	46.77%

[Source: Hospital Year End Financial Reports Submitted to DoH]

Seattle Children's has history to serving low income patients. These percentages are comparable to those identified in the audited financial statements submitted in the application. [Source: Application, Appendix 1] The department concludes Seattle Children's currently serves and will continue to serve low income patients if this project is approved.

Seattle Children's provided a copy of its current Financial Assistance (charity care) policy used at the hospital. That policy outlines who qualifies for charity care. The current policy has been reviewed and approved by the Department of Health's Charity Care Program (CCP) in the Office of Community Health Services. As part of its application Seattle Children's states that it is in the process of updating its Financial Assistance policy and are planning to submit it to DoH in the next several weeks for review and approval. Since the revised Financial Assistance policy has not been reviewed by either the CoN program or DoH's CCP, if this project is approved a condition would be necessary.

Historically, Seattle Children's has been providing the follow level of charity care.

Year	Charity Care Provided	% of Total Revenue	% of Adjusted Revenue
2013	$32,837,240	1.97%	3.73%
2014	$29,843,579	1.60%	3.06%
2015	$26,061,722	1.29%	2.48%

[Source: 2013-2015 Department of Health Charity Care Reports]

Seattle Children's states it projected charity care at 1.50% of total revenue in future years which is slightly higher than 2015.

To determine whether Seattle Children's level of charity care is comparable to other hospitals the department uses DoH Charity Care Report data. For charity care reporting purposes, Washington State is divided into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. Seattle Children's hospital is located in King County within the King County Region. There are a total 22 hospitals within the King County Region.

Table 9 shows the three-year average of charity care provided by the hospitals in the King County region (minus UW Medicine/Harborview[14]) and the three year average of charity care at Seattle Children's.[15] [Source: DoH 2013-2015 Charity Care Reports]

Table 9
Charity Care Percentage Comparisons
Three Year Average

	Percent of Total Revenue	Percent of Adjusted Revenue
King County Region	1.33%	2.57%
Seattle Children's	1.62%	3.09%

As shown in table 9, Seattle Children's 3-year charity care average is higher than the King County region. Although Seattle Children's charity care 3-year average is higher than the King County region, a condition is necessary because the Financial Assistance policy submitted in this application is currently being updated and the amount of charity care is also projected to increase.

With agreement to the conditions in the conclusion section of this analysis, the department concludes **this sub-criterion is met.**

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

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

Seattle Children's

- *"Seattle Children's is the pediatric teaching hospital for the University of Washington School of Medicine, the only allopathic medical school in the WAMI region and whose Department of Pediatrics is consistently ranked by U.S. News & World Report as one of the best Medical School Pediatric Programs. An integral part of Seattle Children's mission is to serve as a resource for training and education, helping to ensure that children of future generations will have access to highly trained professionals specializing in pediatric care.*" [Source: Application, pg. 44]
- "*Table 1 details the 2014 patient origin of Seattle Children's acute inpatients.[1] Approximately eight percent (8%) of Seattle Children's acute inpatient volume originates in*

[14] UW Medicine/Harborview has historically been excluded from this calculation because of it being the state's designated Level I trauma center and receives trauma patients from all areas of the state. UW Medicine/Harborview's charity care level has historically been in the 8 to 12 % range for total revenue and 20% to 23% of adjusted revenue. In comparison, the King County region is between 1.95% to 2.9% for total revenue and 4.0% to 5.4% for adjusted revenue. For 2015 there was a dramatic drop in the amount of charity care provided at UW Medicine/Harborview. This is attributed the Affordable Care Act and the expansion of Medicaid. If this trend continues, removing UW Medicine/Harborview from the charity care calculation may not be necessary.

[15] The department acknowledges that the Affordable Care Act will likely have a long-term impact on the amount charity care provided by facilities. The regional average used to measure an applicant's compliance with the charity care standard is a self-correcting three year rolling average. The department expects an applicant to make documented reasonable efforts to meet that level of charity care.

the North King Hospital Planning Area (the Planning Area in which the hospital is physically located), another 37% originates in other areas of King County, and 49% originates outside King County but within Washington State. As a tertiary and quaternary pediatric specialty hospital, Seattle Children's also serves a significant number of patients from outside of the State. Approximately seven percent (7%), or one of every 14 of our patients in 2014, originated from out of state –primarily from Alaska, Idaho, and Montana…

Table 1 (Reproduced)
Seattle Children's Hospital
2014 Patient Origin - Acute Inpatients

Patient Residence	Discharges	Percentage
North King Planning Area	812	7.5%
Other King County	3,974	36.6%
King County Total	*4,786*	*44.1%*
Other WA	5,282	48.6%
Washington State Total	*10,068*	*92.7%*
Out-of-State	792	7.3%
Total	**10,860**	**100.0%**

Source: WA State CHARS inpatient database, excludes Rehab (DRGs 945/946), Psych (MDC 19) and NICU (MDC 15)" [Source: Application, pg. 5]

- *"Further, the University of Washington Medical School's pediatric residency program is based at Seattle Children's. Seattle Children's is also home to fellowships in adolescent medicine, allergy and immunology, bioethics, cardiology, craniofacial medicine, critical care, developmental pediatrics, emergency medicine, endocrinology, gastroenterology, general academic pediatrics, hematology/oncology, infectious diseases, neonatology, nephrology, neurology, pulmonology, and radiology."* [Source: Application, pg. 30]

Public Comments

- *"UW Medicine consists of eight entities; Harborview Medical Center, University of Washington Medical Center, Northwest Hospital & Medical Center, Valley Medical Center, UW Neighborhood Clinics, Airlift Northwest, the UW School of Medicine and the physician practice plan, UW Physicians. …The UW Medicine mission is to improve the health of the public. We accomplish this by advancing medical knowledge, providing outstanding primary and specialty care to the people of the region and by preparing tomorrow's physicians, scientists and other health care professionals."* [Source: Support letter from Cynthia Hecker, Interim Chief Health System Officer, VP for Medical Affairs, UW Medicine]

Rebuttal Comments

- None

Department Evaluation

It has long been recognized that the University of Washington Pediatric Residency program is based at Seattle Children's Hospital. Both Seattle Children's and UW Medical Center are located in the North King county planning area.

The department looked at 2015 inpatient discharge data for Seattle Children's ages 0-14[16]. The department looked at discharges by county. The data shows Seattle Children's had discharges from 31 of Washington's 39 counties. Table 10 is a summary of that information.

Table 10
Seattle Children's 2015 Discharges for Ages 0-14

	Percent of Total Discharges
Western Washington Counties[17]	86.7%
Central Washington Counties[18]	6.7%
Eastern Washington Counties[19]	2.7%
Out-of-State	4.0%
King County Only	48.6%
Washington State Total	96%

[Source: CHARS 2015 Database]

The department would agree that Seattle Children's serves patients in a larger geographic area than just the North King planning area where the hospital is located. The data shows the majority come from Washington State (96%) and of those 86.7% come from counties in western Washington.

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

Seattle Children's

- *"In addition, as one of the nation's top five pediatric research centers and with $99 million in total extramural funding for the 2015 fiscal year, Seattle Children's Research Institute is dedicated to making breakthrough discoveries that help prevent, treat, and eliminate childhood disease. The portion of our research that is integrated with inpatient care is heavily dependent on having sufficient beds to treat patients who are participating in clinical trials and research studies. A listing of our extramurally sponsored, clinical research projects with active funding is included in Exhibit 9."* [Source: Application, pg. 44]
- *In addition to direct patient care, Seattle Children's Research Institute is ranked as one of the nation's top five pediatric research institutions. Internationally recognized for advancing discoveries in cancer, genetics, immunology, infectious disease, and injury prevention, our researchers have pioneered groundbreaking cystic fibrosis treatments and leading-edge cancer therapies that help a child's immune system defeat cancer. Today, the Seattle Children's Research Institute includes more than 330,000 square feet of clinical and laboratory space, a workforce of over 1,200 people, and $99 million in total extramural funding, all to help children, adolescents, and young adults, live better, healthier lives.* [Source: Application, pg. 25]

[16] The 1987 State Health Plan defines inpatient pediatric services to be for persons 0-14 years of age. [Source: 1987 State Health Plan, pg. B-5]
[17] Western Washington counties include Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Snohomish, Thurston, and Whatcom counties.
[18] Central Washington counties include Chelan, Douglas, Kittitas, Klickitat, Okanogan, and Yakima counties.
[19] Eastern Washington counties include Adams, Asotin, Benton, Grant, Franklin, Spokane, Walla Walla, and Whitman counties.

Public Comment

- None

Rebuttal Comments

- None

Department Evaluation

Seattle Children's provided a listing of 436 items described as clinical research projects with active funding. A review of the listed projects show they range from randomized, double-blind, placebo-controlled studies and clinical trials to promoting optimal parenting and consulting services agreements. The information presented shows Seattle Children's Research Institute is involved in a wide-range of research activity.

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

Department Evaluation

This criterion is not applicable to this application.

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

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

Department Evaluation

See 3a above

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

Department Evaluation

This project does not propose to add any new services. Therefore this criterion is not applicable to this application.

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

Department Evaluation

This criterion is not applicable to this application.

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

Based on the source information reviewed, the department concludes with agreement to the conditions is the conclusion section of this analysis Seattle Children's 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.

Seattle Children's

Seattle Children's expects phase 1 to be operational in October 2016 and Phase 2 to be operational in October 2019. [Source: Application pg. 10] Based on this timeline, year 2017 would be the first full calendar year of operation for phase 1 and 2020 would be the first full calendar year of operation for phase 2. Also based on this timeline, year 2019 would be the third full calendar year of operation for phase 1 and 2022 would be the third full calendar year of operation for phase 2.

Seattle Children's projected its patient days through year 2024. The table below is a reproduction of Seattle Children's Table 5.

"Table 5 (Reproduced)
Projected Acute Care, NICU and Total Days
FY 2016-FY 2024

FY	*Acute Care Days (includes NICU, non-MDC 15, observation)*	*MDC 15 Days*	*Total Acute Care and MDC 15 Days*	*Rehab Days*	*Total Days (includes pysch. & rehab days)*
2016	*74,721*	*4,407*	*79,128*	*2,686*	*93,728*
2017	*76,563*	*4,592*	*81,155*	*2,893*	*97,367*
2018	*78,788*	*4,784*	*83,572*	*2,968*	*100,009*
2019	*80,924*	*4,985*	*85,909*	*3,044*	*102,422*
2020	*83,442*	*5,195*	*88,637*	*3,121*	*105,226*
2021	*85,791*	*5,413*	*91,204*	*3,199*	*107,871*
2022	*88,075*	*5,640*	*93,715*	*3,278*	*110,462*
2023	*90,402*	*5,877*	*96,279*	*3,358*	*113,107*
2024	*92,774*	*6,124*	*98,898*	*3,439*	*115,807"*

[Source: July 7, 2016 Screening Responses pg. 5]

Seattle Children's provided the following assumptions used for the NICU financial projections. [Source: Application, pg. 203]

- Revenue is based on the payer mix and utilization projections detailed in earlier sections of this application. Charges and reimbursement calculations were based on operating experience. Outpatient revenue was based on operating experience. There is no revenue inflation assumed.
- Bad debt is projected at approx. 0.1% of total gross revenue.

- Charity care is projected at approx. 1.5% of total gross revenue.
- Contractual allowances based on experience.
- Salaries are based on current Seattle Children's salaries. The average salary for the incremental staff was assumed to be $88,112. Benefits are assumed to be approx.. 28% of salaries.
- Supplies based on FY 2016 budget. For acute care it is assumed to be $77 per patient day (ppd) and NICU is $88/ppd.
- Purchased services are estimated to be $6/ppd for acute care and $48/ppd for NICU.
- Utilities and Insurance included in cost allocation
- Other expenses (minor repairs, specialty bed rentals, tuition reimbursements, and other miscellaneous expenses estimated at $3.50 for acute care and $4.70/ppd for NICU.

Seattle Children's provided its assumptions used for the total hospital financial projections [Source: Application, pg. 204]

- Revenue is based on the payer mix and utilization projections detailed in earlier sections of this application. Charges and reimbursement calculations were based on operating experience. Outpatient revenue was based on operating experience. There is no revenue inflation assumed.
- Bad debt is projected at approx. 0.1% of total gross revenue.
- Charity care is projected at 1.5% of total gross revenue.
- Contractual allowances based on experience.
- Salaries are based on current Seattle Children's salaries. Benefits are assumed to be. 28% of salaries.
- Supplies based on $900 per adjusted patient day.
- Purchased services include outside reference labs, bone marrow and solid organ acquisition costs, resident and interns (medical education), physician fees, software maintenance, laundry, etc. Assumed to increase from current $1,750 per adjusted patient day to $2,200.
- Utilities assumed to increase from current $13.3 million to $14.9 million with the project
- Rental and Leases includes space and equipment. Assumed to increase from current $12.8 million to $13.6 million with the project.
- Insurance included in cost allocation includes insurance premiums to maintain insurance policies necessary for the operation of the business. Assumed to increase from $5.9 million to $6.5 million with the project.
- Payer mix is 1.0% Medicare; 48.0% Medicaid, 45.0% commercial, 6% self-pay/Other.

Public Comment

- None

Rebuttal

- None

Department Evaluation

To assist in the evaluation of this sub-criterion, the department's Charity Care Program (CCP)[20] within the Office of Community Health Systems the pro forma financial statements submitted by Seattle Children's. Table 11 is a summary of Seattle Children's projected revenue, expenses, and operating income, other revenue, and net profit for FY 2016 through 2019 for the hospital. [Source: September 8, 2016, CCP analysis, pg. 4] As shown in Table 11, Seattle Children's is operating at a profit and projects the hospital would continue to operate at a profit in the projected years.

Table 11
Summary Seattle Children's
Projected Revenue and Expenses for Fiscal Years 2016 - 2018

	FY 1 2016	FY 2 2017	FY 3 2018
Net Operating Revenue	$1,319,942,000	$1,367,645,000	$1,408,393,000
Operating Expenses	$1,228,688,000	$1,281,224,000	$1,347,901,000
Operating Profit or (Loss)	$91,254,000	$86,421,000	$60,492,000
Other Revenue	$28,568,000	$30,436,000	$31,715,000
Net Profit	**$119,823,000**	**$116,857,000**	**$92,207,000**

CCP also reviewed the audited balance sheets for FY 2015 and for the projected FY year 2019. The information is shown in tables 12a and 12b.

Table 12a
Seattle Children's Balance Sheet
FY 2015

Assets		Liabilities	
Current Assets	$293,852,271	Current Liabilities	$178,330,210
Board Designated Assets	$1,148,538,566	Long Term Debt	$675,982,235
Fixed Assets	$969,912,251	Other Liabilities	-
Other Assets	176,842,869	**Equity**	$1,734,833,512
Total Assets	**2,589,145,957**	**Total Liabilities and Equity**	**$2,589,145,957**

Table 12b
Seattle Children's Balance Sheet
FY 2019

Assets		Liabilities	
Current Assets	$347,166,000	Current Liabilities	$225,612,000
Board Designated Assets	$1,248,435,000	Long Term Debt	$677,705,000
Fixed Assets	$1,562,712,000	Other Liabilities	$47,479,000
Other Assets]	$49,566,000	**Equity**	$2,257,082,000
Total Assets	**$3,207,879,000**	**Total Liabilities and Equity**	**3,207,878,000**

[20] The hospital financial analysis previously performed by Hospital Patient Data Section (HPDS) is now performed by staff from the Charity Care Program (CCP) within the Office of Community Health Systems.

CCP 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, CCP 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, CCP compares projected ratios with the most recent year financial ratio guidelines for hospital operations. For this project, CCP used FY 2015 data for comparison with projected years 2017 through 2019. The ratio comparisons are shown in the Table 13. [Source: September 8, 2016, CCP analysis, pg. 3]

Table 13
Current and Projected Financial Ratios for Seattle Children's

Category	Trend*	State 2015	SC 2015	Full Year 1 2017	Full Year 2 2018	Full Year 3 2019
Long Term Debt to Equity	B	0.533	0.390	0.347	0.322	0.300
Current Assets/Current Liabilities	A	2.701	1.648	1.649	1.587	1.539
Assets Funded by Liabilities	B	0.421	0.330	0.304	0.292	0.282
Operating Expense/Operating Revenue	B	0.948	0.851	0.931	0.937	0.957
Debt Service Coverage	A	5.048	8.618	7.545	6.705	6.071
Definitions:			**Formula**			
Long Term Debt to Equity			Long Term Debt/Equity			
Definitions:			**Formula**			
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+Depreciatioon and Interest Expense/Current Mat. LTD and Interest Expense			

* A is better if above the ratio, and B is better if below the ratio

Seattle Children's full year 3 are within acceptable range of the 2015 State average. Current Assets/Current Liabilities is out of range but review of the balance Sheet shows the Board Designated Assets is very strong which means the hospital is diligent about keeping extra cash in investments. The hospital is breaking even in the third year of operation.

CCP concluded in its review of the financial and utilization information show that the immediate and long-range capital expenditure can be met. [Source: September 8, 2016 CCP analysis, pg. 3].

Based on the source information reviewed, 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.

Seattle Children's

- *"Table 14 details the capital expenditure associated with the requested 40 acute care beds, (27 medical/surgical and 13 Level IV NICU):*

Table 14 (Reproduced)
Total Capital Expenditures

		Medical/Surgical	***NICU***	***Total***
a.	*Land Purchase*	*$ -*	*$ -*	*$ -*
b.	*Utilities to Lot Line*	*$ -*	*$ -*	*$ -*
c.	*Land Improvements*	*$ -*	*$ -*	*$ -*
d.	*Building Purchase*	*$ -*	*$ -*	*$ -*
e.	*Residual Value of Replaced Facility*	*$ -*	*$ -*	*$ -*
f.	*Building Construction*	*$11,776,624*	*$ -*	*$ 11,776,624*
g.	*Fixed Equipment*	*$1,435,039*	*$ -*	*$ 1,435,039*
h.	*Moveable Equipment*	*$1,702,536*	*$ 235,000*	*$ 1,937,536*
i.	*Architect & Engineering Fees*	*$ 480,094*	*$ -*	*$ 480,094*
j.	*Consulting Fees*	*$ 57,387*	*$ 4,000*	*$ 61,387*
k.	*Site Preparation*	*$ -*	*$ -*	*$ -*
l.	*Supervision and Inspection*	*$251,463*	*$ -*	*$ 251,463*
m.	*Costs Associated with Financing to Include Interim Interest*	*$ -*	*$ -*	*$ -*
n.	*Sales Tax:*	*$1,171,056*	*$ -*	*$1,171,056*
o.	*Other Project Costs:*	*$2,261,066*	*$ -*	*$2,261,066*
	Permits and Fees	*$64,451*	*$1,000*	*$ 65,451*
	Signage	*$84,375*	*$ -*	*$ 84,375*
	CN Review Fees	*$20,235*	*$20,235*	*$40,470*
p.	***Total Estimated Capital Expenditures***	***$19,304,326***	***$260,235***	***$19,564,561"***

[Source: Application, pg. 45]

- *"A copy of a signed nonbinding contractor's estimate is included in Exhibit 10."* [Source: Application, pg. 46]
- *"This project involves renovation of existing facilities only. The shelled space where the 27 new medical/surgical beds will be located was constructed as part of the major expansion that commenced in 2011; in a phase referred to in our 2010 CN application as 'Phase 1d." The 2010 CN application properly identified the costs associated with shelling this space.*

The NICU will expand into existing adjacent, inpatient space that is estimated to be available by late 2016." [Source: Application, pg. 8]

Public Comments

- None

Rebuttal Comments

- None

Department Evaluation

Seattle Children's identified the capital expenditure associated with the addition of the 40 beds as $19,304,326. These costs are for renovating the existing space and is completion of one floor in the existing tower previously constructed under CN #1440. A non-binding cost estimator letter from Scott Osterhage, Architect, The Seneca Real Estate Group was provided. [Source: Application, pgs. 45 & 200] The department reviewed the cost of previous hospital projects. The costs proposed by Seattle Children's are comparable to those projects.

Based on the information reviewed, the department concludes the cost of the project will probably not result in an unreasonable impact on the costs and charges for health services. **This sub-criterion is met**.

(3) The project can be appropriately financed. [21]

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.

Seattle Children's

- *"This CN project will be financed from existing reserves. Seattle Children's wants the record to reflect that while we intend to use reserves for this project, we are also intending to secure approximately $100,000,000 in new financing in late 2016. There are no CN reviewable projects associated with this new debt, but we have included the interest expense associated with this new financing in the pro forma financials (both the 'with' and 'without' project financials)."* [Source: Application, pgs. 16 and 48]

Table 17 (Reproduced)
Sources and Amount of Financing

	Source	***Amount***
a.	*Public Campaign*	*$*
b.	*Bond Issue-Tax Exempt Bonds*	*$*
c.	*Commercial Loans*	*$*
d.	*Government Loans*	*$*
e.	*Grants*	*$*
f.	*Bequests and Donations*	*$*
g.	*Private Foundations*	*$*

[21] The evaluation of this sub-criterion is limited to using the information the department had in its possession of as of the close of the rebuttal period (August 16, 2016).

Table 17 (Reproduced)
Sources and Amount of Financing

	Source	***Amount***
h.	*Accumulated Reserves/Operations/Philanthropy*	*19,564,561*
i.	*Internal Loans*	*$*
j.	*Capital Allowance*	*$*
k.	*Other*	*$*
l.	*Total*	*19,564,561*

[Source: Application, pg. 48]

- "*This project will not be funded from capital allowance."* [Source: Application, pg. 49]
- "*There is no financing associated with this CN Project. For the new debt, assumed for late 2016 and included in the baseline proformas, we estimated the interest rate to be 4.50%.*" [Source: Application, pg. 49]
- *"The use of reserves for a project the size of the CN expenditure still preserves Seattle Children's strong balance sheet and ratios, and was deemed to be superior to undertaking debt specific to the project. As noted earlier, to capitalize on the low interest rates currently available in the market, Seattle Children's does intend to undertake about $100,000,000 in new financing for non-CN reviewable projects in late 2016."* [Source: Application, pg. 50]
- *"The use of reserves for this project still preserves Seattle Children's strong balance sheet and ratios. The additional debt is being proposed for late 2016 to capitalize on the low interest rates currently available in the market place and will be used for non-CN reviewable projects."* [Source: Application, pg. 51]
- *"A copy of a letter from our Senior Vice President and Chief Financial Officer is included as Attachment 2."* [Source: Screening Responses received June 20, 2016]
- *"I am writing to confirm that Seattle Children Hospital is using reserves to fund the capital cost associated with the addition of the 40 acute care beds proposed in our recently submitted certificate of need (CN) application. The capital cost is estimated at $19,564,561.* [Source: Screening responses received June 20, 2016, Attachment 2]

Public Comments

- None

Rebuttal Comments

- None

Department Evaluation

The capital expenditure identified with this project is $19,564,561. Seattle Children's stated it will fund the project using its reserves. The investment represents less than 1% of total assets and only 1.7% of Board Designated Assets. [Source: September 8, 2016 CCP analysis, pg. 4] Seattle Children's also states it is intending to obtain $100,000,000 in additional financing for non-CoN related projects.

Seattle Children's provided a letter of financial commitment from Seattle Children's Chief Financial Officer, Kelly Wallace. Seattle Children's reports its 2015 audited financial statements identified more than $736,000,000 in cash and investments as of September 30, 2015. [Source: June 20, 2016 Screening Responses, Attachment 2]

The department concludes that Seattle Children's project can be appropriately financed. **This sub-criterion is met.**

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

Based on the source information the department concludes Seattle Children's application 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.

Seattle Children's

- *"Table 19 details the projected additional FTEs. The requested salary and wage information for the CN Project is included in the financial assumptions in Exhibit 11.*

Table 18 (Reproduced)
Total FTEs (2016) and Incremental Staffing, Salaries and Wages, "With" Project, Acute and NICU Incremental Staffing Only

		Incremental Staffing							
	Total 2016 FTEs	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Acute Care/Nursing	*678*	*19*	*17*	*16*	*26*	*20*	*19*	*20*	*20*
NICU Nursing	*83*	*2*	*3*	*4*	*3*	*3*	*3*	*4*	*4*
Other[32]	*4,505*	*18*	*23*	*23*	*27*	*26*	*25*	*27*	*27*
Total	*5,265*	*39*	*43*	*43*	*56*	*49*	*47*	*51*	*51*

[Source: Application, pg. 54]

- *"Over the years, Seattle Children's has enjoyed success in both recruitment and retention of staff. We believe, in large part, that this is attributable to Seattle Children's reputation as one of the nation's leading pediatric hospitals and research institutions, our commitment to provide family centered care, and our dedication to serve as a resource for training and education."* [Source: Application, pg. 55]
- *"Seattle Children's recognizes that meeting the needs of the patients and families that need us can be demanding and has worked to engage, support, and develop our workforce so that our patients and families can receive the best care. This includes maintaining patient to staff ratios that facilitate a supportive work environment…."* [Source: Application, pg. 55]
- *Since employee recruitment and retention of the best staff is critical to the success of Seattle Children's, we offer competitive salaries, a generous paid time off program, benefit packages, tuition assistance, and a variety of programs dedicated to caring for our employees' well-being. As an example of Seattle Children's recruitment and retention strategies include:*

- *Seattle Children's Tuition Assistance Program provides financial assistance to help staff members pursue education to advance toward, or develop in, a career within the organization.*
- *We support both internal and external learning opportunities, including participation in professional associations, continuing education, community activities, and pursuit of advance degrees. Our goal is to help Seattle Children's staff exceed in their roles and provide opportunities for leadership development and employee advancement.*
- *Seattle Children's offers sign on bonuses/relocation assistance for hard to fill positions.*
- *Each and every year, Seattle Children's undertakes an employee engagement survey. The results of this survey are used at the department level to develop action plans to improve staff engagement, as an engaged and committed workforce is vital to our mission.*
- *Seattle Children's engages staff in Continuous Performance Improvement (CPI) in order to enhance the delivery of exceptional healthcare by implementing process improvements to eliminate waste. Involving individuals who do the work in our improvement efforts has not only improved workflow, but it has also worked to gain employee commitment to Seattle Children's.*
- *Seattle Children's also has a Talent Acquisition department that supports our management team in the recruitment and hiring process. Our Talent Acquisition department includes dedicated nurse recruiters who work largely to hire for hard-to-fill positions. These individuals conduct national searches and attend national conferences for pediatric nursing and sub-specialty nursing. In addition, they attend job fairs and reach out to local colleges and universities* [Source: Application, pg. 56]

- *"Dr. Mark Del Beccaro is the Chief Medical Officer of Seattle Children's Hospital and our Chief Nursing Officer is Madlyn Murrey."* [Source: Screening Responses received June 20, 2016, pg. 7]
- *"The Medical Director is employed, not under contract, so this question is not applicable."* [Source: Screening Responses received June 20, 2016, pg. 7]
- *"The job description for Seattle Children's Chief Medical Officer is included as Attachment 3."* [Source: Screening Responses received June 20, 2016, pg. 8]

Public Comments
- None

Rebuttal Comments
- None

Department Evaluation

Between FY 2017 and FY 2024 Seattle Children's projected adding a total of 379 FTEs. Of these 379 FTEs, 26 are identified for the NICU, 157 are identified with acute care/nursing, and 220 are identified in the other category. The FTEs in the other category include areas such as clinical support services, information services, general, administrative, and business services. If all FTEs are hired, this would equate to a 7.2% increase in overall staffing for Seattle Children's. Seattle Children's has a history of recruiting and retaining sufficient supply of qualified staff for its hospital. The department does not expect it to be any different with this project.

Dr. Mark Del Beccara has been identified as the Chief Medical Officer of Seattle Children's Hospital. Dr. Del Beccara is employed by Seattle Children's. Seattle Children's provided the job description that included the roles and responsibilities of the Chief Medical Officer position. [Source: June 20, 2016 Screening Responses, Attachment 3]

Seattle Children's is proposing to add minimal staff over a six year period of time. The described the recruiting and retention programs and activities they use to maintain sufficient staff.

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

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

WAC 246-310 does not contain specific WAC 246-310-230(2) as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs what relationships, ancillary and support services should be for a project of this type and size. Therefore, using its experience and expertise the department assessed the materials contained in the application.

Seattle Children's

- *"In the planning for the recent Tower and bed expansion, Seattle Children's conducted an in-depth analysis of the capacity of our existing ancillary and support services to assure that they were right-sized to accommodate additional capacity. Various projects were undertaken to expand or grow services where deficits were identified. Based on this prior work, we are confident that the existing ancillary and support services will meet the demands of this relatively small, incremental bed addition."* [Source: Application, pg. 57]

Public Comments

- None

Rebuttal Comments

- None

Department Evaluation

Seattle Children's stated it conducted an in-depth analysis of the capacity of its ancillary and support services as part of its planning for their previous expansion. As a result of this analysis, Seattle Children's states changes were made where needed. CoN staff was able to substantiate through the department's Construction Review Services database Seattle Children's statement. Therefore, the department concludes **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.

Seattle Children's

- *"Seattle Children's is licensed by Washington State as an acute care hospital, and is accredited by DNV GL – Healthcare. Seattle Children's also has a number of programs and services that are accredited by several other agencies, including The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), and the Commission of Cancer (CoC)."* [Source: Application, pg. 2]
- *"Seattle Children's has no history with respect to the actions described in the Certificate of Need (CN) criterion WAC 248-19-390 (5) (a), now codified at WAC 246-310-230 (5) (a)."* [Source: Application, pg. 3]
- *"For the NICU, Craig Jackson, MD is the employed medical director."* [Source: Application, pg. 6]
- *"Seattle Children's operates all of its programs in conformance with applicable federal laws, rules, and regulations."* [Source: Application, pg. 58]

Public Comment

- None

Rebuttal Comment

- None

Department Evaluation

Seattle Children's is licensed by the State of Washington as an acute care hospital, and is accredited by Det Norske Veritas-Germanischer Lloyd Healthcare (DNV-GL-Healthcare)[22]. DNV-GL Healthcare visits Seattle Children's annually to ensure that the hospital is meeting the CMS Conditions of Participation and requires that the hospital work towards compliance with international Standards Organization (ISO) 9001 Quality Management Systems requirements. Seattle Children's holds a three year accreditation that expires July 22, 2019. In addition Seattle Children's also holds a three year accreditation from CARF in pediatric specialty program and in brain injury specialty program.

Review of previous surveys in department licensing records and confirmation by Seattle Children's in their application indicates there were no adverse licensing actions as a result of these surveys.

Seattle Children's identified Dr. Del Beccara as its Chief Medical Officer. A review of Dr. Del Beccara's compliance history with the Department of Health's Medical Quality Assurance Commission did not revealed any recorded sanctions. [Source: Compliance history provided by Medical Quality Assurance Commission] In addition to Dr. Del Beccara, Dr. Craig Jackson is identified as the medical director of the NICU. A review of Dr. Jackson's compliance history with the Department of Health's Medical Quality Assurance Commission did not revealed any recorded sanctions. [Source: Compliance history provided by Medical Quality Assurance Commission]

Seattle Children's identified its Chief Nursing Officer as Madlyn Murrey. A review of Ms. Murrey's compliance history with the Department of Health's Nursing Quality Assurance Commission did not

[22] DNV-GL-Healthcare is an accreditation agency and provides accreditation services for Seattle Children's Hospital. Comparable to The Joint Commission, DNV-GL Healthcare has been approved by the Centers for Medicare and Medicaid Services (CMS) to deem hospitals in compliance with the CMS Conditions of Participation.

revealed any recorded sanctions. [Source: Compliance history provided by Nursing Quality Assurance Commission]

The department concludes there is reasonable assurance Seattle Children's will continue to be operated in conformance with applicable state and federal licensing and certification requirements. Based on the information reviewed, the department concludes **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.

Seattle Children's

- *"Seattle Children's utilizes standardized clinical pathways to ensure that each patient is placed in the most appropriate setting to facilitate timely and appropriate discharge. Seattle Children's clinical pathways, while intended to be adapted to each specific patient, provides a starting point in planning the care of any patient with a specific diagnosis. These guidelines are tailored by the patient's healthcare providers to meet the needs of the individual patient."* [Source: Application, pg. 57]
- "*Seattle Children's has a long and extensive history of working with a variety of organizations in the Puget Sound and throughout the WAMI region, in advancement of continuity for the patients and families we serve. For example, Seattle Children's operates regional clinics in Bellevue, Everett, Federal Way, Mill Creek, Olympia, Tacoma, Tri-Cities, Wenatchee, and Anchorage. Additionally, Seattle Children's sends our providers to over 35 hospitals and clinics throughout the WAMI region to provide care for patients closer to home. This includes our hospitalists, who staff the pediatric inpatient units at five community hospitals, and our neonatologists and neonatal nurse practitioners, who provide neonatal leadership and in-hospital coverage for six Level II/Level III NICUs throughout Washington. In each of these areas, Seattle Children's collaborates with local providers, state agencies, and others to ensure continuity of care, access, family support, and education."* [Source: Application, pg. 58]
- *"Currently, Seattle Children's uses telemedicine technology in a variety of settings, improving continuity of care with local providers:*
  - *Outpatient clinics: enabling access to sub-specialty providers and services*
  - *Teaching: access to education and training available such as Autism 100 and 200 series, Bladder Health class, Bowel Health class, case conferences, nursing and medical grand rounds*
  - *Inpatient: pediatric and neonatal intensivists and discharge planning coordination*
  - *Provider to provider consultation"* [Source: Application, pg. 58]
- *"This proposed bed expansion is expected to enhance continuity of care to our patients, including our very vulnerable population – the two-thirds of our patients with chronic health*

care needs. With this bed addition, our goal is to avoid having to delay admissions or divert patients to other facilities due to a lack of available beds." [Source: Application, pg. 59]

Public Comments

- None

Rebuttal Comments

- None

Department Evaluation

Seattle Children's has long establish relationships with a variety of organizations in their planning area.

The formal relationships include providing on site staffing, clinic services, telemedicine and teaching. Nothing in the materials reviewed by the department suggests this project will change the relationships Seattle Children's has with existing area providers. Based on the information reviewed, the department concludes **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, the department concludes that Seattle Children's has met the cost containment criteria in WAC 246-310-240.

(1) Superior alternatives, in terms of cost, efficiency, or effectiveness, is not available or practicable.

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

Step two. If the project has met the applicable criteria in WAC 246-310-210 through 230 criteria including any project type specific 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 in Step three. The superiority criteria are objective measures used to compare competing projects and make the determination between two or more approvable projects, which is the best alternative. If WAC 246-310 does not contain any service or facility type superiority criteria as directed by WAC 246-310-200(2) (a)(i), then the department would use WAC 246-310-240(2)(a)(ii) and (b) for criteria to make the assessment of the competing proposals. If there are no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b), then using its experience and expertise, the department would assess the competing projects and determine which project should be approved.

Department Evaluation

Step One

The department determined Seattle Children's met the applicable review criteria under WAC 246-310-210, 220, and 230. Therefore, the department moves to step two.

Step Two

Seattle Children's

- "*As mentioned in throughout this CN application, for the expansion of our medical/surgical unit, the space we are in the process of completing was originally envisioned as bed replacement space. In other words Seattle Children's intended to complete a new state-of-the-art nursing unit, and then relocate beds and take older beds off-line. However, because inpatient, NICU, and observation census has increased faster than anticipated and because Seattle Children's Board and Leadership are committed to have sufficient bed capacity to meet the needs of our region's children, a decision was made to pursue a modest number of new beds now. Once the decision was made to pursue the new beds, the only alternatives considered were timing and the number of beds. Twenty-seven (27) new beds for our medical surgical unit, put into operation over the span of three years, was deemed to be prudent and can be staffed to realize efficiencies.*" [Source: Application, pg. 61]

- *In terms of the Level IV NICU, as mentioned in the Project Description and Need sections of this application, in 2015 due to consistently high census, we reassigned 7 existing acute care beds to Level IV NICU beds, increasing our Level IV NICU from 19 to 26 beds. Since July 1, 2015, these 26 beds have been operating at higher than 80% midnight occupancy on more than half the days, and more than the target occupancy level of 65% that the CN Program has used for other NICUs, on 96% of the days. Clearly, more beds are needed to assure that we can continue to admit neonates from the State and throughout the WAMI region that present with quaternary needs that are best treated at Seattle Children's. The decision to limit the expansion from 26 to 32 was based on space availability and the desire to preserve some existing intensive care beds to accommodate high census times. The expanded NICU will occupy part of a recently vacated intensive care unit that has the capacity for six (6) more NICU beds. This allowed for a low capital, efficient way to address the growing need."* [Source: Application, pg. 61]

Public Comments

- None

Rebuttal Comments

- None

Department Evaluation

Information evaluated by the department demonstrates there is a need for additional acute care beds for Seattle Children's but not at the requested level. With a reduction in the number of general acute care beds to be added, the department concludes **this sub-criterion is met**.

Step Three

This step is applicable only when there are two or more approvable projects. Seattle Children's application is the only application under review to add acute pediatric bed capacity. Therefore this step does not apply.

Based on the information above, the department concludes **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;

WAC 246-310 does not contain specific WAC 246-310-240(2)(a) criteria as identified in WAC 246-310-200(2)(a)(i). There are known minimum building and energy standards that healthcare facilities must meet to be licensed or certified to provide care. If built to only the minimum standards all construction projects could be determined to be reasonable.

Seattle Children's

- *As discussed in earlier sections of this application, Seattle Children's is proposing to renovate existing shelled space. The shelled space where the 27 new medical/surgical beds will be located, was constructed as part of our major expansion that commenced in 2011 and Continuous Process Improvement (CPI) principles were used to plan the project's operational and facility improvements. The space was ultimately designed and shelled to optimize the use of square footage and staff/provider efficiency.* [Source: Application, pg. 62]
- *Seattle Children's has a long-standing approach to sustainable design, construction, and material selection. As noted in our 2010 CN application, consistent with these principles, Seattle Children's retained LEED experts during the design of our inpatient building expansion and evaluated various energy reduction options. Ultimately, Seattle Children's incorporated elements that are expected to result in lower energy costs throughout the life of the project and was awarded LEED Gold certification by the U.S. Green Building Council (USGBC) in recognition of the building's sustainable design, resource consumption, and construction. These same standards will apply to the proposed bed expansion.* [Source: Application, pg. 63]

Public Comments

- None

Rebuttal Comments

- None

Department Evaluation

The information reviewed by the department is consistent with similar hospital construction projects. Therefore, the department concludes **this sub-criterion is met**.

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

Seattle Children's

- *"The 40 bed expansion will occur in space already constructed as part of the City of Seattle Major Institutions Master Plan (MIMP) approval, which Seattle Children's received on April 5, 2010."* [Source: Application, pg. 18]
- *This approval provides the underlying zoning and other approvals.*
- *"A comparison of the 'with' and 'without' scenario pro formas, demonstrates that the Total Project provides efficiencies that would not be achieved in its absence. As noted in the Financial Feasibility section of this application, (see response to question #12), Seattle Children's intends to incur the capital expenditure needed to make the 40 beds operational. If CN approval is not granted, Seattle Children's will simply "decant" existing patient rooms to increase the percentage of single occupancy rooms. As a result, there is no incremental capital cost (depreciation and interest expense) for this project. However, as noted in other sections of this application, starting in 2020, lower growth rates have been assumed for acute care and NICU in the 'without' project scenario due to capacity and occupancy constraints. Therefore, in the 'without' project scenario, the capital cost would be borne over fewer adjusted patient days and the capital cost per adjusted patient day would be higher 'without' the project, than it would be 'with' the project."* [Source: Application, pg. 62]

Public Comment
- None

Rebuttal Comments
- None

Department Evaluation

This project involves construction. The physical space where the proposed beds are to be located either has or is in the process of being completed. Seattle Children's has stated that if this project is not approved, it would re-distribute currently licensed beds from older parts of the hospital into the new physical space and keeping its licensed bed capacity at the approved level. Even with a smaller number of beds being approved for general acute care, the department does not anticipate an unreasonable impact on the costs and charges to the public of providing these type services by others. Therefore, the department concludes **this sub-criterion is met**.

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

This project will improve the delivery of health services. Even with the reduced number of beds being add, the construction costs for this project will appropriately improve the delivery of health services. Therefore, the department concludes **this sub-criterion is met**.