

EVALUATION OF THE CERTIFICATE OF NEED APPLICATION SUBMITTED ON BEHALF OF BY MANOR CARE OF LACEY WASHINGTON LLC PROPOSING TO ESTABLISH A 120-BED SKILLED NURSING CENTER WITHIN THURSTON COUNTY

PROJECT DESCRIPTION

Manor Care of Lacey WA, LLC is a subsidiary of Manor Care Health Services, LLC, which is a subsidiary of Manor Care Inc, which, in turn is a subsidiary of HCR Manor Care, Inc, which is a subsidiary of the Carlyle Group. For all of the entities identified, only Manor Care of Lacey WA, LLC is registered in Washington State. The remaining entities are registered in the state of Delaware. While Manor Care of Lacey WA does not own or operate any healthcare facilities in Washington or any other state, Manor Care Health Services LLC is the parent company of several subsidiaries. The company operates primarily under the names of Heartland, ManorCare Health Services, and Arden Courts. [source: Application, p2 & Exhibit 1; October 24, 2007 supplemental information, p1 & Attachment A; and HCR ManorCare website]

As of end of year 2007, through its subsidiaries, Manor Care, Inc. owns, operates, or manages over 500 healthcare facilities, which includes skilled nursing centers, assisted living facilities, outpatient rehabilitation clinics, and hospice and home health offices across the nation. The healthcare facilities owned, operated, or managed by Manor Care, Inc. are grouped geographically into six operating divisions:

East Mid-West Central **West** Mid Atlantic Southeast

Washington State is located in the West division [in bold above], and includes facilities owned and operated by Manor Care Health Services, Inc. or its subsidiary Heartland. For Washington State, Manor Care Inc. owns and operates five skilled nursing facilities through its subsidiaries. Further, Manor Care Inc. owns and operates a home care agency and a Medicare certified home health agency through its Heartland subsidiary. The Washington State facilities and city of location are shown in the chart below. [source: Manor Care Website and Wikipedia]

Skilled Nursing Facilities

Manor Care of Gig Harbor WA, LLC, Gig Harbor
Manor Care of Lynnwood WA, LLC, Lynnwood
Manor Care of Spokane WA, LLC, Spokane
Manor Care of Tacoma WA, LLC, Tacoma
Manor Care of Salmon Creek WA, LLC, Vancouver¹

Home Care and Home Health Agencies

Heartland Home Care, Seattle
Heartland Home Health Care Services, Seattle

This application was submitted by Manor Care of Lacey WA, LLC, as a subsidiary of Manor Care, Inc. For Certificate of Need purposes, Manor Care of Lacey, WA, LLC is considered the applicant, and will be referenced in this document as “MC-Lacey.”

This project requests approval to establish a sixth skilled nursing facility (SNF) in Washington State. The proposed SNF would have 120 beds and be located on a parcel of land at 4524 Intelco Loop in

¹ On April 4, 2008, Manor Care was issued Certificate of Need #1366 approving the establishment of a 120-bed skilled nursing facility in Salmon Creek, within Clark County. Given the recent approval, the facility is not yet operational.

Lacey, within Thurston County.² The planning area for this project is Thurston County. [source: Application, p3; February 5, 2008, supplemental information, p2; and Thurston County Assessor website]

The proposed SNF would be a 57,401 gross square foot, two-story building with 28 private rooms and 46 semi-private rooms. The facility will also have two nurses stations, physical therapy, occupational therapy, speech therapy, recreational therapy space, resident lounges, dining rooms, beauty/barber shop, a kitchen, administrative offices and support areas. Services proposed to be provided at the new SNF include skilled nursing care, intensive rehabilitative therapies, respite care, and community outreach services. [source: Application, p4]

In past projects, DSHS has voiced concerns regarding the Program's use of the phrase "skilled nursing facility" or "SNF" when describing this type of project. Washington Administrative Code (WAC) 388-97-005 provides a definition for both "skilled nursing facility" and "nursing facility", which is restated below:

"Skilled nursing facility (SNF)" or "Medicare-certified skilled nursing facility" means a nursing home that has been certified to provide nursing services to Medicare recipients under Section 1819(a) of the Federal Social Security Act.

"Nursing facility (NF)" or "Medicaid-certified nursing facility" means a nursing home that has been certified to provide nursing services to Medicaid recipients under Section 1919(a) of the Federal Social Security Act.

The new facility in Thurston County would seek certification to provide services to the Medicare and Medicaid populations. Based on the definitions above, the new facility is considered both an NF and an SNF. For this evaluation, the department will refer to the proposed facility as a skilled nursing facility or SNF.

The anticipated date of commencement of construction of the facility is October 2008, with an estimated date of completion of November 2009. The facility is expected to begin serving patients in January 2010. Under this timeline, the first full year of operation is projected to be calendar year 2010, and year three is 2012. [source: Application, p4 & p7]

The estimated capital expenditure for this project is \$14,273,000, of which 66% is related to constructions costs; 14% is related to equipment costs; 6% is related to land purchase; 6% is related to corporate overhead; 5% is related to state sales tax; and the remaining 3% is related to fees and real estate taxes. [source: Application, p20]

APPLICABILITY OF CERTIFICATE OF NEED LAW

This project is subject to Certificate of Need review as the construction, development, or other establishment of a new health care facility under the provisions of Revised Code of Washington (RCW) 70.38.105(4)(a) and Washington Administrative Code (WAC) 246-310-020(1)(a) and 246-310-380.

² The Thurston County Assessor's Office identifies the site with parcel #58050002800.

CRITERIA EVALUATION

To obtain Certificate of Need approval, Manor Care of Lacey, WA, LLC must demonstrate compliance with the criteria found in WAC 246-310-210 (need); 246-310-220 (financial feasibility); 246-310-230 (structure and process of care); and 246-310-240 (cost containment); and WAC 246-310-360 (nursing home bed need method).³

APPLICATION CHRONOLOGY

August 29, 2007	Letter of Intent Submitted
September 27, 2007	Application Submitted
September 28, 2007 through March 6, 2008	Department's Pre-Review Activities <ul style="list-style-type: none">• 1st screening activities and responses
March 7, 2008	Department Begins Review of the Application <ul style="list-style-type: none">• public comments accepted throughout review
April 22, 2008	Public Hearing Conducted/End of Public Comment
June 4, 2008 ⁴	Rebuttal Documents Received at Department
July 21, 2008	Department's Anticipated Decision Date
August 21, 2008	Department's Revised Anticipated Decision Date
August 21, 2008	Department's Actual Decision Date

CONCURRENT REVIEW AND AFFECTED PERSONS

As directed under WAC 246-310-130(5), the department accepted this project under the 2007 nursing home current review cycle for the Thurston County planning area. In accordance with Certificate of Need Program policy, when applications initially submitted under a concurrent review cycle are deemed not to be competing, the department has converted the review to the regular review process. Given that this application was the only application received under the concurrent review cycle for Thurston County, the application was converted to a regular review.

Throughout the review of this project, the following five entities sought and received affected person status under WAC 246-310-010:

- Evergreen Nursing and Rehabilitation Center, an SNF located in Olympia;
- Providence Mother Joseph Care Center, an SNF located in Olympia;
- Providence Health System, a healthcare system located in Olympia;
- Puget Sound Healthcare Center, an SNF located in Olympia; and
- Roo-Lan Health Care Center, an SNF located in Lacey.

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

⁴ The applicant sought and received an additional 28 days under the regular review timeline to provide rebuttal comments. The 28-day extension was also granted for affected persons.

SOURCE INFORMATION REVIEWED

- Manor Care of Lacey WA, LLC's Certificate of Need application received September 27, 2007
- Manor Care of Lacey WA, LLC's supplemental information dated February 5, 2008
- Public comment received during the course of the review
- Comments received at the public hearing conducted on April 22, 2008
- Rebuttal comments from Manor Care of Lacey WA, LLC received June 4, 2008⁵
- Rebuttal comments from Providence Health Systems received June 4, 2008
- Rebuttal comments from Puget Sound Health Care and Evergreen Nursing Rehabilitation Center (both owned and operated by Extendicare) received June 4, 2008
- Population data obtained from the Office Financial Management based on year 2000 census published November 2007
- Years 2005 and 2006 Medicaid cost report data provided by the Department of Social and Health Services⁶
- Licensing and/or survey data provided by the Department of Social and Health Services
- Building lid and reimbursement data provided by the Department of Social and Health Services, Office of Rates Management
- Data obtained for nursing homes, adult family homes, and boarding homes from Department of Social and Health Services website www.aasa.dshs.wa.gov
- Information obtained from the applicant's website at www.hcr-manorcare.com
- Certificate of Need Historical files
- Adult Family Home and Boarding Home Data obtained by The Gilmore Research Group received February 2, 2008
- Revised Code of Washington 70.127 governing in-home service agencies

CONCLUSION

For the reasons stated in this evaluation, the application submitted by Manor Care of Lacey, WA is not consistent with applicable criteria of the Certificate of Need Program, and a Certificate of Need is denied.

⁵ Manor Care also submitted a revised Schedule F and revised page 29 of the application. This information was submitted outside the time allowed for submission, therefore this data will not be considered in this review.

⁶ As of the writing of this evaluation, 2007 Medicaid cost report data is not available.

A. Nursing Home Bed Need Method (WAC 246-310-360)

For all applications where the need for nursing home beds is not deemed met as identified in RCW [70.38.115\(13\)](#), the [following] mathematical calculation will be used as a guideline and represent only one component of evaluating need.

As stated in the project description portion of this evaluation, the proposed SNF would be an additional facility in Thurston County, and the 120 beds would be added to the county's total bed count. As such, the need for an additional 120 beds must be demonstrated by the applicant. One component of evaluating need for additional SNF beds is applying the nursing home bed need numeric methodology. The ratio of 40 beds per 1,000 population over 65 years of age (40/1,000) is used for projecting total bed need for SNFs in the state and within a planning area.

The methodology, outlined in WAC 246-310-360, is a four-step process. The first step requires a computation of the statewide and planning area specific estimated bed need for the projection year. For nursing home applications submitted in the 2007 concurrent review cycle, 2010 is the projection year. The second step requires a computation of the projected current supply ratio statewide and for each planning area. The third step requires a determination of the planning areas that will be under the established ratio, or over the established ratio, in the projection year. The fourth, and final step, requires a comparison of the most recent statewide bed supply with the statewide estimated bed need.

Application of the first four steps of the methodology outlined above indicates that Washington State is projected to be under the 40/1,000 established ratio by 7,865 beds in year 2010—the projection year.

Step four provides further guidance if the current statewide bed supply is greater than or equal to the statewide estimated bed need, or if the current statewide bed supply is less than the statewide estimated bed need. Given the current statewide bed supply is less than the statewide estimated bed need, the department must then determine the difference between the statewide estimated bed need and the statewide current bed supply, which is referenced as “statewide available beds.” The methodology then requires a comparison of whether the statewide available beds is sufficient to allocate to each planning area under the established 40/1,000 ratio enough beds to bring that planning area up to the established ratio. If there is not enough beds, the methodology directs the department to assign to each planning area under the established ratio a proportion of statewide available beds equal to the ratio of that planning area's bed need to reach the established ratio in the projection year. The proposed health planning area for this project is Thurston County. Application of this portion of step four to the planning area yields 591 additional beds could be added to bring the planning area to the established ratio in the projection year.

To demonstrate need for an additional 120 beds, MC-Lacey provided calculations that conclude the planning area is currently under the 40/1,000 established ratio. While comments were provided by both affected and interested persons in opposition to this project, none of the comments dispute the methodology's mathematic conclusion of need for additional beds within the planning area.

In conclusion, the numeric methodology is a population-based assessment to determine the baseline supply of nursing home beds within the state and planning areas to determine whether the existing number of beds is adequate to serve the elderly population. Based solely on the numeric methodology, the department concludes that additional nursing home beds are justified in the Thurston County planning area in the projection year 2010.

B. Need (WAC 246-310-210)

Based on the source information reviewed, the department determines that the application is consistent with the applicable need criteria in WAC 246-310-210.

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

WAC 246-310-210 requires the department to evaluate all CN applications based on the population's need for the service and determine whether other services and facilities of the type proposed are not, or will not be, sufficiently available or accessible to meet that need. For nursing home projects, subsection (6) identifies the factors used to evaluate this sub-criterion. Specifically, if the state is below the statewide estimated bed need, the department shall determine the need for nursing home beds, including distinct part long-term care units located in a hospital licensed under chapter [70.41](#) RCW, based on the availability of:

- 1) other nursing home beds in the planning area to be served; and
- 2) other services in the planning area to be served. Other services to be considered include, but are not limited to: assisted living (as defined in chapter [74.39A](#) RCW); boarding home (as defined in chapter [18.20](#) RCW); enhanced adult residential care (as defined in chapter [74.39A](#) RCW); adult residential care (as defined in chapter [74.39A](#) RCW); adult family homes (as defined in chapter [70.128](#) RCW); hospice, home health and home care (as defined in chapter [70.127](#) RCW); personal care services (as defined in chapter [74.09](#) RCW); and home and community services provided under the community options program entry system waiver (as referenced in chapter [74.39A](#) RCW). The availability of other services shall be based on data that demonstrates that the other services are capable of adequately meeting the needs of the population proposed to be served by the applicant.

Services to be provided at the new facility include skilled nursing, rehabilitation, and a variety of therapies. [source: Application, pp4-5] The proposed services are consistent with the types of services provided in the existing nursing homes within the planning area. As a result, the department must consider their availability and determine whether another SNF is needed in the planning area.

Other Nursing Home Beds in the Planning Area to be Served

Before evaluating the availability of other nursing homes, a summary of general information and definitions of commonly used terms is necessary.

Nursing Home

The Department of Social and Health Services (DSHS) is responsible for oversight for nursing homes (licensure and survey), and the definition of "nursing home" below is restated from the DSHS regulations—RCW 18.51.010(1).

"Nursing home" means any home, place or institution which operates or maintains facilities providing convalescent or chronic care, or both, for a period in excess of twenty-four consecutive hours for three or more patients not related by blood or marriage to the operator, who by reason of illness or infirmity, are unable properly to care for themselves. Convalescent and chronic care may include but not be limited to any or all procedures commonly employed in waiting on the sick, such as administration of medicines, preparation of special diets, giving of bedside nursing care, application of

dressings and bandages, and carrying out of treatment prescribed by a duly licensed practitioner of the healing arts. It may also include care of mentally incompetent persons. It may also include community-based care. Nothing in this definition shall be construed to include general hospitals or other places which provide care and treatment for the acutely ill and maintain and operate facilities for major surgery or obstetrics, or both. Nothing in this definition shall be construed to include any boarding home, guest home, hotel or related institution which is held forth to the public as providing, and which is operated to give only board, room and laundry to persons not in need of medical or nursing treatment or supervision except in the case of temporary acute illness. The mere designation by the operator of any place or institution as a hospital, sanitarium, or any other similar name, which does not provide care for the acutely ill and maintain and operate facilities for major surgery or obstetrics, or both, shall not exclude such place or institution from the provisions of this chapter: PROVIDED, That any nursing home providing psychiatric treatment shall, with respect to patients receiving such treatment, comply with the provisions of RCW [71.12.560](#) and [71.12.570](#).

As noted by the definition above, nursing homes provide convalescent and/or chronic care to three or more patients for a period in excess of 24 hours. The patients are unable to properly care for themselves for reason of illness or infirmity.

Eligibility for Medicare and Medicaid skilled nursing services is governed by the Centers for Medicare and Medicaid Services (CMS). Medicare covers skilled nursing services for as long as a patient is eligible and the patient's physician orders the services. Eligibility requirements for coverage by Medicare includes a hospital stay for three consecutive days prior to being admitted into the SNF; further the skilled care must be required on a daily basis and the services must be those that, as a practical matter, can only be provided in an SNF on an inpatient basis. [source: CMS Handbook: [Medicare Coverage of Skilled Nursing Facility Care](#)]

As of the writing of this evaluation, Thurston County has 690 SNF beds distributed among six community-based SNFs (C-SNF) and one-hospital based SNF (H-SNF). The six C-SNFs provide services to the Medicare and Medicaid populations; the one H-SNF does not. [source: 2005-2006 DSHS cost report data]

Of the planning area's 690 total beds, as of May 2008, 675 are currently licensed. Of the remaining 15 beds, 6 are banked under the alternate use provisions of RCW 70.38.111(8)(a) and WAC 246-310-395. RCW 70.38.111(8)(d) states:

“Nursing home beds that have been voluntarily reduced under this section [RCW 70.38.111(8)] shall be counted as available nursing home beds for the purpose of evaluating need under RCW [70.38.115\(2\)](#) (a) and (k) so long as the facility retains the ability to convert them back to nursing home use under the terms of this section.”

As required above, the department must count the 6 beds banked under alternate use as available beds in the planning area.

The remaining 9 beds are banked under the full facility closure provisions of RCW 70.18.115(13)(b) and WAC 246-310-396. On March 1, 2007, the department approved Capital Medical Center's request to bank 9 beds under full facility closure for its H-SNF located within the hospital. Since the 9 beds were banked by the licensee who had operated the beds for the 12 months preceding the request for bed banking, these 9 beds must also be counted as available

beds in the Thurston County planning area. [source: WAC 246-310-396(4)] In summary, all 690 beds in Thurston County must be counted as available beds in this evaluation.

The Thurston County planning area’s number of licensed and the number of banked beds broken down by facility is summarized in Table 1 below. [source: Certificate of Need Bed Supply Log, March 11, 2008]

**Table 1
Thurston County Planning Area 2008 Bed Count by Skilled Nursing Facility**

Name of Facility	# of Lic'd Beds	# of AU Banked Beds	# of FFC Banked Beds	Total # of Beds
Capital Medical Center (H-SNF)	0	0	9	9
Evergreen Nursing & Rehab Center	129	6	0	135
Olympia Manor	28	0	0	28
Panorama City & Rehab Center	155	0	0	155
Providence Mother Joseph Care Center	152	0	0	152
Puget Sound Healthcare Center	108	0	0	108
Roo-Lan Healthcare Center	103	0	0	103
Total # of Facilities = 7	675	6	9	690

To further assist in its determination whether patients proposed to be served by MC-Lacey would also be candidates for the existing SNFs currently operating in the planning area, the department compared the applicant’s proposed average nursing hours per patient day with the existing C-SNF’s averages. It is noted that the comparison does not include the H-SNF associated with Capital Medical Center. Because that facility has elected to not participate in the Medicaid program, data for this facility is not included in the DSHS cost reports. While data for this facility is obtained through the department’s CHARS data, nursing hours per patient day is not collected. Additionally, Olympia Manor was closed for renovations for at least three months in year 2005; as a result, year 2005 data would be slightly skewed for Olympia Manor. Therefore, Olympia Manor’s data is not included in the 2005 data shown in Table 2 below, however, it is included in the 2006 data. The comparison is summarized in Table 2 below. [source: Application, p31 and Medicaid Cost Report data for years 2005 and 2006]

**Table 2
Average Nursing Hours Per Patient Day Comparison**

	RN/PD	LPN/PD	NA/PD	Total NH/PD
Manor Care of Lacey	0.481	0.616	2.005	3.102
Year 2005 Thurston County Averages	0.403	0.737	2.397	3.537
Year 2006 Thurston County Averages	0.495	0.723	2.187	3.404

Based on the summary shown in Table 2 above, the applicant’s patients are comparable—slightly less—than the average patient accepted by the existing C-SNFs in the county. When comparing MC-Lacey’s proposed RN, LPN, and NA hours per patient day to each individual facility in the planning area, MC-Lacey closely compares with all facilities in the planning area with the exception of Providence Mother Joseph Care Center which appears to have had higher acuity patients in years 2005 and 2006. [source: Application, p30 and 2005 and 2006 Medicaid Cost Report data]

In summary, the department concludes that the patients proposed to be served by MC-Lacey would also be appropriate to be served by the existing C-SNFs in the planning area.

The applicant provided data to assist in its demonstration of need for an additional nursing home in Thurston County. A summary of the data is shown below. [source: Application, pp8-14]

- Population data
- Occupancy of the existing nursing homes
- Numeric bed need methodology
- Projected shortage of patient days
- Increased life expectancy
- Assisted living does not address the need Manor Care proposes to serve

This portion of the evaluation will focus on the data and/or assertions provided by the applicant, any comments provided by interested or affected persons, and the department’s evaluation of the data and assertions.

- Population data
Applicant

MC-Lacey asserts that the 2011 elderly population for Thurston County is projected to grow by more than 20% from year 2006 population. Data used to support this assertion is a comparison of Office of Financial Management (OFM) projected population growth for year 2006 and 2010 with projected population growth for years 2006 and 2011 using data obtained from Claritas, Inc.⁷ Focusing on years 2010 and 2011 only, Claritas data projected 32,757 aged 65 and older residents in Thurston County for year 2011. OFM projected 33,735 aged 65 and older residents in county for year 2010. [source: OFM population data, released January 2002]

Department

WAC 246-310 directs the department to use demographic data from OFM for nursing home applications. [source: WAC 246-310-010: Resident population] Further, the program consistently uses the “medium” or “intermediate series” projected population. Table 3 is a comparison of the applicant’s and the department’s population data for residents aged 65 and older in Thurston County for years 2010 and 2011 using the OFM medium series data, released November 2007. [source: OFM population data, released November 2007]

Table 3
Population Comparison by Data Source

Source	2010	2011
OFM-November 2007 (DOH)	33,656	36,071
Claritas, Inc (Applicant)	n/a	32,757

⁷ Claritas [pronounced 'CLAIR–uh–toss'), Inc. is a marketing information resources company dedicated to helping companies engaged in consumer and business-to-business marketing. Claritas, Inc. provides clients' with the data, tools, applications, and expertise needed to examine, target and execute profitable marketing opportunities. [source: Claritas Inc. website]

As shown in Table 3 on the previous page, the OFM medium series data projects at least 3,300 more residents aged 65 and older for year 2011 than Claritas data. As previously stated, Program rules direct the use of OFM data. Most recent OFM data was released November 2007.

- Occupancy of the existing nursing homes

Applicant

MC-Lacey asserts that the average occupancy of the existing nursing homes in Thurston County has equaled or exceeded 95% since year 2003. The data showed the occupancy of the six C-SNFs operating in the planning area in year for years 2001 through 2006. The applicant concludes that families face difficulty in selecting a nursing home because choice is extremely limited with so few facilities having an available bed on any given day. [source: Application pp9-10]

Providence Mother Joseph Care Center

In its public comment, Providence Mother Joseph Care Center (PMJCC) acknowledged that application of the numeric methodology results in a need for additional nursing home beds in the planning area. PMJCC asserts that the occupancy of the Thurston County nursing homes have been stable or declining in the past few years. PMJCC further states that despite the increase in the relevant (aged 65 and older) population, occupancy statistics have not been increasing as the applicant asserts. PMJCC concludes that there is an adequate supply of nursing home beds in the planning area, and MC-Lacey has not demonstrated need for additional beds as required under WAC 246-310-210(6). [source: PMJCC public hearing documents, pp2-3]

Department of Social and Health Services

In its public comments, the Department of Social and Health Services (DSHS) asserts that there is no evidence that additional beds are needed in the county and hospital discharge problems do not exist. DSHS provided a table showing occupancy rates for the Thurston County nursing homes for years 2002 through 2006. The occupancy rates average between 92% in 2002 to 95% in 2004. Year 2006 occupancy is shown at 94%. DSHS also states that initiation of long-term care services is not delayed, citing the April 2005 and November 2005 average length of time between assessment and the authorization start date for home and community-based services averaged 22 days. DSHS reasons that the state policy allows 30 days to complete this process. [source: DSHS public hearing documents, pp14-15]

Department

As previously stated, as of the writing of this evaluation, there are 690 skilled nursing facility (SNF) beds distributed among six operating C-SNFs and one closed H-SNF located in Thurston County. For 2005, only five of the six C-SNFs were operating for the full 12 months. Olympia Manor was closed from January through March for renovations. The H-SNF at Capital Medical Center also operated for the full 12 months. In year 2006, all six C-SNFs and the one H-SNF operated for the full 12 months.

For DSHS cost reporting purposes, facility occupancy is reported on the number of licensed beds within a facility. WAC 246-310-210(6) requires the department to review the occupancy rates of nursing homes and other long-term care services over the previous two-year period. For this project, most recent occupancy rate data is years 2005 and 2006. To

evaluate assertions by PMJCC and DSHS regarding stable occupancy rates in Thurston county, the department will also include a review of occupancy rates for the planning area nursing homes for years 2003 and 2004.

From late 1995 to March 2007, Capital Medical Center operated a 9-bed SNF within the hospital which means that patients admitted into the hospital for services that may require SNF care post procedure are discharged from the hospital and admitted into the SNF. Given that the facility does not participate in the Medicaid program for its SNF, these 9 beds could not be considered an option for all residents of the county. Because the 9-beds do not accept Medicaid patients, occupancy data is not available through the DSHS cost report. For those reasons, the department will not include the 9 beds previously located at Capital Medical Center.

Tables 4A and 4B summarize the occupancy of licensed beds in operation in years 2003 and 2004 at the six C-SNFs in the county. Tables 4C and 4D summarize the occupancy of licensed beds in operation in years 2005 and 2006. [source: DSHS cost report data, years 2003 through 2006]

**Table 4A
Thurston County Year 2003 Number of Beds and Average Occupancy**

	# of Lic'd Beds	Bed Occp'y %	# of Lic'd Beds Available	Plus AU Banked Beds (unlicensed)
Evergreen Nursing & Rehab Center	119	96%	5	16
Olympia Manor	28	73%	8	0
Panorama City & Rehab Center	155	95%	8	0
Providence Mother Joseph Care Center	152	96%	6	0
Puget Sound Healthcare Center	106	94%	6	8
Roo-Lan Healthcare Center	103	96%	4	0
Totals/Average Occupancy	663	91.6%	37	24

For year 2003, Evergreen Nursing & Rehab Center had 16 beds banked under alternate use and Puget Sound Healthcare Center had 8 beds banked under alternate use, for a total of 663 licensed beds and 24 banked beds in the county. While the department considers the banked beds available, the occupancy percentages above are based on the 663 licensed beds in year 2003. Table 4A above shows Thurston County's average occupancy was 92% with 24 beds banked under alternate use.

In year 2004, Olympia Manor closed and began building a new facility at the existing site; the replacement facility was complete on February 3, 2005.⁸ During the replacement Olympia Manor, patients were relocated to a sister facility in Tacoma, known as Park Rose Care Center. This closure and relocation process occurred in October 2003, therefore Olympia Manor's occupancy data for 2003 above would be reflective of approximately 10 months of operation. Table 4B on the next page shows year 2004 utilization.

⁸ RA project authorized under RA #041 issued June 16, 2003.

**Table 4B
Thurston County Year 2004 Number of Beds and Average Occupancy**

	# of Lic'd Beds	Bed Occp'y %	# of Lic'd Beds Available	Plus AU Banked Beds (unlicensed)
Evergreen Nursing & Rehab Center	124	97%	4	11
Olympia Manor	Facility closed for replacement 28 beds not counted			
Panorama City & Rehab Center	155	93%	11	0
Providence Mother Joseph Care Center	152	96%	6	0
Puget Sound Healthcare Center	108	95%	5	0
Roo-Lan Healthcare Center	103	98%	2	0
Totals/Average Occupancy	642	95.8	28	11

In year 2004, Evergreen Nursing & Rehab Center converted 5 of its 16 beds back to skilled nursing use and the remaining 11 beds continued to be banked through year 2004 and into 2005. Further, in 2004, Puget Sound Healthcare converted 2 of its 8 banked beds back to use in the facility and forfeited the remaining 6 banked beds.

Additionally, Tables 4A and 4B above show an increase in occupancy percentages from 92% (year 2003) to 96% (year 2004). Both occupancy percentages are above the statewide average for years 2003 and 2004 of 83% and 86%, respectively.

Table 4C and 4D below show the county's most recent two-year occupancy averages for the facilities in operation.

**Table 4C
Thurston County 2005 Number of Beds and Average Occupancy**

	# of Lic'd Beds	Bed Occp'y %	# of Lic'd Beds Available	Plus AU Banked Beds (unlicensed)
Evergreen Nursing & Rehab Center	124	97%	4	11
Olympia Manor	28	47%	15	0
Panorama City & Rehab Center	155	95%	8	0
Providence Mother Joseph Care Center	152	97%	5	0
Puget Sound Healthcare Center	106	96%	4	2
Roo-Lan Healthcare Center	103	97%	3	0
Totals/Average Occupancy	668	88.2%	39	13

For year 2005, there were 13 beds banked under alternate use at two separate facilities—11 at Evergreen Nursing & Rehab and 2 at Puget Sound Healthcare Center. Olympia Manor was closed from October 2003 through March 2005 for renovations. The 47% utilization for Olympia Manor in year 2005 reflects 9 months of operation, the re-opening of the renovated facility, and its beginning to accept patients. As shown above, the average occupancy for the six facilities was 88.2%, which includes the low occupancy at Olympia Manor. If Olympia Manor is not included in the occupancy data, the average for the remaining five C-SNFs is 96.4%. The occupancy percentages at each facility calculate to

39 empty licensed beds, plus 13 additional beds banked under alternate use for year 2005. The year 2005 statewide average occupancy for all Washington State facilities is 86.1%.

**Table 4D
Thurston County 2006 Number of Beds and Average Occupancy**

	# of Lic'd Beds	Bed Occp'y %	# of Lic'd Beds Available	Plus AU Banked Beds (unlicensed)
Evergreen Nursing & Rehab Center	129	96%	5	6
Olympia Manor	28	79%	6	0
Panorama City & Rehab Center	155	94%	9	0
Providence Mother Joseph Care Center	152	95%	8	0
Puget Sound Healthcare Center	108	94%	6	0
Roo-Lan Healthcare Center	103	96%	4	0
Totals/Average Occupancy	675	92.3%	38	6

In year 2006, Evergreen Nursing & Rehab un-banked 5 of its 11 alternate use banked beds, leaving 6 banked beds. Puget Sound Healthcare Center un-banked its 2 beds, leaving zero beds banked. Reflecting a full 12 months of data, Olympia Manor's occupancy increased as it continued to accept patients in the newly renovated facility. The average occupancy for all facilities was 92.3%. The occupancy percentages at each facility calculate to 38 empty licensed beds, plus 6 additional beds banked under alternate use for year 2006. The 2006 statewide average occupancy is 86.4%.

Table 4E below summarizes the four-year average occupancy for all six C-SNFs in Thurston County.

**Table 4E
Thurston County Four-Year Average Occupancy**

	# of Lic'd Beds	Average Occp'y %	# of Lic'd Beds Available	Plus AU Banked Beds (unlicensed)
Year 2003	663	92%	53	24
Year 2004	642	96%	26	11
Year 2005	668	88%	39	13
Year 2006	675	92%	38	6

As shown in Table 4E above, assertions that the occupancy rates of the Thurston County nursing homes have been stable or declining in the past few years tells a partial story. Not factored in the statements is the number of AU banked beds that have decreased resulting in an increase in licensed beds. The calculation of occupancy rates is based on licensed beds. If that number increases, yet occupancy rates remain stable, then the number of licensed beds required to keep up with the demand has, in fact, increased. Further, with the exception of Capital Medical Center that closed and Olympia Manor's renovation project, all other SNFs in the county maintained above 93% occupancy. With these high occupancies, there is no room for substantial growth in occupancy rates. In fact, PMJCC's own occupancy rates only fluctuated two percent in the four years—from 95% to 97%.

Year 2006 shows the highest number of licensed beds available in the county at 675, yet average occupancies show the facilities averaged 92%, which leaves only 44 empty beds in the county (38 licensed and 6 AU banked beds). When coupled with the population growth PMJCC acknowledges has been increasing, placement for future patients requiring SNF care may be difficult.

- Numeric bed need methodology

Applicant

Based on the numeric methodology, MC-Lacey concluded that the Thurston County planning area's bed-to-population ratio is 27/1,000, significantly below the established ratio of 40/1,000. [source: Application, pp9-10]

Department

When the numeric methodology is calculated for year 2008 using OFM population data released November 2007 and the count of nursing home beds in the planning area as of March 11, 2008, the department's methodology shows the Thurston County planning area at 22/1,000. Regardless of whether the ratio is 27/1,000 or 22/1,000, it is still significantly below the 40/1,000 established ratio. For projection year 2010, the numeric need calculation for Thurston County is projected to be 21/1,000. If this project is approved resulting in another 120 beds added to the supply, the established ratio would increase to 26/1,000 in year 2008 and 24/1,000 for year 2010.

- Projected shortage of patient days

Applicant

Data provided to support this assertion includes the establishment of a "use rate" based on 2002 through 2006 resident days and 65 years and older population for the same years, resulting in a five-year average use rate of 8.68 for persons 65+. The applicant then applied the 8.68 use rate to the projected 65+ population for years 2010, 2011, and 2012. Based on the applicant's calculation of 679 beds in the planning area and assuming all facilities in would be operating at 100% utilization, the calculations result in a shortage of patient days for all three years. The applicant then subtracted its projected patient days for the proposed 120-bed nursing home. Table 5 below provides a summary of the calculations. [source: Application, p10-11]

**Table 5
Applicant's Calculations of Thurston County's Projected Shortage of Patient Days**

	Year 2010	Year 2011	Year 2012
Average Use Rate	8.68	8.68	8.68
Claritas 65+ Population	31,648	32,757	33,866
Projected Resident Patient Days (use rate X 65+ pop)	274,705	284,331	293,957
Minus Resident Patient Days @ 100% Occupancy ⁹	247,835	247,835	248,514
Projected Days Needed	26,870	36,496	45,443
Minus MC-Lacey's Projected Patient Days	11,826	28,470	41,610
Remaining Shortage of Patient Days	15,044	8,026	3,833

⁹ Years 2010 and 2011 are calculated based on 365 days/year; year 2012 is a leap year with 366 days/year.

One of the assumptions used by the applicant in Table 5 is that all existing facilities would be operating at 100% utilization. Existing facilities include Capital Medical Center’s 9 beds that are currently banked under full facility closure and the 6 beds banked under alternate use at Evergreen Nursing & Rehab.

Department

To evaluate the applicant’s information, the department performed its own calculations relying on the following assumptions. A summary of the department’s results is shown in Table 6 below.

- Average Use Rate—the department’s use rate is calculated using years 2005 and 2006 data only and OFM population for those same years. The calculated use rate is 8.529819, rounded to 8.53;
- Projected population—based on OFM projections for years 2010, 2011, and 2012;
- Projected Resident Patient Days—projected 65+ population multiplied by the use rate; and
- Minus Resident Patient Days @ 100% Occupancy—based on 681 available beds in the planning area, which includes all beds at currently operating C-SNFs—whether licensed or banked under alternate use.

Table 6
Department’s Calculations of Thurston County’s Projected Shortage of Patient Days

	Year 2010	Year 2011	Year 2012
Average Use Rate	8.53	8.53	8.53
OFM 65+ Population	33,656	36,071	38,485
Projected Resident Patient Days (use rate X 65+ pop)	287,086	307,686	328,277
Minus Resident Patient Days @ 100% Occupancy ¹⁰	248,565	248,565	249,246
Projected Days Needed	38,521	59,121	79,031
Minus MC-Lacey’s Projected Patient Days ¹¹	11,826	28,420	41,610
Remaining Shortage of Patient Days	26,695	30,701	37,421

Using the assumptions as outlined above, the department calculations shown in Table 6 also demonstrate a need for additional beds in the planning area.

- Increased life expectancy

Applicant

MC-Lacey cites a year 2002 article entitled New Estimates of Lifetime Nursing Home Use that projects increased nursing home use based on several factors:

- longer life expectancy;
- sicker, more disabled, nursing home population;
- increased population of persons aged 65 and older; and

¹⁰ Years 2010 and 2011 are calculated based on 365 days/year; year 2012 is a leap year with 366 days/year.

¹¹ Schedule A provided in the application identifies 28,470 total patient days; however, the breakdown of patient days adds to 28,420.

- patient’s risk of requiring care within a nursing home increases with age—44% for 65 and older compared with 72% for 95 year olds.

MC-Lacey concludes that these factors will double the number of 65 and older persons using a nursing home by year 2020. When applying these factors to the planning area, the applicant concludes that need for additional beds are necessary to accommodate both current and future residents. [source: Application p11]

Department

MC-Lacey cites a six-year-old article to support its claim that the older population in Thurston County is increasing. OFM population data for years 2000 through 2007 for the county support the applicant’s claim that the population as a whole is growing.

In a March 2007 document, OFM states that population growth is comprised of two major components—the natural increase and net migration. The natural increase in population—more births than deaths—is the more stable component of population growth. [source: OFM population data] In a November 2007 document, OFM provides historical and projected 65+ populations broken down by county. These projections show the population of 65+ people in Thurston County will increase by 6,000 by the end of year 2010. In summary, the department can substantiate MC-Lacey’s assertions of population growth in the county, and in the 65 and older age group.

- Assisted living does not address the need Manor Care proposes to serve

Applicant

Using the term “assisted living” at its broadest definition, the applicant discusses all community based services, such as adult family homes, boarding homes, enhanced residential care, and home health services. MC-Lacey provided extensive documentation used to reach the following conclusions regarding assisted living services as an alternative to this project for Thurston County residents.

- Such facilities are not permitted to provide SNF services on a continuous basis.
- There is not a large group of inappropriately placed patients in SNFs who can be relocated to assisted living facilities.
- There is continuing growth in the number of Medicare patients in the county who are appropriate for nursing home care, not assisted living care.
- Assisted living does not provide the same level of care that Manor Care proposes. [source: Application, pp12-14 & Exhibit 19; February 5, 2008, supplemental information, pp2-8]

To further demonstrate that “assisted living” does not address the need that the applicant is proposing to serve, MC-Lacey also provided the results of a survey conducted by the department during a 2005 review of an application submitted by Manor Care for the establishment of a 120 bed facility in Lacey. The survey was conducted under a contract with a research group in 2005.

Department

Information to verify this assertion is difficult to obtain. A survey in 2005—three years before submission of this application—becomes outdated by the time the department is evaluating this project. Throughout its application, MC-Lacey asserts that the alternative community-based providers are not providing the same type of care that would be provided

at the new 120-bed facility. However, under WAC 246-310-210(6), the department must consider their availability and determine whether patients could be better served in those settings. WAC 246-310-210(6) provides a listing of the alternative services to be considered. The listing includes assisted living facilities, boarding homes, enhanced adult residential care facilities, adult residential care facilities, adult family homes, hospice agencies, home health agencies, home care agencies, and personal care services.

Other Services in the Planning Area to be Served

Comments related to community-based services were provided by DSHS, PMJCC, and the Lewis-Mason-Thurston Area Agency on Aging.¹²

Department of Social and Health Services (DSHS)

DSHS states it has spent the last 25 years developing the long-term care system that provides alternatives to nursing home care, regardless of payer source, for Washington State citizens. Patients are placed in the setting of choice, rather than the patient's need for a particular set of services. One-third of the residents in nursing facilities choose to move to a less restrictive setting when a nursing home ceases to operate in the state. Consumers have a broad array of services and settings from which to choose when a need for skilled nursing, rehabilitation, chronic care management or other long-term care need arises. DSHS also asserts that it is wrong to assume that home care services are the least intensive and nursing home services are the most intensive. Skilled nursing services and rehabilitative care are routinely delivered side-by-side with personal care services to persons in home and community settings. [source: DSHS public comments, pp5-13]

Providence Mother Joseph Care Center (PMJCC)

PMJCC asserts that the current number of adult family homes and boarding homes can meet the needs of the majority of the patients proposed to be served by this project.

Lewis-Mason-Thurston Area Agency on Aging (LMTAAA)

LMTAAA states that since 2005, more appropriate residential options have been added or planned for Thurston County. For example, two more boarding homes that have capacity to serve an additional 200 people and seven adult family homes with capacity to serve another 35 people have been added. Additionally, the Area Agency began operating a home care referral registry for the Home Care Quality Authority. The registry is another tool to assist people needing long-term care to receive the care at home. [source: LMTAAA public comments, pp1-2]

Department

Before evaluating the availability of other services, a summary of general information and definitions of commonly used terms is necessary.

A. DEFINITIONS

Personal Care Services [WAC 388-76-540 Adult Family Home]

A brief description of "personal care services" is included within the definition of "functionally disabled person" within DSHS RCW 74.39A.090 which states, functionally disabled person is

¹² Lewis-Mason-Thurston Area Agency on Aging is a local governmental agency that provides home and community services for seniors and adults with disabilities to help them remain living in their own homes. Case Management staff assesses and authorizes home care services for clients in Lewis, Mason, and Thurston Counties. Information and Assistance staff offers free help to individuals and organizations in the communities to identify services and programs for seniors, adults with disabilities, and family caregivers. [source: website]

synonymous with chronic functionally disabled and means a person who because of a recognized chronic physical or mental condition or disease, including chemical dependency, is impaired to the extent of being dependent upon others for direct care, support, supervision, or monitoring to perform activities of daily living. "Activities of daily living" in this context, means self-care abilities related to personal care such as bathing, eating, using the toilet, dressing, and transfer. Instrumental activities of daily living may also be used to assess a person's functional abilities as they are related to the mental capacity to perform activities in the home and the community such as cooking, shopping, house cleaning, doing laundry, working, and managing personal finances. Within the Adult Family Home rules, "personal care services" means both physical assistance and/or prompting and supervising the performance of direct personal care tasks as determined by the resident's needs. Personal care services do not include assistance with tasks performed by a licensed health professional. [emphasis added]

Special Care [DSHS WAC 388-76-540 Adult Family Home]

Special care means care beyond personal care services as defined by "personal care services" in this section [above]. [emphasis added]

Intermittent

Suspending activity at intervals; coming and going. [source: Taber's Cyclopedic Medical Dictionary]

Below is a definition of each alternative to be considered when evaluating this project and additional definitions related to specific phrases in those definitions.

Boarding Home [DSHS RCW 74.39A.009 & RCW 18.20.030]

1. Boarding home means a facility licensed under chapter [18.20](#) RCW [RCW 74.39A.009]
2. Boarding home means any home or other institution, however named, which is advertised, announced, or maintained for the express or implied purpose of providing housing, basic services, and assuming general responsibility for the safety and well-being of the residents, and may also provide domiciliary care, consistent with chapter 142, Laws of 2004, to seven or more residents after July 1, 2000. However, a boarding home that is licensed for three to six residents prior to or on July 1, 2000, may maintain its boarding home license as long as it is continually licensed as a boarding home. "Boarding home" shall not include facilities certified as group training homes pursuant to RCW [71A.22.040](#), nor any home, institution or section thereof which is otherwise licensed and regulated under the provisions of state law providing specifically for the licensing and regulation of such home, institution or section thereof. Nor shall it include any independent senior housing, independent living units in continuing care retirement communities, or other similar living situations including those subsidized by the department of housing and urban development. [RCW 18.20.030]

No person operating a boarding home licensed under this chapter shall admit to or retain in the boarding home any aged person requiring nursing or medical care of a type provided by institutions licensed under chapters [18.51](#) [nursing home], [70.41](#) [hospital] or [71.12](#) [psychiatric or chemical dependency hospital] RCW, except that when registered nurses are available, and upon a doctor's order that a supervised medication service is needed, it may be provided. Supervised medication services, as defined by the department [DSHS] and consistent with chapters [69.41](#) and [18.79](#) RCW, may include an approved program of self-medication or self-directed medication. Such medication service shall be provided only to residents who otherwise

meet all requirements for residency in a boarding home. No boarding home shall admit or retain a person who requires the frequent presence and frequent evaluation of a registered nurse, excluding persons who are receiving hospice care or persons who have a short-term illness that is expected to be resolved within fourteen days. [RCW 18.20.160] [emphasis added]

Boarding Home-Adult Residential Care [DSHS RCW 74.39A.009]

Adult residential care means services provided by a boarding home that is licensed under chapter [18.20](#) RCW and that has a contract with the department [DSHS] under RCW [74.39A.020](#) to provide personal care services. [emphasis added]

Boarding Home-Enhanced Adult Residential Care [DSHS RCW 74.39A.009]

Enhanced adult residential care means services provided by a boarding home that is licensed under chapter [18.20](#) [boarding home] RCW and that has a contract with the department [DSHS] under RCW [74.39A.010](#) to provide personal care services, intermittent nursing services, and medication administration services. [emphasis added]

Boarding Home-Assisted Living Services [DSHS RCW 74.39A.009]

Assisted living services means services provided by a boarding home that has a contract with the department [DSHS] under RCW [74.39A.010](#) to provide personal care services, intermittent nursing services, and medication administration services, and the resident is housed in a private apartment-like unit. [emphasis added]

Adult Family Home [DSHS RCW 74.39A.009 & RCW 70.128.030]

1. Adult family home" means a home licensed under chapter [70.128](#) RCW [RCW 74.39A.009]
2. Adult family home means a residential home in which a person or persons provide personal care, special care, room, and board to more than one but not more than six adults who are not related by blood or marriage to the person or persons providing the services. "Special care" means care beyond personal care as defined by the department [DSHS], in rule. [RCW 70.128.010]

Home Care [DOH RCW 70.127.010]

1. Home care agency means a person administering or providing home care services directly or through a contract arrangement to individuals in places of temporary or permanent residence. A home care agency that provides delegated tasks of nursing under RCW [18.79.260](#)(3)(e) is not considered a home health agency for the purposes of this chapter.
2. Home care services means nonmedical services and assistance provided to ill, disabled, or vulnerable individuals that enable them to remain in their residences. Home care services include, but are not limited to: Personal care such as assistance with dressing, feeding, and personal hygiene to facilitate self-care; homemaker assistance with household tasks, such as housekeeping, shopping, meal planning and preparation, and transportation; respite care assistance and support provided to the family; or other nonmedical services or delegated tasks of nursing under RCW [18.79.260](#)(3)(e). [emphasis added]

Home Health [DOH RCW 70.127.010]

1. Home health agency means a person administering or providing two or more home health services directly or through a contract arrangement to individuals in places of temporary or permanent residence. A person administering or providing nursing services only may elect to be designated a home health agency for purposes of licensure.

2. Home health services means services provided to ill, disabled, or vulnerable individuals. These services include but are not limited to nursing services, home health aide services, physical therapy services, occupational therapy services, speech therapy services, respiratory therapy services, nutritional services, medical social services, and home medical supplies or equipment services.

Hospice [DOH RCW 70.127.010]

1. Hospice agency means a person administering or providing hospice services directly or through a contract arrangement to individuals in places of temporary or permanent residence under the direction of an interdisciplinary team composed of at least a nurse, social worker, physician, spiritual counselor, and a volunteer.
2. Hospice care center" means a homelike, non-institutional facility where hospice services are provided, and that meets the requirements for operation under RCW [70.127.280](#).
3. Hospice services means symptom and pain management provided to a terminally ill individual, and emotional, spiritual, and bereavement support for the individual and family in a place of temporary or permanent residence, and may include the provision of home health and home care services for the terminally ill individual.

Community Options Program Entry System (COPES) Waiver [Federal Social Security Act, Section 1915c]

“The Secretary¹³ may by waiver provide that a State plan approved under this title may include as “medical assistance” under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan. For purposes of this subsection, the term “room and board” shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.

- (2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—
 - (A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;
 - (B) the State will provide, with respect to individuals who—
 - (i) are entitled to medical assistance for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded under the State plan,
 - (ii) may require such services, and
 - (iii) may be eligible for such home or community-based care under such waiver, for an evaluation of the need for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded;
 - (C) such individuals who are determined to be likely to require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded are informed

¹³ For purposes of this definition, the term “Secretary”, means the Secretary of Health and Human Services.

of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded;

- (D) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and
- (E) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.”

To assist in its evaluation of alternative community-based providers, the department enlisted the services of The Gilmore Research Group (GRG) located in the Pacific Northwest.¹⁴ GRG provides research consultation, probability sampling, and data for analysis. For this project, GRG conducted telephone interviews with managers or people in positions of authority at adult family homes and boarding homes in Thurston County. The purpose of the interviews was to learn more about the capacity and limitations of these facilities as alternatives to nursing home services. [source: The Gilmore Research Group website and January 31, 2008, report]

As of January 2008, when GRG began its telephone interview, there were 104 licensed adult family homes (AFHs) and 13 boarding homes (BHs) in Thurston County. [source: DSHS website] GRG conducted telephone interviews with managers or people in positions of authority at 84 of the 102 the AFHs (82%) and 12 of the 13 BHs (92%). [source: January 2008 GRG report]

At the completion of its telephone survey, GRG provided raw data to the Program for review. Program staff extrapolated specific information from the raw data to determine the occupancy, capacity, and limitations of AFHs and BHs in Thurston County as alternatives to the SNF services proposed by the applicant.

To evaluate the planning community based services, one must consider the type facility and services, and limitation of services, provided in each facility based on definitions previously provided.

Boarding Homes

Boarding homes cannot admit or retain a person requiring frequent presence and evaluation of a registered nurse. The two exceptions to this limitation are **1**) if the patient is receiving hospice care at the boarding home; or **2**) if the patient has a short-term illness that is expected to be resolved within 14 days. [RCW 18.20.160] For Thurston County, there are 13 boarding homes in operation at the time of the initial review of this application. GRG contacted and interviewed 12 of the 13 BHs, representing 644 boarding home beds. [source: January 2008 GRG report]

¹⁴ DSHS collects and maintains utilization and occupancy data for all Washington State nursing homes and SNFs that contract with DSHS to provide Medicaid services. The data is collected by DSHS through cost reports submitted by each facility and is available annually from DSHS. For the community-based services, no similar facility reporting process is in place.

Boarding homes with adult residential care services are boarding homes that contract with DSHS to provide personal care services, such as bathing, eating, using the toilet, dressing, and transfer. Of the 12 boarding homes contacted by GRG, all provide personal care services as defined in the adult residential care services definition.

Boarding homes with enhanced adult residential care services are boarding homes that contract with DSHS to provide intermittent nursing services and medication administration services, in addition to personal care services.

Boarding homes with assisted living services are boarding homes that provide the same services as enhanced adult residential care boarding homes; however, the services are provided in a boarding home environment that is a private, apartment-like unit.

Of the 12 BHs contacted by GRG, 3 indicated that they do not contract with DSHS for Medicare or Medicaid services. As a result, these facilities would be providing only personal care services or adult residential care services. The remaining 9 facilities indicate that they contract with DSHS for either Medicare services, Medicaid services, or both services. The proposed SNF will be required to accept all payor sources, including Medicare and Medicaid. The 9 BHs in Thurston County that contract for Medicare or Medicaid services would be considered comparable regarding Medicare and Medicaid as payor sources. Of the 9 BHs, 3 do not accept patients requiring skilled nursing services. Given that the proposed SNF will be providing SNF/NF services, the remaining 6 BHs would be considered a comparable alternative to the proposed facility when considering payor sources and services provided. These 6 BHs considered a comparable alternative to the proposed SNF represent 276 beds, or 43% of the total 644 BH beds. Table 7 below is a summary of the occupancy of the 6 BHs and their 276 beds at the time of the survey. [source: January 2008 GRG report]

**Table 7
Thurston County Boarding Home Data Summary**

Name	# of Beds	% Ocpsy	# of Vacant Beds	Typical Vacancy Yes/No
Alterra Clare Bridge of Olympia	60	93%	4	No
Lacey Group Home	6	83%	1	Yes
Lodge at Roo-Lan, The	30	90%	3	No
Merrill Gardens at Olympia	10	80%	2	No
Sequoia Village	92	99%	1	Yes
Woodland Retirement & AL Community	78	82%	14	No
Totals/Averages	276	87.8%	25	

As shown in Table 7 above, occupancy of the 6 BHs ranges from 83 to 99%. The average occupancy of the BHs was 88%, and all but one facility had less than 5 beds available. When questioned whether the number of vacant beds was typical, representatives of 4 of the 6 BHs stated “No”, and then clarified that number of vacant beds was typically zero. Table 7 also shows that 3 of the 6 BHs were operating at 90% or greater.

Table 7 supports the existing nursing home provider’s statements that BHs are providing a viable option for some number of people requiring nursing facility care. However, the data above also supports MC-Lacey’s assertions that occupancy of BHs in Thurston County is high.

Of the 6 BHs, all had limitations regarding acceptance of patients, and most had more than one limitation. Table 8 below is a listing of the limitations identified for the 6 BHs. [source: January 2008 GRG report]

**Table 8
Thurston County Boarding Home Data Summary**

Most Common Type of Limitation	# of BH with Limitations
No obese or full body lifts	1
No incontinence/colostomy/catheter pts	2
No wandering pts	2
No Alzheimer's or dementia pts	2
No IVs; insulin dependent; diabetics	1
Only accept developmentally disabled pts	1
Only accept dementia pts	1

As noted above, BHs may elect not to serve patients with dementia, mental health issues, developmental disabilities, or patients with specific behavioral issues, such as wandering or violence. While the BH's option to limit types of patients is common and acceptable, limitations could severely reduce the availability of services in a particular BH.

Regarding boarding homes, boarding homes with adult residential care services, boarding homes with enhanced adult residential care services, and boarding homes with assisted living services, in Thurston County, the department concludes:

- these alternative services typically experience high occupancies;
- these alternatives provide many of the same services as an SNF;
- these alternatives have many limitations related to resident eligibility;
- without these types of alternative services, the need for nursing home beds in the Thurston County would be much greater.

Adult Family Homes

Adult Family homes (AFHs) are personal homes that provide personal care, special care, and room & board to more than one, but no more than six adults not related by blood or marriage to the person providing the service.¹⁵ [RCW 70.128.030] As of writing of this evaluation, there were 104 AFHs operating in Thurston County. Of the 104 homes, 84 were contacted by GRG, representing 82% of the homes. The 84 AFHs represent 430 AFH beds. [source: January 2008 GRG report]

As previously stated, the proposed 120-bed SNF will be required to accept all payor sources, including Medicare and Medicaid. Of the 84 AFH in Thurston County, 69 contract for Medicare or Medicaid services or both services and would be considered a comparable alternative regarding payor source. The 69 AFHs represent 351 AFH beds, or 82% of the 430 AFH beds.

Of the 69 AFHs, 7 indicated that they do not contract with DSHS for Medicare or Medicaid services. Given that the proposed SNF will be contracting with DSHS for those services, 62 of the

¹⁵ The maximum number of beds at an adult family home is six.

69 AFHs could be considered a comparable alternative to the proposed facility. Of these 62 adult family homes, only 10 (16%) had no limitations related to the types of patients accepted. For those AFHs with stated limitations, the limitations related to patient admissions include:

- no Alzheimer’s or advanced dementia patients
- no developmentally disabled or mental illness patients
- no communicable diseases (including HIV)
- no non- ambulatory or patients requiring wheelchairs or walkers
- no obese pts or full body lifts or two person transfers
- no mental health or developmentally disabled pts
- no wanderers or exit seekers
- no violent or combative patients
- no sex offenders
- no alcohol or substance abuse pts
- no IVs, insulin dependent, or diabetic pts
- no patients requiring oxygen or patients w/ tracheotomies or patients on a respirator

As with BH, AFHs may also limit the types of patients that would be accepted into the home. Rationale for the limitations may include the AFH owner’s personal preferences related to patients, ability or inability to provide particular services, availability or lack of availability of particular equipment, or many other reasons. While the option to limit the types of patients at a particular AFH is acceptable and expected, some limitations would severely limit a patient’s ability to receive services in adult family homes.

The 62 AFHs considered a comparable alternative to the proposed SNF represent a total of 319 beds, or 74% of the total number of 430 AFH beds. Occupancy of the 319 beds range from 40% to 100% at the time of the survey. Table 9 below is a summary of the number of facilities operating at various ranges of occupancy and number of vacant beds. [source: January 2008 GRG report]

**Table 9
Thurston County Adult Family Home Data Summary**

Name	# of Facilities	# of Beds	# of Vacant Beds
Facilities operating at 40% occupancy	1	5	3
Facilities operating at 50% occupancy	9	44	22
Facilities operating 60% occupancy	2	10	4
Facilities operating 66.7% occupancy	4	21	7
Facilities operating at 75% occupancy	2	8	2
Facilities operating at 80% occupancy	5	25	5
Facilities operating at 83.3% occupancy	7	42	7
Facilities operating at 100% occupancy	32	170	0
Totals	62	325	50

As shown in Table 9 above, 30 of the 62 AFH (48%) were operating at less than 100% occupancy at the time of the survey, which represents 50 vacant AFH beds for the county. The remaining 32 facilities operated at 100% occupancy, with zero vacant beds. The average occupancy for the 62 AFH is 85% (84.7).

Table 9 on the previous page supports public comment assertions that AFHs are also a viable option for nursing facility care. However, the data above also supports MC-Lacey’s assertions that occupancy of adult family homes in Thurston County is high.

Home Care, Home Health, and Hospice services

Home Care, Home Health, and Hospice services are all provided to ill, disabled, or vulnerable patients within the patient’s temporary or permanent residence. The patient’s residence may be a personal home, boarding home, adult family home, nursing home, or any other residence considered by the patient to be “home.”

Home Care

Home care services include, but are not limited to, personal care services, such as assistance with dressing, feeding, and personal hygiene to facilitate self-care; homemaker assistance with household tasks, such as housekeeping, shopping, meal planning and preparation, and transportation; respite care assistance and support provided to the family; or other nonmedical services or delegated tasks of nursing under RCW 18.79.260(3)(e). Given that a home care agency does not provide special services as defined within DSHS WAC 388-76-540, a home care agency could not be considered a viable option for patients proposed to be served by MC-Lacey.

Home Health

Home health services include, but are not limited to, nursing services, home health aide services, physical/occupational/speech/respiratory therapies, nutritional services, medical social services, and home medical supplies or equipment services. Home health services are typically provided to patients discharged to their residence by a long-term care facility or hospital for a lower level of care. A boarding home or adult family home may contract with a home health agency to provide those services to their residents. Additionally, a patient may contract directly with a home health agency to provide services at the patient’s residence.

Of the 12 BHs contacted, GRG obtained data related to the BH’s willingness to contract for home health services. Out of 12 boarding homes, 2 contract for home health services and 10 do not. One of the two BH’s that contract for home health services does not accept patients that require skilled nursing care. As a result, 1 of the 2 BHs would be available to patients similar to those proposed to be served by MC-Lacey. The BH that demonstrated a willingness to contract for home health services was operating at 93% occupancy, resulting in 4 empty beds, however, the facility representative stated that it “only accepts dementia patients.”

For the AFHs in Thurston County, GRG data revealed that 29 of the 84 AFHs (35%) contract for home health services directly.¹⁶ For the 29 adult family homes that contract directly for home health services, 9 do not accept Medicare or Medicaid patients, leaving 20 AFHs that accept Medicare and Medicaid patients and show a willingness to contract for home health services. Of these 20 AFHs, 10—or 50%--were operating at 100% occupancy at the time of the survey. The average occupancy of the 20 AFH that contract directly for home health services is 87%.

Eligibility for Medicare and Medicaid home health services is governed by Center Medicare and Medicaid Services (CMS). Medicare covers home health services as long as a patient is eligible

¹⁶ One AFH representative did not know whether their adult family home contracts for home health services.

and the patient's physician orders the services; however, skilled nursing care and home health aide services are only covered on a part-time or "intermittent" basis. This means there are limits on the number of hours per day and days per week that a patient may receive skilled nursing or home health aid services. Those limits include skilled nursing care needed fewer than seven days each week or less than eight hours each day over a period of 21 days. Additionally, to obtain funding from Medicare for home health services, a home health patient must be home-bound.¹⁷ Medicaid may help with medical costs for some patients, however, to qualify for Medicaid, a patient must be considered a low income patient. [source: CMS Handbook: Medicare and Home Health Care]

As of the writing of this evaluation, there are four home health agencies serving Thurston County, and three of the four are Medicare certified. The Office of Health Care Survey, which licenses and surveys home health agencies, does not collect data regarding occupancy or utilization of the agencies. Given that home health care is provided at the patient's residence, capacity for a home health agency is typically measured by its ability to retain or recruit additional staff to meet the number of the agency's visits and the needs of the patients. Based on the information above, home health services may be an option for a small number of patients described within the MC-Lacey application. Patients described within the application are higher acuity patients, such as those served within existing SNFs within the county. [source: Application, p4] Typically, a patient would be discharged from a nursing home to a residence for home health services.

Hospice or Hospice Care Centers

In contrast to the home health agency that provides curative care for patients, hospice services are designed to offer palliative care for terminally ill patients with a life expectancy of six months or less. Hospice patients and their families are provided emotional, spiritual, and bereavement support in the final stages of the patient's life. Similar to home health services, hospice services are typically provided in the patient's residence. [source: RCW 70.127.010] In some areas, a hospice patient may elect to receive hospice services in a hospice care center. Regardless of the setting, a hospice patient receives the same type of services. A boarding home, adult family home, or nursing home may also contract with a hospice agency to provide those services to their residents. Three hospice agencies serve Thurston County, and two of the three are Medicare certified. There are no hospice care centers located in Thurston County. Given that hospice services are palliative rather than curative, typically a patient would be discharged from a nursing home to a residence for hospice services. In other words, hospice is generally not an alternative for nursing home patients.

Other community-based options

Additionally, DSHS's Aging and Disability Services Administration operates four community programs. These programs allow reimbursements for patients meeting eligibility requirements. [source: DSHS website]

- COPES (Community Options Program Entry System) Waiver is a home and community based service program that covers personal care and some special care in adult family homes, enhanced adult residential care facilities, and assisted living facilities.

¹⁷ CMS states that a patient is considered homebound if leaving home is medically contraindicated or if the patient has a condition that restricts his or her ability to leave home without a supportive device (i.e. crutches, cane, wheelchair, walker), special transportation or the assistance of another person. The person who rarely leaves home because of feebleness or insecurity brought on by advanced age, but does not meet any of the conditions previously described, is not considered homebound.

- The Medicaid Personal Care is a state plan personal care program for Medicare beneficiaries who do not meet the COPEs eligibility criteria. These services are covered in the patient's personal residence, adult family homes, or adult residential care facilities.
- Medically Needy Residential Waiver is a program that pays for personal care and other services for aged, blind, or disabled individuals residing in adult family homes, enhanced adult residential care facilities, and assisted living facilities. This waiver serves patients whose income is too high to qualify for other programs.
- CHORE is a state-funded program that provides in-home personal care services to non-Medicaid eligible, low-income, disabled or very frail adults who still live in their own homes.

Of the four community programs described above, only COPEs Waiver would be an alternative to the nursing home patients proposed to be served by MC-Lacey. The remaining three programs focus on personal care reimbursement, rather than special care proposed to be provided in the proposed SNF. For this project, DSHS did not provide current data regarding the number of Thurston County patients in COPEs Waiver program. Rather, DSHS elected to re-submit comments previously provided related to an application submitted by Manor Care during the 2005 concurrent review cycle. As a result, none of the comments provided by DSHS reflect Thurston County's current need, or lack of need, for an additional SNF in the county. [source: DSHS public hearing documents dated December 11, 2006, and submitted April 22, 2008]

In conclusion, based on data provided by the applicant, data provide during the review of this project, population data provided by OFM, and data obtained by the department regarding occupancy and availability of nursing homes, boarding homes, and adult family homes in the planning area, ten conclusions can be reached to support the needed bed capacity of this project.

1. Thurston County's current (2008) bed to population ratio is 22/1,000 aged 65+ equating to an allocation of 447 additional nursing home beds to the planning area based on the 40/1,000 ratio established in rule.
2. Thurston County's projected (2010) bed to population ratio is 21/1,000 aged 65+ equating to an allocation of 591 additional nursing home beds to the planning area based on the 40/1,000 ratio established in rule.
3. Based on population growth in the county, additional nursing home beds will be needed in projection year 2010.
4. The addition of 120 nursing home beds to the county brings the current (2008) bed to population ratio to 26/1,000, still far below the 40/1,000 ratio established in rule.
5. The addition of 120 nursing home beds to the county increases the projected (2010) bed to population ratio to 22/1,000, still far below the 40/1,000 ratio established in rule.
6. Residents of nursing homes in Thurston County appear to be properly placed.
7. The planning area experiences high occupancies of its existing nursing home beds.
8. The number of boarding homes in the planning area with enhanced adult residential care or assisted living services that accept Medicare or Medicaid payor sources is 6, equating to 276 beds. Average occupancy of the BH was 88% equating to 25 vacant beds at the time of the survey.
9. The number of adult family homes in the planning area that accept Medicare or Medicaid payor sources is 63, equating to 319 AFH beds. Average occupancy of the AFHs was 85%, equating to 50 vacant beds at the time of the survey.
10. The high occupancy of the existing nursing homes within the planning area coupled with the projected population of Thurston County and the growth rate of the county

demonstrates a need for additional nursing home beds in the planning area to serve those patients that would not be candidates for the community based setting.

For the reasons stated in this evaluation, the department concludes that need for a 120-bed skilled nursing facility in Thurston County is supported by the data. Given the documented availability and accessibility of the existing providers in the county, the department concludes an additional SNF is necessary to meet the projected need in the community. As a result, the department concludes that this sub-criterion is met.

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

As previously stated, subsidiaries of Manor Care, Inc. owns, operates or manages over 500 healthcare facilities, including four nursing homes, one home care agency, and one home health agency in Washington State. Through these health care facilities, Manor Care, Inc. provides health care services to residents of the service area including low-income, racial and ethnic minorities, handicapped and other underserved groups. To determine whether all residents of the service areas would continue to have access to an applicant's proposed services, the department requires applicants to provide a copy of its current or proposed admission policy. The Admission Policy provides the overall guiding principles of the facility as to the types of patients that are appropriate candidates to use the facility and any assurances regarding access to treatment.

To demonstrate compliance with this sub-criterion, MC-Lacey provided a copy of its draft Admission Agreement to be used at the new facility. A review of the draft agreement indicates that patients would appropriately be admitted to the Lacey facility provided that the patient was a candidate for nursing care. [source: Application, Attachment 7]

To determine whether low income residents would have access to the new facility, the department uses the facility's Medicaid eligibility or contracting with Medicaid as the measure to make that determination. Given that the new facility is not currently operating, a contract with Medicaid is not yet established. Documents provided in the application demonstrate that MC-Lacey would establish the appropriate relationships with both Medicare and Medicaid.

While both documents above demonstrate the applicant's intent to comply with this sub-criterion, if this project is approved, to ensure MC-Lacey would continue to comply with this requirement, MC-Lacey would have to agree to the following term.

Prior to commencement of the project, Manor Care of America, Inc. shall provide to the department a copy of the Manor Care of Lacey's final Admissions Agreement. This agreement must state that all services at this facility will be accessible to all persons without regard to race, color, ethnicity, sexual preference, disability, national origin, age or ability to pay.

Based upon the information presented in the application and agreement to the above term, the department concludes all residents would have access to Manor Care of Lacey, and this sub-criterion would be met.

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

Based on the source information reviewed, the department determines that the application is not consistent with the applicable financial feasibility criteria in WAC 246-310-220.

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

As stated earlier, the estimated capital expenditure for this project is \$14,273,000, of which 66% is related to constructions costs; 14% is related to equipment costs; 6% is related to land purchase; 6% is related to corporate overhead; 5% is related to state sales tax; and the remaining 3% is related to fees and real estate taxes. [source: Application, p20]

To determine whether MC-Lacey would meet its immediate and long range operating costs, the department evaluated projected balance sheets for the first three years of operation as a 120 bed facility. A summary of the balance sheets is shown in Tables 10 below. [source: Application, Exhibit 11, Schedule B]

**Tables 10
Manor Care of Lacey Balance Sheet for Projected Years 2010-2012
Year 2010**

Assets		Liabilities	
Current Assets	\$ 449,380	Current Liabilities	\$ 192,270
Fixed Assets	\$ 14,333,000	Other Liabilities	\$ 14,429,705
Other Assets	(\$ 592,123)	Total Liabilities	\$ 14,621,975
		Equity	(\$ 431,718)
Total Assets	\$ 14,190,257	Total Liabilities and Equity	\$ 14,190,257

Year 2011

Assets		Liabilities	
Current Assets	\$ 1,049,243	Current Liabilities	\$ 389,567
Fixed Assets	\$ 14,393,000	Other Liabilities	\$ 14,380,771
Other Assets	(\$ 592,123)	Total Liabilities	\$ 14,770,338
		Equity	\$ 79,782
Total Assets	\$ 14,850,120	Total Liabilities and Equity	\$ 14,850,120

Year 2012

Assets		Liabilities	
Current Assets	\$ 1,530,943	Current Liabilities	\$ 546,713
Fixed Assets	\$ 14,635,454	Other Liabilities	\$ 13,621,444
Other Assets	(\$ 789,261)	Total Liabilities	\$ 14,168,157
		Equity	\$ 1,208,979
Total Assets	\$ 15,377,136	Total Liabilities and Equity	\$ 15,377,136

In addition to the projected balance sheets summarized above, the applicant also provided its Statement of Operations for years 2010 through 2012 as a 120-bed facility. [source: Application, Exhibit 11, Schedule C] A summary of the Statement of Operations is shown in Table 11 on the following page.¹⁸

¹⁸ Within its rebuttal documents, MC-Lacey submitted corrections to its financial Schedule F. Specifically, the projected insurance rate is understated in the application and a typographical error misstates the estimated capital costs of the project.

Table 11
Applicant's Projected Statement of Operations Summary
Years 2010 through 2012

	Year One (2010)	Year Two (2011)	Year Three (2012)
# of Beds	120	120	120
# of Patient Days	11,826	28,470	41,610
% Occupancy	27%	65%	95%
Net Revenue*	\$ 3,662,876	\$ 8,810,290	\$ 12,939,825
Total Expense	\$ 4,094,594	\$ 8,298,790	\$ 11,810,627
Net Profit or (Loss)	(\$ 431,718)	\$ 511,500	\$ 1,129,198
Net Revenue per patient per day	\$ 309.73	\$ 309.46	\$ 310.98
Total Expenses per patient per day	\$ 367.21	\$ 277.65	\$ 264.06
Net Profit or (Loss) per patient per day	(\$ 57.47)	\$ 31.81	\$ 46.92

*Includes deductions for bad debt and contractual allowances

As shown in Table 11 above, MC-Lacey anticipates it will operate the new 120 bed facility at a loss in year one with a projected occupancy at 27% for the 'ramp-up' year. By the end of years two and three, the facility is expected to operate at a profit.

As part of this evaluation, the department crosschecked the revenue projections provided by the applicant. MC-Lacey provided its assumption used to prepare its projected financial data provided in the application. The assumptions used to crosscheck the revenue projections shown in Table 11 are outlined in Tables 12 below. [source: Application, Exhibit 6, Schedule A & Exhibit 11, Schedule F]

Tables 12

TABLE 12A	
REVENUE PPD BY PAYER SOURCE	
Medicare	\$471.63
Medicaid	\$144.01
Private	\$224.69
Insurance	\$382.70

TABLE 12B			
PROJECTED PATIENT DAYS			
	FY 2010	FY 2011	FY 2012
Medicare	2,365	5,644	8,322
Medicaid	5,913	14,235	20,805
Private	2,365	5,694	8,322
Insurance	1,183	2,847	4,161
Totals	11,826	28,420	41,610

To correct this error, MC-Lacey submitted a revised Schedule F. The department has determined that this submission constitutes an inappropriate amendment to the application and will not be considered in this review. [WAC 246-310-090, WAC 246-310-100(6), and WAC 246-310-170]

Tables 12 (continuation)

TABLE 12C			
PROJECTED REVENUE IN THE APPLICATION			
	FY 2010	FY 2011	FY 2012
Medicare	\$1,952,117	\$4,699,542	\$6,868,562
Medicaid	\$544,980	\$1,304,245	\$1,969,451
Private	\$531,383	\$1,279,256	\$1,869,681
Insurance	\$603,729	\$1,453,420	\$2,124,230

[source: Application, Exhibit 11, Schedule G]

To substantiate the projected rate per patient day per payer source, the formula is total revenue by payer source divided by patient days by payer source. The Medicare calculation for year 2010 is $\$1,952,117 / 2,365 = \825.42 , and subsequent years 2011 and 2012 calculate to $\$832.66$ and $\$825.35$ respectively, rather than the $\$471.63$ shown in Table 12A. The formula to calculate the Medicaid rate for year 2010 is $\$544,980 / 5,913 = \92.17 . Subsequent years 2011 and 2012 calculate to $\$91.62$ and $\$94.66$ respectively, rather than the $\$144.01$ identified by MC-Lacey in its assumptions. The Other revenue calculations are $\$510.34$ for 2010 and $\$510.51$ for both years 2011 and 2012, rather than the $\$382.70$ identified in Table 12A. Only the private pay rate of $\$224.69$ can be substantiated using the formula. In summary, the Statement of Operations summarized in Table 11 does not appear to support the assumptions identified by the applicant.

In Washington State, Medicaid nursing facility rates are set by the Nursing Home Rates Section of the Office of Rates Management part of the Aging and Disability Services Administration of the Department of Social and Health Services. Medicaid rates for long-term care nursing facilities are set individually for each specific facility. Rates are based generally on a facility's costs, its occupancy level, and the individual care needs of its residents. The Medicaid payment rate system does not guarantee that all allowable costs relating to the care of Medicaid residents will be fully reimbursed. The primary goal of the system is to pay for nursing care rendered to Medicaid-eligible residents in accordance with federal and state laws, not to reimburse costs—however defined—of providers. A facility's overall Medicaid rate is comprised of rates for the following seven separate components:

- Direct care - nursing care and related care provided to residents
- Therapy care - speech, physical, occupational, and other therapy
- Support services - food and dietary services, housekeeping, and laundry
- Operations - administration, utilities, accounting, and maintenance
- Variable return - an incentive payment for relative efficiency
- Property - depreciation allowance for real property improvements, equipment and personal property used for resident care
- Financing allowance - return on the facility's net invested funds i.e., the value of its tangible fixed assets and allowable cost of land

[source: An Overview of Medicaid Rate Setting for Nursing Facilities in Washington provided by DSHS]

For existing nursing homes, the component rates are based on examined and adjusted costs from each facility's cost report. For new nursing homes, such as this project, the initial Medicaid rate is set using a peer group review. [source: DSHS WAC 388-96-710(3)]

All component rates require, directly or indirectly, use of the number of resident days—the total of the days in residence at the facility for all eligible residents—for the applicable report period. Resident days are subject to minimum occupancy levels. Effective July 1, 2002, the minimum occupancy for direct care, therapy care, support services, and variable return component rates is 85%; for operations, financing allowance, and property component rates, the minimum occupancy rate is 90%.¹⁹ If resident days are below the minimum, they are increased to the imputed occupancy level, which has the effect of reducing per resident day costs and the component rates based on such costs. If the actual occupancy level is higher than the minimum, the actual number of resident days is used. [source: An Overview of Medicaid Rate Setting for Nursing Facilities in Washington provided by DSHS]

Information obtained from the Office of Rates Management within DSHS indicates that MC-Lacey’s Medicaid reimbursement rate would be approximately \$171.57 per patient day. Documents provided in the application indicate that MC-Lacey based its projected revenues shown in Table 11 on a Medicaid reimbursement rate of \$144.01. [source: Application, Exhibit 11, Schedule F] As previously concluded, the Statement of Operations does not appear to support this assumption stated by the applicant.

Generally, if a nursing facility construction project requires a Certificate of Need (or Replacement/Renovation Authorization), it requires a Certificate of Capital Authorization (CCA) from DSHS. If a CCA is required, it must be obtained from DSHS before the funds spent on construction or renovation of the facility can be recognized in the Medicaid reimbursement rate. Two of the seven components used to determine the Medicaid reimbursement rate are affected by the CCA—Property and Financing Allowance. Before June 12, 2008, applications for CCA would be considered by DSHS on a ‘first-come, first-served’ basis. On June 12, 2008, changes related to the way DSHS prioritizes requests for CCA became effective.²⁰ Specifically, applications must be processed and approved in the following order:

1. Applications for renovation or replacement of existing facilities that incorporate innovative building designs that create more home-like settings.
2. Application for renovation of existing facilities.
3. Applications for replacement of existing facilities.
4. Application for construction of new facilities.

Within the first three priorities, further preference is given to facilities with the greatest length of time since their last major renovation or construction. Within the last category, the ‘first-come, first-served’ prioritization still applies. The funding levels, which are set in the state operating budget, remain at \$16 million per fiscal year. As of the writing of this evaluation, virtually all of the allotted \$16 million has been allocated to projects through FY 2010.

Based on the CCA information above, it is reasonable to assume that MC-Lacey would not be able to obtain a CCA for its entire capital costs of \$14,273,000 in year one (2010); it is also reasonable to assume that the applicant could not obtain a CCA for the entire capital cost for years two and three. To evaluate the financial feasibility of this project, the department must consider a “worst

¹⁹ For essential community providers—i.e., facilities at least a forty minute drive from the next closest nursing facility—the minimum occupancy is set at 85% for all components in recognition of their location in lesser-served areas of the state. MC-Lacey’s facility in Thurston County would not meet the definition of an essential community provider.

²⁰ RCW 74.46.803 and 74.46.806.

case scenario” that MC-Lacey would not receive a CCA for the project in its first three years of operation. As a result, MC-Lacey’s Medicaid reimbursement rate would decrease from the \$171.57 projected by DSHS’s Nursing Home Rates analyst, and decrease from the \$144.01 stated as an assumption in the pro forma Statement of Operations shown in Table 11. Once the “property” and “financial” components are excluded from the rate calculation, the Medicaid reimbursement rate is \$138.02. Table 13 below shows a recalculation of the 120-bed facility’s Statement of Operations based on the \$138.02 Medicaid reimbursement rate and using the Medicare, Private, and Other reimbursement rates identified by the applicant in and shown in Table 12A.

Table 13
Applicant’s Projected Statement of Operations Summary
Years 2010 through 2012

	Year One (2010)	Year Two (2011)	Year Three (2012)
# of Beds	120	120	120
# of Patient Days ²¹	11,826	28,420	41,610
% Occupancy	27%	65%	95%
Net Revenue*	\$ 2,946,310	\$ 7,069,353	\$ 10,366,597
Total Expense	\$ 4,094,594	\$ 8,298,790	\$ 11,810,627
Net Profit or (Loss)	(\$ 1,148,284)	(\$ 1,229,437)	(\$ 1,444,030)
Net Revenue per patient per day	\$ 249.14	\$ 248.75	\$ 249.14
Total Expenses per patient per day	\$ 367.21	\$ 278.14	\$ 264.06
Net Profit or (Loss) per patient per day	(\$ 118.07)	(\$ 29.39)	(\$ 14.92)

*Includes deductions for bad debt and contractual allowances

As shown in Table 13 above, with the reduced Medicaid reimbursement and correcting the calculations based on the assumptions provided in the application, the 120-bed facility would be operating at a loss of \$1,148,284 in year 2010, which increases to a loss of \$1,444,030 by the end of year 2012. The projections shown in Table 13 above assume 32% Medicaid payer and the facility is able to reach its projected occupancy levels in each of the years of operation. Lower occupancies or greater percentages of Medicaid patients would result in a greater net loss for the facility.

Five separate entities provided comments in opposition to this project related to this criterion. Those comments are summarized below.

Roo-Lan Healthcare Center

Roo-Lan Healthcare Center provided concerns regarding the applicant’s ability to secure CCA funding, and suggested at a minimum, any approval should be conditioned upon the applicant’s securing CCA funding. [source: April 22, 2008, public comments]

Applicant

MC-Lacey provided responses all concerns regarding the CCA funding. The applicant reasons that while it will apply for the CCA, and would most likely receive CCA reimbursement, it is not absolutely necessary. MC-Lacey further states that it operates a number of nursing centers in states

²¹ The applicant identified year two patient days at 28,470; however, the breakdown of patient days by payer source provided in Exhibit 6 of the application adds to 28,420. The decrease in patient days affects the net revenue and expense per patient day calculations for year 2011.

without CCA reimbursement and the facilities are financially successful. [source: MC-Lacey June 4, 2008, supplemental information, pp12-13 & 16]

Department

A portion of MC-Lacey’s responses to the comments provided by Roo-Lan Healthcare provides assurance that the new facility would obtain a Medicaid contract, and, therefore would provide services to the Medicaid patients. [source: MC-Lacey June 4, 2008, supplemental information, pp12-13] This issue is not in dispute, because Certificate of Need rules and regulations require any new nursing home to provide services to all residents of the service area regardless of payer source. However, the focus of this comment is not whether the facility would participate in the Medicaid program, rather, it focuses on whether the Medicaid reimbursement rate would include the factors that rely on issuance of a CCA . This issue was addressed extensively above, and will not be re-addressed here.

SEIU Healthcare 775NW²², Puget Sound HealthCare Center, Evergreen Nursing and Rehabilitation Center, Providence Mother Joseph Care Center

All four entities expressed concerns regarding the percentage of Medicaid services proposed at the new nursing facility. All entities suggest that compared to the existing facilities in Thurston County, the proposed facility would provide significantly less Medicaid services. [source: April 22, 2008, public hearing documents]

Applicant

In response to the concerns raised, the applicant states that while its application anticipates 32% of its patients would be Medicaid based on its experience at its facility located in Tacoma, within Pierce County. Given that the payer sources identified on page 29 of the application are projections, MC-Lacey also provided a summarized projected Statement of Operations using the assumption that 50% of its patients would have Medicaid payer source. That supplemental Statement of Operations shows that the revenues of the 120-bed facility would cover the expenses at the higher Medicaid rate. [source: June 4, 2008, rebuttal comments, pp11-12 & Attachment H]

Department

MC-Lacey’s projected payer sources are shown below. [source: Application, p29]

Source	Percentage
Medicare	35%
Medicaid	32%
Private Pay	20%
Insurance/HMO	13%
Total	100%

As shown above, 67% of the revenues are expected to come from state entitlements (Medicare and Medicaid combined). Additionally, Medicaid percentage appear to be low when compared to the 53% average percentages provided by the existing SNFs in the county for year 2006. [source: April 22, 2008, DSHS public hearing documents, p20] While the applicant provided an example of its

²² SEIU Healthcare 775NW is a home care and nursing home workers union representing 30,000 home care and nursing home workers throughout the state. [source: SEIU Healthcare 775 NW website]

projected Statement of Operations based on 50% Medicaid payer source, the document does not take into account that likelihood that MC-Lacey would not receive a CCA, resulting in two of the seven components used to determine a Medicaid reimbursement rate excluded from the Medicaid reimbursement rate calculation. It is reasonable to conclude that if the new 120-bed facility's revenues would not cover its expenses at a 32% Medicaid payer source as shown in Table 12 any increase in the Medicaid percentage would only exacerbate the net loss in projected years 2010 through 2012.

To further analyze short-term and long-term financial feasibility of nursing home projects and to assess the financial impact of a project on overall facility operations, the department uses a financial ratio analysis. The analysis assesses the financial position of an applicant, both historically and prospectively. The financial ratios used are: 1) current assets to current liabilities; 2) current and long-term liabilities to total assets; 3) total operating expense to total operating revenue; and 4) debt service coverage ratio. If a project's ratios are within the expected value range, the project can be expected to be financially feasible. Table 14 below summarizes the projected financial ratios for MC-Lacey. [source: Application, Exhibit 12]

**Table 14
Manor Care of Lacey Projected Financial Ratios**

RATIO	GUIDELINE:	*	Year 1 2010	Year 2 2011	Year 3 2012
Current Ratio	1.80-2.50	Above	2.34	2.69	2.80
Assets Financed by Liabilities	0.60-0.80	Below	0.01	0.03	0.04\4
Total Operating Expense to Total Operating Revenue	1.00	Below	1.19	0.90	0.85
Debt Service Coverage	1.50-2.00	Above	N/A	N/A	N/A

*A project is considered more feasible if the ratio is above or below the value/guideline as indicated.

The applicant provided the following statement in reference to the ratios:

“Due to the accounting of interunit transactions between the facility and the Corporate entity, the true value of some of the facility’s assets and liabilities are not accurately represented, (i.e. the facility does not keep its own cash, therefore they show a minimal cash balance). This obviously affects the ratio calculations shown above”. [source: Application, Exhibit 12]

The projected financial ratios shown above are based on the assumptions used by MC-Lacey summarized in Table 11 and the projected 32% Medicaid payer source. Again, the ratio analysis does not take into account the likelihood that MC-Lacey would not receive a CCA, resulting in two of the seven components used to determine a Medicaid reimbursement rate excluded from the Medicaid reimbursement rate calculation. The projected net loss shown in Table 13 would substantially affect the applicant's “total operating expense to total operating revenue” ratio, resulting in a ratio above the guideline for years 2010 through 2012. As a result, the ratio analysis shown in Table 14 above cannot be considered reliable.

Based on the financial information above, the department concludes that the project's immediate and long-range operating costs are not met, which would jeopardize the financial viability of the new facility. This sub-criterion is not met.

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

The per-patient-day costs were compared to the costs of the six C-SNFs and one H-SNF operating in Thurston County in years 2005 and 2006. Based on that comparison, MC-Lacey’s per patient day costs are comparable. [source: 2005 and 2006 DSHS cost report summaries] This sub-criterion is met.

(3) The project can be appropriately financed.

As stated in the project description portion of this evaluation, the estimated capital expenditure for this project is \$14,273,000. A breakdown of the capital expenditure is shown in Table 15 below.

[source: Application, p20]

Table 15
Manor Care of Lacey Projected Capital Expenditures

Item	Amount
Construction Costs	\$ 9,390,100
Land Purchase & Site Preparation	860,000
Equipment (Fixed and Moveable)	2,022,750
Corporate Overhead	805,100
Washington State Sales Tax	755,750
Fees	434,300
Real Estate Tax	5,000
TOTAL	\$ 14,273,000

Included above is a line item entitled: Corporate Overhead. MC-Lacey provided the following explanation for this line item:

“These costs would be better described as “other development costs” and are the additional indirect costs that area associated with the project. These costs include a portion of the salaries of Manor Care’s internal health planning, land development, architecture, construction, purchasing, interior design, accounting, financial planning, quality assurance, management, legal and other support staff associated with this project. [The costs also include] a portion of the overhead costs (such as rent and utilities) that are necessary to house the above staff.”

[source: Application, p21]

Based on the explanation, the department concludes it is reasonable to include corporate overhead in the estimated costs for this project. To further demonstrate compliance with this sub-criterion, the applicant provided a copy of the Deed Zoning Approval, which identifies the Thurston County Assessor Office parcel number, for the land currently owned by Manor Care. [source: Application, Exhibit 5]

The source of financing for the project will be from Manor Care, Inc. cash reserves. [source: Application, p25 and Exhibit 9] To demonstrate compliance with this sub-criterion, MC-Lacey provided Manor Care, Inc.’s 2005 and 2006 historical financial documentation. [source: Application, Exhibit 10] Those documents confirm that Manor Care, Inc. currently has the funds to finance the project, and this project would not adversely affect the financial stability of Manor Care, Inc.

Based on the above information, the department concludes that the project can be appropriately financed. This sub-criterion is met.

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

Based on the source information reviewed, the department determines that the application is not consistent with the applicable 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.

As previously stated, Manor Care, Inc. or one of its subsidiaries owns, operates, or manages over 500 healthcare facilities, which includes skilled nursing centers, assisted living facilities, outpatient rehabilitation clinics, hospice and home health agencies across the nation. [source: Manor Care website] For this project, MC-Lacey proposes to recruit approximately 116 FTEs to staff the new 120-bed facility. Table 16 below shows the breakdown of FTEs. [source: Application, p30]

**Table 16
Manor Care of Lacey Projected FTEs**

FTE	Total
RNs	9.6
LPN	12.3
Nurses Aides & Assistants	40.0
Dietitians	1.0
Aides	10.1
Administrator	1.0
Activities Director & Assistant	2.0
In-Service Director (RN)	1.0
Director of Nursing & Assistant	2.0
Clerical	3.5
Housekeeping/maintenance	6.9
Laundry	3.5
Physical Therapists & Aides	5.5
Occupational Therapist & Aides	3.5
Medical Records	1.0
Social Worker	3.0
Plant Engineer	1.0
Others ²³	9.4
Total FTE's	116.3

As shown in Table 16, MC-Lacey expects to recruit approximately 116 FTEs for the new 120 bed SNF. Additionally, MC-Lacey provided job descriptions for key staff, such as medical director, administrator, administrative director of nursing services, physical therapists, etc. The applicant states that it has developed over 100 new facilities in the past 20 years, and has never had difficulty recruiting staff for a new facility. MC-Lacey would offer transfer opportunities to employees and through its career ladder programs, has the ability to offer promotion to nurses from existing Manor

²³ Other FTEs include HR director, speech therapist, admission coordinator, case manager, and nurse specialists.

Care facilities to staff this new center. MC-Lacey expects its recruitment of staff to have little impact on existing providers because the facility would grow slowly over three years and any impact would not be sudden or unmanageable. [source: Application, p30; February 7, 2008, supplemental information, pp10-11]

Based on the information provided in the application, the department concludes that MC-Lacey provided a comprehensive approach to recruit and retain staff necessary for the new, 120-bed SNF. Additionally, as previously stated, the department compared years 2005 and 2006 average nursing hours per patient day of existing Thurston County nursing homes with the applicants proposed nursing hours per patient day. That comparison revealed that MC-Lacey's projected nursing hours per patient day are comparable to the county's average. [see Table 2 within this evaluation.]

Based on the above evaluation and information provided in the application, the department concludes that qualified staff can be recruited. 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.

Manor Care, Inc. is an established provider of SNF services in Washington State, as such; some ancillary and support services are already established. MC-Lacey would participate in the corporate national contract for pharmacy, IV therapy and radiology (X-ray) services. The application identified the remaining ancillary and support services required and recognized that local providers had not yet been contacted. If this project is approved, MC-Lacey stated that local providers "will be contacted at the appropriate time to establish contracts for services." [source: Application, p31]

As indicated above, some ancillary and support services would be provided through a national contract with Manor Care, Inc. and the remaining support services would be contracted with community providers in Thurston County. Based on the information provided in the application, the department concludes that MC-Lacey intends to meet this requirement; however, if this project is approved, to ensure that appropriate agreements will be established, the applicant must agree to the following term:

Prior to providing services at Manor Care of Lacey, Manor Care Inc. will provide functional plans outlining the services to be provided through a national contract with Manor Care, Inc. and those that would be provided within Thurston County.

If the applicant agreed to the term outlined above, the department would conclude that there is reasonable assurance that Manor Care of Lacey would have appropriate ancillary and support services, and this sub-criterion would be 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.

As stated in the project description portion of this evaluation, HCR Manor Care, Inc. is located in Delaware and is the operating group of Manor Care, Inc, an owner and operator of long-term health care centers in the United States. As of the writing of this evaluation, Manor Care, Inc. has over 500 skilled nursing centers, assisted living facilities, outpatient rehabilitation clinics, and hospice

and home health offices in 30 states.²⁴ The majority of the health care facilities are operated under the names of, or dba of, Manor Care, Arden Courts, and Heartland.

To evaluate this sub-criterion, the department requested quality of care histories from the states where Manor Care, or any of its subsidiaries, owns or operates healthcare facilities--which represents a total of 291 health care facilities. Through either return of the quality of care survey or by accessing the Center for Medicare and Medicaid Services website, the department was able to obtain information representing all 30 states. A review of data from the 30 states revealed that four states—Florida, Indiana, Michigan, and West Virginia—reported substantial non-compliance issues at one or more of the healthcare facilities operated by HCR Manor Care or one of its subsidiaries. There are a total of 69 facilities within the four states, and of those, 8 facilities--or 12%--indicated significant non-compliance issues that were subsequently corrected by Manor Care or one of its subsidiaries. Further, the majority of the significant non-compliance citations related to isolated incidences and did not represent immediate jeopardy to patients. [source: compliance survey data provided by each state agency or CMS website] According to documents provided by the out-of-state licensing agencies, Manor Care resolved the significant non-compliance issues and no disciplinary actions were taken by the out-of-state surveying agencies.

Further, Manor Care or one of its subsidiaries owns or operates five skilled nursing facilities two in-home services agencies in Washington State. A review of the quality of care histories from those seven healthcare facilities from January 2005 through March 2008 revealed no significant non-compliance issues at any of the six facilities.²⁵

SEIU Healthcare 775NW

SEIU Healthcare 775NW submitted comments in opposition to this project related to this sub-criterion. The comments focused on the recent purchase of MC-Lacey's parent corporation, Manor Care, Inc., by The Carlyle Group, a for-profit entity. SEIU is concerned that the ownership change may result in reduced staffing resulting in poor quality of care. [source: SEIU April 22, 2008, public hearing documents]

Applicant

In its rebuttal responses, MC-Lacey disputed the concerns and provided copies of its 2005 through 2007 quality of care performance records for its Washington State nursing homes. Further, MC-Lacey provided copies of 2005 through 2007 quality of care performance records for randomly selected nursing homes across Washington State. [source: June 4, 2008, Manor Care rebuttal documents] A comparison of the documents reveals that Manor Care's quality of care history is comparable, and in some cases, better than, existing Washington State providers.

Department

When this application was submitted in September 2007, the purchase of Manor Care by The Carlyle Group had not yet occurred. Manor Care announced that the purchase would occur on July 2, 2007, however, the regulatory process was finalized in December 2007—almost six months later. All regulatory requirements were met in the states where Manor Care operated health care

²⁴ States include: Arizona, California, Colorado, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Maryland, Michigan, Missouri, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin.

²⁵ On April 4, 2008, Certificate of Need #1366 was issued to Manor Care for the establishment of a new 120-bed nursing home in Clark County. The facility is not yet operational, and therefore, has no quality of care history.

facilities. At least five states—Florida, Illinois, Michigan, Pennsylvania, and Wisconsin—conducted hearings on the action, which included Senate Committee on Aging and the House Ways and Means Subcommittee on Health. Additionally, a number of states—including Washington—conducted public hearings on the action. Those hearings were facilitated by the licensing and/or surveying entity for the Manor Care facilities. In attendance for the Washington State hearing were the Secretary of DSHS, DSHS Chief Licensure, Washington Senior Citizen’s lobbyists, legislators, resident advocates, long-term care ombudsman, and community members. Representatives from both Manor Care and The Carlyle Group also attended the hearing.

DSHS required Manor Care and The Carlyle Group to submit all appropriate documentation for the ownership change. DSHS completed its review and then waited for the results of the other states’ investigations before approving the transaction. In short, DSHS was thorough and cautious about approving this transaction. If DSHS had concerns regarding reduced staffing or quality of care for Manor Care, the department would expect DSHS would voice those concerns during its review of the ownership change. Currently, Manor Care has a record of compliance with state and federal regulations in Washington and other states. Data reviewed for this project does not suggest that the change of ownership would affect staffing or quality of care at the Manor Care facilities.

Based on the above information, the department concludes that there is reasonable assurance that Manor Care of Lacey would be operated in conformance with applicable state and federal licensing and certification requirements, and 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.

With this project, MC-Lacey anticipates it will promote continuity in the provision of health care to the residents of Thurston County by improving local access to health care services for a growing community. Given that the new SNF will also be part of the Manor Care, Inc. healthcare system, MC-Lacey will participate in the existing working relationships with local nursing homes and other health services in the service area.

Additionally, the department considered the results of the financial feasibility criterion outlined in WAC 246-310-220. Without issuance of a CCA by DSHS, MC-Lacey was unable to demonstrate that its projected revenues could cover projected expenses in the first three years of operation.

Therefore, the department concludes that approval of this new, 120-bed SNF in Thurston County, though supported by the need methodology, is showing a financial loss in the projection years. This would have the potential of fragmentation of long-term care within the planning area if it were to close as a result. This sub-criterion is not 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 considered met.

E. Cost Containment (WAC 246-310-240)

Based on the source information reviewed, the department determines that the application is not consistent with the applicable cost containment criteria in WAC 246-310-240.

- (1) Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable. Before submitting this application for review, MC-Lacey considered and dismissed three options. Those options and the reasons they were rejected are discussed below. [source: Application, p33]

Option 1-Do nothing

MC-Lacey considered the average (95%) occupancy of the existing nursing homes coupled with the county's projected population growth between 2006 and 2010. The applicant concluded that these factors would force patients requiring skilled nursing care to "receive services at an inappropriate level." MC-Lacey further states that this option reduces competition among nursing home providers because they could remain fully occupied without competing.

Option 2-Purchase or lease an existing building to convert to nursing home care.

MC-Lacey asserts that this option was dismissed because there are no buildings in the Olympia area of Thurston County that could be appropriately converted to nursing home use. Further, the increased operating costs that could result from operating a converted building (as opposed to new construction) could make this option less financially attractive.

Option 3-Expansion of existing facilities

MC-Lacey states that none of the current providers filed a letter of intent to add beds to their facility to address the need. The applicant further states that prudent planning and implementation does not rely on waiting for a particular provider to take action.

The department notes that while the applicant identified the three options above, expansion of existing facilities (Option 3) is not a decision that can be made by MC-Lacey. Therefore, the department does not consider it an alternative for the applicant to consider.

Further, both options 2 and 3 require prior Certificate of Need review and approval. For Certificate of Need applications for additional skilled nursing beds, regardless of whether it is a bed addition to an existing facility or the establishment of a new facility, an applicant must demonstrate that need exists for the additional bed capacity and existing providers are neither available nor accessible.

For this project, when applying the numeric methodology, the department and the applicant both concluded that Thurston County is under the target 40/1,000 bed to population ratio. As previously stated, the numeric methodology is a population-based assessment to determine the baseline supply of nursing home beds within the state and planning areas to determine whether the existing number of beds is adequate to serve the elderly population. Results of the numeric methodology are not disputed by affected or interested persons during the review of this project. The applicant must also demonstrate that the existing providers are not available or accessible to meet the skilled nursing need of the county [WAC 246-310-210(1)]. Documents within the application met this sub-criterion.

In determining the best available alternative, the department must also consider its findings on the other applicable review criteria. MC-Lacey's project failed to meet the review criteria of financial feasibility and structure and process of care.

Based on the above information, the department concludes that this sub-criterion is not met.

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

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

As stated in the project description portion of this evaluation, this project involves construction. This sub-criterion is evaluated within the financial feasibility criterion under WAC 246-310-220(2). Within that evaluation, the department determined the sub-criterion was met, therefore, this sub-criterion would also be considered met.

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

This sub-criterion is also evaluated within the financial feasibility criterion under WAC 246-310-220(2). Within that evaluation, the department determined the sub-criterion was met, therefore, this sub-criterion would also be considered met.

Based on the above evaluation, the department concludes that costs, scope, and methods of construction and energy conservation are reasonable, and this sub criterion is met.