Dear Examiner Tanner, Re: Swedish MIMP 2015 July 19th, 2015

The Central Area is Seattle's oldest, residential neighborhood. My home, along with a few still remaining, is older than the original Sisters of Providence Hospital. My home was built in 1903; the hospital was built in 1910. It must've been exciting for the residents of this neighborhood, at the turn of the previous century, as they watched a modern hospital being built next to their homes. I can imagine they felt fortunate to have the hospital in their midst, offering desirable services to the near neighbors, as well as to distant citizens of a growing Seattle. Fast forward one hundred and five years, to this neighborhood today, and the residents feel a bit less fortunate.

The neighborhood has changed, the hospital has changed, and the way we access healthcare has changed. The Sisters of Providence Hospital, now Swedish: Cherry Hill, has become an unwelcome corruption-of-a-hospital, with 60% of the campus owned by Sabey Corporation.

I am one of the near neighbors who has been at 90% of the CAC meetings in the last two-plus years. During that time, it became searingly apparent that Swedish/Sabey care only about the profit to be made by adding hospital-support-services to their campus. Although they say that these support services are vital to the operations of the hospital, the same laboratory, Labcore, services the rest of the Swedish campuses. I'm sure they would argue that the First Hill, Ballard, and Issaquah campuses are receiving optimal services from Labcore, even though Labcore is not located on these campuses.

What worries me about this hearing is the number of witnesses that Swedish has trotted out to testify about their care at Swedish Cherry Hill. These witnesses have not attended one CAC meeting, and are testifying while only understanding Swedish's side of the issues. All of Swedish's witnesses either work there or have been encouraged by Swedish to testify. The neighbors, on the other hand, have educated themselves on both sides of the issues and are far more aware of the impacts on this neighborhood, as well as on neighborhoods east of the hospital.

The neighbors, and advocates for this neighborhood, who are reading the materials, going to CAC meetings, and meeting on our own to talk about the issues and strategize about how to best serve our neighborhood, keep saying the same things over and over again:

- The proposed square footage is too large for this neighborhood
- The streets cannot support this increase in traffic
- A building of this size should be built in an urban village
- The Central Area is not an urban village
- A building of this size should be build NEXT TO mass transportation routes and major arterials

These points are true and important.

I encourage you to reject this MIMP. Endorse the minority report, or don't. This hospital and their corporate partner, Sabey, are bad neighbors and are driven by greed.

Thank you for your service,

Abil Bradshaw
529 19th Avenue
Seattle WA 98122
206-324-0421

Testimony July 20, 2015 for:
Project Number: 3012953
Project Name: Swedish Medical Center Cherry Hill Campus Master Plan
C. F. Number 311936
By: Aleeta Van Petten, M.D. Appellant, Member Concerned Neighbors

Dear Ms Tanner,

Throughout the process of this MIMP, Swedish and Sabey have made many claims about their needs which I think are exaggerations. Friday, I heard more of what I think are exaggerations of their need from a dentist employed by them, Dr Amy Winston, D.D.S.

In her testimony, Dr Winston claimed that Swedish provides the only dental clinic in the area that will do extractions and other surgical dental care for free, and that they provided over $2,000,000.00 in dental care last year and are on the way to exceeding that amount this year.

It is wonderful that Swedish is doing its part to help take care of the dental needs of the community. She made it sound like Swedish is unique in this community for this service. While it may offer "free" services to some, there are a number of other providers in the community that are doing similar work. Oral surgery is done at Harborview, some of which is almost certainly low cost or charity care. I am providing a list of services provided at UW clinics as an example.

The thing that made me most unhappy about her testimony however, is that she claimed that she and the building managers at Swedish Cherry Hill searched the campus and could not find as much as an empty "broom closet" in which to start a another dental clinic there. Surely, if Swedish and Sabey are such close partners in delivering health care at the Cherry Hill campus, they could have found *something* within the grounds that Swedish and Sabey own together that could have served that need. *Right now* there is 4,164 sq ft of space available in the Jefferson Tower. I am certain that that would be more than enough.

Mr. Cosentino also stated that it would not be possible to decrease the amount of space devoted to LabCorp because of the "acuity" of services provided to the operating rooms. He did not provide documentation of that, and maybe he does not need to, but I would question the veracity of *that* statement.

I believe that Swedish First Hill has a larger and busier surgical service than does Swedish Cherry Hill. If it is not busier, it is at least as busy. Also, Swedish First Hill does cancer surgery and Cherry Hill does not list that as one of the services it provides on its website (though I know they do cancer surgeries at the neuroscience center). In my experience, most

of the consultations from pathologists during surgery are on oncology patients, so if Cherry Hill justifies having such a large space for LabCorp at its hospital, why does not LabCorp have as large a presence at the First Hill hospital? I think this is yet another exaggeration/half truth from Mr Cosentino. It is my suspicion that a very large amount of LabCorp space at Swedish Cherry Hill is devoted to processing specimens that come from all of Swedish's outpatient clinics and the other many regional clients that LabCorp boasts of on its website, otherwise, their courier service would not be nearly as busy. LabCorp could easily transport all of those specimens to another site for processing.

As I have previously testified, they talked about the amount of research they do and the quality of their Neuroscience Center of Excellence. They did not bring forth any objective measures to document their claims about research or the degree of excellence in the care that they perform. We only have their word for it. The testimony from their patients is anecdotal and is not recognized in science (or medicine) as proof of anything other than they have some good outcomes and have some loyal patients.

I produced documents which I have previously provided to you: The NIH grant data and the report from US News and World Report that, as far as I know, Swedish did not try to refute. Both of those documents counter claims that Swedish has made on its own behalf.

Even Kurt Salmon, one of their experts states on his website that the love affair that insurers have had with expensive, highly technologically driven medical care probably has peaked and may be on the downswing.

It is my contention that these examples call into question the veracity of the rest of their testimony.

I thank you once more for your time.

Respectfully,

Aleeta Van Petten, M.D.

Aleeta Van Petten, M.D.
732 15th Avenue
Seattle, WA 98122

Project Number: 3012953
Project Name: Swedish Medical Center Cherry Hill Campus Master Plan
C. F. Number 311936
By: Aleeta Van Petten, M.D. Appellant, Member, Concerned Neighbors
July 16, 2015

Dear Ms. Tanner,

I thank you for the opportunity that I had to testify before you this Monday.

I have additional written testimony that I would like to present in response to some of the testimony that I heard from the patients and doctors of Swedish Cherry Hill, and the planning consultants paid for by Swedish and Sabey on Monday after I gave my testimony.

I would like to briefly review some of my credentials at this point; something that I did not do in the interest of time during my testimony, but would like to take the time to do here. You may also refer to the CV that I turned in with a more detailed written account of my testimony Monday and documentation of my sources.

I am board certified in Family Medicine. I have been dedicated to the practice of medicine for my entire adult life. I trained in Family Medicine at what is now the Swedish Hospital First Hill Family Medicine Residency. I was on active staff at both Swedish Hospital and the former Providence Hospital from the time I graduated from my residency in 1979 until January of 1998. I was teaching faculty at the Swedish Hospital Family Medicine Residency until February of 1987 and was associate faculty for the University of Washington for that same period. Family Medicine certification is maintained with 50 credits of CME yearly and board exams every 7 years. As part of this recertification process, Family Doctors are tested on all aspects of medicine including Preventive Medicine, Public Health and Statistics, so I feel qualified to make the observations that I am making here.

I heard several things from the Swedish Cherry Hill doctors, their patients, and the Swedish/Sabey consultants that concerned me, and some that profoundly alarmed me, and I would like to comment on them here.

First and foremost, I was very disturbed by the testimony from the last Swedish consultant Monday afternoon. I believe his name was Hoffman.

His needs analysis discussed in vivid detail what he described as a seemingly never ending trajectory of need for the services of the Swedish Neuroscience Institute. The services that he was referring to were primarily those related to the treatment of stroke, heart attacks and other forms of cardiovascular disease (that are largely preventable) through various high tech means at the disposal of the Swedish Neurosurgeons. I was temporarily stunned by his statistics—it did not seem possible, but I knew that he would not present data that he could not prove. After a few minutes of consideration however, I came to realize that his data is real, but it mirrors the epidemic increase in the lifestyle diseases of obesity, diabetes and hypertension in this country.

Two things are important about this relationship:

1) The increase in the medical complications related to lifestyle will eventually plateau—either the population will stop getting ever more obese, or we will reach 100% obesity, and then the need for these services will also plateau. (I am only half joking.)

2) Public policy is being developed to slow and reverse the epidemic of obesity, diabetes and hypertension, etc—so one would expect that the increase in need for these services will slow and even reverse.

If I understood his testimony, the doctors of Swedish Hospital Neuroscience Institute are proudly using a large part of their very expensive technology and highly specialized surgical skills to treat diseases that can be prevented.

I have no problem with the use of this kind of technology to treat this kind of established serious disease. I have often referred these kinds of patients for similar care. Also, as a physician, I understand the thrill and excitement and reward of treating serious diseases and seeing good outcomes. *However*; it seems unethical to invest this kind of money into the study and use of highly technological treatment of preventable disease without similar investment into preventive services and studies of prevention. This is capitalism at its worst. Doctors are supposed to be better than that, and hopefully hospitals and hospital CEOs as well.

Also, you may recall during my earlier testimony, that I observed that Swedish was trying to capture "market share" from University of Washington in the Neurosciences. I was gratified to hear one of the Swedish consultants admit (and he seemed to think that this was great) that Swedish was trying to develop market share, though he did not specifically refer to UW. (I believe that this was from Kurt Salmon.) Unfortunately, from the testimony about charity care, it appears that the development of market share only implies to the share of the population that has insurance and can pay for services.

In addition, I found an interesting quote from Mr. Salmon's website that I would like to present here. It seems to contradict much of his testimony on behalf of Swedish and calls into question his veracity. It *also agrees* with one of my complaints about Mr. Hoffman's testimony:

> "Most healthcare leaders would agree that the industry is in the midst of one of the most transformational changes in its history. There is recognition from payors, providers, and government officials **that the current system is based on a perverse incentive model that rewards the provision of "sick care" as opposed to "well care."** Tolerance for the current model is rapidly declining. Today, numerous healthcare organizations have started their transformational journeys, and promising models have emerged that are having early successes. While best practices will continue to evolve, the care delivery models and incentive structures that need to be developed for future success are becoming more defined. Networks of providers will be accountable for managing the health of defined populations, and provider reimbursement will be at risk for providing high value care. It is our belief that **to have success in this new paradigm, organizations must remove significant amounts of excess utilization and lower the medical cost of their attributed lives.** What is not clear is how much utilization will need to be removed and how quickly it must happen."

I would consider the failure to institute preventive measures, and the use of expensive "quaternary" medical procedures to treat preventable disease, would be what the writer is referring to above when he talks about "significant amounts of excess utilization".

I will further point out, that, as I recall, not one of the Swedish physicians, not even Dr Weiss, the Family Medicine doctor, mentioned any research into prevention of cardiovascular disease or any directed clinical approach to prevention of such disease at the Cherry Hill campus.

It was also interesting that a number of the patients that Swedish brought for testimony had a story to tell about missed diagnoses or unsuccessful treatments at the University of Washington. This is not uncommon in medicine—there are almost certainly similar stories about misdiagnosed patients from Swedish that are now being treated at the UW. That was unprofessional and in my opinion, should not have been allowed by Swedish.

I think this information confirms and adds to, the evidence that I have previously presented against Swedish Cherry Hill, and the assertion by Swedish and Sabey of need for the expansion of the Neuroscience Center at the Cherry Hill Campus.

I call for you to deny their request for expansion.

Thank you for your time.

Respectfully,

Aleeta Van Petten, M.D.

P.S. I am including here printouts for documentation of the US News and World Report that I alluded to in Monday's testimony. I was unable to figure out how to print it out until today.

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Testimony presented on July 13, 2015
Project Number: 3012953
Project Name: Swedish Medical Center Cherry Hill Campus Master Plan
C. F. Number 311936
By: Aleeta Van Petten, M.D. Appellant member, Concerned Neighbors

The objectives of the MIMP process are to balance the needs of major institution development with the need to preserve adjacent neighborhoods. I do not believe that this MIMP fulfills this function.

A needs analysis paid for by Swedish stated that the King County population aged 65+ will be increasing by 127% in the next 20-30 years. Because of this Swedish Cherry Hill states that they need more space for doctors offices, hospital rooms, clinical research, education, hotel, long term care and support. I believe that this conclusion is erroneous.

The stated primary reason for expansion is to develop a center for Neuroscience Excellence. Swedish Hospital administration has claims that the expansion will benefit the neighborhood. We in the neighborhood disagree.

Few in our neighborhood will ever directly benefit from the level of tertiary specialty care envisioned at the Cherry Hill Neuroscience Institute. Tertiary care centers draw patients from very large geographic areas, not just the neighborhoods surrounding them. Often new tertiary care and research centers are developed by hospitals to increase market share, revenue and profits—things that will not benefit this neighborhood, and will, in fact, harm this neighborhood. In addition, most of the functions mentioned above, such as doctors offices, research, hotels, long term care facility and education, can, and should be, fulfilled in other locations. This would dilute the impact on any one neighborhood and provide the benefit of locating care near the homes of patients served by the physicians and the long term care facility.

The increase in traffic from the commutes of more doctors, nurses, researchers, support personnel, patients, family and friends that correspond to requested expansion of the physical plant will clog the I-5 and I-90 corridors even more that they are clogged now. There will be worsened traffic congestion on the main thoroughfares and side streets for blocks around the campus, with more pollution, parking problems and danger for pedestrians and cyclists as well as delays for the commuters.

In fact, the increased traffic, pollution, noise, parking problems, shadowing will significantly decrease the quality of life in this neighborhood.

If serving our neighborhood is the goal, what our neighborhood needs is what every community needs: We need access to good general medical care and community based medicine. We need classes in nutrition, exercise, and how to avoid the unnecessary use of

antibiotics. We need parenting classes, drug and alcohol rehab, mental health care, smoking cessation classes, appropriate early childhood education, support for young families and affordable child care. All of these things will, over time, produce a healthier population and bring the cost of healthcare down. Those are the things that Swedish Hospital should be developing. If they wanted and needed to expand their campus to provide these functions they would not be facing this level of opposition.

If we need research in our community and by our health care system it is research into preventive medicine.

Chronic diseases such as heart disease, cancer, diabetes, hypertension, obesity, alcoholism, nicotine addiction and narcotic addiction take a huge toll on Americans in all communities every year. The number of Americans that suffer from chronic neurologic conditions (some of which are treatable and others not), while not insignificant, is small in comparison with the above list of diseases, many of which are preventable.

Yes, with a growing and aging population, there is going to be an increase in need for medical care in the Puget Sound area in the near and distant future, but the Swedish Hospital Cherry Hill campus does not need to absorb all of that increase in need. King County is huge. Much of this increase in need will be centered in growth areas *outside* of Seattle. There are multiple hospitals in this region that can, should, and want to share the burden.

In fact, that need is theorized but not guaranteed. Medical care has changed dramatically in the last 20-30 years, and has markedly decreased the number of hospital beds needed to care for the population. It is impossible to predict precisely the needs in the future.

One thing *is* clear from the presentation their expert made: The majority of the increased need for medical care will come from the elderly. Everyone who cares for the elderly knows that they do better, prefer to be cared for, and are more easily managed, in facilities near their homes. They prefer facilities that have easier access for them, and where friends and family can visit without a long commute or need for hotel stay. Facilities for their care, particularly rehab centers, should not be located on Cherry Hill, but closer to their own communities.

Swedish representatives extol the virtues of the Swedish Neuroscience Institute (SNI) located on the Cherry Hill campus. They claim that, because SNI is engaged in "leading-edge clinical research", it is a great boon to the Seattle area.

But Seattle already has a well-established center for neurology, neurosurgery and neuroscience research at the University of Washington School of Medicine and UW Medical Center (UW Medicine). UW Medicine, which operates the only academic medical center and the only Level I trauma center in the region (Cherry Hill is not an academic medical center, nor is it a designated trauma center), is already the recognized regional leader for neurosurgery, neurological care, and neuroscience research.

One (rather good) indicator of the extent to which an institution is engaged in "leading-edge clinical research" in a specific area is the number of grants and monetary amount of research funding it receives from the National Institutes of Health (NIH). A search of the NIH research grant database covering the period from the beginning of federal fiscal year 2010 through March 2015 shows that:

- Swedish and Providence facilities in the Puget Sound region received seven NIH grants (totaling $2,245,471) for research concerning neurology, neurosciences and neurosurgery during this time period;
- By sharp contrast, during the same time period, UW Medicine facilities received 159 NIH grants (totaling $44,266,074) for research in these areas.

It is widely acknowledged among healthcare resource planning professionals that it is an unwise use of healthcare resources to create and fund multiple specialty care centers in a region. Swedish/Sabey's attempt to create at the Cherry Hill campus a second tertiary care facility for specialty neuro care and neuroscience research is both unnecessary and an unwise use of resources. Doctors become proficient with practice. If one hospital draws cases from another, then neither may see an adequate number of cases to be proficient in caring for certain rare conditions

The research that Swedish is planning almost certainly *not* be funded primarily by governmental or philanthropic agencies. All researchers know that such funding is drying up. Medical insurance companies absolutely will not fund research. The pharmaceutical industry is the only other major funding option, and we know that profits will be the primary motive. The goal will be the development of new (expensive) drugs and "innovative" (expensive) technologies to increase their profits. And the research that they produce cannot be completely trusted. Pharmaceutical companies often suppress unfavorable data and exaggerate favorable data. This has been proven in the news repeatedly. The drug Celebrex is one such example.

In a national ranking of hospitals published this May in US News and World Report, University of Washington Hospital was ranked # 1 in the Puget Sound area, Swedish was ranked #8. In a national ranking of Neuroscience centers, University of Washington was ranked #21 and Swedish Cherry Hill was not listed in the top 50.

During the CAC proceedings Andy Cosentino made a number of what I consider to be misleading statements about Swedish Cherry Hill's need for expansion and I would like to comment on two of those.

At one point he presented data to show projected need for hospital beds. In his statement he projected 20 years of need from the previous 6 months of data. Not only is 6 months of data statistically inadequate for such a prediction, he actually used 6 months starting in early flu

season for his projection—of course, this will show his numbers showed increasing need. This was very misleading data.

Mr. Cosentino also discussed increasing capacity of the medical center as if an increase in capacity is always good for a community and the patients served. Capacity versus need is a complicated equation. It has been well proven that if capacity of a medical system exceeds need, then quality of care goes down: unnecessary medical tests and procedures are done, more complications occur and the cost of medical care goes up. I believe that this is where the Swedish Hospital MIMP is taking us.

I do believe that this expansion is primarily profit driven. Seattle does not need two centers of Neuroscience excellence. It already has one at the University of Washington. I believe that Swedish Hospital is trying to develop market share and draw business, as well as neuroscience experts away from the University of Washington. I believe this will be to the detriment of an excellent and previously well established neurosurgical program and its community.

Aleeta Van Petten, M.D.

CURRICULUM VITAE

EDUCATION

9/68-6/72	Knox College Galesburg, Illinois	B.A.
9/72-1/73	University of Illinois Medical School Chicago, Illinois	
1/73-6/76	University of Illinois Medical School Rockford, Illinois	M.D.
7/76-6/79	The Doctors' Hospital (Now Swedish Hospital First Hill) Family Practice Residency Seattle, Washington	Family Medicine Certification
6/79-present	Family Medicine Board Recertification	Current

EMPLOYMENT

7/79-10/81	Jefferson Park Medical Center Seattle, Washington	Private Practice
7/79-7/80	The Doctors' Hospital Emergency Room Seattle, Washington	Hospital Staff
7/79-2/87	The Doctors' Hospital/Swedish Hospital Family Practice Residency	Faculty
10/81-5/92	Uptown Family Practice Seattle, Washington	Private Practice
5/92-1/98	Providence/Medalia Uptown Seattle, Washington	Medical Center Employee
3/98-present	Eastside Family Medical Center Bellevue, Washington	Private Practice

Aleeta Van Petten, M.D.
CURRICULUM VITAE

Medical Staff Affiliations

7/79-1/98	Swedish Hospital First Hill Medical Center Seattle, Washington	Active Staff
1984-1988 1986-1988	Executive Committee Member Chief of the Family Practice Department	
7/79-1/98	Providence Medical Center Seattle, Washington	Active Staff
3/98-present	Overlake Hospital Medical Center Bellevue, Washington	Courtesy Staff

Other Experience

While at Swedish Hospital I also served on the Credentials Committee and was the Family Practice representative on the Obstetrical Morbidity and Mortality Committee

I am currently serving on the Credentials Committee at Overlake Hospital Medical Center

I am a Board Member of the King County Medical Society.

Amy Hagopian
802 16th Av. #1
Seattle, WA 98122
206-706-0989
Hagopian.amy@gmail.com

July 13, 2015

City of Seattle Hearing Examiner
PO Box 94729
Seattle WA 98124-4729

Dear Hearing Examiner,

I would like to attend the Sabey - Swedish hearings this week, but I will be out of town. Please accept this letter in lieu of a personal testimony.

I am on the faculty in public health at the University of Washington (by way of identity, not speaking for the UW of course). I'm a mother of three adults who grew up in Seattle and still live here, as do my parents. I have two grandchildren, the eldest six-year-old is in Seattle public schools. I live one block north of the Swedish Cherry Hill hospital in a building that also houses my aging parents.

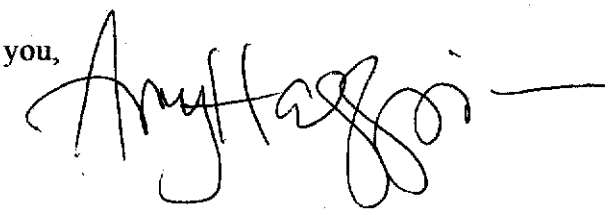
I'm a big fan of good medical care, of course (perhaps more than most), and I also understand the importance of good community-based care delivered by strong non-profit institutions. Swedish is making all sorts of wild claims, however, about the importance of placing destination specialty care in a neighborhood facility. The neurosurgery center it claims is so important is really far better delivered by Harborview at Ninth and Jefferson, rather than by upstart Swedish / Sabey at 16th and Cherry.

It strikes me the institution is much more concerned about its bottom line than about the appropriateness of its care delivery. The strange bedfellow arrangement Swedish is in with Sabey makes me question motives and objectivity.

I do not support the expansion plan here.

Perhaps what Seattle needs is a citywide health delivery planning effort, where we bring together the few remaining hospital providers and map out what services ought to be placed where. This is best done in a rational approach that includes all actors, and considers the best interests of the citizens. I would prefer this approach than leaving expansion decisions to entrepreneurial and aggressive development corporations finding health care partners to cover for their ambitions.

Thank you,



Ku, Tiffany

From: ahendric99@yahoo.com
Sent: Monday, July 20, 2015 12:14 AM
To: Tanner, Sue
Cc: Examiner, Hearing
Subject: Swedish MIMP Comments

Dear Mrs. Sue Tanner,

I am writing to you to voice my frustration with City of Seattle failing to uphold the City's Land Use Code and the City's Comprehensive Plan, specifically regarding Swedish Medical Center's Cherry Hill hospital.

As a resident of Squire Park I am deeply troubled that the Department of Planning and Development (DPD) would so blatantly turn a blind eye and not uphold their fundamental responsibility to the public. I have taken my own personal time to attend at least 3 public meetings, facilitated by DPD, listening to the concerns of my neighbors, giving public comment when asked, and supplying my personal information in the hopes of being kept informed of the Major Institutions Master Plan (MIMP) process. I think DPD failed in this review process and do you know I never received one email from DPD? The voice of the community went dismissed, our concerns with applicable city codes were ignored and the City's Comprehensive Plan apparently isn't worth the paper it was written on.

The City needs to evaluate whether the Swedish Medical Center Cherry Hill hospital qualifies for a MIMP? The original MIMP was created for the Sisters of Providence, who operated a non-profit hospital in that location for the benefit of the community. That fits perfectly into the notion of why a MIMP might be needed in a residential neighborhood. When Swedish purchased the location and entered into a former partnership with Sabey Real Estate Development the dynamics changed. The MIMP was not intended for a for profit commercial office facility in a low rise zoned residential neighborhood. Swedish and Sabey have voluntarily admitted that the bulk of the proposed growth is not needed for hospital beds or even for the hospital support functions but the new space would generate revenue as commercial leases.

The community infrastructure is not equipped to handle a development of the size they are proposing with the volume of occupants and associated commute needs. The facility is smack in the middle of single lane residential streets, there is no light rail nor is there any street cars. In fact there are no traffic lights in this area, it really is a residential neighborhood. Current bussing would never accommodate the increased occupants and occupants will continue to park on our residential streets at the detriment to those who live in Squire Park. Swedish and Sabey argue the infrastructure will suffice, city transportation engineers could easily validate that claim or not. DPD is not being transparent, has a City Transportation Engineering Study occurred? What were the results? Did they factor in Swedish's desire do away with two residential streets? Common sense seems to be misplaced, how can they increase occupancy with fewer streets, no street improvements or additional public transportation?

This whole thing smacks of a Civil Rights / Environmental Justice lawsuit waiting to happen. The Central District historically was a redlined district where underserved and discriminated populations were forced to live. The community in the Central district lived through redlining and today is a strong diverse middle-class community that is thriving. By allowing the Swedish expansion into the Central District, the City is destroying

one of the last middle-class residential communities, and continuing to redline out diverse and middle class communities that live in the Central District.

Please help us save a very special community by ensuring the existing building codes, and comprehensive plan is adhered to. Do not allow this behemoth of a structure to become a blight to our community and to Seattle. There are more suitable areas in Seattle per the City's Comprehensive plan to accommodate their desire to develop commercial office space.

I would be happy to discuss further, should you or others want to talk. I tried attending the session last week but only learned of it Thursday night. When I went to the Hearing Examiners office on Friday at 2pm I was told that business had concluded early.

Thank you for your consideration and support.

Sincerely,

Andrew J. Hendrickson
327 20th Ave,
Seattle, WA 98122
(206) 320-0013
ahendric99@yahoo.com

Ben Lile
537 19th Ave
Seattle, WA 98122

Dear Examiner Tanner,

I've lived in the Central Area of Seattle for the last 7 years on 19th Avenue, between Cherry and Jefferson. I rented my house for 6 years before purchasing it last summer. I am committed to living in this neighborhood and am concerned that the expansion of the Swedish Hospital campus will adversely affect my family and my neighbors of this Central Area neighborhood.

Plainly, the height, bulk, and scale of Proposal-12 is inappropriate for the quality-of-life of the people living in this neighborhood. The construction phase of such an aggressive project will without a doubt make living near the site very difficult. After the build, the resulting, out-of-scale campus will disrupt life for the Central Area residents. The people living in the neighborhoods of Leschi, and Mount Baker, also depend on the thoroughfares of Cherry and Jefferson streets to commute. In the fall, my daughter will be attending Nova, which has just moved back into the building across from Garfield, and I am very concerned about the proposed rating (an "C-D") of the crosswalks that she will be crossing every day. As far as I have heard there is no mitigation for these crosswalks.

Given the existence of several other Swedish campuses in Seattle and Issaquah, I think the hospital-support facilities that Swedish wants to locate on their Cherry Hill campus can be built elsewhere, in order to preserve the character and livability of the Squire Park neighborhood.

I am though not opposed to development. I am in favor of the Minority Report, which advocates for remodel of the existing facilities and a build out of a more reasonable height, bulk and scale. For me in particular I am most concerned about the half-block on the east side of 18th Avenue. Proposal-12 shows a four-story, monolithic building. The minority report recommends several, freestanding buildings, with space between, and even a green-space. These lower-rise, separate buildings are an actual transition to the neighbors' homes, which abut this Sabey property.

Please reject this MIMP and adopt the minority report put forth by the CAC.

Thank you,

Ben Lile

Squire Park is a small scale residential neighborhood. The Major Institution Master Plan Alternative 12 proposed by Swedish & Sabey does not fit the neighborhood. It is inappropriate in building mass and character, and it will introduce inappropriate volumes of traffic to an area with few public transportation alternatives, and an area where there are limited physical opportunities in the street grid to improve or increase traffic flow in the future. An expanded and out of scale development like Alternative 12 creates more problems than it solves.

If the proposed development is completed as Alternative 12 indicates, the project would impose thousands of additional daily single occupancy vehicle trips onto a neighborhood that is already stressed beyond it's carrying capacity at peak travel times. If development of this scale is encouraged by the city of Seattle without addressing the number of trips through street improvements and public transportation, the adjacent neighborhood and connecting communities will suffer for it through reduced mobility and parking. As far as I am aware, the proposed development will be serviced by the same inadequate transportation infrastructure we currently share for the foreseeable future.

Swedish is a wonderful, high-talent, high-quality institution, and we are lucky to have them in the community. I would like to see them continue to develop high quality facilities that fit within the neighborhood we share. However, the motivation behind this proposed plan appears to be one prioritizing real estate development motives ahead of public need. It's my understanding that zoning exemptions in the existing MIMP are intended specifically for the use of institutions that the community considers valuable enough to allow exemptions in a residential zone. Why should Sabey Corporation be allowed to utilize Swedish's zoning exemptions to develop the current campus site, retain property ownership, and develop nearby properties for their own gain? It's profit that will be had at the expense of the surrounding neighborhood and community.

As a neighbor, I'd like to see Swedish continue to work more closely within the existing MIO height and mass guidelines that were previously established to prevent out of scale developments.

Ben Nechanicky
448 14th Avenue
Seattle, WA 98122

Swedish Medical Center Major Institution Master Plan

Hearing Examiner File MUP 15-010

Public Comments of Bill Zosel

I am Bill Zosel, whose address is 904 13th Avenue. I attended many of the Citizens Advisory Committee meetings in this matter. Also, I have reviewed much of the written material in the case and I was present for all of the testimony at the public hearing of the Hearing Examiner. At the Hearing Examiner hearing I was the spokesperson for one of the appellants in the EIS case, the Squire Park Community Council. The following are my personal comments which I ask be included in the record.

The Major Institution Master Plan provisions of the Seattle Land Use Code and the Seattle Comprehensive Plan require that the proposed MIMP be rejected. What is described in the proposed MIMP is too much and too big. It is possible for a plan to be fashioned that meets the reasonable needs of the institution to grow and that also protects the livability of the neighborhood. I hope that, in the future, the institution will submit such a plan for approval.

Up to now, the major obstacle to arriving at an acceptable plan has been the real estate development goals of the Sabey Corporation, owner of nearly half of the Providence-Swedish campus. In 2002 when the administration of Swedish Medical Center determined that it had too much land within its control and decided to "right-size" its holdings, it sold much of the campus to the Sabey Corporation which, at the time, was working on a project to develop a biotech research center.

The development of a biotech research center did not pan out. Consequently, Sabey scrambled to find other tenants for its new holdings. They secured the Laboratory Corporation (LabCorp), Seattle University School of Nursing, the Northwest Kidney Center and, finally, some Swedish Medical Center uses did in fact expand to take some of the Sabey space.

Now, more than ten years later, the arrangement between Swedish and Sabey is described as similar to many other medical center business arrangements where a private development company owns the real estate and the non-profit medical institution carries on its businesses within.

That is not an accurate description. Rather, Swedish made a conscious decision to sell nearly half of its campus knowing that it would not be available to it for future expansion --- a future expansion which it did not expect to carry out in this location. Subsequently, the Sabey Corporation and its tenants occupied much of the campus, and now that the administration of Swedish has changed directions, it is

claiming that, while the Sabey tenants should stay, future Swedish expansion requires 2.75 million square feet of new development space. That additional development space, in the Swedish proposal, will result in buildings as tall as 160 feet and, according to their estimates, generate vehicle trips numbering 11,000 per day.

1. Decentralization must be studied

The institution's needs could be satisfied if it is required to establish priorities. It may be possible to develop the "super bowl champion" neuroscience institute, as one of the applicant's witnesses described it. However, it may not be possible to develop that desired facility, and retain the Sabey tenants --- most notably the Northwest Kidney Center and LabCorp, and Seattle University nursing school, and build a hotel, and establish a rehabilitation center, and other ancillary services.

A review of other major institution MIMP proposals shows that the height and area of individual buildings on the existing campus is not provided. A reasonable interpretation of the Land Use Code would be that that information is required. However, the Swedish Cherry Hill MIMP does not include that information and it is difficult to know exactly how much space was lost by Swedish to the Northwest Kidney Center, LabCorp, and other Sabey tenants not affiliated with Swedish.

The Hearing Examiner should recommend, and the City Council should decide, that the institution make choices. There is the possibility of a "win-win" outcome. The institution's needs and the neighborhood's needs can both be accommodated by prioritizing needs and finding other locations for those which can reasonably exist elsewhere.

In addition to the potential presented by the possibility of recapturing some of the real estate currently controlled by Sabey, it must be noted that Swedish is now controlled by Providence Health and Services. Providence is one of the largest, if not *the* largest, health care provider in the Pacific Northwest. Its subsidiary Swedish has three hospitals in Seattle and one in suburban Seattle. Providence has numerous other locations throughout the area.

The Land Use Code *requires that a decentralization option be considered.* This was not done. The purpose of the Major Institution chapter of the Land Use Code is to "encourage the concentration of Major Institution development on existing campuses, or alternatively, the decentralization of such uses to locations more than two thousand five hundred feet from campus boundaries, " SMC 23.69.002. E.

The Citizens Advisory Committee expressed great concern that the height, bulk and scale of the proposed development could not be accommodated in this location without an unacceptable negative impact on neighborhood livability and vitality. Consequently, several times the CAC requested that DPD study the potential for all of the relevant interests to be served through decentralization. This was not done.

Now, it is the position of the institution that, even though no serious study or analysis regarding any decentralization was done, it should be given approval for all of its requested expansion. In its presentation at the hearing the institution argued that reducing heights or increasing setbacks would result in an unacceptable loss of future hospital space. This argument should not be accepted in the absence of a consideration of decentralization options.

The Hearing Examiner should recommend, and the City Council should decide that there must be a serious analysis of decentralization of some Providence-Swedish uses to locations outside the current Swedish Cherry Hill campus.

2. There has been no adequate analysis of "need"

Throughout her Recommendation, the Director of the Department of Planning and Development refers to the "stated" need of the institution. Based on that "stated" need, the Director would approve almost all of what the institution has requested.

It is clear from the record that there was little or no investigation or critical analysis of the "needs" of the institution. For example, at the hearing in her statement on behalf of the Citizens Advisory Committee, the Chair of the CAC said as much. The record in this matter contain the work of two consultants hired by the institution to support what they state their need is.

On the other hand, Jack Hanson, a neighbor who happens to have considerable relevant experience in assessing the needs of medical institutions attempted to present part of a bigger picture. However, his opportunity to present oral testimony at the hearing in a few minutes is not ideal. Earlier, during the course of the CAC and DPD deliberation he made a reasonable request for some background data that he explained was necessary to inform a considered decision. The institution did not provide that information. DPD did not express any interest in receiving that information and, instead, remained satisfied with relying on the institution's "stated" need.

No one is disputing the great benefits received by many from Swedish and its caregivers as pointed out by a number of people providing public testimony on behalf of the institution. All are grateful for that care and for those outcomes. However, the impact on that care and those outcomes from some reasonable limits on the expansion of the institution is not explained. During such testimony by patients, and similar testimony by caregivers, one could not help but wish that those concerned patients and caregivers and concerned neighbors could have a conversation in which both sides could speak to the real issues in this matter.

While the Land Use Code may limit the ability of the CAC to "negotiate" regarding the stated need of the institution, the Director of DPD and the ultimate decision makers have the obligation to inquire seriously into the stated needs of the institution. Otherwise, the balancing of the needs of the institution and the needs of the neighborhood will occur only through a reduction of the needs of the neighborhood. There is not adequate evidence in the record to support approval of the MIMP by the Hearing Examiner and, ultimately the City Council.

3. The proposed MIMP cannot be approved because it exceeds the level of development that is allowed by Seattle's Comprehensive Plan.

Much can be said, and has been said about that, but I want to call attention to two specific areas:

A. The height, bulk, and scale of the proposed MIMP are wildly out of scale for the lowrise and single family neighborhood in which Providence-Swedish would develop. There is no precedent in Seattle that would support the permitting of a 160 foot high building in a lowrise or single family neighborhood.

Specifically, regarding setbacks, the Hearing Examiner and the City Council should consider the following. The approved Swedish Medical Center First Hill MIMP provides that, for that campus which is bordered by zones that are highrise (not lowrise or single family), upper levels beyond 70 feet are set back for *one half block for the entire campus perimeter* (with one extremely small exception on Broadway.) (See the Swedish Medical Center First Hill MIMP as adopted by the Seattle City Council.)

Regarding the ground level setback on the eastern boundary of the campus where the separation from the MIO from the SF zone (and the single family homes) is simply a lot line, the buffer proposed by Swedish is a 25 foot setback. It is argued that this is the same back yard setback that would be required if the development within the MIO were single family. However, this ignores the fact that the development standards would require not only a 25 foot ground level setback, but also would limit the lot coverage so as to prevent the continuous very long one block building proposed by the institution.

Both of these points are emphasized in the letter in the record from the Central Area Land Use Review Committee presented by Jonathan Konkol.

B. Besides the direct impacts of height, bulk, and scale, this large development proposed by the institution will support increased intensity of use. The level of increased vehicle traffic is one notable and measurable part of that. The MIMP proposes a daily average trip total of approximately 11,000 vehicles.

Swedish and the drafter of the EIS state that an improved Transportation Management Plan and a new commitment to observe a TMP will be sufficient. Of course, even if that were the case, the increase in vehicle trips will be massive and the best that can be said of a possibly effective TMP is that the increase won't be as bad as it otherwise could be.

In its hearing presentation, the institution and DPD focus on one strategy for attempting to tame the increase in SOV trips. The EIS states that transit capacity at the 17th and Jefferson bus stop is more than adequate. There is nothing presented by the institution to indicate the transit capacity for the only all-day Metro bus route (Route 3, or what has been route 3 and 4) for that route's trip between downtown and 17th and Jefferson. Those who travel on Route 3 and 4 between downtown and the institution (I am one of them) know that that route is frequently full with standing passengers at least between Harborview Medical Center and downtown. It is also our experience that, while the route is on a schedule that Metro considers the "most frequent" with less than fifteen minute headway much of the day, the schedule is extremely unreliable. It must compete with heavy vehicle traffic going to and from Interstate 5 on Cherry Street. This is the same street that is mentioned in the EIS and for which travel time, already abysmal, will increase, in the case of the westbound peak period, more than 50% from five minutes and 52 seconds, to over nine minutes. (Table 16 of the EIS Appendix C, page C-105.)

The estimate of that travel time and other nearby travel impacts may be underestimated. The EIS in this case calls out a number of "pipeline" projects that may have an additional impact on traffic in the affected area. However, the pipeline projects recognized in the EIS do not include a significantly larger list of projects for the same area for which permit applications were on record with the DPD at the time the EIS was published in December 2013. Those additional projects, as stated in the DPD Web site are set forth in an attachment.

The best strategy for getting people into transit is to locate jobs where there is robust transit service, particularly, in Seattle, light rail stops. This was noted by several people who appeared at the hearing, including John Stewart of Feet First, John Shaw of DPD, and the Executive Director of Commute Seattle. They all noted that the SOV rate of the TMP for this institution is high, relative to other institutions such as Virginia Mason Medical Center, and Swedish First Hill because Swedish Cherry Hill is not located in an urban center with better transit service and more transit options. (Virginia Mason has already achieved a SOV rate of 28%. The SOV goal proposed for this institution would be gradually reduced to reach a goal of 38% in twenty-five years.)

There is a further fact to be observed regarding the ability of a better planned TMP and an increased observance of the TMP, as promised by the institution. The TMP relates to travel by staff of the institution. Medical Centers are extremely heavy generators of visits by others who are not governed by a TMP. Even if one were satisfied with the reduced SOV rate promised by the institution, it must be considered that the ultimate SOV rate tells only a small part of the story, unlike a Boeing, or an Amazon, or some other large traffic generator where a much larger percentage of those travelling to the location are staff.

There are reasons that the Comprehensive Plan wants significant job growth to be concentrated in urban centers and urban villages. As a City and as a region we are making public investments in rapid transit that will effectively remove the largest number of SOV's off of our streets and highways. There are certain locations where a large number of frequent, all-day bus service is in place. We cannot afford, nor should we try to put in place a transit system that serves residential areas with this level of intensity.

Providence-Swedish and Sabey are asking for approval of a plan that flouts the intention of the Comprehensive Plan and relies on a hope that some time in the future transit agencies will be able to find enough money and find enough room on the street to add more bus service to a low-scale residential area that is intended to be adequately served by existing streets and something like the existing level of bus service. DPD is abdicating its responsibility to be a steward of the Comprehensive Plan by approving this proposed MIMP which would allow a significant demand to be created outside of the intended planning area.

The residents of Squire Park, and the Central Area, reasonably expect observance of the Comprehensive Plan that was put in place to encourage certain kinds of neighborhoods and support the vitality of those neighborhoods. Change will occur and all neighborhoods will adapt to those changes. The Comprehensive Plan is not intended to freeze the City in amber. However, if the City allows the interested parties that are Providence-Swedish and Sabey to reshape the Comprehensive plan to suit their particular needs, that would be a betrayal of the promise of the Plan.

The Hearing Examiner should recommend, and the City Council should decide that the intentions of the Comprehensive Plan should be upheld.

Bill Bond
7/21/15

ATTACHMENT 1
VIRGINIA MASON TMP REPORT
(MOST RECENT ON LINE)

B. Numerous small tenant improvement projects have occurred within the existing buildings. They have not changed the occupied area of the campus.
C. Virginia Mason has not leased additional space within its MIO to Non-Major Institution uses within the reporting period.

IV. Major Institution Development Activity Outside but within 2,500 feet of the MIO District Boundary

A. Land and Building Acquisition during the Reporting Period: None.

B. Leasing Activity during the Reporting Period: Additional area has been leased within the Metropolitan Park West building at the corner of Minor Avenue and Howell Street on the 5th and 10th floors, which is within 2500 feet of the MIO. This property is is within a DMC 340 zone, and therefore not subject to limitations requiring conditional use per 23.69.022 subsection c. Some of Virginia Mason's leased off-site parking within 2500 feet of the MIO has been changed or relocated. This offsite parking is allowed per 23.69.022 a.1, and is included in our Transportation Management Plan, per 23.69.022.a.5.

V. Progress in Meeting Transportation Management Program (TMP) Conditions

A. General Overview of progress in achieving the goals and objectives contained in the TMP:

The 1992 Master Plan established an SOV goal for Virginia Mason employees of 50% or lower. By 1998, Virginia Mason had achieved a rate of 28% and that number has continued to drop. Virginia Mason continues to provide one of the most successful Transportation Demand Management Programs in the City. Only 23% of employees use SOVs and over 49% use mass transit or rail. The service is promoted to all new employees, and updates are offered regularly via on-site transportation fairs and other promotional events.

Virginia Mason installed three new charging stations for electric cars in 2011 that are open to the public in their parking lot on Terry Avenue, and has located spaces for zip Cars at two of their surface parking lots for employees or neighbors. These Zip cars are offered free to employees for up to 5 hours per month for personal errands while at work.

Virginia Mason updates its transportation demand management plan every 2 years, per the City of Seattle requirements. The next update is in late 2012. The most recent Transportation Demand reports are attached.

Thank you

Attachments:
2011 annual report VM Main Campus with signature
2011 annual report VM Met Park with signature

ATTACHMENT 2

Additional "Pipeline" projects

The EIS in this case lists twelve pipeline projects. The following project are not listed but are ones that I have noted on the DPD Web site with applications for permits dated before the date of the publication of the EIS in December 2013

The following "pipeline" projects that are within the same area or distance from Swedish, are not listed:

	Stories	Units	Parking Spaces
1001 James (3019215)	8 stories	350 units	300 parking
1050 James (3019219)	7	70	30
524 Broadway	7	200	110
800 Columbia	30	287	234
1315 E. Jefferson	4	32	16
301 12th	7	75	20
1023 E. Alder	8	85	13
12th and Spruce	3 six story bldgs.	400	270
1427 11th	6	136	128
1021 E, Pine	5	20 + office	142
1200 E. Pike	6	88	38
601 E. Pike	6	60	30
2407 E. Union	4	39	21
1801 S, Jackson	5	152	137

The following projects have just been completed (or are nearly complete) and are part of the Yesler Terrace project: It is unclear whether or not they were included in the EIS

12th and Yesler	7	75	20
1105 E. Fir	6	103	51

The following projects are the Yesler Terrace projects currently in the DPD permitting process:

120 Broadway	7	235	170
123 Broadway	7	193	133

ATTACHMENT 3

DATA FROM KING COUNTY REGARDING METRO TRANSIT ROUTE 3

King County Metro Transit
2014 Service Guidelines Report

October 2014

King County METRO

We'll Get You There

Department of Transportation
Metro Transit Division
King Street Center, KSC-TR-0415
201 S. Jackson St
Seattle, WA 98104
206-553-3000 TTY Relay: 711
www.kingcounty.gov/metro

Alternative Formats Available

206-477-3832 TTY Relay: 711

14076/DOT/comm

ATTACH. 3
(Page 2)

CORRIDOR ID NUMBER	BETWEEN	AND	VIA	MAJOR ROUTE	Load at Preliminary Service Level			Load-Based Service Level Improvements			Cost Recovery at Preliminary Service Level			Cost Recovery-Based Service Level Improvements			Night Service Additions			Service Level Improvements		
					PEAK	OFFPEAK	NIGHT	PEAK	OFFPEAK	NIGHT	PEAK	OFFPEAK	NIGHT	PEAK	OFFPEAK	NIGHT	PRIMARY CONNECTIONS BETWEEN URBAN CENTERS	COST RECOVERY BASIS (8% / 16%)	CORRIDOR HAS 15 MIN PEAK SERVICE	ADD WHAT FREQUENCY NIGHT SERVICE?	PEAK	OFFPEAK	NIGHT
1	Admiral District	Southcenter	California Ave SW, Military Rd, TIBS	128	0.79	0.76	-	1	1	-	41%	27%	13%	-	-	-	-	60	30	30	1	1	-
2	Alki	SODO	Alaska Junction	50	0.69	0.46	-	-	-	-	27%	15%	8%	-	-	-	-	-	-	-	-	-	-
3	Auburn	Burien	Kent, SeaTac	180	0.44	0.85	-	1	-	-	15%	27%	14%	-	-	-	-	60	30	30	-	1	-
4	Auburn	Federal Way	15th St SW, Lea Hill Rd	181	0.58	0.55	-	-	-	-	24%	21%	14%	-	-	-	-	60	60	60	-	-	-
5	Aurora Village	Seattle CBD	Aurora Ave N	E Line	1.50	0.96	2	1	-	-	58%	51%	29%	1	1	-	-	30	30	30	2	1	-
6	Aurora Village	Northgate	Meridian Av N	346	0.67	0.54	-	-	-	-	46%	23%	11%	-	-	-	-	-	60	60	-	-	-
7	Avondale	Kirkland	NE 85th St, NE Redmond Wy, Avondale Wy NE	248	0.18	0.28	-	-	-	-	10%	15%	9%	-	-	-	-	60	30	30	-	-	-
8	Ballard	U. District	Green Lake, Greenwood	48	1.23	1.50	1	2	-	-	59%	79%	47%	1	-	-	-	30	30	30	1	2	1
9	Ballard	Northgate	Holman Road, Northgate	40	1.02	1.10	1	1	-	-	50%	58%	19%	-	1	-	-	60	30	30	1	1	-
10	Ballard	Seattle CBD	15th Ave W	D Line	1.30	1.08	1	1	-	-	61%	64%	35%	1	1	1	-	60	30	30	1	1	1
11	Ballard	U. District	Wallingford (N 45th St)	44	1.46	0.56	1	-	-	-	74%	42%	54%	1	-	1	-	60	30	30	1	-	1
12	Ballard	Seattle CBD	Ballard/Interbay MIC, Fremont, South Lake Union	40	1.02	0.55	1	-	-	-	33%	29%	19%	-	-	-	-	60	30	30	1	-	-
13	Beacon Hill	Seattle CBD	Beacon Ave	36	1.69	1.22	2	1	-	-	104%	72%	39%	2	1	1	-	-	30	30	2	1	1
14	Bellevue	Eastgate	Lake Hills Connector	271	0.56	0.32	-	-	-	-	21%	11%	8%	-	-	-	-	-	30	30	-	-	-
15	Bellevue	Redmond	NE 8th St, 156th Ave NE	B Line	0.72	0.50	-	-	-	-	52%	29%	23%	1	-	-	-	60	30	30	1	-	-
16	Bellevue	Renton	Newcastle, Factoria	240	0.24	0.57	-	-	-	-	12%	18%	5%	-	-	-	-	-	30	30	-	-	-
17	Burien	Seattle CBD	Delridge, Ambaum	120	1.67	0.52	2	-	-	-	96%	36%	28%	1	-	-	-	60	30	30	2	-	-
18	Burien	Seattle CBD	1st Ave S, South Park, Airport Wy	131	0.37	0.25	-	-	-	-	75%	13%	18%	-	-	-	-	30	30	30	-	-	-
19	Burien	Seattle CBD	Des Moines Mem Dr, South Park	132	0.36	0.26	-	-	-	-	70%	11%	14%	-	-	-	-	60	30	30	-	-	-
20	Capitol Hill	White Center	South Park, Georgetown, Beacon Hill, First Hill	60	0.95	0.53	1	-	-	-	40%	18%	15%	-	-	-	-	60	60	30	1	-	-
21	Capitol Hill	Seattle CBD	15th Ave E	10	1.52	0.71	2	-	-	-	127%	43%	27%	2	-	-	-	-	30	30	2	-	-
22	Capitol Hill	Seattle CBD	Madison St	12	1.01	0.44	1	-	-	-	98%	28%	13%	1	-	-	-	60	60	30	1	-	-
23	Central District	Seattle CBD	E Jefferson St	348	1.44	1.24	1	1	-	-	79%	68%	38%	1	1	1	-	30	30	30	1	1	1
24	Kolman Park	Seattle CBD	Leich, Yesler	27	0.56	0.21	-	-	-	-	17%	12%	7%	-	-	-	-	-	30	30	-	-	-
25	Cowen Park	Seattle CBD	University Way, I-5	71EX/72EX/73EX/74EX	1.93	1.41	2	1	-	-	98%	92%	N/A	1	1	-	60	-	30	30	2	1	-
26	Discovery Park	Seattle CBD	Gilman Ave W, 22nd Ave W, Thorndyke Av W	33	0.97	0.37	1	-	-	-	37%	21%	16%	-	-	-	-	-	30	30	1	-	-
27	Eastgate	Bellevue	Newport Wy, S. Bellevue, 112th	241	0.13	0.18	-	-	-	-	16%	14%	9%	-	-	-	-	-	60	60	-	-	-
28	Eastgate	Bellevue	Somerset, Factoria, Woodridge	246	0.14	0.08	-	-	-	-	6%	5%	N/A	-	-	-	-	-	-	-	-	-	-
29	Eastgate	Overlake	Phantom Lake	226	0.47	0.42	-	-	-	-	38%	23%	5%	-	-	-	-	-	-	-	-	-	-
30	Enumclaw	Auburn	Auburn Wy S, SR 164	186/915	0.49	0.20	-	-	-	-	10%	6%	N/A	-	-	-	-	-	-	-	-	-	-
31	Fairwood	Renton	S Puget Dr, Royal Hills	148	0.56	0.35	-	-	-	-	21%	13%	17%	-	-	-	-	-	30	30	-	-	-
32	Federal Way	SeaTac	SR 99	A Line	0.74	0.72	-	-	-	-	45%	46%	32%	-	-	-	-	60	30	30	-	-	-
33	Federal Way	Kent	Military Road	183	0.20	0.21	-	-	-	-	13%	8%	N/A	-	-	-	-	60	-	30	30	-	-
34	Fremont	Seattle CBD	Dexter Ave N	26/28	1.20	0.44	1	-	-	-	64%	28%	36%	1	-	1	-	60	30	30	1	-	1
35	Fremont	U. District	N 40th St	31/32	1.12	1.10	1	1	-	-	75%	57%	31%	1	1	-	-	-	30	30	1	1	-
36	Fremont	Whittier Hts	8th Av NW, 3rd Av NW	28	1.46	0.47	1	-	-	-	63%	29%	9%	1	-	-	-	-	60	-	60	1	-
37	Green River CC	Kent	132nd Ave SE	164	0.89	0.66	1	-	-	-	52%	33%	23%	1	-	-	-	-	30	30	30	1	-
38	Greenwood	Seattle CBD	Greenwood Ave N	5	1.21	0.49	1	-	-	-	47%	37%	54%	-	-	1	-	-	30	30	30	-	1
39	High Point	Seattle CBD	35th Ave SW	21	0.61	0.43	-	-	-	-	35%	26%	25%	-	-	-	-	-	30	30	30	-	-

Peak Direction Service Levels and Trends			
PEAK	MIDDAY	NIGHT	RESULTING SERVICE FAMILY
15	15	30	Very Frequent
30	30		Local
30	15	30	Very Frequent*
30	30		Local
< 15	< 15	15	Very Frequent
30	30	60	Local
15	30	30	Frequent
< 15	< 15	15	Very Frequent
< 15	15	< 15	Very Frequent
< 15	< 15	15	Very Frequent
< 15	15	30	Very Frequent
< 15	15	30	Very Frequent
< 15	15	30	Very Frequent
30	30	30	Frequent
< 15	15	30	Very Frequent
< 15	15	30	Very Frequent
< 15	< 15	15	Very Frequent
< 15	15	30	Very Frequent
< 15	15	30	Very Frequent
30	30	60	Local
			Hourly
30	30	0	Local
30	30	30	Local
< 15	15	15	Very Frequent
30	30	30	Frequent
< 15	15	30	Very Frequent
30			Local
15	30	30	Frequent
< 15	15	15	Very Frequent
15	15	30	Very Frequent

Above Target
Below Target

* Figures rounded for display purposes.

Load Factor*	Peak	Off Peak
1.50	2	2
0.75	1	1

Cost Recovery*	Peak	Off Peak	Night
>= 100%	2	2	2
>= 50%	1	1	1
>= 33%	---	---	1
>= 16%	---	30 min	30 min
>= 8%	---	---	60 min

* Load Factor and Cost Recovery service level improvements move the preliminary levels of service up one or two levels, e.g. a load factor or cost recovery service level improvement of 2 changes a 30 min. service to <15 or a 60 min. service to 15, etc. A cost recovery >8% warrants 60 min. night service; >16% warrants 30 min.

Tanner, Sue

From: Bob Cooper <Bob@EvergreenPublic.com>
Sent: Tuesday, July 14, 2015 8:14 AM
To: Tanner, Sue
Subject: Additional comments on Swedish Cherry Hill MIMP
Attachments: HE Follow up letter.pdf

Ms. Tanner:

Please accept the attached letter to complete my testimony on the Swedish Cherry Hill MIMP currently before you.

Thank you.

- Bob Cooper
  (206) 852-3616
  Bob@EvergreenPublic.com

349 16th Avenue
Seattle, WA 98122-5614
July 14, 2015

Sue Tanner, Hearing Examiner
City of Seattle Hearing Examiner
PO Box 94729
Seattle WA 98124-4729

Re: MIMP for Swedish Medical Center Cherry Hill, CF-311936

Ms. Tanner:

Thank you for the opportunity to testify on the Major Institution Master Plan for Swedish Cherry Hill yesterday. While I provided written materials, I would like to supplement the record with a written copy of my verbal remarks that were somewhat truncated due to time constraints.

The comments below are largely an executive summary of the longer document I submitted at the hearing on July 13.

My name is Bob Cooper, and I have been a homeowner in the neighborhood since the spring of 1988. I was the Vice Chair of the standing advisory committee for now expired MIMP from June 2006 until it was dissolved in late 2011.

- I was the author of the SAC resolution leading to ultimate determination that the massive development proposed by Sabey Corp. for the east side of 18th was "major amendment," prompting this process – a proposal not radically different than what is currently proposed.

- as with that that proposal, this proposal is fundamentally incompatible with the low-density, primarily single-family neighborhood in which it is situated.

- Further, this process has been marked by
  - attempted violations of open meetings act
  - legally deficient notices of meetings
  - locked doors preventing public access to public meetings
  - intimidating armed guards hired by Sabey Corp.
  - video recording prompting fear of SLAPP actions (even more pertinent now that the state supreme court has invalidated the anti-SLAPP statutes)
  - threats against CAC members and city staff

- Hospital staff interested in the neighborhood point of view being fired or reassigned
- late posting of meeting minutes, hampering participation by those not able to attend to meetings.
- inaccurate or outdated information (signs with Marcia Petersen's name listed as the institutional contact still posted as of last Friday – she was fired more than a year ago)
- factual errors (detailed in my longer, written submission and testimony of others)
- assertions not supported by facts
- failure to account for significant environmental factors, particularly a known aquifer under the site
- omission of information -- not the least of which are omission of comments in the EIS process and failure to note the reduction from the expired MIMP heights in the center campus do not represent a concession but rather reflect the reality of what has already been built
- conflation of the larger organization's community benefits with the mitigation required for this specific plan
    - Even Sabey Corp. lawyers argue there has to be a nexus between impacts and mitigation (Koontz Collective v city of Seattle)
- non-binding language in the proposal

- There is a conflict of interest between the non-profit institution and the for-profit Sabey Corporation.
    - Most notably, but not confined to, the parking garage -- owned by Sabey, who then has motivation to under-cut the transportation management plan to keep revenue flowing from their investment
- Sabey should not have standing to be a party to this proceeding -- like me, they are an interested party, but not an applicant or appellant.
- A minority report by two members who may not be eligible to be members of the CAC
    - A manager at Swedish who has been given the designated-by-city-code "non-management" slot on the CAC
    - Another member of the CAC (Mr. Letrondo, author of the questionable minority report) has an apparent, if not actual, conflict of interest, having worked for Sabey in the past and presumably wanting work in the future
- Meanwhile, City staff recommendations and community petitions that I be appointed were ignored

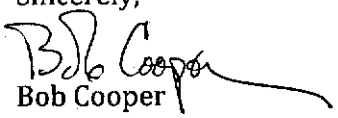
- The community, and often the CAC, were ignored by the institution – particularly by Mr. Cosentino – during the process

- Sky-bridge re-permitted between standing committee dissolution and CAC process start in the absence of legally required community comment/input
- lack of historical information
    - James Tower built in the absence of a legally required standing committee
        - overbuilt (more than six times what was supposed to be built)
    - tradeoff of setbacks for lower height on parking garage at 15th & Jefferson
    - mitigation promised in 1994 plan never materialized (e.g., childcare)

- neighbors do not support any of the mitigation proposed -- a survey to that effect should be in exhibit 7 submitted by the Dept. of Neighborhoods. (They apparently just made things up they thought people might like)
- Historical section also neglects history of institutional racism in the neighborhood (covenants prohibiting sale to "negros") – and the plan does not address institutional racism, which can be a particular problem in health care.
- Charity care declining and below average in the state
    - lack of charity care a cause of the death of the mother of Marcellus Owen -- the neighborhood child who stood next to President Obama as he signed the Affordable Care Act.
- I am an award-winning former journalist cited for excellence in science and health news by the western Washington chapter of the Society of Professional Journalists and note the MIMP Assertion of need to grow is at odds with objectives of the Affordable Care Act; additionally
    - The institution has a 20+ year decline trend in use of hospital beds (numbers in my longer written submission)
    - If there is a real need for growth, why is there no application for a new certificate of need?
- For these reasons and those that will be put forth by Mr. Zossel, Ms. Schiantarelli, Ms. Solid and others, I ask that this plan be rejected in its entirety.

Thank you for your consideration.

Sincerely,



Bob Cooper

Bob Cooper
349 16th Avenue
Seattle, WA, 98122-5614
(206) 852-3616

BEFORE THE HEARING EXAMINER,

CITY OF SEATTLE

IN THE MATTER OF	) CF 311836
Swedish Medical Center, et al	) For approval of a Major Institution Master Plan for property located at 500 17th Avenue, Seattle, WA
Major Institution Master Plan	) And
	) 3012953
	) SEPA Determination by the Director, Department of Planning and Development

I, BOB COOPER, hereby declare that the following is true and correct to the best of my knowledge.

1. I live at 349 16th Avenue, Seattle, WA 98122-5614 in a home which I have owned and resided in since April 30, 1987.

2. I was the vice-chair of a Standing Advisory Committee (SAC) for the 1994 Major Institution Master Plan from its reestablishment on June 19, 2006 (Council Resolution 30880) until it was dissolved in late 2011. (The previous MIMP had operated without the required CAC for an unknown period of time that included construction of James Tower, and was reestablished after complaints following the tower's grand opening advertising "plenty of free parking in the neighborhood.")

3. It was an SAC resolution authored by myself and approved by the SAC recommending a previous application for a "minor amendment" to the 1994 plan to permit massive development on the east side of 18th Avenue be declared a "major amendment" that ultimately led to the present MIMP process (following a hearing examiner's decision issued on 25 October 2010 overturning the Director's minor amendment Determinations). Determination of an amendment to be "major" under the governing ordinance required commencement of a new Major Institution Master Plan process.

4. The Director of the Department of Planning and Development (DPD) has issued a recommendation on the proposed Swedish Medical Center Cherry Hill Campus Master Plan, and an environmental determination based on the Final Environmental Impact Statement for the proposal.

The application includes a rezone to modify existing Major Institution Overlay Heights, increasing heights in several locations within the current Major Institution Boundary. The proposal also includes future aerial and below grade term permits to accommodate a skybridge and below grade tunnel.

5. The Director's determination is faulty; the environmental determination is deficient; and the proposed height, bulk, and scale of the proposal is fundamentally incompatible with requirements set forth in the Seattle Municipal Code and policy adopted by the Seattle City Council. Some of the reasons for this were set forth in comments submitted 19 June 2014 (Appendix A) and incorporated here by reference, and other reasons are detailed below.

6. Additionally, the process has been marked by:

A) Attempted violation of the Open Meetings Act (RCW 42.30.010), intimidation, threats, and ignoring the community,

B) legally deficient notices of meetings and inaccurate, outdated, or unavailable information,

C) factual errors, assertions not supported by facts,

D) failure to account for significant environmental factors,

E) conflation of actions of the larger organization with the specific institution,

F) non-binding language in the proposal, and

G) a direct conflict between the responsibility of the non-profit institution to achieve policy / legal goals with the motivations of the for-profit development partner holding ownership of a significant portion of the land and buildings at issue.

H) The fact that Sabey Corporation, a for-profit organization, has participated and continues to participate inappropriately as a part of the process instead of as an interested party that would have a much more limited role.

I) The appointment of a Swedish Medical Center manager to the statutory "non-management representative" position on the CAC and appointment of a CAC member with an apparent conflict of interest.

For these and other reasons it is requested that the Hearing Examiner reject the proposal in its entirety.

Attempted violation of the Open Meetings Act and Intimidation, Threatened and Ignored

Often, meeting notices were not issued within the time frame required. An example is the "second notice" for meeting #23, sent

January 7, 2015, for a meeting less than 20 days away, when no first notice was issued. This happened multiple times.

There was also an early attempt to hold subcommittee meetings not open to the public. When I advised the committee of the legal requirements to hold open meetings and their potential liability should they attend a closed meeting, it was met with a response from committee member David Letrondo that "the elimination of non-quorum meetings means less time to get things done correctly," seeming to imply that actually including the public in the process was just a formality.

And committee member Patrick Angus suggested an attempt to skirt the technical requirements of the Public Meetings Act, suggesting: "We could keep the CAC participants to a number below the threshold of 6" which would technically comply with the act but violate its spirit.

Numerous meetings included armed security guards (off-duty police officers or Sheriff's deputies). Those who inquired were told that there were unspecified "threats" they were hired to guard against. No specifics were ever offered, but many community members in attendance were intimidated by the presence. The guards, when questioned, said they were hired by Sabey Corp.

Members of the Citizen Advisory Committee were reportedly threatened by Swedish and/or Sabey Corp. representatives when they spoke against any key aspects of the proposals put forth. City employees were also threatened, including but not limited to Steve Sheppard, the key Department of Neighborhoods staff assigned to the process.

And, despite requests that the practice stop, meetings were video recorded by the institution and/or Sabey Corporation (SMC's development partner and owner of significant land at issue). More than one neighbor cited a fear of being sued, again, by SMC and Sabey Corp. when asking that the recording stop. One of these neighbors, Ms. Vicki Schiantarelli, and possibly others, had previously been sued by either one or both SMC and Sabey Corp. in an appeal of a aforementioned Director's Decision related to the property at issue in this current process. Ms. Schiantarelli stated in a public meeting that the recording made her fearful of fully sharing her thoughts for fear of being sued again. This type of suit is known as a Strategic Lawsuit Against Public Participation, or SLAPP. And fear of being subjected to a SLAPP suite is only exacerbated by the recent state Supreme Court decision in Davis v Cox that invalidated Washington's anti-SLAPP statute (RCW 4.24.525).

Fired or Reassigned Staff

Ms. Marcia Petersen, the long-time representative of SMC, abruptly disappeared from the process when she began dialogue with the broader community. She was reportedly terminated from her employment. No reason was given to the committee or public for her departure, but it is rumored that her interest in accommodating neighborhood objections were a contributing factor if not the sole impetus.

Dr. John W. Henson, VP of Medical Affairs, was put forth as an institutional representative, but disappeared from the process after having meetings with myself and other members of the broader community. He appears to still be employed by the institution. No reason was given for his departure from the process.

Ignored by the institution and committee chair

In the final phases of development of the MIMP, the institution put forth Mr. Andy Cosentino as its representatives. He was continually witnessed at meetings with the CAC concentrating on his smart phone and ignoring both the committee and public comments. He would look

up if verbally called out by members of the public during comment periods, but otherwise seemed to ignore the concerns being voiced.

At the December 18, 2014, meeting, Chair Katie Porter seemed amazed when neighbors continued their call to reject the plan in its entirety. She said it was the first time she had heard a call to reject the plan, even though the neighbors' deep dissatisfaction was reported in the Seattle Times on June 19, 2013, and in the Puget Sound Business Journal on July 2, 2014; and the record will show neighbors had repeatedly asked for rejection of the proposed plans.

Locked Doors

During at least one meeting, held on December 18, 2014, and possibly others, the exterior doors closest to the meeting room were locked shortly after the meeting began. Since those were the doors described in the formal notice of the public meeting, Karen Gordon, a manager with the city of Seattle's Department of Neighborhoods, had to find Swedish staff who could unlock the doors and restore public access to the Citizen Advisory Committee meeting. There is no way of knowing if anyone attempted to attend the meeting(s) but was unable to access the venue.

Inaccurate, Outdated or Unavailable Information

From the beginning, the process has been marked by inaccurate, unavailable, and/or outdated information.

When city staff recommended my appointment to the CAC, and that recommendation was vetoed by Sabey Corp. and Swedish, council members were, according to staffer Michael Jinkins, advised that they could not discuss the rejection in individual meetings because the whole process was quasi-judicial. Appointment of CAC members does not appear to be a quasi-judicial process under SMC 23.76.036, and no evidence of this advice was ever provided. Although council member Tom Rasmussen did meet with me, no others would schedule meetings. Ultimately, the council rubber-stamped the department recommendations as approved by Sabey Corp. and Swedish. Repeated petitioning by the Squire Park Community Council and others for me to fill vacancies as they arose on the committee were similarly ignored.

As someone who, for professional reasons, is usually not available for meetings during the first calendar quarter of the year, it is important to me that a record of meetings be available. For a long

stretch of time during the crucial period leading to the culmination of the Citizen Advisory Committee process, those records were not available.

On March 13, 2015, the minutes of eleven of the previous twelve meetings of the committee were not available, dating back to mid-October of the previous year. (A complaint about this should be included in the city's official record submitted to the Hearing Examiner.)

This thwarted timely public participation in the process, and is counter to the goals stated about encouraging community input.

As late as July 1, 2015, the required four-foot-by-eight-foot signs providing notice of the MIMP process that are posted, as required by law, around the SMC Cherry Hill property continued to inaccurately contain the name of Marcia Petersen as the institutional contact (Ms. Petersen has not been an employee of the institution for more than a year); and continue to inaccurately show a configuration withdrawn from consideration early in this process. It is the responsibility of the applicant to maintain these signs, presumably in an accurate form, and they have not been so maintained.

The MIMP application lacks historical data, which would have informed the Citizen Advisory Committee in its decision making. Lacking information includes:

a) That the James Tower building was allowed to be built in the absence of a legally-required Standing Advisory Committee;

b) that the James Tower building was built substantially larger than allowed in the 1994 MIMP - a two-story, 28 foot tall "skilled nursing facility" of 24,000 square feet was permitted under the plan, and a six-story building of approximately 160,000 square feet was developed;

c) that the parking garage at 16th Ave. and E. Jefferson St. was allowed to be built with setbacks of less than the 20-feet required in the 1994 plan in return for reducing the height of the building;

d) that projects to mitigate the impact of development under the 1994 plan, including but not limited to a child care center that would have accepted neighborhood children, were never completed;

e) assertions were made to the CAC that the 1994 plan allowed shifting of square footage inside a development "envelope" when, in

fact, the governing ordinance allowed only specific, discrete buildings and did not constitute development "envelopes," and

f) That the permit for the skybridge over 16th Avenue was renewed between the termination of the SAC and the formation of a new CAC, in apparent violation of city ordinances.

The historical section of the document also ignores the history of institutional racism in the Squire Park neighborhood. Deeds originally included a covenant where landowners "*hereby mutually covenant … that no part of said lands owned by them … shall ever be used, occupied by or sold, conveyed, leased, rented or given to negroes, or any person or persons of the negro blood.*"[1]

The MIMP does not adequately address any of this history.

Factual Errors, Assertions Not Supported By Facts

Throughout the process, Swedish and Sabey Corp. have intimated that the land is near, next to or adjacent to downtown. This is most-graphically illustrated in an aerial photo in the introduction (page 1) that, using a photographic trick of perspective, seems to place the campus nearer to downtown than is actually true. It is,

[1] http://depts.washington.edu/civilr/covenants_report.htm

instead, located in a residential neighborhood with a predominance of single-family homes.

The introduction asserts that "*The MIMP balances the institution's ability to change and the public benefit derived from change with the livability and vitality of adjacent neighborhoods*" when the institution has been informed over and over by neighbors that it does not. This assertion is not supported elsewhere in the document.

The introduction further asserts that a community benefit is covering the cost of care for those who cannot pay, although charity care as a portion of the institution's work has declined in recent years, according to reports[2] filed by SMC with the Washington state Department of Health. The latest available report for 2013 shows charity care averaging three percent of total patient revenue and 6.3% of non-Medicaid, non-Medicare patient revenue, and generally trending upward over the past decade. Swedish Cherry Hill 2013 charity care amounted to a below-average 2.27% of total patient revenue and a below-average 5.77% of non-Medicaid, non-Medicare patient revenue.

[2] http://www.doh.wa.gov/Portals/1/Documents/5300/2013CharityCareReport.pdf

It was, in fact, Marcelas Owens, the son of a woman whose death was caused in part by a lack of charity care from the hospital who stood next to President Barack Obama as he signed the Affordable Care Act to illustrate the need for more widely available health care.

The MIMP asserts that the hospital will need to grow to serve more patients because of the Affordable Care Act. This is directly contrary to the policy goals of the act, which aims for a reduction in hospital care that is replaced by access to primary care physicians through public and private insurance plans.

The plan further asserts that population growth over the past 20 years, and expected growth into the future, will put additional demands on the campus facilities. But it fails to explain how that aligns with a 20 year decline trend in facility use and relinquishment of authorized beds under the institution's Certificate of Need from the historic high of 436 beds in 1994 to the current 385 beds, and occupancy rates that have also declined as a percentage of authorized beds over the same period of time (see appendix B).

The MIMP also fails to explain why, when an increased need is asserted, that the institution is not simultaneously applying for

any increased capacity under the state's Certificate of Need process.

Failure To Account For Significant Environmental Factors

There is groundwater known to flow underneath the SMC Cherry Hill campus, but it is not mentioned or considered in the official plan and EIS documents filed.

Conflation Of The Larger Organization With The Specific Institution

Many of the "community benefits" touted in the MIMP as offsetting the impact of the Cherry Hill facilities are system-wide benefits of Swedish and Providence.

This includes, but is not limited to, equating its tax exemption with community benefits.

As Sabey Corp. lawyers John McCullough, Jessica Clawson, and others argued in Koontz Coalition v City of Seattle (US District Court, Western District of Washington, 2014), *"Koontz held that the government "may not leverage its legitimate interest in mitigation to pursue governmental ends that lack an essential nexus and rough proportionality to those impacts." Koontz, supra, __ U.S. at __."*

Similarly, there must be nexus and rough proportionality between the community benefits required to be provided here and the specific geography where mitigation is required.

Any system-wide benefits that are not, and cannot be, tied to specific benefits to the community surrounding the Cherry Hill facilities should not be included in any consideration of community benefits required under the Seattle Municipal Code in the MIMP process required to mitigate the impacts of development at Cherry Hill.

Non-Binding Language

Numerous sections of the MIMP "require" the institution to "consider" certain actions or mitigations as development progresses. There is no criteria stated to measure what constitutes "consideration." There is no criteria about how a decision will be made on acceptance or rejection of considered actions.

The lack of such criteria renders the actions to be "considered" unenforceable, and, as such, these measures or actions should not be considered as mitigating any impacts in evaluating the plan.

Direct Conflict Between The Responsibility Of The Institution To Achieve Policy and/or Legal Goals With The Motivations Of The For-Profit Development Partner Holding Ownership Of A Significant Portion Of The Land And Buildings At Issue

The Major Institution Master Plan ordinance was adopted to govern non-profit medical and educational institutions, with the apparent presumption that such institutions' public benefit goals would drive decision making.

What we have in this case, however, is a direct conflict between the institution's legally required actions and the motivations of the major property owner, the for-profit Sabey Corporation's presumed profit-making motives. (If Sabey Corporation were not motivated by profit, it could reincorporate under Section 501 of the internal revenue service code as a not for profit corporation.)

One example of this is in the management of traffic.

The transportation management plan that is required under the MIMP ordinance should, over time, reduce the number of vehicles - especially single-occupancy vehicles - arriving at the institution. But because the parking facilities on the campus are owned and operated by the for-profit Sabey Corporation, Sabey has a

motivation to maximize return on their investment by keeping these facilities as full of paying customers as possible. Thus, Sabey Corporation has a perverse incentive to minimize any reduction in vehicles arriving at the facilities. And since Sabey Corporation is also the major lessor of campus facilities, they have little or no motivation to push their paying customers to reduce vehicle use.

Sabey Corporation has been given an inappropriate role in the process and should not have standing.

A Major Institution Master Plan, under SMC 23.69.026, is to be prepared (and, presumably, submitted for approval) by a Major Institution as defined under the code. Swedish Medical Center (Swedish) is clearly a Major Institution as defined in SMC 23.84A.025. Sabey Corporation clearly is not.

Yet, Sabey Corporation was given extraordinary access in this proces. They were allowed to screen applicants to the Citizen Advisory Committee. They are the proponents of a major building on property they own on the east side of 18th Avenue – a building that may have a functional relationship with the hospital, but is not described in the MIMP as critical to the functioning of the institution. And Sabey Corp. lawyers have been inappropriately

assumed to have standing in the appeal process when they should have been relegated to an "interested party" status.

Additionally, documents procured under the state's public records act, show that I was clearly the choice of city staff to be a member of the Citizen Advisory Committee, yet I was rejected (see appendix C). It appears the rejection was at the behest of Sabey Corp.

Conversely, Linda Carol was appointed to represent Swedish under the terms of SMC 23.69.030. However that representative position is specifically called out in the SMC as "a non management representative of the institution."

Ms. Carol holds herself out to have been a manager for the last 16 years, which should have made her ineligible to sit on the committee, meaning the composition of the committee was improper. A printout of her LinkedIn page is included as appendix D.

Committee member David Letrondo stated in his application to be a member of the CAC that he had previously worked for David Sabey of Sabey Corp. This is a clear conflict of interest in that he has profited from this relationship in the past and can be presumed to be interested in further work from Sabey Corp. As such, his

membership on the committee carries at least the appearance of a conflict of interest, again making the composition of the committee appear to be improper under the enabling ordinance.

Neighbors do not support the plan

A number of so-called "amenities" were put forth for consideration, some of which ended up in the final plan. However, a survey of neighbors showed little or no support for these amenities, and the institution never asked what neighbors really wanted.

A neighborhood survey showing levels of support for these amenities is included in the record submitted by the Department of Neighborhoods.

For the reasons stated above, I ask the Hearing Examiner to reject the proposed MIMP in its entirety.

DATED: July 9, 2015

Bob Cooper
349 16th Ave.
Seattle, WA 98122-5614
(206) 852-3616

Appendices

A) Comments to CAC submitted June 19, 2014

B) Occupancy Trend at Swedish Cherry Hill

C) City of Seattle staff notes on CAC appointments

D) Linda Carroll LinkedIn page capture

Appendix A

Comments to the Citizen Advisory Committee on the Swedish/Cherry Hill Major Institution Master Plan 19 June 2014

- The plan and EIS before you are inaccurate in many key respects – detailed in part in my specific comments you should have received this afternoon.
- Speakers in favor of the plan are concentrating on the value of health care – a point no one disputes.
- Health care is not the issue here – the issue is compatibility of expansion plans with the surrounding neighborhood environment.
- And the height, bulk, and scale of the proposal before you is grossly inappropriate and fundamentally incompatible with the neighborhood.
- Children's Hospital – which has no other options – was approved for half the volume of development at issue here on a site significantly larger and with buffers at the edges.
- Swedish cannot do everything they want to do here – they have to prioritize, and use one of their many other sites for some functions.
- Development needs to be spread to areas not currently proposed for significant change – areas likely left out because they have been recently under-developed.
- And any entity developing anything under a new plan, such as Sabey Corporation, should be required to adhere to the same ongoing restrictions on other development as the institution.
- Any mitigation or neighborhood amenities must be enforceable.
- The institution has never achieved transportation management goals and it is unlikely they can, since this institution will soon be served by only one 24-hour bus line.
- Ideally, this plan should be rejected and the institution should come back with a more realistic plan for consideration.

349 16th Avenue
Seattle, WA 98122-5614
July 14, 2015

Sue Tanner, Hearing Examiner
City of Seattle Hearing Examiner
PO Box 94729
Seattle WA 98124-4729

Re: MIMP for Swedish Medical Center Cherry Hill, CF-311936

Ms. Tanner:

Thank you for the opportunity to testify on the Major Institution Master Plan for Swedish Cherry Hill yesterday. While I provided written materials, I would like to supplement the record with a written copy of my verbal remarks that were somewhat truncated due to time constraints.

The comments below are largely an executive summary of the longer document I submitted at the hearing on July 13.

My name is Bob Cooper, and I have been a homeowner in the neighborhood since the spring of 1988. I was the Vice Chair of the standing advisory committee for now expired MIMP from June 2006 until it was dissolved in late 2011.

- I was the author of the SAC resolution leading to ultimate determination that the massive development proposed by Sabey Corp. for the east side of 18th was "major amendment," prompting this process – a proposal not radically different than what is currently proposed.

- as with that that proposal, this proposal is fundamentally incompatible with the low-density, primarily single-family neighborhood in which it is situated.

- Further, this process has been marked by
  - attempted violations of open meetings act
  - legally deficient notices of meetings
  - locked doors preventing public access to public meetings
  - intimidating armed guards hired by Sabey Corp.
  - video recording prompting fear of SLAPP actions (even more pertinent now that the state supreme court has invalidated the anti-SLAPP statutes)
  - threats against CAC members and city staff

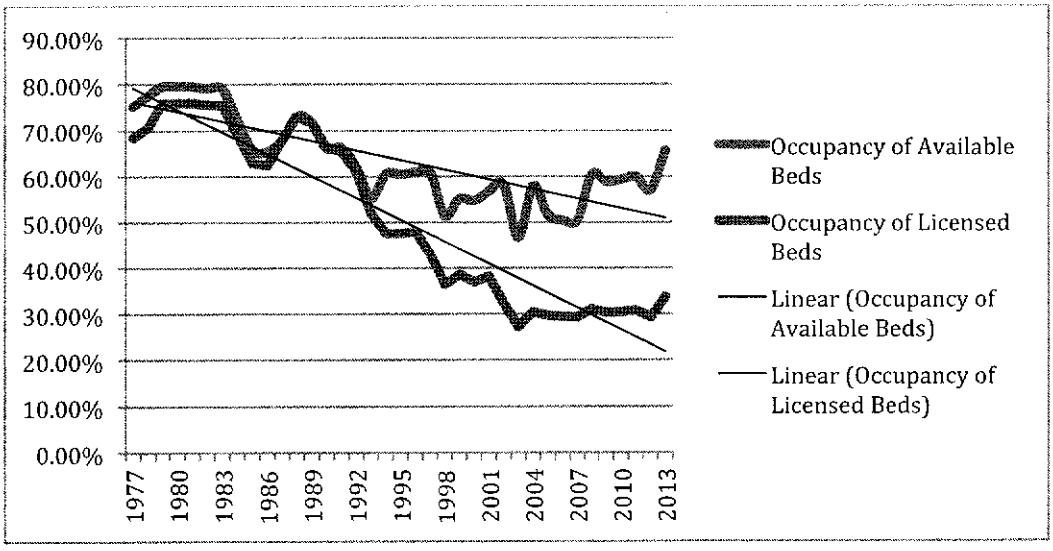
- factual errors (detailed in my longer, written submission and testimony of others)
- assertions not supported by facts
- failure to account for significant environmental factors, particularly a known aquifer under the site
- omission of information -- not the least of which are omission of comments in the EIS process and failure to note the reduction from the expired MIMP heights in the center campus do not represent a concession but rather reflect the reality of what has already been built
- conflation of the larger organization's community benefits with the mitigation required for this <u>specific</u> plan
    - Even Sabey Corp. lawyers argue there has to be a nexus between impacts and mitigation (Koontz Collective v city of Seattle)
- non-binding language in the proposal

- There is a conflict of interest between the non-profit institution and the for-profit Sabey Corporation.
    - Most notably, but not confined to, the parking garage -- owned by Sabey, who then has motivation to under-cut the transportation management plan to keep revenue flowing from their investment
- Sabey should not have standing to be a party to this proceeding -- like me, they are an interested party, but not an applicant or appellant.
- A minority report by two members who may not be eligible to be members of the CAC
    - A <u>manager</u> at Swedish who has been given the designated-by-city-code "<u>non</u>-management" slot on the CAC
    - Another member of the CAC (Mr. Letrondo, author of the questionable minority report) has an apparent, if not actual, conflict of interest, having worked for Sabey in the past and presumably wanting work in the future
- Meanwhile, City staff recommendations and community petitions that <u>I</u> be appointed were ignored

Appendix B

Occupancy Trends

(source: WA State Department of Health)



	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
SWEDISH HEALTH SERVICES - CHERRY HILL													
Lic Beds	376	376	376	376	376	376	376	376	376	376	376	376	376
Avail Beds	342	342	359	359	359	359	359	359	359	359	376	376	376
Admits	12,127	13,505	13,704	13,839	13,574	13,534	13,783	13,530	13,228	13,634	15,782	16,924	17,236
Patient Days	93,794	96,803	104,205	104,286	104,204	103,618	103,551	94,758	86,246	85,678	93,132	100,265	98,396
Avg LOS	7.73	7.17	7.60	7.54	7.68	7.66	7.51	7.00	6.52	6.28	5.90	5.92	5.71
Occ %	75.14%	77.55%	79.52%	79.59%	79.52%	79.08%	79.03%	72.32%	65.82%	65.39%	67.86%	73.06%	71.70%
Births	503	583	559	617	707	708	802	826	872	1,066	1,226	1,226	1,296
Occupancy of Available Beds	75.14%	77.55%	79.52%	79.59%	79.52%	79.08%	79.03%	72.32%	65.82%	65.39%	67.86%	73.06%	71.70%
Occupancy of Licensed Beds	68.34%	70.54%	75.93%	75.99%	75.93%	75.50%	75.45%	69.05%	62.84%	62.43%	67.86%	73.06%	71.70%

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
SWEDISH HEALTH SERVICES - CHERRY HILL														
Lic Beds	404	409	409	409	436	436	436	436	436	436	436	436	436	436
Avail Beds	404	404	404	384	343	343	343	308	309	305	294	294	243	254
Admits	17,982	18,960	18,688	14,722	16,249	16,794	17,438	15,696	13,369	12,780	11,701	11,871	10,751	8,705
Patient Days	97,579	97,698	91,229	77,420	75,762	75,598	76,290	68,298	58,010	61,402	58,687	60,847	51,696	43,207
Avg LOS	5.43	5.15	4.88	5.26	4.66	4.50	4.37	4.35	4.34	4.80	5.02	5.13	4.81	4.96
Occ %	66.17%	66.25%	61.87%	55.24%	60.52%	60.38%	60.94%	60.75%	51.43%	55.16%	54.69%	56.70%	58.29%	46.60%
Births	1,403	1,613	1,514	1,486	1,938	1,974	1,957	1,931	1,705	1,550	1,623	1,519	1,044	0
Occupancy of Available Beds	66.17%	66.25%	61.87%	55.24%	60.52%	60.38%	60.94%	60.75%	51.43%	55.16%	54.69%	56.70%	58.29%	46.60%
Occupancy of Licensed Beds	66.17%	65.44%	61.11%	51.86%	47.61%	47.50%	47.94%	42.92%	36.45%	38.58%	36.88%	38.23%	32.48%	27.15%

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
SWEDISH HEALTH SERVICES - CHERRY HILL										
Lic Beds	385	385	385	385	385	385	385	385	385	385
Avail Beds	202	221	224	224	198	198	198	198	198	198
Admits	8,162	8,620	8,798	8,920	9,250	8,746	8,880	8,263	7,737	9,445
Patient Days	42,658	41,664	41,209	41,132	43,601	42,499	42,784	43,283	41,173	47,440
Avg LOS	5.23	4.83	4.68	4.61	4.71	4.86	4.82	5.24		
Occ %	57.86%	51.65%	50.40%	50.31%	60.33%	58.81%	59.20%	59.89%	56.97%	65.64%
Births	0	0	0	0	0	0	0	0		
Occupancy of Available Beds	57.86%	51.65%	50.40%	50.31%	60.33%	58.81%	59.20%	59.89%	56.97%	65.64%
Occupancy of Licensed Beds	30.36%	29.65%	29.33%	29.27%	31.03%	30.24%	30.45%	30.80%	29.30%	33.76%

Appendix C

City of Seattle Staff Notes on Committee Appointments

Meeting/Discussion Notes (directors from mon.)

(1) Re: concern with Eric Olmer - OK to advocate for Mark Tilke

(2) Rob Gola: management feels strongly that there is too much of an appearance of conflict of interest.

(3) Neighbors + Near Neighbors:

Concluded that we need at least one, and preferably two from the following

Cooper
Biando
Schiavarelli
Matsui
Hadock

Prefer Cooper despite his possible time conflicts. Hadock is a bit of an unknown + will need to speak with her more. (Set up interviews with Karen G)

(4) Patrick Carter + Cynthia Andrews seem good on the surface as add-ons for replacements of SMG invited folks but need to inform Cynthia who is a bit unknown to manager. (Set up interviews with Karen G)

SCH-CAC #138

17	Mark Tilbe ✓ as the Citywide)	• Live at Seward Park • Architect	Address: Seattle, WA Also Seattle WA Phone: E-Mail:	• Citywide • Architectural background *(Qualifies as Citywide only)*	• Very strong background in streetscape design. • Past president (chair) of Design Commission for Vanouver British Columbia and Richmont British Columbia • Major work with health care design nationally but not recently herer • Principal of Maruse Associates.
18	[redacted] ✓	• Past Near Neighbor on 17th Ave. • Master's degree in urban and regional planning	Address: Seattle, WA Phone: E-Mail:	• Near neighbor • Active in neighborhood affairs • Urban planning background	• Near neighbor • From longstanding well know family • Urban planning and design background
19	Jacobson, Joy ✓	• Near Neighbor • Present member of SAC	Address: Seattle, WA Phone: E-Mail:	• Near Neighbor • Maintain continuity with past committee	• Maintains continuity with past committee
20	Bob Cooper ✓ ? **Perhaps as alternate but for past continuity might best be on.**	• Near Neighbor • Present member and vice chair of SAC	Address: Seattle, WA Phone: E-Mail:	• Near Neighbor • Maintain continuity with past committee	• Maintains continuity with past committee • Institution has some concerns with his past positions and whether he can step back from them. • Time commitments in Olympia may be a constraint
21	Andrew Coates X ?	• Real estate investment manager • President of the Austin Foundation • Sincerely,	Address: Seattle, WA Also Bellevue, WA Phone: E-Mail:	• Citywide • Development and real estate *(Qualifies as Citywide only)*	• He seemed development oriented and I had some concern that he would be seen as essentially an extension of SMC. (This was not a strong conclusion on my part.)
22	Jerry Matsui X	• Near Neighbor • Member of Squire Park	Address: Seattle, WA Phone: E-Mail:	• Near neighbor • Active in neighborhood affairs	• Wife's involvement would be a better match.

Appendix D

Linda Carrol LinkedIn page capture

Linda Carrol

3rd

Manager at Swedish Medical Center

Greater Seattle Area | Hospital & Health Care

Previous: Franciscan Family Care, Tacoma Radiological Associates

Education: University of Phoenix

Connect | Send Li

Sofia Aragon has a new job...

179 connections

l/12/190/3a3/en

Background

Experience

Manager
Swedish Medical Center
May 1999 – Present (16 years)

Staff Technologist
Franciscan Family Care
1989 – 1999 (10 years)

Staff Technologist
Tacoma Radiological Associates
1981 – 1989 (8 years)

Skills

Top Skills

- 23 Healthcare
- 16 Healthcare Management
- 14 Hospitals
- 7 Process Improvement
- 7 Customer Service
- 6 Physician Relations
- 5 Performance Improvement

Others With a Similar Position at Swedish Medical Center

Stacy Lyons Smith
Billing/Cash Posting Supervisor at Swedish Medical Center

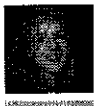
Michelle Chapman
Manager at Swedish Medical Center

Richmond JoLynn
Administrator of The Maternal and Fetal Medicine Center, Perinatal Ultrasound and The Diabetes Education Center- Swedish

Marnie Sy-Abutin
Manager at Swedish Medical Center

Kevin Kindall
Manager at Swedish Medical Center

People Also Viewed



Kristen Foss
Clinic Administrator Trainee at Swedish Medical Center

Jan Gallagher
Administrative Supervisor at Swedish Medical Center

Coleen Hogan
Medical Records at Avamere Health Services

Annie Radosevich
--

Kristina Coltrin
Community Relations Manager at Enlivant

Date: July 13, 2015

To: Hearing Examiner in the case of Major Institution Master Plan application of Swedish Medical Center

From: Central Area Land Use Review Committee

Subject: Comments on proposed Major Institution Master Plan

The Central Area Land Use Review Committee (LURC) is a committee composed of residents and property owners in the Central Area. Over the last two plus years the LURC has conducted numerous public meetings in connection with reviews of many proposed developments in the Central Area. Our meetings are open to all, and we do everything reasonable to solicit and encourage input and participation. The mission of the LURC is to advocate for and support development that contributes to the vitality of our neighborhoods and that supports the Seattle Comprehensive Plan and the Central Area Neighborhood Plans.

The Major Institution Master Plan (MIMP) proposed by Swedish Medical Center will have a profound impact on the Central Area and the outcome is of great concern to Central Area residents.

We would like to focus our comments on the heights and setbacks in the proposed MIMP.

Protecting the livability of the neighborhood.

The LURC believes that additional reductions in height, bulk and scale are necessary to adequately minimize the impacts associated with future development and protect the livability of the neighborhood.

Development within this Master Institution Overlay (MIO) is complicated in part because of its location outside of an area with a higher underlying zoning, land use designation, or Urban Village classification. The land use code consistently refers to transitions between zoning types. The inherent implication is a gradual transition from low heights to higher heights, as well as low intensity uses to higher intensity uses. The land use code recognizes the need for higher limits allowed to institutions with the designation of MIO districts as compensation to restrain horizontal spread. However it likely did not intend to allow highrise construction adjacent to residential neighborhoods without appropriate transition. Because there is neither available land nor existing environmental buffers to create appropriate gradual transition to the surrounding residential neighborhood, the transitions must occur with at-grade setbacks, upper story setbacks, and lower perimeter heights to establish the transitional zone.

Height limits.

The LURC believes that additional reductions to height are necessary to ensure compatibility with the adjacent single family and low-rise neighborhood. The Citizens

Advisory Committee acknowledges a desire for the whole site to stay below 105 feet, but recommends two exceptions: 1) that the central portion of the site proposed at MIO 160 feet be conditioned down to 140 feet and 2) that a section that lies mid-block between 15th and 16th be reduced from the proposed MIO 160 feet to either 105 or 125 feet. LURC agrees with the CAC recommendations to limit development along 18th to MIO 37 feet, and urges that the heights between and 15th and 16th be limited to MIO 105 feet.

Setbacks and modulation on 18th Avenue.

LURC agrees that heights on the block of 18th Avenue that abuts residential development should be limited to MIO 37 feet, removing the need for upper level setbacks at the proposed higher MIO 50 heights. However, LURC would like to see more serious consideration of how to better ensure compatibility with the abutting single-family zone. This compatibility could include additional ground-level setbacks, limits on the maximum lot coverage, and modulation that would break up the massing of the building façade.

The development proposed in the MIMP would extend continuously from East Jefferson to East Cherry, a full long block building just under 600 feet in length. This a proposal that is very much incompatible with the adjacent Single Family zone to the east, composed of 11 single family lots, and one condominium lot along E. Jefferson.

It is extremely rare for a Major Institution Overlay boundary to be placed in the middle of the block, without the buffer effect of some natural feature or major arterial. In such a case, where not even an alley buffers development from the adjacent Single Family zone to the east, it is important to produce development standards that are respectful of the underlying zone and the needs of the residents on the other side of the boundary line. Here the boundary between the MIO zone and the Single-Family zone is simply the lot line.

The proposals to limited to limit height to 37 feet and establish a rear setback of 25 feet, which are similar to what would be allowed in the SF zone, both contribute to mitigating potential impacts. However, the development standards for the Single Family zone also prohibit lot coverage of more than 35%. In order to achieve compatibility with the 35% lot coverage standard for the Single Family zone, the LURC recommends that the 600 foot long mass be broken up into separate buildings with adequate breaks between the buildings. The Design Guidelines for Downtown Development encourage similar techniques to create a transition to the height, bulk, and scale of development in neighboring or nearby less intensive zones. Such techniques include increasing ground-level setbacks from the zone edge, reducing the build of the buildings' upper floors, and limiting the length of facades.

Upper level setbacks on Jefferson Street.

LURC agrees that the upper level setback along Jefferson St should be amended, and supports the CAC recommendation with one exception: that new development or additional height over the existing garage structure in Section FF (between 15th and 16th) have an upper level setback of 20 feet for new construction and approximately 20 feet to the closest existing structural grid in the existing parking facility for all other

development. This length of block directly faces single family homes on the south side of E. Jefferson, and should be respectful of the scale and privacy of the homes.

Setbacks along 15th Avenue.

LURC urges that the setbacks along 15th Avenue should be amended, and believes that the height between 15th and16th should be limited to 105 feet. In addition, LURC recommends that all development on this street at grade sets back 10 feet, and above 65 feet have an upper level setback of at least 30 feet.

16th Avenue Frontages.

LURC shares the CAC's concern with the creation of a canyon effect along 16th Avenue and believes that the setbacks along this block should be increased both at the ground level and at upper levels. Preventing a canyon effect along this section of the site is imperative to preventing a single family and low rise neighborhood from being fractured by high rise construction and the effect of cutting off light, views and bisecting a neighborhood.

At minimum, LURC recommends that all development in sections KK1 and KK2 have a ground-level setback of 5 feet up to MIO 37, and that development above MIO 37 feet have an upper level setback of at least 30 feet. Establishing a substantial setback at MIO 37 feet will maintain a pedestrian scale to this important north-south connecting street in the community.

Additionally, LURC recommends that the design of future development attempt to create transparency at the street level for human interaction and pedestrian scale, and limit large expanses of blank faces or driveways.

Closing Remarks

Regarding height limits and setbacks, the LURC believes the Swedish First Hill MIMP provides an instructive comparison. The zones adjacent to the Swedish First Hill campus are as follows: a commercial zone with a 160 foot height limit to the north, a High Rise zone to the west, a commercial zone with an 85 foot height limit to the south, and several zones with limits varying from 85 to 160 on the east.

However, even though the adjacent zones have tall height limits, almost all of the Swedish First Hill MIO height is *limited to MIO 70 for a depth of at least one half block* on all sides of the campus. (There is a very small exception on Broadway across from a parking garage.) The LURC believes that the respect for adjacent zones that is demonstrated in the Swedish First Hill MIMP should serve as a framework for the proposed Cherry Hill MIMP.

Respectfully submitted,

Central Area Land Use Review Committee

Washington Community Action Network
La Red Activa Comunitaria Estatal de Washington
1806 East Yesler Way, Seattle, WA 98122
P: 206-388-0810 F: 206-329-0049
www.washingtoncan.org

July 21, 2015

Sue Tanner
Hearing Examiner
City of Seattle
700 5th Ave #4000
Seattle, WA 98104

Re: Swedish Medical Center Cherry Hill Campus Master Plan, Project No. 3012953

Dear Examiner Tanner:

We asked two consultants, Ross Tilghman and Dr. Sharon Sutton, to prepare comment letters on our behalf to provide you with their expert opinions on the Final Major Institution Master Plan for Swedish Cherry Hill. Ms. Newman told me that on the last day of the hearing, you ruled that our consultant, Ross Tilghman, could not submit a comment letter on the MIMP because he was not a member of the public.

I am writing to make clear that Ross Tilghman was submitting his letter on behalf of Washington CAN and Washington CAN members are members of the public. If our experts/consultants cannot submit written comment letters on the MIMP, that means that members of the public are barred from submitting expert testimony on the Final MIMP in response to the evidence that Swedish/Sabey have submitted. This seems unfair. Swedish/Sabey had unlimited time to introduce expert testimony, new information, and changes to the Final MIMP during the hearing. It seems to me that this violates the due process rights of Washington CAN.

At the time of your ruling on Friday morning, Dr. Sharon Sutton had not yet submitted her public comments on the Final MIMP. While your ruling was applicable to Ross Tilghman's letter, I understand that it may also apply to Dr. Sutton's letter. We recognize that you, therefore, may not accept Dr. Sutton's public comments on the MIMP based on that ruling, but we want to be sure to have Dr. Sutton's letter in the record for future proceedings. For that reason, I have attached Dr. Sharon Sutton's letter and ask that it be part of the MIMP public comment record.

Sincerely,

Chris Genese

Ms. Sue Tanner
Hearing Examiner
City of Seattle

Re: Swedish Medical Center Chery Hill Application #3012953

Dear Hearing Examiner Tanner:

I live at 545 19th Avenue between Cherry and Jefferson. My home is on the other side of the block of the 18th Avenue half-block of the Cherry Hill campus and near the loading dock.

Noise from the loading dock is already incompatible with our low rise residential neighborhood. Arrival and departure of trucks is a noisy endeavor. I hear them in the evenings when they roar up to the dock and then idle their engines for up to an hour. This can begin as late at 9 pm. Their noise has driven me out of my backyard and back into my house, preventing me from enjoying many a beautiful spring, summer and fall evening.

Last summer, neighbors complained about the 4 a.m. truck arrival and the noisy banging of them being unloaded. While Swedish Sabey agreed to limit this noise, they reserved the right for trucks to arrive as early as 6 a.m. and as late as 10 p.m. They are not enforcing the ban with their suppliers as we still hear the occasional roar and banging at 4 a.m. Believe me, once is more than enough to be awoken by this noise at 4 a.m.

Truck noise is not limited to the weeknight evenings. Trucks arrive during the weekday and even on the weekend.

With the current noise level from one loading dock, I cannot imagine the roar of the 16-17 loading docks proposed for 18th Avenue. This will destroy the livability of the neighborhood. It is also at odds with the traffic for the proposed parking garage on 18th Avenue. 18th Avenue simply cannot support the volume of trucks on the west side and the volume of cars on the east.

By the way, noise is not limited to trucks. Around 8 a.m. on the recent 4th of July holiday, the grounds crew was out with noisy gas engine-powered tools. There was no need for this work to be done at such an early hour on a *holiday*. This is another example of how Swedish Sabey does not recognize or respect its location in a residential neighborhood.

Sincerely,

Cindy Thelen
545 19th Avenue
Seattle, WA 98122

I'm Cindy Thelen, owner of 545 19th Avenue since 1991.

I'm a member of the appellant group 19th Avenue Neighbors and regularly attended and commented at CAC meetings.

Thank you for this opportunity to offer my comments on the MIMP.

As described on the Seattle department of neighborhoods website: the objectives of the MIMP are to balance the needs of major institution development with the need to **preserve** adjacent neighborhoods. Preserve is a strong word that Webster defines as

to keep (something) in its original state or in good condition
to keep (something) safe from harm or loss.

The proposed MIMP does nothing to preserve our neighborhood's livability. Overall, the height, bulk, scale, density and intensity of the MIMP are fundamentally incompatible with the low-rise residential character of our neighborhood.

I support the minority report of Dean Paton, et al, with exception. Tying subsidized housing to employment at Swedish Providence Sabey is very risky because if a Swedish Sabey employee living in Swedish Sabey subsided housing loses her job or otherwise changes employers, her housing subsidy is also lost. This would fling the person into the realities of a very difficult Seattle housing market. An alternative way to replace the housing lost on 18th Avenue is for Swedish Sabey to purchase housing in the immediate neighborhood and transfer the ownership to a third party for management of rental or sale to low income persons, regardless of their employer. This is similar to the process of the 1994 MIMP that created housing on 19th Avenue.

I also call for the return to owner-occupied housing all Sabey-owned single family homes on 19th Avenue and on 16th Avenue north of Cherry. Outrageously, one of those 19th Avenue homes now owned by Sabey and operated as a rental property was built as owner-occupied low- to moderate- income housing as a result of the 1994 MIMP.

I do not support a parking garage on 18th Avenue. The block is not able to absorb the amount of traffic that will come and go from the lot. Vehicles turning on and off each end of the block already present a significant danger to pedestrians and bicyclists—I ride past 18th and Jefferson on my morning commute and can attest to the danger.

The current MIMP did not explore the decentralization of services across the Swedish Providence system. Nor did it explore recapturing for Swedish Cherry Hill use the property Providence sold to Sabey Corporation.

There are no transitions to the residential neighborhood in this MIMP. For example. development of one monolithic building the entire length of 18th Avenue from Jefferson to Cherry does not provide a transition to the neighborhood. Setbacks proposed are non-existent or inadequate.

TRANSITION ON 18TH AVENUE: 25' GROUND LEVEL SETBACK IS NOT SUFFICIENT

I will start with an overarching statement and then provide to specifics. This project does **not provide adequate transitions to the neighborhood on any side of the proposed development.** The lack of setbacks on the arterials reinforces the fortress-like quality of the planned development. Setbacks are a problem, as is the out-of-scale heights of specific sections: for example, the plan for 15th Ave. on the western border should match the adjacent Seattle U MIO of 65' rather than the proposed 150'. But the most egregious issue with scale, setbacks and lack of transition is on 18th Ave.

In keeping with the neighborhood's character, heights on the block of 18th Ave. that abuts residential development should be limited to 37'. But there should be additional measures to improve the transition from the institution to the abutting Single Family zone. Additional ground-level setbacks, limits on the maximum lot coverage, and modulation that would break up the mass of building are all options that would improve these transitions and are supported by the neighborhood and the Central Area Land Use Review Committee.

The proposed development would extend without break from E. Jefferson to E. Cherry – an almost 600 foot block-long building. This is utterly incompatible with the adjacent Single Family zone to the east, where there is 11 single-family lots (and one condominium lot) along E. Jefferson.

The proposals to limit height to 37' and establish a rear setback of 25', which are similar to what would be allowed in the Single Family zone, both help to mitigate potential impacts - but this is not sufficient.

Single Family zone development standards prohibit lot coverage of more than 35%. To comply or be compatible with the 35% coverage standard for the Single Family zone, the MIMP must break up the 600' long mass into separate buildings with adequate breaks between them.

Finally, it's my understanding that it's extraordinary for a Major Institution Overlay boundary to be in the middle of the block, without a buffer of some kind. With no alley or any other buffer between the proposed project and the adjacent Single Family zone to the east, there needs to be additional accommodations to the needs of residents and the character of the neighborhood. Unlike what's proposed, development standards should be respectful of the residents on the other side of the boundary line. Right now the proposed boundary between the MIO zone and the Single-Family zone is simply the lot line – the transition is not just insufficient, there is none.

The Central Area Land Use Review Committee recommended The Design Guidelines for Downtown Development. Those Guidelines attempt to ensure an adequate buffer or transition to the height, bulk, and scale of development in nearby less intensive zones. These include expanding ground-level setbacks from the zone edge, reducing the bulk of the buildings' upper floors, and limiting the length of facades. The neighborhood needs this kind of buffer and transitions.

Sincerely,
Claire Lane
832 16th Ave

Hearing Examiner Testimony
MUP 15-010 – MUP 15-015
DPD #3012953

I am Claudia Montemayor and I live in 700 16th Ave. Seattle, WA 98122

I am an appellant member of the Concerned Neighbors Swedish Hill. I believe reasonable growth that balances the needs of the major institution with the livability and continued well-being of the neighborhood is possible but the height, bulk, and scale of the proposed expansion is fundamentally inconsistent with the surrounding residential neighborhood.

Rather than minimize adverse impacts on the neighborhood, as demanded by the Land Use Code, the current Swedish/Sabey MIMP goes to the opposite extreme: projected traffic congestion will rise and destroy the quality of life in the surrounding neighborhood; the proposed heights, bulk and scale of the planned buildings are without question incompatible with the low-rise neighborhood, design setbacks are minimal and in some places nonexistent, providing nothing close to appropriate transitions from this out-of-scale new construction to the neighborhood in which the campus sits.

Swedish/Sabey has proposed zero lot line setbacks and minimal upper level setbacks for the vast majority of new campus buildings. The current proposal does not provide appropriate transitions along the perimeter, through ground level or upper level setbacks or building modulations.

This is the reason that I support the CAC Minority Report authored by Dean Paton et al that propose solutions based on the current capacity of the campus as well as its recent history. I agree with the recommendation of a scaled-back version of development for the Cherry Hill Campus smaller in height, bulk, intensity and scale than that which has been approved recently by the Department of Planning and Development.

The CAC Minority Report explains how to lower the height, bulk and scale with the below:

- <u>18th Avenue Half Block</u>
  Currently it has a maximum height of 50' and the CAC Minority Report recommends a maximum height of 37', bulk 4 buildings.

- <u>Façade Along East Cherry Street from 16th Avenue to 18th Avenue</u>
  Currently it has the tallest building on campus and the CAC Minority Report recommends the tallest building on campus will be at 112 feet. The tallest building on the 16th Avenue half-block, on the west side, would be a maximum of 105 feet.

- Setbacks
  That all existing ground level setbacks would remain. No reduction in ground level setbacks. Upper level setbacks of 25 feet from the property line at a height of thirty feet for any new development along Cherry and Jefferson. Rear setbacks on 18th Avenue half block would be a minimum of 25 feet.

I agree that this proposal does the best job of meeting the stated needs of Swedish/Sabey to change and grow while also maintaining the livability and vitality of the surrounding neighborhoods that have long lived in partnership with this major institution.

Best Regards,
Claudia Montemayor

Bricklin & Newman LLP

Seattle Office:
1001 Fourth Avenue
Suite 3303
Seattle, WA 98154

Spokane Office:
25 West Main
Suite 234
Spokane, WA 99201

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Reply to: Seattle Office

July 15, 2015

Sue Tanner
Hearing Examiner
City of Seattle
700 5th Ave #4000
Seattle, WA 98104

Re: Swedish Medical Center Cherry Hill Campus Master Plan, Project No. 3012953

Dear Examiner Tanner:

I am writing on behalf of Washington Community Action Network (Washington CAN) to comment on the Swedish Cherry Hill Medical Center Major Institution Master Plan (MIMP). The Project No. is 3012953 and the project address is 500 17th Ave in Seattle.

Swedish and Sabey Corporation are proposing to more than double the size of the existing facility on the Cherry Hill campus based on a claim that they need to construct an additional 1.9 million new square feet on top of the existing 1.2 million square feet.[1] But Swedish has not provided sufficient information to show a genuine "need" for this additional square footage. To make matters worse, the Final MIMP does not include any specific and concrete public benefits that would be offered as part of the expansion. The issues of human development and community benefits require special scrutiny because, in recent years, the new ownership, Providence, has not demonstrated a willingness to commit to truly pursuing its public benefit mission.

In the meantime, the proposal will significantly and adversely impact the livability and vitality of adjacent neighborhoods. The height, bulk, and scale of the proposed development on the campus is disproportionate to the lower heights and density of the surrounding residential neighborhoods. The FEIS concluded that the Final MIMP's proposed greater heights and more densely developed MIO is generally inconsistent with policies in Seattle's Comprehensive that apply to areas zoned for single family and low rise residential development. FEIS at 3.3-37. The FEIS repeatedly concludes that the Swedish Cherry Hill proposal's height, bulk and scale is inconsistent with goals and policies in the Comprehensive Plan. *See* FEIS at 3.3-32-33; 37-38; 40, and 42. And the FEIS ultimately concluded that the height, bulk, and scale of the proposal would cause significant adverse impacts on the neighborhood. FEIS 3.4-50. It also concluded

[1] Swedish claims that it needs an additional 1.9 million new square feet, but it has proposed Alternative 12, which would add approximately 1.55 million square feet.

that the increase in traffic volumes for the proposal and the resulting impacts on traffic operations would create significant adverse impacts in the area. FEIS 3.7-58.

The CAC majority report also concluded the proposal in the Final MIMP would adversely impact the livability and vitality of adjacent neighborhoods. The majority of CAC members agreed that the height, bulk, and scale of the proposed development on the campus is disproportionate to the lower heights and density of the surrounding residential neighborhoods. They recommended significant reductions in the height, bulk, and scale of the proposal. Five of the Citizen Advisory Committee members, plus one former CAC member, prepared a minority report in which they also concluded that the proposal would adversely impact the surrounding neighborhood. The minority report recommended even greater reductions in height, bulk, and scale than those recommended in the majority report.

For these reasons and for the reasons explained in more detail herein below, Washington CAN requests that the Examiner either recommend denial of the proposed MIMP or conditioned approval.

A. Swedish Has Failed to Provide Information Sufficient to Demonstrate Need

A MIMP must balance the *need* of a major institution to develop its facilities with the need to minimize the impact of major institution development on surrounding neighborhoods. SMC 23.69.025. Thus, on one side of the equation is the question of Swedish's "need" and on the other side of the equation is the question of the needs of the surrounding neighborhoods to avoid adverse impacts. This makes sense – major institutions are given the special privilege of overriding underlying zoning requirements and the neighbors must bear the brunt of adverse impacts caused by these deviations from the Code. It is critical that the major institution prove that it truly needs the specific additional square footage that it is requesting.

Swedish has failed to provide information or evidence sufficient to demonstrate a genuine need for an expansion of the size that it proposes at the Cherry Hill Campus. The Final MIMP states: "Studies show that in order for Swedish Cherry Hill to meet the community's growing demand for health care over the next 30 years, we will need to add approximately 1.9 million new square feet, which amounts to a growth rate of about three percent a year." Final MIMP at 4. This statement begs the question: what studies? Where are those studies and why weren't they submitted to the record? While the Final MIMP includes Appendix G, Volume and Space Projections, that appendix does not give any insight into how Swedish landed on 1.9 million new square feet for this particular facility. The information is insufficient to demonstrate a genuine need for an expansion of this size. Swedish lists (and the Director of DPD repeats) seven general "drivers" of its need for growth such as an aging campus, regional demand, aging population, and the like. These are generalities that could or could not affect Swedish Cherry Hill specifically and that may or may not require expansion. There are no specifics to show how these general concepts lead to the number -- 1.9 million new square feet at the Cherry Hill campus.

I refer the Examiner to, and incorporate herein, the testimony of Jack Hanson concerning space need projections for the Cherry Hill campus that is being submitted to the Hearing Examiner.

His testimony explains in more detail what information is lacking in the Final MIMP and why that information is critical to prove a genuine need. Jack Hanson has worked as a health care policy analyst for over a decade and has served on state committees in Washington dealing with health care planning and hospital bed need. His experience leaves him particularly well suited to address this issue.

The Director of DPD simply accepted that number as a given without any scrutiny. *See* Director's Report at 25, 30, 37-38, 53. To make matters worse, the Director rejected the CAC recommendations on grounds of need. The Director stated: "DPD does not agree with the CAC's recommendation. In order to accommodate the stated needs of the institution portions of the campus have increased height to allow for additional square footage." Director's Report at 53. *See also* Director's Report at 55. The Director is "accommodating" Swedish's "stated need" to the detriment of the neighborhood and against the recommendations of the CAC without any scrutiny of the basis for that so-called "need."

While looking at the question of need, Mr. Hanson and neighbors of the proposal formally requested additional specific information from Swedish that would allow them to understand more fully, and to evaluate more carefully, the claims about future space needs. Swedish refused to provide them with information responsive to their request and failed to provide such information to the CAC or DPD. To the extent that Swedish attempts to provide this or any additional information on need to the Hearing Examiner at the eleventh hour during the hearing, we object on the grounds that we have not had an opportunity to adequately review and respond to that information. We ask that that information either be disregarded or that the Examiner allow additional time for the public to review the material and respond.

Relevant to the subject of need is a requirement in the Seattle Municipal Code connected to the assessment and approval or denial of a Final MIMP. Specifically, the Code requires that the application for a master plan include a "description of alternative proposals for physical development and decentralization options . . ." SMC 23.69.032. The Code, therefore, requires that the MIMP application include a discussion of other potential sites, not on the Cherry Hill campus, where some of the planned services and research facilities might be located. In fact, the CAC requested this very information early in the process. They requested a description of decentralization options in its first written comments on the proposed MIMP in April, 2013. Neither Swedish nor the FEIS provided this information.

B. Swedish Has Not Provided Sufficient Information to Show Specific Public Benefits Associated with the Expansion

In its assessment of the Final MIMP, the Examiner must balance the public benefits of the development with the need to maintain livability and vitality of adjacent neighborhoods. SMC 23.69.032.E.2. Thus, on one side of the equation with this code required assessment is a review of public benefits "resulting from the plan's new facilities and services." SMC 23.69.032.E.2.a. On the other side of the equation for balancing is the need to maintain livability and vitality of adjacent neighborhoods. I address the "public benefits" in this section.

In the Final MIMP, Swedish includes a section entitled "Applicable Goals, Policies, and Public Benefits of the Institution." Final MIMP at 69-71. In that section, Swedish describes the direct community benefits, patient care, community education, community outreach, charity and subsidized care and other benefits that it is claiming in an attempt to convince the Examiner to balance the scale in favor of Swedish public benefits. Earlier in the MIMP, Swedish described its past and current contributions as being at the forefront of technology and innovation and providing health care to the Puget Sound region. Final MIMP at 2. Swedish generally describes its Neuroscience and Heart and Vascular Institute, its general offerings in the Western Washington regions (108 medical clinics), its current tax and community benefit contributions, and some of the services provided at the campus.

Of course, the Swedish Medical Center provides these benefits – it is a hospital. That is why Swedish is allowed to supersede development standards of the underlying zoning in the first place. But noticeably missing from the Final MIMP are specifics on precisely what public benefits will be offered with this particular proposal to this particular community above and beyond the current public benefits that the Swedish Medical Center offers generally. The assessment that is required by SMC 23.69.032.E.3 must assess *future* concrete, specific actions that will accompany the expansion for *future* consistency with these policies and goals.

The Final MIMP does not address this requirement adequately. It does not propose meaningful, concrete actions that it will take associated with its expansion. Swedish could make concrete and specific promises to forgive medical debt and increase charity care access in the community. They could offer specific programs to support neighbors of Swedish Cherry Hill who are struggling with or facing foreclosure from huge medical bills that should be forgiven as charity care. They could make access to charity care and other financial assistance easier and more transparent. A public benefit package could include specific items that make sure patients get the care they need by meeting good staffing standards and respecting the recommendations of bedside nurses. They could also include in the package some give back to the local schools. They could give generously to Bailey Gatzert Elementary and other local schools in need, supporting the next generation of potential Swedish-Providence staff. They could improve public transit by giving money to Metro in a way that both enriches the quality of life in the neighborhood and partially mitigates the traffic impact of the expansion. These are just a few examples of the potential areas in which Swedish could provide a specific and concrete public benefit package in conjunction with its obligation for expansion. We request that the Examiner require that Swedish put together a package that contains concrete and specific promises for public benefits such as those listed above for the community to mitigate the impacts of the development.

The Examiner's Recommendation must also assess the way in which the proposed development will serve the public purpose mission of Swedish. SMC 23.69.032.E.2. When considering this component of the decision, keep in mind that since Providence Health & Services acquired Swedish in 2012, it changed the local hospital that we know and trust into part of a big chain. Since then, it appears that a desire for profit has taken precedence over the desire to further the public purpose mission of the institution. Any approval of an expansion should be accompanied by commitments that ensure that, in the future, Swedish/Providence will be responsive and

accountable to the community, patients, and workers as is called for in its public purpose mission.

The FEIS states that the mission of Swedish Cherry Hill is to provide a wide range of community benefits, strategies, and solutions that meet people's health care needs. FEIS at 3.3-54. As the FEIS continues, "That means covering the cost of medical care for those who can't pay, offering free health screenings, assisting patients with their rent in times of health care crisis, and supporting research projects that help to create valuable medical advances, both here at home and across the world." *Id.*

The evidence at the hearing will show that questions should be asked and conditions should be attached to the proposal to ensure that this public purpose mission quoted in the FEIS is indeed served with the expansion. When Providence took over Swedish in 2012, the organization began losing its focus on innovative, quality patient care. Staff report that patient volumes are increasing while staffing has stagnated or decreased, resulting in a different working environment for providing care. Providence has also made health care less affordable for its own workers. Their own employees have healthcare bills that are beyond what they can afford. They receive calls from collectors demanding payment to Swedish/Providence. Since it has become part of Providence, the Swedish commitment to patient care has not been the same. The decisions that Providence have made reflect a desire to put profit ahead of its public purpose mission. Expansion in the name of even greater profit should be accompanied by commitments that ensure that Swedish/Providence is responsive and accountable to the community, patients and workers.

It is also important to recognize that Swedish has enormous capacity to increase the amount of charity care that it provides. In the Director's Report, the Director states "on a system-wide basis, Swedish Medical Center provided more than $142 million in community benefit in 2013. This included: over $37 million in charity care; over $64 million in Medicaid subsidy; over $3 million in non-billed services; over $17 million in research programs; and over $2 million in community building activities." Director's Report at 28. While Swedish touts this estimated cost of charity care and total community benefits in the Final MIMP and FEIS, it fails to note either its own or its parent, Providence's total, operating and net revenues. Providence had a total annual profit of $253 million in 2013, bringing its 2011-2013 total profit to over $1 billion.[2] And this is after all spending on charity care, Medicaid shortfalls, and other alleged community benefits has been deducted. As of a few months ago, Providence was still holding onto over $5 billion in unrestricted cash.[3] It also fails to note the year-to-year decrease in Swedish's Cherry Hill charity care expenditure – between 2013 and 2014, the number of charity care patients dropped by 46% to 458 and the estimated cost of charity care provided dropped by 39% to $4.8 million.

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2 $362 million in 2011, $411 million in 2012, and $253 million in 2013.

3 Providence 1st quarter 2014 financial report.

It is important to consider these numbers in context. First of all, non-profit hospitals are exempt from a wide range of taxes and fees and enjoy other special treatment that for-profit hospitals and other for-profit businesses do not. In exchange for that, non-profit hospitals are expected to serve a charitable mission by providing community health benefits that address serious unmet community health needs. In 1956, the Internal Revenue Service required sufficient levels of charity care as a requirement for maintaining tax exempt status for hospitals.[4]

Second, we should consider what exactly are appropriately considered "community benefits?" Upon closer inspection, the entire $140 million in claimed community benefits are not genuine community benefit dollars. A very large portion of those dollars include government sponsored medical care shortfalls. These Medicaid shortfalls are, as a matter of course, borne by every provider and the federal and state governments disperse additional payment to hospitals in order to offset the costs of providing care to large numbers of Medicaid patients. In addition, a large part of the community benefit dollars claimed were for medical educational research and also should not count as genuine community benefit dollars. There are other dollars included in that number that are questionable as genuine community benefit dollars, such as subsidized clinical and social services and so-called community building activities. I anticipate that this topic will be addressed in more detail during the public testimony, but it is a critical consideration in response to the claims of "public benefits."

Swedish also fails to note what amount of charity care is specifically attributable to the Cherry Hill campus. Swedish Health Services covers metropolitan Seattle with five full service hospitals, two free standing emergency rooms and specialty centers, and a network of more than 100 clinics. The numbers they provided are generally covering this whole system. The information on benefits should be specific to the proposal.

The following complaints, which have been made about Swedish/Providence, should be addressed:

- Charity care is not well-advertised or offered during admission. Patients have to ask for information about it. Allegedly, posters are no longer clearly posted in the lobby areas.

- The application process is too complicated, requiring paperwork and documentation that the average person does not have readily available. This discourages people from seeking care at Swedish – some of them go to Harborview instead because the application is simpler.

- We believe that the income requirements are 400 percent of the federal poverty line. If that is the case, this is too limiting for many people. Families and individuals making more than the maximum allowed income to qualify are often times struggling pay medical bills.

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[4] This directive was later amended in 1969 to a broader but vaguer requirement for the provision of community benefit, part of which included the provision of free and reduced care.

- The length of time a patient is covered by charity care is too limited. Patients tell stories of years past where one complex application and approval would last for 6 months, but now it is only valid for one month, then people have to update/re-apply. This further discourages people from seeking charity care at Swedish.

- Charity care provided by Swedish does not cover services provided by contractors, even though the services are rendered on the campus.

- The amount of time patients are given to fill out charity care applications is too short, especially given the amount of documentation required and the fact that people are often not in good health during this process.

- Patients' applications have been lost, with no communication from Swedish before finding out that their bills have been sent to collections agencies. Swedish has even sent its own employees to collections over unpaid medical bills.

Overall, we hope that the Examiner's recommendation will include a critical and thoughtful analysis of whether Swedish/Providence's expansion plans include adequate conditions to ensure that it will indeed serve the public purpose mission of the institution (rather than the solely private need for even more profit). Any expansion approval should be accompanied by specific, concrete, future commitments to ensure that Swedish/Providence provides meaningful charity care to the local community and is responsive and accountable to the local community and its patients and workers.

C. The Proposal Will Significantly Harm the Livability and Vitality of Adjacent Neighborhoods

As mentioned above, MIMP review requires a balancing of the needs of the major institution to develop facilities for the provision of health care against the need to minimize the impact of major institution development on surrounding neighborhoods. SMC 23.69.025. The decision must consider the extent to which the growth and change will significantly harm the livability and vitality of the surrounding neighborhood. *Id.* Before a MIMP can be approved, all adverse impacts associated with development must be minimized and the livability and vitality of adjacent neighborhoods must be protected. See SMC 23.69.002; SMC 23.69.032.E.2. There are also a number of requirements specific to the development program and development standards components of the proposed master plan that call for more specific protections of the neighborhood and community interests. SMC 23.69.032.E.4 and 5.

1. The height, bulk, and scale of the proposal will adversely impact the livability and vitality of adjacent neighborhoods

The height, bulk and scale of the proposal that is currently proposed by Swedish is outrageously out of balance with the height, bulk and scale of existing and allowed uses in the surrounding neighborhood. While a proposed MIMP is allowed to supersede development standards of the underlying zoning, that privilege is not without limitation. The aesthetic context of the

surrounding neighborhood as well as the current uses therein are relevant. The underlying zoning and surrounding neighborhood and the overall designation in the Comprehensive Plan are all relevant to the question of what new development standards are appropriate for the MIMP.

An urban village strategy has been developed by the City, with the intention of concentrating growth in the urban villages. Seattle's Comprehensive Plan, Toward a Sustainable Seattle (hereinafter referred to as "Comp Plan") at 1.3. Areas outside of urban villages are meant to accommodate growth in less dense development patterns consisting primarily of single family neighborhoods, limited multi-family and commercial areas, and scattered industrial areas. *Id.* at 1.4. The proposal site is outside of Urban Centers and Villages in the area.

The proposal goes far beyond appropriate growth of this institution and the enormous height, lot coverage and setback disparities will have adverse aesthetic and land use impacts to the surrounding neighborhoods. There is no balance with this proposal. It goes too far against the neighborhood and too much in favor of Swedish.

a. Aesthetic context of the neighborhood

While the remainder of this section addresses the height, lot coverage, setbacks, and façade individually, I note that, from a design perspective, it is important to consider how all of these work together. As Dr. Sutton will testify, minimizing the impacts of height, bulk, and scale on the neighborhood requires a look at the design of the building as a whole and a closer look at the context of the surrounding neighborhood. Dr. Sutton will explain this in detail in her oral and written testimony on the Final MIMP. Her testimony is incorporated herein.

b. Height

Swedish is requesting a right to tower over the rest of the neighborhood with buildings as high as 160 feet. That is five times the 30 foot limit that is allowed by the underlying zoning on the project site and that is allowed by the zoning in the great majority of the surrounding neighborhoods. The uses in the areas immediately north, east, and south of the campus are primarily single family and multi-family residential. *See* Swedish Cherry Hill MIMP FEIS, Figure 3.3-4, p. 3.3-8. The height limits for SF-5000 and LR-3 are 30 feet. The height limit for LR-1 is 25 feet. The height limit for Seattle University is 65 feet.

With respect to heights, the Majority Citizen Advisory Committee Decision concluded that heights below 105 feet when imbedded within a low rise neighborhood should be the default position. They concluded that greater heights presented unavoidable adverse impacts to the surrounding area. Swedish Medical Center Cherry Hill Campus Major Institution Master Plan Citizens Advisory Committee Final Report and Recommendations (May 28, 2015) at 16. The CAC therefore recommended that most of the campus be retained at either MIO 37, 65, or 105. They recommend greater heights above 105 feet be restricted and allowed only for the hospital wing. In this single special circumstance, the CAC recommended 140 foot height for that limited area.

A large minority of CAC members (Patrick Angus, Maja Hadlock, Dean Patton, James Shell, J. Elliott Smith, and former CAC member Nicholas Richter) recommend that the heights of buildings bounded by East Cherry Street and East Jefferson on the north and south and by 16th Avenue and 18th Avenue on the east and west allow at the maximum 105 feet. They recommend that the tallest building on 15th Avenue half block on the east side facing Seattle University would be a maximum of 65 feet. And they recommend that all existing ground level setbacks remain as is and there should be no reduction in ground level setbacks.

It is important to note that the Director's summary of the majority CAC's recommendation is not consistent with the CAC's Final Report and Recommendations. The Director stated that the majority of the committee recommended a 125 foot height for the central portion of the block between 15th and 16th Avenues and East Cherry and East Jefferson Streets. *See* Director's Report at 53. That is not what the CAC recommended in its final report. The CAC recommends a 105 foot height for the central portion of the block between 15th and 16th Avenues and East Cherry and East Jefferson Streets.

Allowing the height proposed in the Final MIMP will have significant adverse impacts on the neighborhood, is inconsistent with the Comp Plan, and does not minimize the impact of the major institution development on the surrounding neighborhood.

c. Lot coverage

Like the height, the proposed lot coverage is also significantly out-of-balance with the underlying zoning and the zoning in the surrounding area. The minimum lot requirements for the underlying Single Family zone call for a maximum lot coverage of 35% of the lot area. SMC 23.44.010. The maximum lot coverage for the majority of property surrounding the site is 35% of the lot area. Swedish is proposing a maximum lot coverage of 76.5%. That goes too far and creates a bulk that will have significant adverse impacts to the surrounding neighborhood.

d. Setbacks

The proposed setbacks are also significantly out-of-balance with the surrounding area. Swedish proposes far smaller ground level setbacks than those required by the underlying zoning. Lots in the single family zone generally require a 20 foot front yard setback and a 25 foot rear yard setback and these requirements apply to institutions in SF zones. SMC 23.44.014; SMC 23.44.022. In addition, institutions in the SF zone must have a side yard setback of 10 feet. *Id.* The LR-3 zoning setback requirements are a bit more complicated, but range generally from 10 feet to 20 feet for front and rear setbacks and 10 feet from a side lot line that abuts any other residentially zoned lot. SMC 23.45.570.

In the Final MIMP, Swedish claims that "Front setbacks would vary by street and range from 5' to 20' at ground level and from 10'to 80' at upper levels." Final MIMP at 22. When you look closely at the details, you see that the 20' setback proposed at ground level is a tiny area in proportion to the enormous project. The great majority of ground level setbacks are 5 feet and 0 feet, with far fewer areas at 10 feet or higher. The Director recommended tweaks to the setbacks

changing some of the zero setbacks to five feet, but those changes do not adequately mitigate or minimize the impacts of the building.

The CAC recommended a number of increases in setbacks, including upper level setbacks. Dr. Sharon Sutton will also address the setback issue in her oral and written testimony and I incorporate that testimony herein.

Curiously, in the Final MIMP's analysis of consistency with the purpose and intent of the Seattle Land Use Code, the MIMP states that the proposed setbacks vary to provide "a quality pedestrian experience within the campus along 16th and 18th Avenue." Final MIMP at 66. It is worth noting that the setbacks proposed in the MIMP along 16th Avenue were primarily 0 feet, with only a tiny portion set at 5 feet or 10 feet. In other words, along the majority of the street, the MIMP proposed no setbacks at the pedestrian level at all. Similarly, there is 0 foot setback along the entire east side of 18th Avenue and only a 5 foot setback along the west side of that street. The setbacks do not a "quality" pedestrian experience.

One particularly vexing statement that finds its way into both the Final MIMP and the FEIS, is the characterization of the setbacks as "mitigation." The Final MIMP takes the position that these "setbacks are proposed to provide an appropriate pedestrian scale and transition to the surrounding neighborhood," and it claims that the setbacks are proposed as "mitigation" or as a benefit to the neighborhood. Final MIMP at 25 and 44. That is not a fair characterization. The ground floor setbacks violate the underlying zone's development standards – Swedish is requesting approval to violate the setback requirements so it can expand. The decreased setbacks will not mitigate impacts and they do not benefit the neighborhood - they *cause* the impacts.

e. Façade

Swedish proposed unmodulated facades be allowed up to a maximum façade with 125 feet. The limit in the underlying zoning, LR-3, allows a maximum structure without green factor to be 60 feet. Thus, Swedish is requesting that the unmodulated façade be more than twice the amount allowed by the underlying zoning. Swedish is also requesting that the structure depth be changed. The maximum permitted depth of institutional structures in the R-3 zone is 65 percent of the lot depth. Swedish is essentially requesting a complete waiver of this requirement and proposing to build based on the 0 to 5 foot setbacks with no limitations on the structure depth. The floor area ratio (FAR) proposed by Swedish is 4.74, when the existing MIO floor ratio is 2.07. This is yet another design issue that will increase impacts to the surrounding area due to height, bulk, and scale of the project.

f. The FEIS concludes that the expansion is inconsistent with the Comp Plan

The FEIS concludes that the Final MIMP is inconsistent with multiple goals and policies in the Comprehensive Plan. *See* FEIS at 3.3-32 through 3.3-42. The FEIS repeatedly concludes that the Swedish Cherry proposal's height, bulk and scale is inconsistent with many of the goals and policies in the Comprehensive Plan. *See* FEIS at 3.3-32-33; 37-38; 40, and 42. Specifically, the FEIS concludes that the Final MIMP is inconsistent with the following policies:

UV-38: Permit limited amounts of development consistent with the desire to maintain the general intensity of development that presently characterizes the multi-family, commercial, and industrial areas outside of urban centers and villages and direct the greatest share of growth to the urban centers and villages.

UVG-36: Allow limited amounts of development in areas of the city outside urban centers and villages to maintain the general intensity of development that already characterizes these areas and to promote the targeted level of growth in village and center locations.

LU-6: In order to focus future growth, consistent with the urban village strategy, limit higher intensity zoning designations to urban centers, urban villages, and manufacturing/industrial centers. Limit zoning with height limits that are significantly higher than those found within single family areas to urban centers, urban villages, and manufacturing/industrial centers and to those areas outside of urban villages where higher height limits would be consistent with an adopted neighborhood plan, a major institution's adopted master plan, or with the existing built character of the area.

LUG-8: Preserve and protect low density, single family neighborhoods that provide opportunities for home ownership, that are attractive to households with children and other residents, that provide residents with privacy and open spaces immediately accessible to residents, and where the amount of impervious surface can be limited.

LUG-9: Preserve the character of single family residential areas and discourage the demolition of single family residences and displacement of residents, in a way that encourages rehabilitation and provides housing opportunities throughout the city. The character of single family areas includes use, development, and density characteristics.

LU-179: Permit the establishment of zoning overlay districts, which may modify the regulations of the underlying land use zone categories to address special circumstances and issues of significant public interest in a subarea of the city, subject to the limitations on establishing greater density in single-family areas. Overlays may be established through neighborhood planning.

> LUG-35: Promote the integration of institutional development with the function and character of surrounding communities and the overall planning for urban centers.

Id. There are additional policies that the FEIS either did not review or incorrectly assumed consistency with, but the main point is clear from just looking at the FEIS -- the proposal is inconsistent with multiple policies in Seattle's Comprehensive Plan.[5]

The FEIS states:

> The Final MIMP's proposed greater heights and more densely developed MIO is generally inconsistent with policies that apply to areas zoned for single family and low rise residential development. The proposed height limits would be substantially higher than the 30-foot height of structures that define the neighborhood's existing character.

FEIS at 3.3-37. The FEIS also states that "the scale of both the existing and proposed buildings is more intense than the surrounding neighborhood character, and that aspect of the proposal is inconsistent with the "goal of promoting the integration of institutional development with the function and character of surrounding communities and the overall planning for urban centers. FEIS at 3.3-42. The FEIS also concluded that "the proposed addition of approximately 1.55 million gross SF does not appear to constitute a "limited amount of development" as called for in UVG-36 and would therefore be inconsistent with that goal.

Over and over again, the FEIS confirms that the height, bulk, and scale of proposed development on the campus is disproportionate to the surrounding lower heights and density of the residential development. The FEIS concludes that the height, bulk, and scale of Alternative 12 would cause significant adverse impacts in the neighborhood. FEIS 3.4-50. The FEIS characterizes these impacts as "unavoidable," but they are completely avoidable. They can be avoided by reducing the height, bulk and scale of the proposal. The MIMP regulatory requirements clearly require that change.

g. SEPA substantive mitigation

On the subject of a development's height, bulk and scale, the City's policy is to preserve the character of individual city neighborhoods. SMC 25.05.675.G.1.a. The code states:

> It is the City's policy that the height, bulk and scale of development projects should be reasonably compatible with the general

[5] The Director's conclusions in its Report concerning SEPA mitigation are inconsistent with the FEIS. The Director concludes, incorrectly, that the "discussion in the FEIS establishes that the Master Plan is generally consistent with the planning goals of the various plans, policies, and regulations." Director's Report at 95. The Report fails to inform the Examiner that the FEIS concluded that the proposal was inconsistent with at least seven land use policies in the Comp Plan.

> character of development anticipated by the goals and policies set forth in Section B of the land use element of the Seattle Comprehensive Plan regarding Land Use Categories, the shoreline goals and policies set forth in Section D-4 of the land use element of the Seattle Comprehensive Plan, the procedures and locational criteria for shoreline environment redesignations set forth in SMC Sections 23.60.060 and 23.60.220, and the adopted land use regulations for the area in which they are located, and to provide for a reasonable transition between areas of less intensive zoning and more intensive zoning.

The Code expressly allows the City decision maker to condition or deny a project to mitigate the adverse impacts of substantially incompatible height, bulk and scale. SMC 25.05.675.G.2.b. Mitigating measures may include but are not limited to:

> i. Limiting the height of the development;
>
> ii. Modifying the bulk of the development;
>
> iii. Modifying the development's facade including but not limited to color and finish material;
>
> iv. Reducing the number or size of accessory structures or relocating accessory structures including but not limited to towers, railings, and antennae;
>
> v. Repositioning the development on the site; and
>
> vi. Modifying or requiring setbacks, screening, landscaping or other techniques to offset the appearance of incompatible height, bulk and scale.

If there ever was a situation to apply this mitigation, this is that situation. The height, bulk and scale of the proposal should be limited and modified pursuant to the authority in the SEPA regulations.

2. <u>The traffic impacts will adversely affect the livability and vitality of the neighborhood</u>

It is evident from the Final MIMP and the FEIS that the traffic and transportation generated by the Swedish Cherry Hill expansion will cause significant adverse impacts to the surrounding community. Full build-out will cause the current traffic numbers to nearly double. The livability and vitality of adjacent neighborhoods will be severely compromised by this enormous increase in traffic in the area. I incorporate herein the written testimony of Ross Tilghman, which is attached to this letter and which addresses these issues in detail.

The FEIS provides further evidence that the livability and vitality of adjacent neighborhoods will be severely compromised by the increase in traffic in the area caused by the proposal. The FEIS states:

> [The] added congestion [from the proposal] would contribute to measurably poor performance of the transportation network, in terms of increased delays along several of the corridors and at some specific intersections. The increase in traffic and pedestrian and bicycle activity due to development would result in more conflict points and increased hazards to safety. The increase in traffic volumes for Alternatives 8, 11, or 12, and the resultant impacts on traffic operations are considered significant unavoidable adverse impacts.

FEIS at 3.7-58. The FEIS characterization of these impacts as "unavoidable," suggests that the proposal should be denied outright under the MIMP regulations because it will adversely affect the livability and vitality of the neighborhood. In the alternative, the SEPA policies do authorize mitigation measures that would include a reduction in the size and/or scale of the proposal to mitigate traffic and transportation impacts.

It is the City's policy to minimize or prevent adverse traffic impacts which would undermine the stability, safety and/or character of a neighborhood or surrounding areas. SMC 25.05.675.R.2.a. In determining the necessary traffic and transportation impact mitigation, the decisionmaker shall examine the expected peak traffic and circulation pattern of the proposed project weighed against such factors as the availability of public transit; existing vehicular and pedestrian traffic conditions; accident history; the trend in local area development; parking characteristics of the immediate area; the use of the street as determined by the Seattle Department of Transportation's Seattle Comprehensive Transportation Plan; and the availability of goods, services and recreation within reasonable walking distance. SMC 25.05.675.R.2.b.

Mitigation of traffic and transportation impacts shall be permitted whether or not the project meets the criteria of the Overview Policy set forth in SMC Section 25.05.665. SMC 25.05.675.R.2.c. Mitigation measures that may be applied to this proposal pursuant to the City's SEPA substantive authority includes a reduction in the size and/or scale of the proposal if other mitigation is inadequate to effectively mitigate the adverse impacts of the project. SMC 25.05.675.R.2.f.

Thus, under the SEPA policies the Examiner could recommend denial or mitigation measures that would include a reduction in the size and/or scale of the proposal to mitigate traffic and transportation impacts.

D. Swedish Has Failed to Provide Adequate Information to Show Consistency with the Goals and Policies of the Human Development Element of the Comp Plan

In the Examiner's recommendation, an assessment must be made of the extent to which Swedish Cherry Hill, *with its proposed development and changes*, will address the goals and applicable policies under Education and Employability and Health in the Human Development Element of the Comprehensive Plan. SMC 23.69.032.E.3. This section requires a clear and definitive statement about how the existing medical center meets the goals, it requires a specific assessment of how the "proposed development and changes" will address the goals and policies in the Comprehensive Plan. The Final MIMP and FEIS fail to show, in specific and concrete detail, how the proposed expansion will address and contribute positively in the future to human development issues in the community.[6]

The vision statement of the Human Development Element is:

> The City of Seattle invests in people so that all families and individuals can meet their basic needs, share in our economic prosperity, and participate in building a safe, healthy, educated, just, and caring community.

Comp Plan at 9.3. There are 37 goals and policies that follow that vision statement. These goals and policies are broken down into four groups: Building Supportive Relationships within Families Neighborhoods & Communities, Food to Eat & a Roof Overhead; the Education & Job Skills to Lead an Independent Life; and Effective Disease Prevention, Access to Health Care, Physical & Mental Fitness for Everyone. SMC 23.69.032.E.3 focuses the assessment on the Education and Employability and Health sections of that element.

The Final MIMP includes an "Appendix C," which is titled "Consistency with City's Comprehensive Plan Goals and Policies." The table in Appendix C analyzes only nine goals and policies from the Human Development Element section. It is unclear why Appendix C only analyzes certain hand-picked goals and policies and omits others. In the Human Development Goals and Policies section of the Comprehensive Plan, there are at least 15 goals and policies in the Human Development Element section that speak to Education and Employability and Health.[7]

Overall, there are two predominant problems with the Final MIMP's assessment: (1) the content of the analysis is so vague that it is largely meaningless and (2) the analysis refers only to past and current activities – *i.e.*, actions that are already occurring with the existing sized facility and

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[6] Because the FEIS is yet another document that the Hearing Examiner and ultimately the City Council will rely on to inform the decision on the Final MIMP, I point out, in that context, where the FEIS lacks information necessary to make a decision on the MIMP. The FEIS discussion on Human Development element of the Comp Plan was inadequate and incorrect.

[7] If Swedish omitted the remaining six goals and policies because it believes that those goals or policies are inapplicable, that should have been explicitly stated in the table.

that will occur even if the MIMP is denied. I have attached to this letter a table that contains Washington CAN's detailed assessment of the applicable goals and policies in the Human Development Element and describes the extent to which the Final MIMP fails to adequately address each one of those goals and policies.

Some points to consider:

- "providing excellent care to the region" does not specifically address benefits to the neighborhood around Cherry Hill (Final MIMP Section C.12, p. 69).

- Swedish Medical Center claims it provided community benefit in 2013 of $143 million (MIMP Section C.12, p. 69). Setting aside the questionable inclusion of some activities as community benefits and the lack of transparency in how they are accounted for, it does not address explicitly how much of this system-wide benefit went to neighborhood schools, residents, etc. around Cherry Hill. Nor does it specify plans to increase donations and activities.

    - SMC should also address how it will offset the decline in charity care – according to the Washington Department of Health's annual data on the Cherry Hill campus, gross charity care dollars have declined from $32.9 million in 2013 to $17.9 million in 2014. Using the respective annual mark-up ratios, this is an estimated decline from $7.8 million to $4.8 million, or 38%, in charity care valued at cost.

    - The number of charity care patients declined from 856 in 2013, to 458 in 2014 (Swedish – Cherry Hill annual reports to WA DH).

- The claim that Swedish Cherry Hill volunteers provided 29,492 hours of service in 2012, does not clarify exactly 1) whether SMC paid for staff to do this work on staff-time, and 2) the specific allocation of volunteer hours or other services to organizations, schools and events in the neighborhood around Cherry Hill.

- In Part IV, B of DPD's report, it cites Swedish's work on reversing negative health trends in the "local population," and then Cherry Hill's work on various "community education" efforts. Swedish should report 1) how many Squire Park and other near neighbors take advantage of these classes, programs and screenings, and 2) which ones are actually free or offered at a financial loss to Swedish.

The Director's Report is inadequate in that it accepts Swedish's vague description and quantification of current and past activities that it claims to be community benefits without any scrutiny.

As mentioned above with respect to the public benefits, Swedish should be required to make concrete and specific promises to forgive medical debt and increase charity care access in the community so that its proposal is consistent with the Human Development element of the Comp Plan. They could offer specific programs to support neighbors of Swedish Cherry Hill who are

struggling with or facing foreclosure from huge medical bills that should be forgiven as charity care. They could make access to charity care and other financial assistance easier and more transparent. They could also include in the package some give back to the local schools. They could give generously to Bailey Gatzert Elementary and other local schools in need, supporting the next generation of potential Swedish-Providence staff. We request that the Examiner require that Swedish put together a package that contains concrete and specific promises for benefits for the local community consistent with the Human Development goals of the Comprehensive Plan.

E. The Rezone Criteria Have Not Been Met by the Swedish Proposal

Washington CAN requests that the Hearing Examiner deny the rezone proposed by Swedish Medical Center on the grounds that the proposal does not meet the criteria for approval of a rezone.

Generally, courts apply the following rules to rezone applications:

> (1) There is no presumption of validity of favoring the action of rezoning;
>
> (2) The proponents of the rezone have the burden of proof in demonstrating that conditions have changed since the original zoning; and
>
> (3) The rezone must bear a substantial relationship to the public health, safety, morals, or welfare.

Citizens for Mount Vernon v. City of Mount Vernon, 133 Wn.2d 861, 874-75, 947 P.2d 1208 (1997).[8] When a proposed rezone implements the policies of a Comprehensive Plan, the proponent is not required to demonstrate changed circumstances. *Bjarnson v. Kitsap County*, 78 Wn. App. 840, 845-46, 899 P.2d 1290 (1995).

The Seattle Municipal Code states that the most appropriate zone designation shall be that for which the provisions of designation of the zone type and the locational criteria for the specific zone match the characteristics of the area to be rezoned better than any other zone designation. SMC 23.34.008. The Code requires that the impact of more intensive zones on less intensive zones shall be minimized by the use of transitions or buffers, if possible. SMC 23.34.008.E.1. A gradual transition between zoning categories, including height limits, is preferred. *Id.* The evaluation of a proposed rezone shall consider the possible negative and positive impacts on the area proposed for rezone and its surroundings. SMC 23.34.008.

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[8] The Seattle Municipal Code states that "evidence of changed circumstances shall be taken into consideration in reviewing the proposed rezones, but is not required to demonstrate the appropriateness of a proposed rezone." SMC 23.34.008.G.

Among other things, the Code requires that the height limits be consistent with the type and scale of development intended for each zone classification and that they reinforce the natural topography of the area and its surroundings. SMC 23.34.009. The height limits established by current zoning shall be given consideration and any permitted height limits shall be compatible with the predominant height and scale of existing development. SMC 23.34.009.C. Height limits for an area shall be compatible with actual and zoned heights in surrounding areas.[9]

The section specifically concerning MIO districts requires that in addition to the general rezone criteria, the comments of the Citizen Advisory Committee shall be considered. SMC 23.34.124.

The Code states the following:

> Public purpose. The applicant shall submit a statement which documents the reasons the rezone is being requested, including a discussion of the public benefits *resulting from* the proposed expansion, the way in which the proposed expansion will serve the public purpose mission of the major institution, and the extent to which the proposed expansion may affect the livability of the surrounding neighborhood.

SMC 23.34.124.A (emphasis supplied).

The height limits proposed in the Final MIMP do not match the characteristics of the area to be rezoned. As mentioned above, the FEIS concluded that the height limits proposed in the Final MIMP will have significant adverse impacts on the surrounding area. With respect to service capacities, the FEIS concluded that the proposal would have significant adverse impacts on traffic and transportation in the area. With this project, the impact of the more intensive height of MIO 160 is not adequately minimized by the use of transitions or buffers. The majority CAC has recommended, generally, heights lower than 105 feet for the facility, with one small exception of 140 feet.

With respect to public benefit, as was explained above, the applicant has not adequately demonstrated what public benefits will *result specifically from* the proposed expansion.

For these reasons, Washington CAN requests denial of the proposed rezone.

F. Conclusion

Washington CAN requests that the Examiner recommend that the City Council deny the proposal outright for failure to meet the MIMP criteria. In the alternative, we ask that the Examiner recommend that any expansion be accompanied by specific, concrete, future

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[9] This section excludes buildings developed under major institution height limits, but it excludes them from being considered as the "actual and zoned heights" in relationship to the requested zone heights. In other words, the compatibility assessment does not include existing MIMP heights. SMC 23.34.009.D.1.

commitments to ensure that Swedish/Providence provides meaningful charity care and is responsive and accountable to the local community and its patients and workers.

In the alternative to denial, Washington CAN also requests that the Examiner recommend that the proposal size be reduced significantly to address the traffic impacts and the height, bulk, and scale impacts of the proposal. As explained above, significant negative impacts to the surrounding neighborhoods and community have not been adequately mitigated. The benefits to Swedish are extraordinarily high while the impacts to the local community are significant and adverse. The proposal is completely out of balance and must be changed significantly before it can be approved.

Thank you for your consideration of our comments.

Very truly yours,

BRICKLIN & NEWMAN, LLP

Claudia M. Newman

CMN:psc

Attachments:

Attachment A	Critique and Suggestions Around Human Development Goals in the Final EIS and Final MIMP (Jul. 13, 2015)
Attachment B	Letter from Ross Tilghman to Hearing Examiner Tanner (Jul. 9, 2015)

cc: Client

Critique and suggestions around Human Development Goals in the Final EIS and Final MIMP
July 13, 2015

Swedish needs to address the Cherry Hill campus specifically in its analysis of the *future* MIMP's consistency with Seattle's Comprehensive Plan Goals and Policies, Human Development Goals (HDG) 4, 4.5, 5 and 6. The following is a critique of the Swedish-Cherry Hill MIMP and the information provided in the Final EIS.

MI Goals and Policies	**Critique**
HDG 4	Swedish provides an analysis of what it has done in the past (and would occur even if the MIMP is denied). To make matters worse, the Final EIS contains a very vague description of its specific role and impact. Swedish does not address how it promotes an "excellent education system." Swedish should quantify data for classes offered and people taking them at Cherry Hill specifically in the past, and must provide a detailed summary of what Swedish will do as part of the expansion to improve these numbers and programs in order to meet this HDG. The Final MIMP provides descriptive data of the training of health care practitioners and researchers at both its First Hill and Cherry Hill campuses, with no specific quantitative details on the types of position trained or training hours. The MIMP states that 30% of downtown Seattle residents have a bachelor's degree or higher without specifying Swedish's own role in this specific demographic.
HDG 4.5	Swedish addresses 4 and 4.5 together in the EIS. It could do more by specifying funding and/or partnering goals with specific neighborhood schools around Cherry Hill (see below). For example, does it provide a full nurse at Madrona, or donate some supplies? Swedish does not address HDG 4.5 in the MIMP.
HDG 5	Swedish does not address HDG 5 in either the EIS or the MIMP. It could do so by specifying funding and partnering goals with existing nearby organizations, such as Casa Latina (see below).
HD 15	Swedish does not address HD 15 in the EIS. In the MIMP, Swedish describes a partnership with Ballard High School, something that residents around the Cherry Hill campus are unlikely to benefit from. Swedish should specify how programs at the Cherry Hill campus and/or contributions to nearby schools (such as Bailey Gatzert Elementary School) and organizations will support learning readiness for impacted neighbors and school-linked services.
HD 16	Swedish does not address HD 16 in the EIS or MIMP. Swedish could work with nearby Seattle Public Schools (such as Bailey Gatzert, Madrona K-8, and Garfield High School) to promote academic and personal achievement for all children, by contributing money and time for programs already in place, and/or facilitating a program like the one at Ballard High School which supports physical and mental health. The most current available data on Bailey Gatzert indicates that student achievement in reading, writing, math and science is well below District averages,

ATTACHMENT A

	and student's year-to-year growth is also relatively weak in math and reading.[1] Swedish could also promote service-learning and volunteering that exposes youth to healthcare careers and opportunities. The Draft MIMP must specify specific plans and goals in these areas.
HD 17	Swedish does not address HD 17 in the EIS or MIMP. Similar to HD 16, Swedish could use such programs to build relationships with Squire Park/nearby neighborhood groups and schools, and to promote healthcare opportunities that inspire youth to continue their education. The Central Area Youth Association (CAYA) would be a potential partner, especially with their computer classes and emerging healthcare phone apps and information technology. The Draft MIMP must specify specific plans and goals in these areas.
HD 18	Swedish does not address HD 18 in the EIS or MIMP. Given the diverse population in the vicinity of the Cherry Hill campus, it could provide space on campus for literacy and English for Language Learners (ELL) programs. Bailey Gatzert Elementary School's population includes 40% English Language Learners, well above the District average[2] and a signal that many adults in the area are also ELL. Casa Latina is nearby – it is a worker center and educational non-profit that already has programs to help immigrants learn English and navigate their new communities ("community literacy" workshops). Entre Hermanos is also nearby, and would be a good partner in helping LGBTQ Latinos. Swedish could provide funding for programs and participate in workshops to promote their charity care, and to hear from the community about patients' needs for linguistically- and culturally-appropriate care. The Draft MIMP must specify specific plans and goals in these areas.
HD 19	Swedish does not address how it works with community colleges, universities and other institutions of higher learning (it notes that it is located next to Seattle University). It should specify how the Cherry Hill expansion will promote life-long learning opportunities for community members. Also it should specify how this expansion will "encourage the broadest possible use of libraries, community centers, schools, and other existing facilities throughout the city, focusing on the development of these resources in urban villages areas." The MIMP does not address HD 19.
HD 20	Swedish's RN Residency Program with a Learning Center to be located on the Cherry Hill campus is a good example of this policy. However, Swedish should also address how it might address HD20 for Squire Park community members. In the MIMP, Swedish refers to its Community Health Needs Assessment (CHNA), which is now required by the Patient Protection and Affordable Care Act (ACA), and a plan to prioritize needs around each campus. There is nothing explicitly in the CHNA about HD20 – it is all about health needs. Moreover, Swedish has a

[1] Bailey Gatzert Elementary School Report the 2013-2014 School Year. Downloaded June 26, 2015 from: http://sps.ss8.sharpschool.com/cms/One.aspx?pageId=15709&portalId=627&objectId.26153=305196&contextId.26153=304696&parentId.26153=304697. While Madrona K-8 public school is not in the Squire Park neighborhood, its attendance area includes the northern part of Squire Park. Its student achievement (3rd-8th grades) and growth (3rd-8th grade, math) scores are also well below District averages. 2013-2014 report downloaded June 26, 2015. http://www.seattleschools.org/modules/cms/pages.phtml?sessionid=7620e8782e4ba82e981b60a1cd256227&pageid=222659&sessionid&sessionid=7620e8782e4ba82e981b60a1cd256227

[2] IBID.

	combined CHNA for its First Hill and Cherry Hill campuses, which yet again does not enable an analysis of how any programs specifically benefit Cherry Hill neighbors currently and in the future.
Health	
HDG 6	Again, Swedish provides vague narrative about serving "the community" The community benefit numbers and charity care numbers are system-wide, not Cherry Hill specific. Moreover, Swedish should address how it plans to offset declines in charity care due to Medicaid expansion. See below for more suggestions on specific actions it could take in the future to address the policies, especially affordable health care, under HDG 6.
HD 21	In the EIS, The programs and partnerships should be limited to Cherry Hill for an accurate assessment of how this campus meets the needs of neighbors. The information in the EIS is inadequate for the H.E. to rely on to make a decision. In public meetings, neighbors have noted that many of Swedish's free health education and promotion classes do not happen on the Cherry Hill campus. For example, on the list provided, Global to Local (Tukwila area) and the Ballard teen program are included. It is unclear where the remaining services are offered – given that a quick scan of classes in 4 areas found few at Cherry Hill, this should be specifically addressed. Swedish should also clarify if any of these programs will change with campus expansion and possible shifting of services across its campuses
HD 22	Swedish should specify which outreach, classes and support groups are offered on the Cherry Hill campus, how frequently, as a proportion of all Swedish campuses, and include attendance (by zip code of attendee if possible) and outreach efforts. Most importantly, Swedish should specify how/if the new MIMP will allow for the same or more educational offerings at the Cherry Hill campus. For example, none of the, none of the monthly pre-diabetes classes are offered at Cherry Hill through June 2015, none of the Women's Health classes are offered at Cherry Hill through October 2015, and none of the cancer classes are offered at Cherry Hill through October 2015.[3] If no one is attending the classes that are offered at Cherry Hill, Swedish should work with the community, such as the United Black Christian Clergy, to 1) develop better outreach, 2) develop better implementation and evaluation of classes, and/or 3) offer classes that are responsive to community requests. Swedish does not specify if nearby neighbors who are low-income and/or people of color are accessing free education and support groups. Moreover, HD 22 is about the reduction of health risks and behaviors, which emerging research shows is related to social determinants of health: the neighborhood and built environment, economic stability, education, and social and community context.[4] Factors that Swedish should address here include but are not

[3] Swedish events calendar searched June 26, 2015. Previously, the Swedish events calendar was searched March 28, 2015 – none of the following were offered at Cherry Hill: weight loss seminars and health weight classes through the end of 2015, monthly pre-diabetes classes through June 2015, Women's Health classes through October 2015, and cancer classes through October 2015. The calendar showed results through June 2015 for diabetes, through December 2015 for weight loss, and through October 2015 for women's health and cancer. Since March, the calendar now shows that 2 weight loss classes will be offered at Cherry Hill.
https://www.eventsvc.com/swedishhealth/?hideregclosed=1

[4] http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39

	limited to: how the expansion of the Cherry Hill campus will affect the safety for walkers and bicyclists in the neighborhood; how/if Cherry Hill will promote access to educational, economic and job opportunities; how Cherry Hill can support transportation options, public safety, and more.
HD 23	Swedish should address the impacts of increased traffic on the environment in the Cherry Hill neighborhood, and how its development will support or discourage walking, bicycling and other forms of outdoors exercise in the neighborhood. (Swedish omits 23c, which relates to development that promotes physical activities.)
HD 24	From the EIS, Swedish should specify precisely how it invests in programs and services at Cherry Hill and in Squire Park and how much in charity care (at estimated cost) the Cherry Hill campus provides, and if possible report this by zip code of patient. The Global to Local program does not benefit neighbors. Should Swedish Medical Center take credit for programs funded through the Swedish Medical Center Foundation? Doesn't the Foundation raise a significant amount of money independently? How much money does SMC donate to the Foundation? How much of this could be allocated from the Cherry Hill campus budget? Swedish should also address how it will continue to improve access to care with the ACA and Medicaid expansion reducing the number of uninsured patients, and having unknown effect on underinsured patients. Swedish should detail a plan for helping patients with large co-insurance and out-of-pocket costs, as well as current or future medical debt. See notes below on challenges with charity care. Swedish Cherry Hill's provision of healthcare to patients of all ages and economic status does not address how/if it coordinates service delivery. Swedish should discuss its plans to promote access to healthcare, and specifically charity care, by collaborating with neighborhood organizations (such as Casa Latina) and schools.
HD 24.5	Swedish discusses its partnership with Country Doctor Community Health Center on the Cherry Hill campus. Does Swedish provide staff hours? Subsidize space? Swedish does not address 24.5 in the MIMP.
HD 25	Swedish does not address HD 25 in the EIS. In the MIMP, Swedish is again vague: Swedish should specify the current and future programs and financial contributions attributable to the Cherry Hill campus and/or accessible by those neighbors. The Global to Local program does not benefit neighbors.

**94% of students at Bailey Gatzert qualify for free/reduced lunch. 61% of students at Madrona K-8 qualify.

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ATTACHMENT STRICKEN FROM RECORD

TILGHMAN GROUP
TRANSPORTATION PLANNING

8 July 2015

Sue Tanner
City of Seattle Hearing Examiner
700 Fifth Avenue
Suite 4000
Seattle, WA 98104

re: Swedish Cherry Hill MIMP

Dear Examiner Tanner:

This letter discusses the adequacy of mitigation for the proposed expansion of the Swedish Cherry Hill medical campus and argues that, absent more aggressive measures, the project is simply too large for its neighborhood. In preparing this letter I have reviewed the final MIMP, the project's FEIS transportation section, and DPD's Director's Report, among other documents.

1. **The proposed Transportation Management Plan (TMP) is not sufficiently aggressive at the outset, and its conditioned target may not be achievable.** Swedish Cherry Hill currently has 56% - 58% (the FEIS and MIMP report slightly different rates) of its employees commuting by single occupant vehicles (SOV). Consequently, it fails to meet Seattle's code-minimum requirement of no more than 50% SOV, and it falls far short of the performance at other major institutions including Seattle University and Seattle Children's hospital. While the Director's Report supports the CAC recommendation for an eventual 38% SOV rate, it gives Swedish Cherry Hill ***25 years*** to reach that level. By comparison, Seattle Children's achieved that level of performance prior to its recently approved expansion. And it did so with measures far more aggressive than those outlined in the MIMP's TMP, including operating a sophisticated shuttle system.

   Indeed, Swedish Cherry Hill has a long way to go to achieve lower SOV rates. Swedish Cherry Hill has failed to reduce employee driving for many years, and staff could not provide explanations for why its current TMP fails to perform better. The MIMP and DPD's Director's Report outline additional TMP measures to encourage commuting alternatives but the effectiveness of those measures is not known and cannot be known without data regarding employee's transportation needs. For example, for how many employees is transit a realistic option? For how many is a carpool or vanpool realistic? To what extent is the site's location away from transit hubs an impediment to less driving? What transit and/or shuttle capacity would be required to meet the 38% SOV goal?

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ATTACHMENT B

Swedish and the City should evaluate whether significant reductions can actually be achieved, and whether they can be reached in less than 25 years. If not, a smaller project should be identified such that it would not create any LOS F conditions.

2. **The analysis of transit capacity is misleading and the recommendation to increase transit subsidies overlooks the problem of limited transit service in this neighborhood.**

Decision makers rely on the FEIS' examination of transit capacity and its report that substantial excess capacity exists on routes serving the campus. It reports that only about 30% to 45% of capacity is used in morning and afternoon peak periods. That picture, however, is deeply misleading. It is misleading because the reported capacity counts buses regardless of direction, whereas Swedish Cherry Hill trips go strongly in one direction. Therefore, the question of transit capacity must be considered in light of the directional distribution of Swedish Cherry Hill trips. Even though buses in the opposite direction might have surplus capacity, that capacity is not effectively available to Swedish Cherry Hill staff.

The trip distribution for transit riders would be similar to that of employees in cars. The FEIS assumes that only 15% of trips occur to and from the east. Thus, the majority (85%) of transit demand travels primarily to and from the west. Riding the bus east of Cherry Hill allows only one connection to another route. Even if seats are available, few employees could use them since few travel that direction.

The FEIS does not reveal that Metro reports (2014 Service Guidelines Report, Appendix E) that Routes 3/4 (which operate together sharing the majority of the route) experience a load factor of 1.44 in the peak period and 1.24 in the off-peak between the Central District and Downtown. That means that there are 1.44 passengers for every seat on the bus throughout the peak period (3 hours), so it's standing room only. And that's true of the off-peak period, too, when there are 1.24 passengers per seat. Load factors above 1.50 indicate very crowded conditions. Thus, there is little extra capacity for new riders. I estimate that by 2023, the project's extra riders would increase peak hour load factors to 1.65 passengers per seat on buses headed west of the campus (the peak hour is used since the EIS provided peak hour trip information, not peak period). Those routes already operate at high frequencies using trolley buses, so are unlikely to add capacity readily. The other routes near campus are express routes heading to places such as Wedgewood, Federal Way and Shoreline, destinations that may not serve many Swedish employees, even if those routes have seats available.

Of the six area routes that will continue to operate in future years, only one, Route 3, provides service throughout the day past the campus. Three routes are express routes operating in peak periods only. Two other routes operate on streets about one-half mile from campus. In short, the campus has limited transit service considering hours of service, convenient access and route choice. Such limited transit access and service is inadequate to support a major institution that employs thousands of people needing transit service over many different hours to many different destinations. That the campus lies outside of an urban village means that it is never likely to get the level of transit service necessary to meet its employees' and visitors' needs.

The Director's Report recommends that Swedish Cherry Hill increase transit subsidies to 100% until the institution achieves a 50% SOV rate, after which it could reduce the subsidy. While the small difference in cost savings to employees may encourage some to switch to transit, the condition overlooks the problem of transit capacity and availability. Indeed, as I have noted previously, Swedish does not know why it falls short of meeting the 50% SOV rate now. One reason might be that transit simply doesn't work well for many of its employees due to factors including: overfull Park & Ride lots regionally; poor schedule reliability so that riders may not get to work on time or are forced to start their trips much earlier than they prefer; too many transfers to make the trip attractive and reliable; or too little access to transit where they live, not to mention limited route choices at the campus. Simply requiring a full subsidy may have little influence on use of transit.

If Swedish Cherry Hill is allowed to expand, it should be required to provide more transit capacity to campus and more connections between the campus and major transit hubs.

3. **The proposed MIMP creates unacceptable traffic impacts that are not mitigated.** Four intersections near campus fall to LOS F as a result of the MIMP: 13th/Cherry; 15th/Cherry; 16th/Cherry and 14th/Jefferson. Mitigation is proposed for only two of those intersections. For the other two (13th/Cherry and 15th/Cherry), the recommendation is for residents to shift to other less congested intersections. That is not appropriate mitigation, especially for a residential neighborhood.

   The problem is that the residents bear a disproportionate burden at those intersections. Stop signs control traffic on the north/south residential streets, while traffic on Cherry Street does not stop. Swedish Cherry Hill adds traffic to Cherry Street causing longer delays to cars on 13th and 15th. Those delays increase to LOS F conditions with the MIMP, with only 13th facing LOS F in 2023, and all four intersections facing LOS F by 2040. It's important to note that under No Build conditions, no LOS F results occur. Thus, the medical campus gets the benefit of driving along Cherry and Jefferson, but residents face long delays because of that added traffic.

   The suggestion that residents can simply use a different intersection to avoid such long delay ignores the frustration such changes cause to neighbors, and ignores the impact on other residential streets of diverting traffic to them. The EIS clearly hesitated to consider proposing signals at each intersection. Apart from whether new signals would meet applicable signal warrants, the addition of multiple signals would further indicate that the neighborhood is transitioning from a residential to a more commercial/institutional area.

   Additionally, the project adds the majority of its traffic to the already highly congested James Street corridor, west of Broadway. While the FEIS reports that travel speeds would decrease, the magnitude of the change may not be fully understood by many readers. This chart attempts to clarify the degree that travel speeds decline due to the project:

Travel Time in 2023

AM Peak Hour	Direction	No Build (mm:ss)	Alt. 8 2023 (mm:ss)	Change	% Difference
James St. (6th Ave to Broadway)	EB	4:12	4:14	0:02	1%
	WB	3:31	3:45	0:14	7%
E. Cherry Street (Broadway to 23rd Ave)	EB	4:19	4:13	-0:06	-2%
	WB	2:59	3:01	0:02	1%
PM Peak Hour					
James St. (6th Ave to Broadway)	EB	4:11	4:11	0:00	0%
	WB	6:30	7:32	1:02	16%
E. Cherry Street (Broadway to 23rd Ave)	EB	1:51	1:51	0:00	0%
	WB	3:10	3:29	0:19	10%

Travel Time in 2040

AM Peak Hour	Direction	No Build (mm:ss)	Alt. 8 2040 (mm:ss)	Change	% Difference
James St. (6th Ave to Broadway)	EB	4:24	4:23	-0:01	-0.4%
	WB	3:34	4:11	0:37	17%
E. Cherry Street (Broadway to 23rd Ave)	EB	4:09	4:13	0:04	2%
	WB	2:53	3:04	0:11	6%
PM Peak Hour					
James St. (6th Ave to Broadway)	EB	4:11	4:13	0:02	1%
	WB	5:52	9:06	3:14	55%
E. Cherry Street (Broadway to 23rd Ave)	EB	1:51	1:52	0:01	1%
	WB	3:11	3:39	0:28	15%

Source: FEIS C-85, Table 11; Tilghman Group

The increase in PM peak hour travel time on James Street, westbound in 2040 (highlighted above) is profound: the project's traffic would increase travel time for all users on this segment by 55%. Travel speeds would be reduced to walking speed.

The FEIS also showed the effect of a 38% SOV rate on travel times, noting that 1 minute would be saved on James Street, westbound in the PM Peak Hour in 2040. That still results in a 38% increase in travel time for all users on that segment, a significant increase to an already highly congested corridor.

A more appropriate approach to mitigate the impacts to residents would be to consider reducing the amount of project traffic so as to avoid creating LOS F conditions, and to avoid increasing James Street travel times by more than 15%. Clearly, the volume by 2023 begins to reach the limit of residential intersection capacity, and is slightly beyond the 15% increase on James Street. That 2023 volume allows for approximately a 50% net increase in trips over the No Build alternative. Beyond that level, residents will experience increasingly unacceptable delays.

In conclusion, the MIMP has not provided decision makers with the clarity needed to evaluate the impacts of such a large project on the surrounding residential neighborhood. It fails to inform them about the feasibility of meeting new TMP goals. It misleads them regarding available transit capacity. And it fails to consider methods to avoid LOS F conditions that disproportionately affect residents.

Sincerely,

Ross Tilghman

Tilghman Group
4618 44th Ave South
Seattle, Washington 98118
Voice & Fax: 206-577-6953

7/21/2015

Dear H. E. Tanner,

I moved to Seattle in 2011 to create a better life for myself than what I grew up with. I knew as soon as I set my feet on Seattle ground, that this was home for me. Its rich cultural diversity, welcoming community, and historic architecture make for a truly unique environment that needs to be fought for. I found my home in a beautiful 113 year old craftsman home. This picturesque home is located directly behind Swedish Hospital.

Unfortunately, I've had growing cause to be fearful for this hard-won lifestyle. In the past four years, I've seen Seattle change rapidly. Bit by bit, another historic gem is torn down and replaced with pricey but cheaply built condos filled with people who have no regard for the culture and the community around them. This change in population is pushing out those who make up the vibrant Seattle culture and whitewashing the diversity.

Sabey Corporation is becoming a part of this problem. With the proposed additions to the Hospital, a beautiful and historic neighborhood will be greatly diminished. The construction alone will cause major disruption. Sleeping babies will be disturbed with jackhammers, migraines will worsen for our neighbors who have medical conditions, and dust will become a major issue for yards, houses, and asthma.

Traffic has been a growing concern with those trying to commute to and around the hospital. This neighborhood does not have the infrastructure to support the 3000 extra cars trying to access the new garage. The road re-development, crosswalks, and additional traffic lights will only cost the city and ultimately, the taxpayer to catch up to this sudden change. This is Seattle's oldest residential neighborhood, not an urban center. It is simply not built to accommodate this. The children who love playing outside will be put into unnecessary danger with such a major traffic increase.

Swedish Hospital's plan does not serve the neighborhood in any way. Their expansion is centered around building large private rooms for their wealthy patients and investors and research labs that can and should be somewhere else.

Thanks to your diligence in thoroughly investigating this matter. I'm aware that little to none of this information is new to you at this point. However, I do urge you to take a look at the entire livelihoods being effected in such directly invasive ways. Please carefully consider how staggering the evidence against this expansion is. The repercussions are overwhelming and the benefits are nearly non-existent to a community that can't afford those private waiting rooms. Sabey is only looking out for their bottom line. Reject this plan. Tell Sabey to be a good neighbor.

Thank you for your careful consideration,

Courtney McBride

529 19th Ave
Seattle, Wa, 98122

Additional Written Testimony of Dean Paton
Sent to the Hearing Examiner on Tuesday, July 21, 2015

Dear Examiner Tanner:

I had never been through this public-hearing process before; and I came away in awe of the overwhelming mountain of evidence you've been presented with. At the risk, then, of earning your lifelong enmity, I would like to add a couple more pages to your mountain, things I would have said if public testimony had been unlimited.

For the first point to be effective, may remind you of my profession: I'm a reporter, a journalist. For almost 16 years I've been Seattle Correspondent for The Christian Science Monitor, and since 1994 I've worked as a medical writer in Seattle, and for all of the major medical institutions with exception, ironically, of Swedish. As a reporter, I have to be assiduous with facts and data. One can't be otherwise and continue working for a newspaper with the credibility of The Monitor.

In 2007 and 2008, while researching the concepts for successive corporate annual reports I wrote for Group Health Cooperative, I came upon white papers from not only the US Centers for Disease Control in Atlanta (CDC) but also two US Congressional committees charged with solving the nation's health care crisis. The researchers for the CDC as well as the Congress all said the same thing: The main problem driving out-of-control health care costs in the country is the dominant business paradigm, customarily called fee for service. I suspect you know much of this, but, for the record, the problem with fee-for-service medicine is that its incentive is to increase profits—by doing more: more costly imaging, more surgeries, more buildings, more, more, and still more. Because the more procedures this model of medicine can proffer, the greater the profits of the institutions as well as the physicians practicing in this manner. Once upon a time, this model worked well enough, but that was before technologies and insurers made health care so expensive. A once-okay model is now the problem.

The solution, according to the CDC, the US Congress, and also public-health professionals at institutions such as Harvard University, John Hopkins University, and the American Public Health Association, is a different business model. In fact, the CDC points out, this model is already in practice in several places across the United States: Geisinger Health System in Pennsylvania; Mayo Clinic in Minnesota; Intermountain Healthcare in parts of Colorado and the Southwest; Kaiser Permanente in California and Oregon; and, of course,

Dr. Lewis had inadvertently been too candid. There are excess profits to be made in this kind of "boutique" medicine, where the wealthy ill fly to "world class" institutes for personalized treatments.

To be equitable about this, Harborview, the University of Washington, and Virginia Mason also are looking for ways to bring in wealthy patients for boutique treatments. But one key difference is that Harborview, the UW, and VM aren't seeking out-of-scale expansions into fragile low-rise neighborhoods. A second is that, without some patients with good insurance, Harborview cannot possibly care for the army of people with no insurance. This inability to care for our poor and homeless, a key mission at HMC, ought to be a primary concern for the city, the county, the state, and the entire WWAMI Region (Washington, Wyoming, Alaska, Montana and Idaho—the Harborview service area). The way to success in boutique medicine is to market the institution as unique and "world class," which is precisely the case Swedish physicians tried to promote last week, with scant evidence. The UW system has years of evidence and pounds of documents supporting their established and proven world-class status.

As I, along with Dr. Aleeta Van Petten and others, pointed out, Swedish is hardly unique, and certainly not yet world class. Seems clear to me Swedish had not one quam about wrecking the Central District in its quest to call itself "world class" and reap the profits such marketing can produce.

I'll conclude with what, for me, is the most important outcome at stake today. And I'll do so with another story:

If there was a single most shocking moment during the almost two years I was on the CAC, it was the evening the representative from the Department of Planning and Development announced that DPD had essentially recommended that the city grant Swedish and Sabey all they had demanded.

As she read through the DPD report, point by point, you could feel the energy in the room turn upside down. There were quiet gasps from around the table. CAC members would look around at each other and make eye contact—that kind of eye contact you make quietly, when you have to check with others to make sure what you're hearing—is really what you're hearing.

After the meeting, neighbors as well as a lot of us CAC members were shaking our heads and rolling their eyes in disbelief. How could DPD do that—when it was obvious to most of us—and I mean all but a couple of CAC members—

Thank you very much for your time.

Dean Paton
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Testimony of Dean Paton
733 16th Avenue at East Columbia
Before the Hearing Examiner
July 16, 2015

Twenty-four years ago today I bought my home, one block north of Swedish Cherry Hill. For more than 35 years I have worked as a magazine journalist, and also as a medical writer in Seattle, and have consulted with all of the major medical centers—except Swedish. Since 1999 have been Seattle Correspondent for The Christian Science Monitor. I joined the CAC in 2013.

When people in Seattle ask where I'm from, my standard answer is: "I was born at Swedish Hospital.

In 2007, I had a life-threatening medical emergency, the paramedics showed up in less than 90 seconds, and took me to the emergency room at Swedish Cherry Hill, less than two blocks from my front door.

The physicians and staff there saved my life.

So I came this process with a soft spot for Swedish. I am one of those people, like Brianne Cassidy, Phillip See, and the others who testified earlier this week to the high quality of care we've received at Swedish Cherry Hill.

With all due respect to the admiration all of those patients feel for the dedicated physicians and staff who may well have saved their lives, their experiences with health care have absolutely nothing to do with the essence of why we're here today.

And that is: What the applicant wants—their MIMP—cannot ALL be accommodated at Cherry Hill Campus without irreparably harming the livability of the surrounding low-rise, NON-URBAN VILLAGE neighborhood. It simply can't.

Please don't interpret this as a knock on the quality of care. But understand that the testimony we've heard from the Swedish physicians was delivered with the kind of pride and loyalty one would expect from just about any physician from just about any medical center in Seattle. They all think they are "world class." And that's a good thing.

Additional Written Testimony of Dean Paton
Sent to the Hearing Examiner on Tuesday, July 21, 2015

Dear Examiner Tanner:

I had never been through this public-hearing process before; and I came away in awe of the overwhelming mountain of evidence you've been presented with. At the risk, then, of earning your lifelong enmity, I would like to add a couple more pages to your mountain, things I would have said if public testimony had been unlimited.

For the first point to be effective, may remind you of my profession: I'm a reporter, a journalist. For almost 16 years I've been Seattle Correspondent for The Christian Science Monitor, and since 1994 I've worked as a medical writer in Seattle, and for all of the major medical institutions with exception, ironically, of Swedish. As a reporter, I have to be assiduous with facts and data. One can't be otherwise and continue working for a newspaper with the credibility of The Monitor.

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The solution, according to the CDC, the US Congress, and also public-health professionals at institutions such as Harvard University, John Hopkins University, and the American Public Health Association, is a different business model. In fact, the CDC points out, this model is already in practice in several places across the United States: Geisinger Health System in Pennsylvania; Mayo Clinic in Minnesota; Intermountain Healthcare in parts of Colorado and the Southwest; Kaiser Permanente in California and Oregon; and, of course,

Group Health in Washington state. Such models work to control costs by putting both the medical and the insurance functions under the control of a single organization. When that happens, the incentive to "do more" goes away. Runaway costs are better contained.

At a meeting this spring of the Citizens Advisory Committee, I told the CAC that Swedish really *did* need all of the space it was asking for. People were a bit taken aback, because by this time I had emerged as the most vocal critic of Alternative 12.

"Swedish needs all of this space," I said (and I'm paraphrasing myself now). "It needs this height, bulk and scale because its fee-for-service business model demands more of everything—more space, more doctors, more technology—because that's all it knows how to do. Grow. Expand. Build profits."
I went on to say that if we, the Citizens Advisory Committee, decide to give Swedish the heights, bulk and scale it's wanting, we will be fostering everything wrong with the American health-care system. And that, along with contributing to the destruction to the Central District neighborhood, the CAC will be endorsing and enabling most of what has gone terribly wrong with the country's health-care.

I didn't have time to make this point this during the hearing, and I will likely bring it up in any City Council hearings, but I wanted to mention it to you as well. It may not be within the statutory scope of the Citizens Advisory Council, but I do think it within the scope of what an informed Seattleite might consider her or his duties.

I see it as an ancillary reason to deny Swedish its Alternative 12.

The first meeting of the CAC I attended was in June 2013. I had not been officially appointed yet, but I wanted to see how things worked. At that meeting, Dr. Rayburn Lewis, who was Chief Operating Officer for Swedish Cherry Hill at the time, spoke. At one point he said (and again I'm paraphrasing), "This expansion will allow us to bring patients in from the Middle East (he might have said Dubai) for these specialized treatments."

There was a pause. He and I—and maybe others in the room—realized he hadn't meant to speak those words publicly. Quickly, he added, "Oh, and those same treatments will be available for you, too, right here in the neighborhood."

Dr. Lewis had inadvertently been too candid. There are excess profits to be made in this kind of "boutique" medicine, where the wealthy ill fly to "world class" institutes for personalized treatments.

To be equitable about this, Harborview, the University of Washington, and Virginia Mason also are looking for ways to bring in wealthy patients for boutique treatments. But one key difference is that Harborview, the UW, and VM aren't seeking out-of-scale expansions into fragile low-rise neighborhoods. A second is that, without some patients with good insurance, Harborview cannot possibly care for the army of people with no insurance. This inability to care for our poor and homeless, a key mission at HMC, ought to be a primary concern for the city, the county, the state, and the entire WWAMI Region (Washington, Wyoming, Alaska, Montana and Idaho—the Harborview service area). The way to success in boutique medicine is to market the institution as unique and "world class," which is precisely the case Swedish physicians tried to promote last week, with scant evidence. The UW system has years of evidence and pounds of documents supporting their established and proven world-class status.

As I, along with Dr. Aleeta Van Petten and others, pointed out, Swedish is hardly unique, and certainly not yet world class. Seems clear to me Swedish had not one quam about wrecking the Central District in its quest to call itself "world class" and reap the profits such marketing can produce.

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If there was a single most shocking moment during the almost two years I was on the CAC, it was the evening the representative from the Department of Planning and Development announced that DPD had essentially recommended that the city grant Swedish and Sabey all they had demanded.

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After the meeting, neighbors as well as a lot of us CAC members were shaking our heads and rolling their eyes in disbelief. How could DPD do that—when it was obvious to most of us—and I mean all but a couple of CAC members—

that this MIMP as written couldn't possibly fly, was vastly out of scale, and was such a flagrant violation of the city's codes, statutes, and sensibilities?

From that moment onward, there was a new cynicism at CAC meetings. Neighbors threw around wild charge: The process was fixed. Swedish somehow "got" to DPD. The whole process was rigged.

And—there's no evidence for any of those wild concoctions. DPD just did what it does, and now we're here at the hearing stage.

But my point is, when a decision is made that makes zero logical sense, people lose faith. They lose trust. They give up and quit participating.

In the case of the Swedish MIMP, I believe there has been an overwhelming case for sending this MIMP back for drastic revision and re-conceptualizing. The CAC thinks so. And every one of the surrounding neighbors who testified in person at the 30-plus meetings thinks so. Every single one. Not a single neighbor who testified in any of those public sessions supported any version of this MIMP.

What I want to say now, your honor, is that your decision can either fan flames of public cynicism, or inspire hundreds of people who have believed in this process—to continue believing in the idea of democracy. In staying engaged participants in the world they live in.

Of all the "isms"—communism, fascism, socialism—none is worse for society than cynicism. Nothing fosters healthy democracy than participation of the public on a large scale.

I believe that if you uphold the recommendations of the Department of Planning and Development, the result will not just be the slow devastation of the neighborhoods surrounding Swedish Cherry Hill, but it will foster even more cynicism than we already struggle against in today's world.

I hope you are able to see past the parade of off-the-point testimonials, past the $400-an-hour attorneys and their endless briefs, past the paid-for "experts"—on both sides—whose testimony will only show which side has the biggest budget for smoke and mirrors.

I hope you'll find in favor of the low-rise neighborhoods surrounding the Cherry Hill Campus—and for the very idea of democracy, right here in Seattle.

Thank you very much for your time.

Dean Paton
Citizens Advisory Council Member
733 16th Avenue
Seattle, WA 98122
206-323-1263
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Testimony of Dean Paton
733 16th Avenue at East Columbia
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Please don't interpret this as a knock on the quality of care. But understand that the testimony we've heard from the Swedish physicians was delivered with the kind of pride and loyalty one would expect from just about any physician from just about any medical center in Seattle. They all think they are "world class." And that's a good thing.

Specialized hospitals are the future. Yes, indeed. And, in Seattle, what Swedish talks about creating already exists. The University of Washington Neurosciences Department is titanic in relation to the Neurosciences Institute at Swedish Cherry Hill. The UW dwarfs Swedish not only in numbers of talented physicians, but in terms of research, prestigious federal grants, and scope of treatments offered. The difference between the quantifiable "world class" qualities of the neurosurgeons and other neuroscientists at the UW—and the aspirations to one day be "world class" by the folks at Swedish, are extreme and quantifiable.

No one is against quality health care. But a lot of us came to see this MIMP as simply too much – in terms of height, bulk, scale and impact on the surrounding low-rise neighborhood.

That no one is against quality health is important to keep in mind when one considers the results of that survey, commissioned by the applicant, and presented to at this hearing on Monday.

If the surveyors had called me, or you, or anyone in this room, I'm willing to bet that every one of us would have been in favor of a better Swedish Medical Center…in favor or better access to care at Swedish…in favor of the good doctors there having state-of-the-art technology. Sounds good to me.

But if we take any of those 200 nearby neighbors and put them on the CAC, or bring them to ten, fifteen, twenty meetings of the CAC and expose them to the mountain of material with which the committee was presented, I'd have to say it would be virtually impossible for their glowing survey answers not to change.

Compared to the members of the CAC, and even compared to the many neighbors who came month after month to the CAC meetings, those 600 people surveyed know practically nothing. In my opinion, I'd put the value of that survey somewhere less than zero.

I'll shift gears now:

Katie Porter, the CAC chair, mentioned how contentious this entire CAC process was.

I want to illustrate this with a quick story:

Near the conclusion of the CAC process, I think it accurate to say that I emerged as the most outspoken critic of the MIMP. (I know, somebody had to do it.) But then the CAC finished its work, and we were done. It was a relief. In May I took a car trip down the Pacific-ocean coast and back, and on the way back I checked my email.

There was a message from Wayne Barnett of the city's Ethics and Elections Commission, informing me that the ethics violation charge against me had been dismissed.

What ethics violation? I tried contacting Mr. Barnett, but he didn't respond. So I called Steve Sheppard of the Department of Neighborhoods, and he informed me that agents of Swedish had charged me with an official ethics violation. Turns out I was seen talking with someone during or after one of the meetings who turned out to be an attorney representing Washington CAN. And, four days after our final CAC meeting, Swedish moved to have me disqualified from this process.

In fact, the Ethics and Elections Commission found that I was doing precisely what I was supposed to be doing as a CAC member—talking with people.

The letter from the Ethics and Elections Commission states, in part, "By opposing the MIMP as a member of the CAC—by submitting a Minority Report—and in his individual capacity—by filing an appeal with the Hearing Examiner—Mr. Paton did not violate the Ethics Code." The letter essentially slammed Swedish.

This is just one example of what the applicants are willing to do to gain unfair advantage. They were either unable or unwilling to answer my questions or address my assertions in the official CAC meetings – so they sought to impugn my integrity and disqualify me—so I would never be able to appear here today.

I submit a copy of the letter from city's Ethics Officer dismissing the complaint filed against me by Swedish.

You can see why I lost the "soft spot" I had for the institution that brought me into the world and then saved my life in 2007.

• • •

Finally, in 1994 Swedish sold 40 percent of its Cherry Hill Campus to the Sabey Corporation for $13 million. At the time Marcel Loh, Swedish's Chief Operating Officer, said the space was not needed and that the move was "right-sizing" the campus.

Sabey Corporation rolled out plans to create a shiny new biotech center at its new holdings—which, by the way, was never an approved use for the campus. Nonetheless, the biotech center never materialized. I'd like to submit three articles for the record: one from The Seattle Times, one from the Puget Sound Business Journal, and from written by a employee of the Sabey Corporation.

If Swedish had not sold off 40 percent of its Cherry Hill Campus, we would not be arguing over the need to shoehorn too many services and way too much square footage onto the campus today.

Some of us on the CAC, and many in the surrounding community, believe the neighborhood should not be penalized for the less-than-visionary future projections Swedish made in 1994.

That 40 percent that Swedish owns? That's really where many of the services called for in this MIMP should properly be put.

Instead, we have a for-profit corporations—a landlord—entrepreneurially benefiting under cover of Swedish's standing as a Major Institution.

And the result is the contentious process in which Swedish and Sabey are asking you to approve a MIMP where the heights, bulk, scale and impacts on the neighborhood are unacceptable.

If they really want that approval, I would suggest—in all seriousness—that they compensate the several hundred homeowners in the surrounding neighborhood that will see their quality of life degrade and their property values decline. $500,00 per household might be a reasonable place to begin these negotiations.

I know: This might sound absurd. But it's not, really. It's not to the neighborhood, which will be transformed for the worse. And not to those hundreds of folks who will have to live with the gridlock and the increased noise. And it should not sound absurd even to hard-boiled business entities, such as Swedish and Sabey Corporation, where they understand the simple "costs of business."

It's not right—and I would say it's not legal under city statutes—to ruin what supposedly is a protected low-rise neighborhood in the name of "world class" profits, whether these go to a for-profit corporation or a supposedly nonprofit medical organization.

I hope you are able to see past the parade of off-the-point testimonials, past the $400-an-hour attorneys and their endless briefs, past the paid-for "experts"—on both sides—whose testimony will only show which side has the biggest budget for smoke and mirrors.

Thank you so much for your time and consideration.

sollodstudio

T. Ellen Sollod
[illegible] 15th Avenue
Seattle, Washington [illegible]

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HEARING EXAMINER

July 20, 2015

Sue Tanner
Hearing Examiner
City of Seattle
Seattle Municipal Tower, 40th Flr
Seattle, WA

RE: Swedish/Sabey MIMP Proposal: Two-story skybridge

Dear Ms Tanner:

I am writing with respect to the above referenced project. Swedish/Sabey has proposed a double level skybridge. This should not be approved.
• City of Seattle Policy discourages skybridges.
• A better solution is to deny the skybridge altogether and recommend that Swedish/Sabey build a second tunnel across 16th Avenue for use of transporting patients.
The public should use the sidewalk and crosswalk to cross the street. A designated mid-block crosswalk could serve the function of allowing the public to cross the street safely from one building entrance to the other. This being a low-volume street, it does not pose a burden to cross at grade.
• Patients in wheelchairs being released from the hospital could be picked up in the main hospital entry after caregivers retrieve a vehicle from the garage.

Below is my rationale for this recommendation
• Swedish/Sabey argued they need a skybridge for patients and hospital personnel and a separate skybridge for public use. This is a faulty argument.
• There are no separate hallways exclusively for patients and hospital personnel use.
• There are no elevators designated exclusively for patients and hospital personnel.
• The public is allowed to visit patients in their rooms.
• Patients, hospital personnel and the public mix in all public areas of the hospital
• The hospital functions, including OR and patient rooms are located in the hospital tower. The tower on the east side of 16th Avenue, according to the MIMP will house a parking garage, research facilities, education spaces, medical offices and potentially clinics. There are few uses that would be related to the hospital in this building. Consequently, the volume of use that the skybridge would get is potentially low.
• 16th Avenue is a low volume street for vehicles and does not justify a skybridge for pedestrian safety.
• A two-level skybridge creates a 20' wall across the street at a height of 24' above grade. It degrades the character of the street and effectively further bifurcates the neighborhood.
• Swedish First Hill does not include any two-story skybridges in its MIMP.

I encourage you to deny approval of the skybridge for Swedish Cherry Hill.

Thank you.

Respectfully submitted,

Ellen Sollod

sollodstudio

T. Ellen Sollod
Seattle, Washington 98122

Date: July 12, 2015

To: Hearing Examiner in the case of Major Institution Master Plan application of Swedish Cherry Hill

From: Ellen Sollod

Subject: Comments on Proposed Swedish/Sabey MIMP

My name is Ellen Sollod. I live at 724 15th Avenue. I am an appellant of Concerned Neighbors Swedish Cherry Hill. I am a design professional and public artist and routinely work with architects, landscape architects and engineers designing and constructing public spaces including parks, plazas, infrastructure projects, schools, hospitals and other public buildings. I create models to visualize projects and to represent plans in 3-dimensions.

We created this model after multiple requests to Swedish/Sabey produced no result. They produced their model after we presented ours.

The model illustrates the massing proposed by Swedish/Sabey for Alternative 12 and illustrates the ownership of the campus property.

The model was derived from the diagram of Alternative 12 on page 53 of the MIMP and is built at 1/32nd scale. It accounts for the change in elevation from the west to the east of the campus but does not account for the change in elevation from Cherry to Jefferson where there is elevation change, with the property at a higher elevation on Cherry than on Jefferson, particularly between the north and southern points on 18th Avenue.

The model demonstrates how the proposal does not conform to the Land Use Code or the intent of the Comp Plan.

The institution did not provide full-scale diagrams so the measurements were developed based on the scale illustrated in the MIMP. The purpose of the model is to

1. **Illustrate the height, bulk and scale relative to the surrounding community.**
2. **Illustrate ownership of property within the MIO boundaries**
3. **Illustrate discrepancies between the MIMP document and illustrations of proposed expansion which show setbacks that are not included in the MIMP**
4. **Illustrate the impacts depending upon how elevations are derived**
5. **Demonstrate that the expansion does not provide adequate transitions to the surrounding uses as required by the Land Use Code.**

1. Illustrate the height, bulk and scale relative to the surrounding community.
It is a massing model and does not suggest architecture. It does illustrate setbacks around the campus that have a direct impact on the surrounding neighborhood.

2. Illustrate ownership of property within the MIO boundaries
The MIMP is quite vague about how it describes property ownership. It never mentions Sabey Corporation to whom Swedish sold 40% of its property in 2002. Sabey owns all property topped with blue. The light-green is owned by the Rehabilitation Center NW and the Carmack House property. The only property owned by Swedish is the tan property. It should be noted that Swedish owns only a portion of the property

bounded by Cherry and Jefferson and the west side of 18th and the east side of 16th. Swedish leases some of the property in James Tower and some of the property in the Jefferson Tower. The remainder is leased by un-affiliated medical providers or for-profit corporations such as Lab Corps.

According to the diagram Swedish will own the skybridge. The building that it connects to, according to the MIMP, is an "affilitiated use" property that is owned by the Sabey Corporation and described as providing "public circulation" on the diagrams. The MIMP states "the existing skybridge may be replaced with a 2 level bridge to provide both public flow and separate patient flow." City policy discourages skybridges in general and has approved them for hospitals in the past when they provide for patient circulation. Public circulation should occur at ground level if there is a desire to separate uses. Simply providing a convenience should not be an adequate justification for constructing a 2-level (approximately 20'h) wall obstructing views down the street and creating, in effect, a two-story building crossing the street.

3 and 4. Illustrate discrepancies between the MIMP document and illustrations of proposed expansion which show setbacks that are not included in the MIMP and impacts based on how grades are derived.

Figure C-3 on page 52 purportedly illustrates "planned future height, bulk and form". Since this is neither architecture nor binding on the institution, it is not a reliable illustration of actual impacts. This illustration is shown from the southeast, from which the impacts of expansion are minimized due to the institution's current buildings which they are illustrating as not changing, though they are not bound by the MIMP not to redevelop these properties. Consequently, the 12-15 story wall that flanks the campus on the west and north is not perceivable from this illustration. The campus is effectively turned into a fortress, turning its back on the neighborhood. In addition, this illustration shows a significant upper level setback on the center building on 15th Avenue. This setback is not listed in the MIMP in Section GG on page 30 or in Table B-2 and, consequently, the institution is not bound by this setback. With the exception of the designation of the 150' height on 15th Avenue and the 125' height on 16th Avenue, the MIMP does not indicate how maximum elevations will be derived.

The CAC in its report requested specific measurements be used to ensure that buildings along the 18th Avenue half-block would not exceed 37'. However, the MIMP is silent on how Sabey who owns this property would determine the grade. This could have a significant impact, particularly on the adjacent 19th Avenue half-block because of the change of elevation north to south between Cherry and Jefferson. If the institution uses a point at the north end of 18th Avenue, the properties on the southern end could be much taller.

5. Demonstrate that the expansion does not provide adequate transitions to the surrounding uses as required by the Land Use Code.

The Land Use Code Chapter 23.69 Major Institution Overlay District section 002.
States:

A. Permit appropriate institutional growth within boundaries while minimizing the adverse impacts associated with development and geographic expansion
B. Balance a Major Institution's ability to change and the public benefit derived from change with the need to protect the livability and vitality of adjacent neighborhoods
I. Make the need for appropriate transition primary considerations in determining setbacks. Also setbacks may be appropriate to achieve proper scale, building modulation or view corridors.

The model clearly illustrates the significant impact of the increased height, bulk and scale on the surrounding single family and low-rise residential neighborhood. The surrounding zoning is for 30' high residences. The adjacent MIO of Seattle University used a maximum of 65' as a transition to the neighborhood. Swedish/Sabey's proposal for 150' and 105' buildings directly across the street from low-rise residential buildings and a 160' h building within 30' of the adjacent low-rise zoning does not provide an appropriate transition. Zero lot line setbacks and setbacks of 5' do not provide adequate transition or allow for a landscaped buffer. Upper level set backs of 10'-15' do not mitigate the wall of buildings that creates a fortress-like quality on the north and west sides of the campus. A single block-long building along

the 18th Avenue half-block creates an unrelenting barrier with building heights looming above single-family homes.
Transitions according to the Land Use Code includes natural barriers, changes in elevation or significant setbacks such as open spaces and green spaces. In the case of Swedish, there are none of these. The transition between the west ½ block of 18th Avenue and the 19th Avenue single family zone is a lot line with the equivalent of a rear yard setback—hardly a transition when the properties are not even separated by an alley.

In the case of Swedish First Hill, a high-rise zone, upper level setbacks are considerably more than those proposed for Swedish Cherry Hill. In the case of the SU MIO, the 14th Avenue transition included the arterial of 14th Avenue, a 15' ground level setback and upper level setback of 80', all on a building totaling 65'. Swedish proposes buildings of 150' on its western border with 0' lot line setback at the ground plane and 10' and 15' at 37' and 65' respectively. Along Cherry Street, its proposal for an upper level setback at 105' is 30'. None of this represents the kinds of transitions envisioned in the Code.

The Hearing Examiner, in the case of Children's Hospital MIMP found that proposed setbacks of 40' at the ground plane was not reasonable and that setbacks of 75' with a requirement of an extensive landscaped buffer would be appropriate. She also found that the impact of zoning property to MIO 160 or MIO 125 "cannot be minimized by the use of transitions in height, upper level setbacks and 20-40' setbacks". The Hearing Examiner went on to say "Although greater than 40', the proposed MIO160/140 and MIO 160/125 districts may be considered outside an urban village, but only if the proposed heights would be consistent with an adopted neighborhood plan, a major institution's adopted master plan or the existing built character of the area." Like Laurelhurst, Squire Park is outside an urban village and has adopted no neighborhood plan that includes such language. The proposed heights are not consistent with the expired Swedish MIMP that capped heights at 105' and are not consistent with the area's existing built character which is overwhelming one and two story single-family residences and low-rise multifamily. The entire area is zoned SF5000 and Low-rise 1 and Low-rise 3. If the Hearing Examiner found transitions and heights inappropriate for Laurelhurst, the same should be found for Squire Park.

EIS
Section 3.4.1 Height, Bulk and Scale

3.4.1.2 Affected Environment
The EIS erroneously characterizes the blocks to the north of the campus across E Cherry Street as "a mix of office/commercial, 2-story condominiums, a multi-story condominium complex, and single-family residential."

In fact only the office/commercial use and multi-story condominium are directly across from the campus. The remaining properties are single-family homes and low-rise residences. While there is a state-owned office building, a church, a school and a non-profit neighborhood organization located in the blocks north of Swedish, the description in the EIS is completely inaccurate. Any use that is not single family or low-rise residential has been permitted as a conditional use or is grandfathered and would not be able to built today. The attached document showing the street and development pattern from East Cherry Street to Union between 15th and 20th, clearly illustrates that this is the case.

3.4.16 Viewpoint 3:
3.4.17 Alternative 12
The viewpoint obscures the ability to discern the two-level sky bridge and but clearly illustrates that it is impossible to view down the street to Jefferson. The narrative does not call attention to the presence of this expansion and does not describe its impact on the ability to see down the street.

3.4.40 Viewpoint 11
3.4.42 Viewpoint 11: Alternative 12
Illustrates a solid second level of skybridge, clearly illustrating the massive impact on the street.
3.4.1.6 Significant Unavoidable Adverse Impacts

The EIS clearly states the increases in height, bulk and scale would have "significant unavoidable adverse impacts." Yet, no alternative was evaluated that would result in not having these impacts on the surrounding neighborhood.

3.4.1.3 View Impacts
The EIS clearly states that under all build alternatives, views of the James Tower that is designated as a Seattle landmark would be blocked from adjacent street and that it would not be visible from Seattle University. No mitigation measures such as upper level setbacks were suggested. A dispersal alternative that would have eliminated this impact was not evaluated.

Finally, the Code that established the Major Institution District Overlay never anticipated that a for-profit developer would be an applicant for a MIMP. The Code states that its purpose "is to regulate Seattle's major educational and medical institutions." It is inappropriate that Sabey Corporation has been given status as a proponent in this proceeding and as an author of the MIMP. Sabey is neither an educational nor medical institution. It is a for-profit developer that will benefit from up-zoning that was never intended in this neighborhood for anything other than a hospital. That it will rent property to Swedish or will rent commercial medical office space for potentially medical uses does not make it a hospital. The MIMP was not created to encourage or allow end-runs on the City's zoning code. While an institution is not required to own all property within its MIO, the assumption was that the MIMP would allow the institution to acquire property within the MIO to advance its purposes and benefit the public. There have been cases when an institution has used a for-profit developer to develop property within the boundaries that it owned, it has been that that property was developed for the direct use and benefit of the institution. For example, in the case of Seattle University, the Seneca Group developed a dorm on SU-owned property. That dorm will revert to SU ownership after a set period. Sabey has made no such guarantees.

The fact that Sabey has been given standing in this process undercuts the public's trust. It gives a commercial developer the same rights and benefits that were intended for a non-profit institution that is providing a public benefit in the form of education or medical services. This should not be allowed.

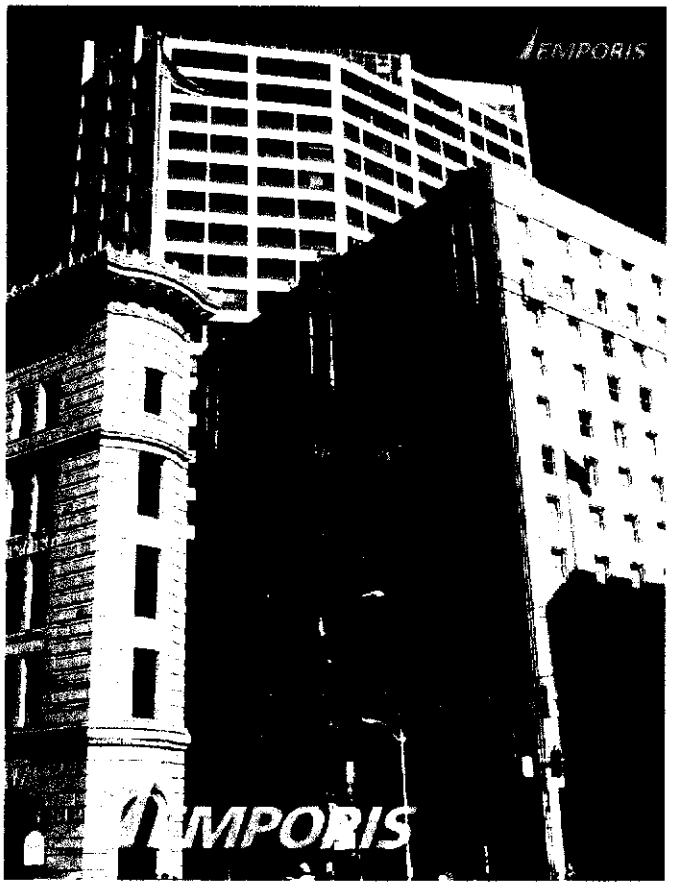
The MIMP neither conforms with the Land Use Code for Major Institutions nor the City's Comprehensive Plan. Alternatives that would have dispersed use to minimize impacts were not proposed by the institution or evaluated by the EIS. The Comp Plan says that employment centers should be located where there is transportation infrastructure to support them. The EIS found that multiple intersections would be degraded to LOS F and that there are unmitigatable transportation impacts. It is not near light rail. There are only two very crowded bus lines that serve the campus. It is not within the streetcar walk shed.

The MIMP should not be approved as proposed. There is too much height, bulk and scale. It does not provide appropriate transitions to the surrounding neighborhood. It provides significant financial benefit to a commercial developer that would not be allowed were the developer to seek a rezone for this property.

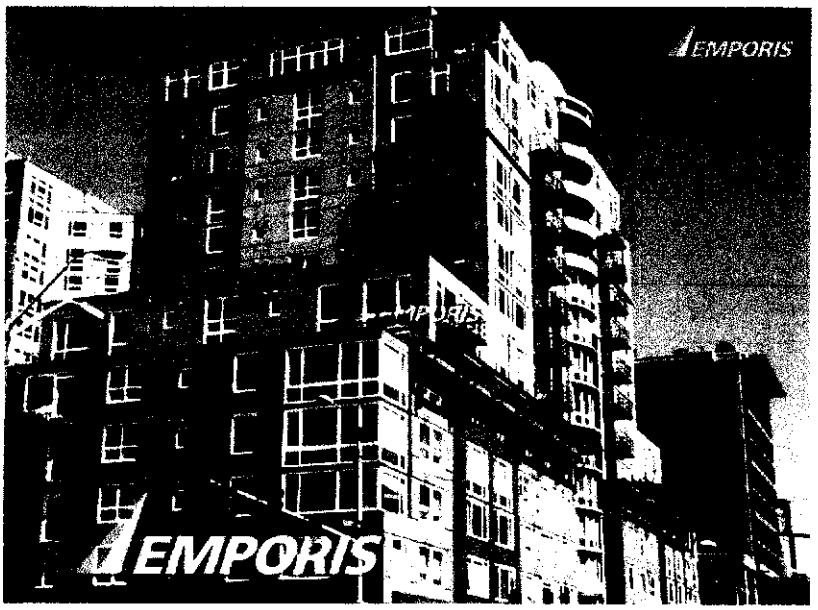
All of the neighborhood associations have spoken out against this expansion: Squire Park Community Council, Cherry Hill Community Council, and 12th Avenue Stewards. I am member of each and support their statements. Furthermore, I support the CAC Minority Report authored by Dean Patton, et al.

BUILDING HEIGHTS COMPARABLE TO SWEDISH/SABEY MIO PROPOSAL

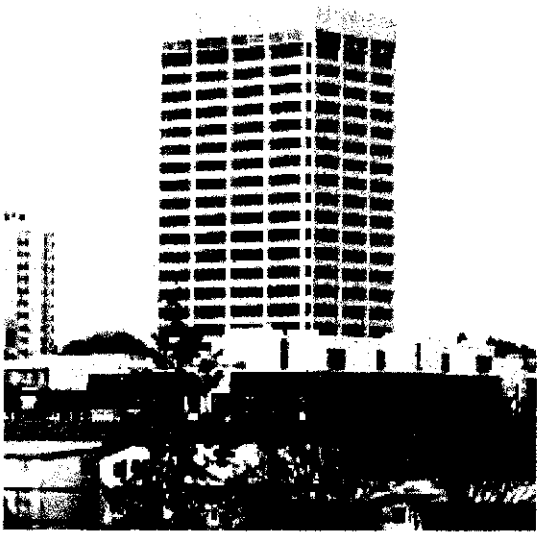
Harbor Steps 160'
Downtown



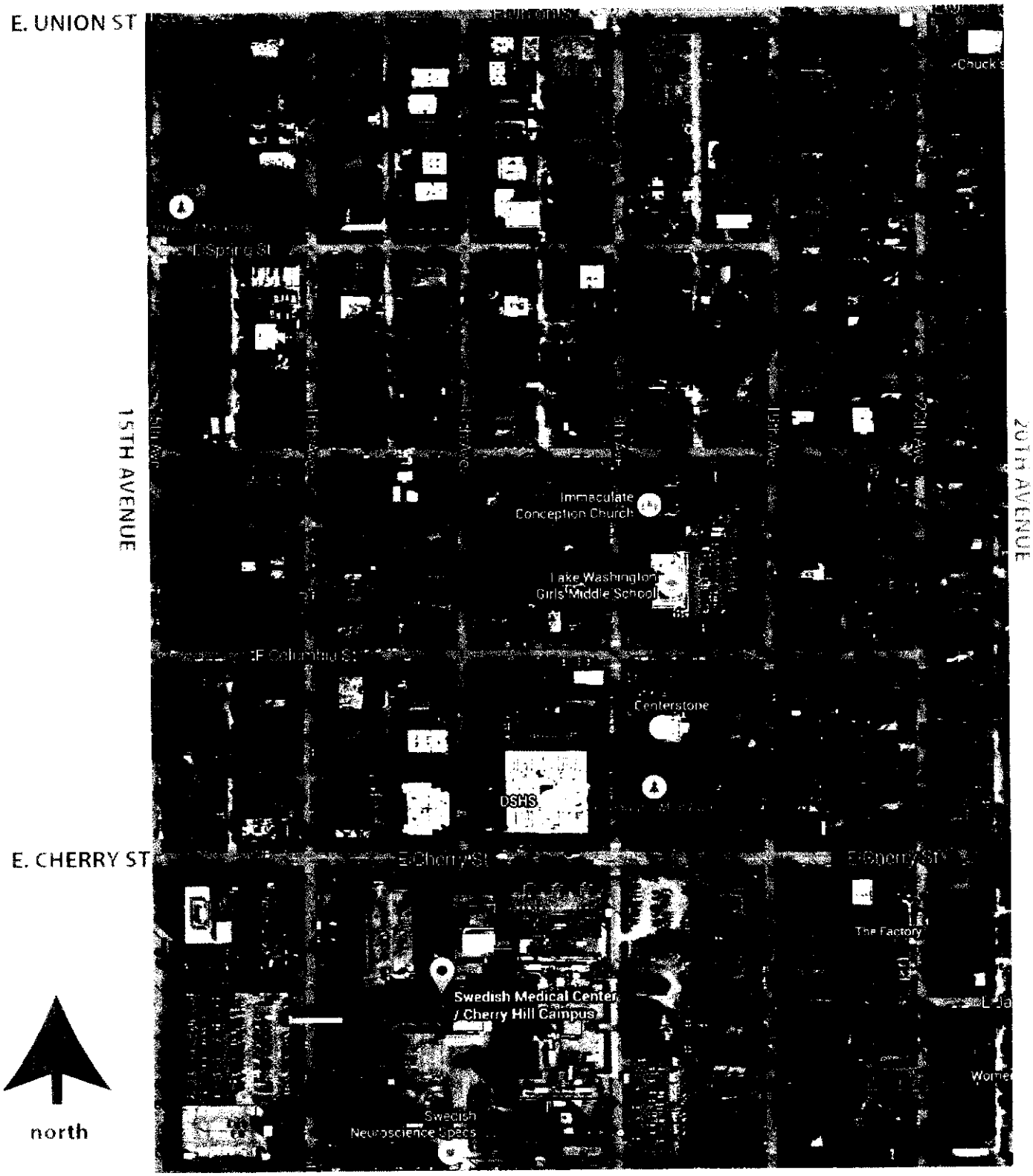
Mayflower Park Hotel 160'
Downtown



The Olympus Condominium 150'
Belltown

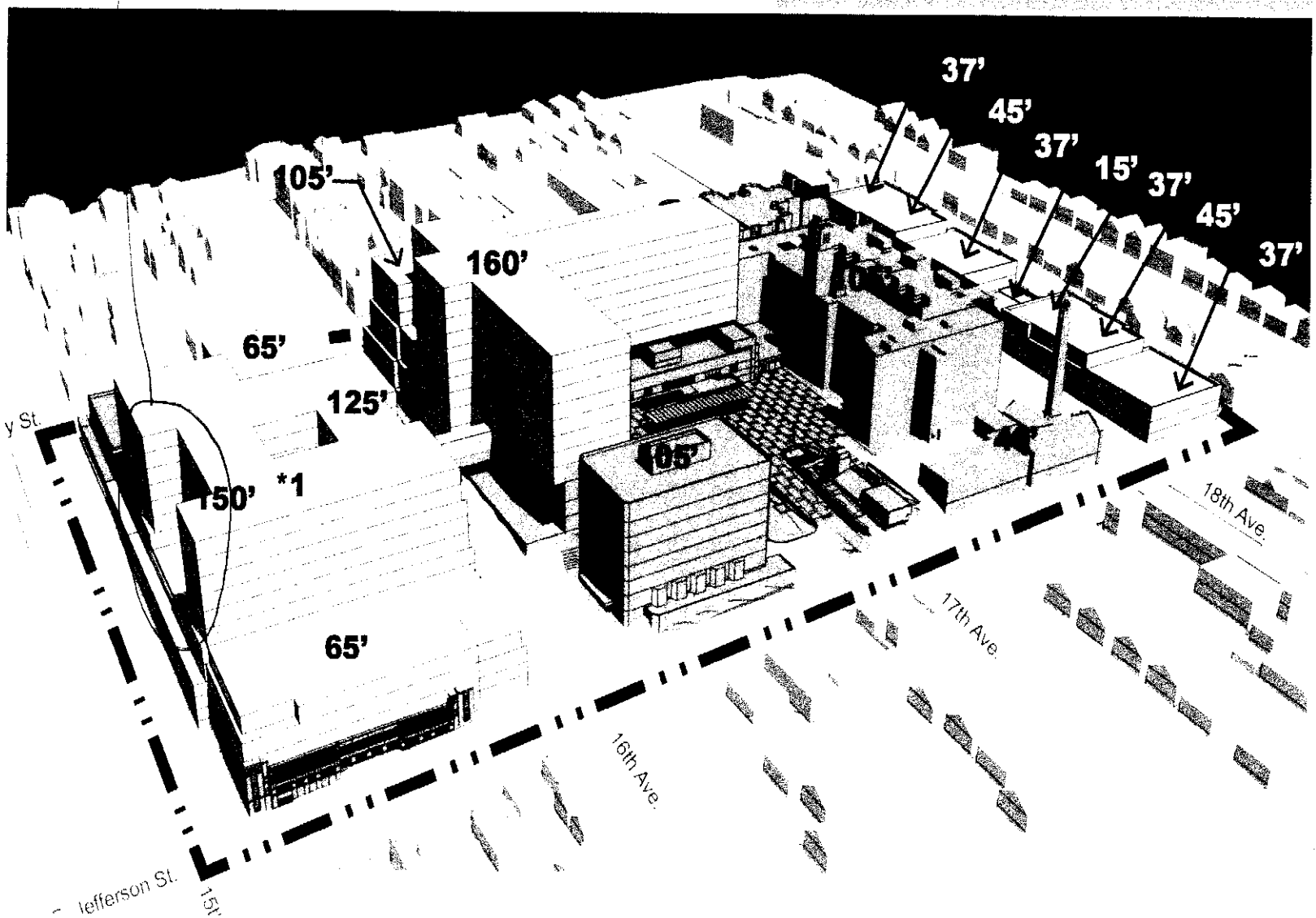


Safeco Tower 125'
University District



DEMONSTRATION OF SINGLE FAMILY AND LOW-RISE [illegible]NTIAL DEVELOPMENT PATTERN NORTH OF SWEDISH CHERRY HI[illegible]

SETBACK NOT INCLUDED IN GG OR TABLE B-2



GRADES OF SURROUNDING STREETS

East-West Grade Changes		
Cherry & 14th: 282 ft	Cherry & 15th: 315 ft	+33'
Cherry & 15th: 315 ft	Cherry & 16th: 335 ft	+20'
Cherry & 16th: 335 ft	Cherry & 17th: 354 ft	+19'
Cherry & 17th: 354 ft	Cherry & 18th: 367 ft	+13'
Cherry & 18th: 367 ft	Cherry & 19th: 344 ft	-23'

North-South Grade Changes		
Cherry & 14th: 282 ft	Jefferson & 14th: 282 ft	0'
Cherry & 15th: 315 ft	Jefferson & 15th: 295 ft	-20'
Cherry & 16th: 335 ft	Jefferson & 16th: 315 ft	-20'
Cherry & 17th: 354 ft	Jefferson & 17th: 338 ft	-16'
Cherry & 18th: 367 ft	Jefferson & 18th: 338 ft	-29'
Cherry & 19th: 344 ft	Jefferson & 19th: 328 ft	-16'

b) The extent to which any structure is permitted to achieve the height limit of the MIO District. The Director shall evaluate the specified limits on the structure height in relationship to the amount of MIO District area permitted to be covered by structures, the impact of shadows on surrounding properties, the need for transition between the Major Institution and the surrounding area, and the need to protect views:

The development program laid out in the MIMP lists planned and potential projects with enough specificity that some of their potential impacts can be anticipated. The MIMP discusses lot coverage on pages 117-118. Chapter 3.6 of the FEIS presents a detailed shadow analysis for various times of day and year. The MIMP discusses building setbacks on pages 110-115. These discussions analyze these questions as far as the available information permits. Impacts from additional bulk and scale cannot be fully analyzed due to the preliminary conceptual level at which each building has been designed. The MIMP includes a set of design guidelines that will help address how building design will mitigate impacts from additional bulk and scale of new construction at specific sites. If necessary, additional consideration of potential bulk and scale impacts will occur at the time of MUP review of future projects.

Because the campus is in a valley, views in the area are generally limited and localized. There are no designated view corridors in the area although limited views do occur along public rights of way. None of these public views will be negatively affected by the development contemplated in the MIMP. Therefore Seattle University's proposed growth would have no impact in this regard. The Final Master Plan would affect no views from public rights-of-way or other public spaces.

On the existing campus, the MIO height limits would remain much as they are today, with structures regulated by the MIO 160 along the western edge and MIO 105 over the central part of campus. The height limits on the property at the northwestern quadrant of Columbia and 14th would be increased from 37 feet to 65 feet. The southwestern quadrant would be increased from 37 feet to 65 feet. The height limit on the area of campus generally east of 12th would increase from 37 feet and 50 feet to 37 feet and 65. Two sites include limited height restrictions. Figure 2 shows the existing MIO boundaries and height limits. Figure 3 shows both the existing MIO boundaries and the height limits, as well as the proposed boundaries and height limits.

The transition along 14th Avenue poses the most sensitive transitional relationship in height, bulk and scale, and DPD considers this to be a critical boundary edge. From the east, single family homes would be separated from the new development by the width of the street right-of-way of 14th Avenue, a 66-foot buffer. In addition, there is a 15 foot ground level setback and then upper level setbacks (above 37 feet) of 60 feet (on the 1500 East Columbia site) and 80 feet (on the 1313 East Columbia site). The 37 foot height approximates the heights allowed by the underlying Lowrise zones, as well as the current MIO height designation. It should also be noted that the topography rises across 14th Avenue to the east, so many of the existing structures would be around the same level or above the 37-foot height portion of the proposed structures. These upper level setbacks were proposed as part of the Revised Final MIMP – October 2011 and increased from 40 feet as stated in the Final MIMP – June 2011. The right-of-way width

Dear Examiner Tanner,

I lived in the Central Area in Seattle for several years on the west side of 19th Avenue, between Cherry and Jefferson. I am concerned that the expansion of the Swedish Hospital campus will adversely affect the near neighbors and the Central Area neighborhood. The height, bulk, and scale of Proposal-12 is inappropriate for the quality-of-life of the people living in this neighborhood.

The long, construction phase of such an aggressive build will make living near the site very difficult. After the build, the resulting, out-of-scale campus will disrupt life for the Central Area residents, but also for several neighborhoods to the east. The people living in the neighborhoods of Leschi, and Mount Baker, also depend on the thoroughfares of Cherry and Jefferson streets to commute.

Given the existence of several other Swedish campuses in Seattle and Issaquah, I think the hospital-support facilities that Swedish wants to locate on their Cherry Hill campus can be built elsewhere, in order to preserve the character and livability of the Squire Park neighborhood.

I am in favor of the Minority Report, which advocates for remodel of the existing facilities and a build out of a more reasonable height, bulk and scale. Of special concern is the half-block on the east side of 18th Avenue. Proposal-12 shows a four-story, monolith. The minority report recommends several, free-standing buildings, with space between, and even a green-space. These lower-rise, separate buildings are an actual transition to the neighbors' homes, which abut this Sabey property.

Swedish should be updated, but not at the expense of such a treasure as the neighborhood home of Ernestine Anderson, Jimi Hendrix, Quincy Jones, and Bruce Lee.

Thank you,

Ellen Fink

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City of Seattle Telephone Survey 2015
April 30th – May 8th, 2015
Seattle Effective n=416; Margin of Error = ± 4.9 Percentage Points
Neighborhood Oversample Effective n=200; Margin of Error = ± 6.9 Percentage Points
EMC Research #15-5609

Hello, my name is _____, may I speak with **(NAME ON LIST. MUST SPEAK WITH NAME ON LIST).**

Hello, my name is _____ and I'm conducting a public opinion survey for EMC Research. This is a public opinion research study on how people in Seattle feel about some of the issues facing them. This is not a sales or telemarketing call. Your answers are strictly confidential and will be used for research purposes only. We thank you in advance for participating.

		Seattle	Oversample
1.	Sex **(RECORD FROM OBSERVATION)**		
	Male	47%	52%
	Female	53%	48%
2.	Are you registered to vote in Seattle?		
	Yes	100%	100%
	No → **TERMINATE**	-	-
3.	How likely are you to vote in this year's November 2015 election for statewide initiatives, Seattle City Council, and city ballot measures? Are you almost certain to vote, will you probably vote, are the chances 50/50, or do you think you will not vote in next year's November 2015 election?		
	Almost certain/ (Definitely will vote)	90%	88%
	Probably	9%	9%
	50/50 Chance	2%	3%
	Will not vote/(Don't know) → **TERMINATE**	-	-
4.	Do you feel that things in your neighborhood are generally going in the right direction or do you feel things have gotten pretty seriously off on the wrong track?		
	Right direction	64%	53%
	Wrong track	23%	29%
	(DNR: Don't know)	14%	19%

	Seattle	Oversample

[ASK QUESTIONS Q5-6 BELOW OF SQUIRE PARK AREA SAMPLE ONLY]

5. Are you aware of or have you heard about any new construction projects currently being considered in your neighborhood?

Yes	91%
No	9%
(DNR: Don't know)	-

(IF Q5 = 1, ASK Q6)

6. What projects are being considered? **(OPEN-END, TAKE UP TO THREE RESPONSES, DON'T PROBE)**

Apartments/multiunit dwellings/residential	64%
Commercial construction/retail buildings	28%
Adding bike lanes/expanding roads/ construction	12%
Hospital expansion	9%
Public transit expansion	5%
23rd Avenue corridor project	5%
Public buildings (court, detention center...)	3%
Parks/green-space	1%
School remodeling/construction	1%
Other	3%
Don't know	4%

(RESUME ASKING EVERYONE)

7. Swedish Medical Center has proposed to expand and modernize its Cherry Hill location in the Squire Park neighborhood of the Central District. The finished facility would stay within its current boundaries, but the tallest buildings could be eleven stories instead of the current eight. It would include new operating rooms, expanded vascular, brain research, diabetes, and heart health services, a small inn for families of patients, and seismic upgrades. In general, do you favor or oppose this Swedish Cherry Hill Hospital expansion **[IF RESPONSE IS FAVOR/OPPOSE THEN ASK FOLLOWUP:** "Is that Strongly or Somewhat Favor/Oppose?"**]**

Strongly Favor	39%	25%
Somewhat Favor	36%	38%
Somewhat Oppose	4%	10%
Strongly Oppose	3%	13%
(DNR: Undecided/Don't know)	16%	13%
(DNR: Refused)	1%	1%

(IF Q7=1 or 2, ASK Q8. IF Q7=2 or 4, ASK Q9. IF q7=5, ASK Q10. IF Q7=6, SKIP TO Q11)

	Seattle	Oversample
8. What is the main reason you favor this proposal? (n=430) **(OPEN-END)**		
Need choices for healthcare/ access to quality health care services	22%	26%
Expansion is a good thing/ progress/facility upgrades needed	20%	15%
To keep up with growing population	9%	5%
They do a good job/help people/ will benefit community	9%	12%
Building up, not out/ 3 more stories ok	7%	9%
Excellent facility	5%	7%
Research/ research facilities are important	3%	1%
Born there/had my kids there/been a patient there	3%	4%
No reason not to/ don't see a problem	3%	3%
Will create jobs/ help economy	3%	5%
Bad neighborhood/ forgotten area of Seattle will benefit	3%	2%
Support idea of healthcare/hospitals in general	2%	5%
Personal work experience at facility/understand the need for upgrade	2%	1%
Seismic upgrades are needed	2%	1%
Sounds good/reasonable in general	2%	1%
Other	2%	1%
Don't know	3%	2%
9. What is the main reason you oppose this proposal? (n=74) **(OPEN-END)**		
No need for the expansion	36%	18%
It's taking over the neighborhood	35%	24%
Need more information	7%	3%
It's terrible for traffic/congestion/parking	6%	24%
Height is too much for residential area	6%	20%
Other	7%	10%
Don't know	-	-
10. What is the main reason you are undecided about this proposal? (n=96) **(OPEN-END)**		
First I'm hearing of expansion	14%	11%
Need more information	49%	57%
Too much growth/expansion	7%	6%
Don't live in the neighborhood	25%	17%
Other	3%	0%
Don't know	2%	6%

(RESUME ASKING EVERYONE)

11INT. Please tell me whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree with each of the following statements.
(READ AFTER EACH UNTIL UNDERSTOOD: Do you strongly agree, somewhat agree, somewhat disagree, or strongly disagree with that statement?**)**

	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	(No Opinion/ Dont know)	(Refused)	Agree	Disagree
(RANDOMIZE)								
11. Seattle's population is growing and we're going to need more quality health care facilities to serve our residents.								
Seattle	58%	33%	3%	1%	4%	0%	**91%**	**4%**
Ovrsmpl.	48%	35%	7%	4%	5%	1%	**83%**	**11%**
12. When more medical research is done in Seattle, everyone here benefits from the advances made in health care.								
Seattle	62%	27%	5%	2%	4%	0%	**89%**	**7%**
Ovrsmpl.	48%	32%	8%	4%	6%	2%	**80%**	**12%**
13. Now that more people have health care coverage as a result of the Affordable Care Act there is greater demand for Seattle's hospitals.								
Seattle	28%	39%	8%	5%	19%	1%	**67%**	**14%**
Ovrsmpl.	20%	39%	16%	6%	19%	1%	**59%**	**22%**
14. **[ASK IN SQUIRE PARK SAMPLE ONLY]** My neighborhood is growing and changing too fast. I don't want any new developments that bring more traffic and change to my neighborhood, no matter what it is. (n=400)								
Ovrsmpl.	18%	25%	32%	20%	4%	-	**43%**	**53%**
(END RANDOMIZE)								

	Seattle	**Oversample**
15. Swedish Medical Center's Cherry Hill hospital has been in the Squire Park neighborhood for one hundred years. The hospital has several areas of specialty including brain care, heart and vascular care, treatment for stroke victims, kidney dialysis, and an advanced treatment center for M-S. In general, do you think having this hospital located in the neighborhood is positive or negative for the area?		
Positive	89%	84%
Negative	3%	7%
(DNR: Not Sure/Don't know)	8%	9%
(DNR: Refused)	0%	-

16INT. Some project opponents suggest that instead of modernizing and expanding on Cherry Hill, Swedish should build a new hospital for these specialties in the suburbs to avoid impacts on the Squire Park neighborhood. Please tell me whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree with each of the following statements.

(READ AFTER EACH UNTIL UNDERSTOOD: Do you strongly agree, somewhat agree, somewhat disagree, or strongly disagree with that statement?)

(RANDOMIZE)

	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	(No Opinion/ Dont know)	(Refused)	Agree	Disagree
16. I want a hospital with these specialties close by where they can care for my family and friends, not somewhere in the suburbs.								
Seattle	50%	30%	8%	4%	7%	0%	**80%**	**12%**
Ovrsmpl.	44%	34%	9%	8%	4%	1%	**77%**	**17%**
17. Building a new hospital in the suburbs may not be as convenient for people living in Seattle, but hospitals don't belong in residential neighborhoods. Swedish should build a new hospital for these specialties in the suburbs so there is no traffic impact on the Squire Park neighborhood.								
Seattle	8%	17%	32%	34%	8%	1%	**25%**	**66%**
Ovrsmpl.	15%	13%	33%	33%	6%	1%	**27%**	**65%**
18. The new Swedish Cherry Hill hospital will house state of the art medical treatment and care for breathing problems, heart issues, and brain care. The hospital expansion is good for the neighborhood and good for everyone in Seattle.								
Seattle	39%	42%	6%	4%	9%	0%	**81%**	**10%**
Ovrsmpl.	36%	39%	12%	7%	6%	0%	**75%**	**19%**
19. Increasing the height of the Cherry Hill Medical Center to eleven stories is too much and will be out of place in the single-family neighborhood.								
Seattle	8%	18%	36%	29%	8%	0%	**27%**	**65%**
Ovrsmpl.	24%	17%	27%	26%	5%	1%	**41%**	**53%**
20. Hospitals drive community health and economic vitality. They benefit neighborhoods by creating jobs at all skill levels, offering emergency services and family medicine, and providing a needed customer base so small businesses can thrive in the community.								
Seattle	46%	42%	5%	2%	5%	0%	**88%**	**7%**
Ovrsmpl.	45%	36%	7%	5%	6%	0%	**81%**	**13%**

(END RANDOMIZE)

21INT. Some neighbors of the Swedish Cherry Hill Medical Campus have expressed concern about the proposed expansion and modernization project, saying it will bring increased traffic to the neighborhood. I'd like to read you some things that have been proposed by Swedish to mitigate traffic impacts on neighbors. For each of the following please tell me if that proposal would make you more likely or Less Likely to support the Swedish Cherry Hill expansion and modernization project.

[AFTER EACH UNTIL UNDERSTOOD: would this make you more likely or less likely to support the project?]
[IF RESPONSE IS MORE/LESS THEN ASK FOLLOWUP: "Is that Much or Somewhat MORE/LESS likely?"]

	Much More Likely	Somewhat More Likely	Somewhat Less Likely	Much Less Likely	(Undecided/ Dont Know)	(Refused)	More Likely	Less Likely
(RANDOMIZE)								
21. Providing hospital employees with free transit passes so they can get to work without using a car								
Seattle	64%	27%	4%	2%	2%	0%	**91%**	**7%**
Ovrsmpl.	62%	29%	3%	4%	3%	-	**91%**	**6%**
22. Adding off-street parking to meet the increased need								
Seattle	49%	34%	4%	6%	7%	0%	**82%**	**10%**
Ovrsmpl.	43%	30%	11%	5%	10%	1%	**73%**	**17%**
23. Patrolling neighborhood streets regularly and penalizing hospital employees who are parking there								
Seattle	19%	31%	21%	11%	18%	1%	**50%**	**32%**
Ovrsmpl.	17%	33%	18%	15%	16%	1%	**50%**	**33%**
24. Providing housing subsidies to employees who find housing close to the hospital and agree to walk to work								
Seattle	48%	30%	8%	7%	7%	0%	**78%**	**15%**
Ovrsmpl.	43%	34%	4%	8%	10%	1%	**77%**	**13%**
25. Staggering start and end times for employees to avoid traffic congestion at particular times of day								
Seattle	40%	44%	6%	2%	8%	0%	**85%**	**8%**
Ovrsmpl.	34%	42%	6%	6%	11%	1%	**76%**	**12%**

(END RANDOMIZE)

	Seattle	Oversample
26. Increasingly, hospitals are partnering with private developers to build facilities so hospitals can use their resources to purchase advanced medical equipment instead of funding buildings and facilities. For this project, Swedish has partnered with a private developer to help with the facility expansion and improvements. In general, do you think having the hospital partner with a private devloper is a good idea or bad idea, or doesn't really matter one way or the other?		
Good idea	21%	17%
Bad idea	14%	22%
Doesn't matter one way or the other	46%	41%
(DNR: Not Sure/Don't know)	19%	18%
(DNR: Refused)	1%	1%

	Seattle	Oversample

27. For this project, the local developer is Sabey Corporation. Do you have a favorable or unfavorable opinion of Sabey Corporation? If you have never heard of Sabey please say so? **(IF FAVORABLE/UNFAVORABLE)** Is that strongly favorable/unfavorable or somewhat favorable/unfavorable?

Strongly Favorable	3%	1%
Somewhat Favorable	9%	4%
Somewhat Unfavorable	5%	4%
Strongly Unfavorable	2%	6%
Never Heard of Sabey	66%	71%
(Cant Rate/ Don't know)	15%	13%

28. I would like to ask you again about the proposed expansion and modernization of the Swedish Medical Center on Cherry Hill in the Squire Park neighborhood of the Central District. The proposed expansion would add new facilities and renovate the one hundred year old hospital building. The finished facility would stay within its current boundaries, but the tallest buildings could be up to eleven stories instead of the current eight. It would include new operating rooms, expanded vascular, brain research, diabetes, and heart health services, a small inn for families of patients, and seismic upgrades. Hearing this, would you say that you favor or oppose the Swedish Cherry Hill Hospital expansion?
[IF RESPONSE IS FAVOR/OPPOSE THEN ASK FOLLOWUP: "Is that Strongly or Somewhat Favor/Oppose?"]

Strongly Favor	50%	34%
Somewhat Favor	33%	34%
Somewhat Oppose	6%	10%
Strongly Oppose	3%	14%
(DNR: Undecided/Don't know)	7%	7%
(DNR: Refused)	1%	0%

And finally, a few questions for statistical purposes only.

	Seattle	Oversample
29. Have you or a member of your family used the services of one of Seattle's hospitals in the last twelve months?		
Yes	62%	60%
No	37%	37%
(DNR: Don't know/Not Sure)	1%	3%
(DNR: Refused)	0%	0%
30. Have you or someone close to you ever used the Swedish Cherry Hill facility? **[IF YES: was it yourself, someone close to you, or both?]**		
Yes, self	21%	21%
Yes, someone close to you	29%	21%
Yes, both	18%	17%
No	30%	39%
(DNR: Don't Know/Not Sure)	2%	1%

31A. What year were you born? **[RECORD YEAR - VALID RANGE: 1910-1997; IF REFUSED, Q31A=9999]**

31B. **[AGE RANGE - CODE FROM PREVIOUS QUESTION]**
[IF Q31A=1986 thru 1997 Q31B=1]
[IF Q31A=1976 thru 1985 Q31B=2]
[IF Q31A=1966 thru 1975 Q31B=3]
[IF Q31A=1951 thru 1965 Q31B=4]
[IF Q31A=1910 thru 1950 Q31B=5]
[IF Q31A=9999 THEN ASK FOLLOWUP: "Would you say you are age **(READ LIST)**..."**]**

18 to 29	7%	9%
30 to 39	17%	26%
40 to 49	19%	24%
50 to 64	30%	23%
65 or over	27%	18%

32. Do you generally think of yourself as a Democrat, an Independent, a Republican or something else? **(IF DEMOCRAT/REPUBLICAN)** Would you call yourself a strong **(DEMOCRAT/ REPUBLICAN)** or a not very strong **(DEMOCRAT/REPUBLICAN)**? **(IF INDEPENDENT)** Do you think of yourself as closer to the Democratic or Republican party? **(IF NEITHER CODE AS "Independent")**		
Strong Democrat	48%	55%
Not very strong Democrat	13%	17%
Independent, closer to Democrat party	9%	9%
Independent	8%	3%
Independent, closer to Republican party	2%	2%
Not very strong Republican	2%	0%
Strong Republican	3%	0%
(DNR: Something Else/Don't Know)	15%	13%

FINISH: Those are all of my questions. Thank you very much for completing this survey. Again, this survey was for informational purposes only. Thank you and have a good day.

July 12, 2015

To:
Seattle Hearing Examiner

From:
Greg Harmon, near neighbor
536 19th Ave

Re: Swedish MIMP proposal, Project 3012953

There are numerous problems with the Swedish MIMP proposals that we've seen. We are now at Alternative 12 and have the Final MIMP. Alternative 12 and the CAC's majority report should not be accepted. I support the Minority Report by "Dean Patton and Others". It comes much closer to balancing the needs of the institution and the livability of this neighborhood.

The MIO is meant to balance needs of the institution with the livability of the neighborhood. Alternative 12 and the Majority report do not find a balance. The institution and its private development partner are getting so much, and what's to show for the public benefit? As I and many neighbors see it, there is very little offered in the way of mitigation, nor is there any way to sufficiently mitigate such a large development.

In terms of setbacks, those in Alternative 12 and the Majority report should be increased. The setbacks need to work to ensure a transition from the MIO to the adjacent Single Family and Low Rise zoning. They should conform to what the underlying zoning requires or otherwise clearly transition to the neighborhood. All around the perimeter of the MIO the setbacks should be maintained, as in Patton's Minority Report.

Traffic

There will be such adverse traffic impacts from this development. The final EIS says there will be FOUR MORE intersections operating at Level of Service F. This is relative to future traffic, not current traffic, as some CAC members were wondering at the 1/8/15 meeting.

> "Alternatives 11 and 12 would result in two additional intersections operating at LOS F and one less intersection operating at LOS E during the weekday AM peak hour and four additional intersections operating at LOS F during the weekday PM peak hour, the same as with Alternative 8." (page 3.7-43)

The TMP does consider adding traffic signals at two intersections, but there is no guarantee that it would happen, nor is there an analysis of how that would affect the LOS.

There is just too much more traffic. The EIS projects that daily trips will DOUBLE due to Alternative 12 by 2040 (5,439 now vs 10,942 in 2040; see Table 3.7-12).

Swedish and its tenants have done some work recently to try to improve their transportation and get closer to their SOV goal. But this work has only started now, during their MIMP renewal

process. They have had decades to work on their TMP compliance and have done very little until time has come to renew their MIMP. This kind of behavior does not inspire confidence that they will be able to meet their current TMP SOV goal or a new proposed TMP SOV goal.

As they recommend, the MIMP should restrict each phase of new development until TMP goals are met.

Height / Transition
The MIMP needs to work on its transitions to its Residential and Low Rise underlying and adjacent zones. It proposes 125' along its border with SU! It needs to come down to the SU height of 65'. This is one of the important points of an MIO, that there is a transition to its surroundings.

Sabey
Much of the development is on Sabey property. Giving this private developer permission to build so much *commercial* medical office space in an otherwise residential neighborhood does not seem to match the intention of the MIO code. It appears that they are getting an unfair advantage over other corporations that cannot build medical office space in this area, so Sabey should be restricted in how much they can build in this MIO.

APPENDIX J

1987 Washington State Health Plan – volume 2:
Performance Standards for Health Facilities and Services

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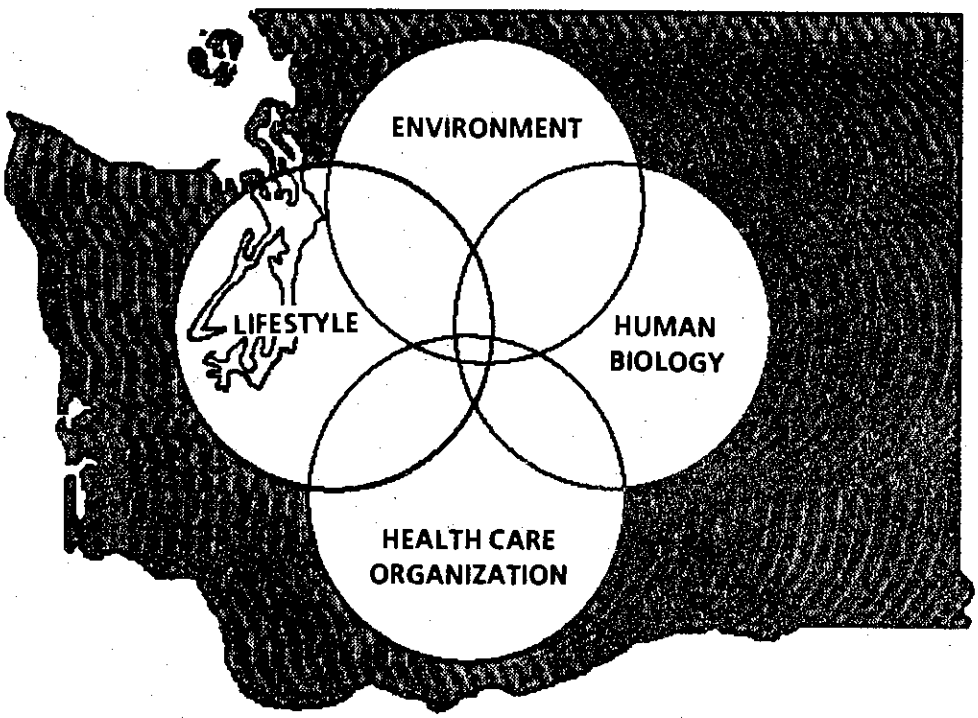
WASHINGTON STATE HEALTH PLAN



VOLUME 2: PERFORMANCE STANDARDS FOR HEALTH FACILITIES AND SERVICES

Adopted by the State Health Coordinating Council
January 21, 1987

Approved by Governor Booth Gardner
May 12, 1987

WASHINGTON STATE HEALTH PLAN

VOLUME 2: PERFORMANCE STANDARDS FOR HEALTH FACILITIES AND SERVICES

Adopted by the State Health Coordinating Council
January 21, 1987

Approved by Governor Booth Gardner
May 12, 1987

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STATE OF WASHINGTON
OFFICE OF THE GOVERNOR

OLYMPIA
98504-0413

BOOTH GARDNER
GOVERNOR

May 15, 1987

Ward C. Miles, M.D., Chair
State Health Coordinating Council
Mail Stop OB-43F
Olympia, Washington 98504

Dear Mr. Miles:

I am pleased to approve the State Health Plan (SHP) developed by the State Health Coordinating Council under the provisions of the State Health Planning and Resources Development Act (RCW 70.38). This document presents ambitious and worthy objectives for the improvement of health status and development of health services in the state. Executive agencies should take appropriate steps within available resources to assure that their policies are consistent with the directions set forth in this plan.

The content of the State Health Plan has been developed over many months, and there are areas where recent events require an update of the situation described in Volume 1 of the Plan:

Acquired Immune Deficiency syndrome (AIDS). The plan was developed before the scope and severity of the AIDS problem was fully recognized. I am confident that the SHCC, the Department of Social and Health Services and other responsible entities will expand their consideration of this important issue.

Conditions in correctional institutions. The overcrowding of correctional institutions referred to in the plan is mitigated by the opening of a a new state correctional facility at Clallam Bay.

Prenatal Care. Significant movement toward the plan's prenatal care goal has been made in recent months due to legislative action to appropriate additional funds for expansion of the program as I had requested. This action demonstrates the high priority placed on this goal by both the executive branch and the legislature.

Basic health care. Progress also has been made toward the plan's goal of equitable access to health care and the provision of a basic level of health services to all state residents as a result of pending legislative action on the Basic Health Care Plan (House Bill 477).

I want to thank the members of the state Health Coordinating Council and the many health care consumers and providers around the state who contributed to the development of this State Health Plan. Your continuing interest and involvement will help us to develop an efficient and effective health care system and to seek ways to improve the health status of state residents.

Sincerely,

Booth Gardner

Booth Gardner
Governor

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APPENDICES

A. INTRODUCTION

Volume II of the State Health Plan was originally developed by the State Health Coordinating Council, Department of Social and Health Services and Health Systems Agencies (HSAs) as a set of integrated state and local health planning and Certificate of Need (CON) review policies. Subsequently, federal funding for the regional HSAs was ended and these agencies began to modify their roles. Moreover, changes in health care payment systems made the long term status of the state CON program less certain. As a result of these developments, modifications were made in material originally put together for this document. The facilities and services plan now has the following characteristics:

1. Provisions for a unique planning or review role for standing "regional health councils" or some other local agencies is not initially included. However, the State Health Coordinating Council strongly supports the participation of local health care consumers and providers in health planning processes. For this reason, they will work and advocate for development, maintenance and funding of regional health councils cited in RCW 70.38.085.

2. Specific reference to CON review is not included in the plan. This feature recognizes that the specifications presented in the plan are "performance standards" or desired service characteristics that can have utility for purposes other than CON. For example, health care purchasers could use performance indicators to assess the efficiency or effectiveness of alternative providers competing for their business. Although specific reference to CON is not included, CON or other capital expenditure review decisions shall be consistent with performance standards in this plan, as required by RCW 70.38.115(4).

3. The document does not include performance standards for the public health programs cited in Volume I of the State Health Plan. It is expected that the State Health Coordinating Council and Board of Health will collaborate in the development of such performance standards in the future. Performance standards for other public health programs may also be included at a later date.

The scope and nature of health system performance standards that will be most useful is supporting purchasing and resource allocation decision-making in the future is uncertain. For this reason, it is expected that over the next few years the SHCC and DSHS will systematically assess the need for and utility of such performance standards, and alternative processes for their development. This evaluation will provide the basis for conclusions about the continuation and refinement of this plan.

B. HEALTH FACILITY/SERVICE PERFORMANCE STANDARDS

1. APPLICATION OF PERFORMANCE STANDARDS

State and local planning and monitoring, and any capital expenditure regulation decisions to establish, expand, replace or upgrade health facilities and services, shall be based on these performance standards.

2. GENERAL PERFORMANCE STANDARDS

a. All health facilities and agencies providing health care services in the state shall meet applicable licensing standards.

b. All health facilities and agencies providing health care services shall have an active utilization review program.

c. All facilities and agencies providing health care services shall have a patient priority policy which requires acceptance of patients according to clinical evidence of medical need and potential benefit to patients.

d. Preference shall be given to facilities and agencies providing health care services whose policy it is to serve patients without discriminating against those sponsored by public payment programs.

e. Preference shall be given to facilities and agencies providing health care services which accept their responsibility to share equitably in the provision of care for those patients who are unable to pay.

f. All facilities and agencies providing health care services shall have written policies evidencing a coordination and referral system that assures that patients receive care at the least intensive and restrictive level appropriate to their needs.

g. All facilities and agencies providing health care services shall ensure effective continuity of care through discharge planning initiated early in the course of treatment.

h. All facilities and agencies providing health care services shall have personnel with qualifications appropriate to the level and intensity of care they are providing and with training specific to the technologies they are using.

i. In making decisions where benefits and costs are being weighed, community costs shall be calculated as the difference between the estimated net revenues (receipts) of a service in a particular area with the proposed project, for

its first three years, accounting for projected reduced caseloads in existing facilities, and the estimated net revenues of that service in that area without the proposed service. The net community cost result shall not be the sole basis for action.

j. Planning and review decisions shall be based primarily on the needs of the population in the planning area.

k. Radiation therapy, critical care, cardiovascular, ambulatory surgery, end-stage renal disease, computed tomography, magnetic resonance imaging, innovative technology, home health and hospice services should maintain a data collection system consistent with requirements established by the health planning system to implement policies of this plan. The data collection activity should be carefully defined and coordinated with other agencies, such as the Washington State Hospital Commission (WSHC) and with other provider associations and representatives to avoid unnecessary costs and issues of patient confidentiality and uniform disclosure.

l. Special consideration shall be given to facilities that demonstrate the potential benefits of cooperative operating and/or ownership agreements, plus mutual granting of privileges to qualified physicians of participating institutions for the service proposed.

3. ACUTE CARE PERFORMANCE STANDARDS

a. General

(1) Where defined, Level I health services shall be available within 30 minutes driving time (under normal road conditions) for ninety percent of residents of each health planning region.

(2) The following guidelines should be used in planning for the geographic availability of more specialized health facilities and services:

(a) Where defined, one Level II or III unit should be available within 120 minutes driving time for 90 percent of the population in each health planning region.

(b) Level II and III units (when applicable) should be located in the smallest number of facilities that will meet the needs of the population taking into consideration concerns for access, quality, and cost of care.

(3) Level III services shall coordinate consultation, education and transportation services for residents of their regions.

(4) For equipment replacement, the alternative of upgrading existing equipment at lower cost to the provider and the health care system must be fully evaluated. Factors to evaluate include: overall replacement costs, equipment capabilities, and potential of length of service.

(5) All hospitals should be responsible for providing their fair share of uncompensated care.

(6) Preference for major medical equipment shall be given to projects operated by acute care facilites, unless it is demonstrated that other providers will operate equipment with appropriate utilization and quality controls and provide services at lower community costs.

(7) The most recent SHCC-approved version of the Washington State Hospital Bed Need Forecasting Method shall be used in projections of hospital bed need.

(8) Hospital planning areas identified by SHCC and DSHS shall be used in planning and in projections of hospital bed need, consistent with the requirements of the Hospital Bed Need Forecasting Method.

(9) New beds for a specific service shall not ordinarily be built in a planning area having a net excess of total hospital beds (before or after the addition), unless it is demonstrated that the area's needs cannot be met by conversion of use of hospital beds already existing in the area.

b. Obstetric and Neonatal Services (OB)

Inpatient obstetric and neonatal care consists of hospital care during pregnancy, labor and birth, and care following birth. Neonatal special care services focus on life-threatening conditions for neonates from birth until hospital discharge in hospital areas designated, organized, and equipped to provide specialized care for high risk babies.

Family-centered maternity and newborn care are services provided in in-hospital birthing rooms, free-standing birth centers, and organized home birth services, designed to meet the needs of women seeking an alternative to traditional prenatal labor and delivery care and wanting a birth experience with more co-management capabilities.

There shall be a regionalized system of obstetric and neonatal services in Washington State. This regionalized system of services shall have the following characteristics:

(1) There shall be four levels of obstetric and neonatal facilities/services, as follows:

- Level IA: Out-of-hospital birthing services which provide an alternative for low-risk women.
- Level I: Hospital services which primarily provide uncomplicated maternity and newborn care to low-risk patients and stabilization and referral to Levels II or III for high-risk patients. In-hospital birthing rooms and single unit delivery systems may be part of Level I care.
- Level II: Hospital services which provide specialized services for the majority of complicated obstetric and neonatal problems.
- Level III: Hospital services which receive referrals for and provide all the specialized services applicable to complicated obstetric and neonatal problems for a region.

(2) Planning for a regionalized system of neonatal/obstetric care shall recognize the four geographic regions designated by the DSHS Office of Maternal and Child Health Services (MCH) as the service areas for which patient care, education, consultation, and transportation are planned and coordinated. These geographic regions are as follows: Northwest (Seattle), Eastern (Spokane), South Central (Yakima), and Southwestern (Tacoma).

(3) Level I obstetric services shall have a minimum of 100 births/year. Level II and III obstetric services shall have a minimum of 1200 births per year and an average occupancy of 70 percent.

(4) Level II neonatal special care shall be located only in facilities which provide Level II obstetric services.

(5) All obstetric and neonatal units shall have written procedures for identification of acuity care level needed for each patient and for referral to or receipt by the appropriate level.

(6) A single Level II or Level III neonatal special care unit shall contain a minimum of 15 beds; neonatal special care service shall be provided only in dedicated neonatal special care units.

(7) For Level I obstetrics, preference may be given to those proposing a family-centered maternity and newborn care program.

(8) Existing Level II and III neonatal services shall have an average annual occupancy rate of 75 percent. Proposals for new or upgraded Level II services shall project an occupancy rate of 75 percent by the end of the third year of operation, and shall demonstrate that all existing Level II and III services in the MCH planning area have an occupancy rate of 75 percent for the year prior to the application.

c. Pediatric Services (PEDS)

Inpatient pediatric services are medical/surgical services in acute care hospitals available to persons 0-14 years exclusive of neonatal, psychiatric and obstetric services offered this age group.

A pediatric bed is a medical/surgical bed that is licensed for inpatient use and is used by patients 0-14, exclusive of neonatal, psychiatric and obstetric patients.

A pediatric unit is a distinctly designated section, ward, wing, hospital, or unit devoted primarily to the care of medical and surgical pediatric patients.

There shall be a planned system of hospital pediatric services based on patient need for basic or specialized care. This system shall have the following characteristics:

(1) There shall be two levels of pediatric facilities/services recognized in the state:

- Basic services: hospital services which primarily provide uncomplicated pediatric care to meet the majority of pediatric needs. These services are not usually in a separate unit, but they should be designated pediatric beds distinct from medical/surgical beds.

- Specialized services:* hospital services which primarily provide specialized services for complicated pediatric problems. These services shall be provided in dedicated pediatric units with appropriate specialized and sub-specialized personnel and a separate nurses' station.

(2) Hospitals with dedicated pediatric units should have 16 or more pediatric beds, and shall maintain a minimum occupancy rate for the pediatric unit of 65 percent for up to 39 beds, 70 percent for 40-79 beds, and 75 percent for 80 beds or more.

*These services correspond to pediatric Levels II and III in WAC 248-19-230.

(3) Hospitals which provide basic pediatric services should have dedicated pediatric beds if they have an average daily census of 10 or more pediatric patients, and should maintain an occupancy rate of 65 percent.

(4) All hospitals providing pediatric services shall have written procedures for identification of level of care needed and for referral to and receipt by the appropriate level.

(5) All specialized pediatric services shall have a pediatrician in house or on call 24 hours a day and should have available on staff or on contract for consultation a qualified mental health practitioner who specializes in children.

(6) The three children's hospitals in the state should coordinate pediatric consultation and education networks and transportation services in the state.

d. Cancer Management Services (CMS)

Cancer management is the effective supervision of the cancer patient through all phases of illness through a system composed of the following services: prevention, detection, diagnosis, pre-treatment evaluation, treatment (surgery, transplantation, radiation therapy, chemotherapy), and continuing care (rehabilitation, maintenance, and terminal care).

Radiation therapy is the use of ionizing radiation to destroy or inhibit the growth of potential cancer cells. It may be curative or palliative. The most common type of radiation therapy is carried out by external beams of radiation that are classified by their energy range (superficial, orthovoltage, and megavoltage).

The two most common types of megavoltage equipment are the Cobalt-60 units and linear accelerator units. The Cobalt-60 produces 1.17 to 1.33 MeV (million electron volts). There is a continuing trend to replace Cobalt-60s with linear accelerators because of technical advantages and versatility. Linear accelerators are commercially available in three energy levels: 4-8 MeV, 10-20 MeV, and over 20 MeV.

Other types of radiation therapy involve the application, implantation (brachytherapy), or systemic administration of radioactive substances.

(1) Each hospital providing cancer diagnosis and treatment services shall:

- Have written procedures to involve the referring primary care physician and social worker/counselors in pre-treatment planning and ongoing care for every patient with a major malignancy;

- Participate in a cancer registry;

- Have referral agreements with a cancer rehabilitation program which meets minimal service and staffing standards for its size as established by the Fred Hutchinson Cancer Research Center Committee on Rehabilitation (Appendix A).

(2) Each hospital providing radiation therapy service shall have available in-house or by arrangement 1/ with other providers:

- A full range of diagnostic tests and procedures; and

- The broad range of treatment modalities including superficial x-ray and brachytherapy capabilities.

(3) Megavoltage radiation therapy is a specialized service which shall be regionalized according to the following criteria:

(a) Need for units will be computed using area-specific da where possible. If unavailable, age-specific incidence from reliable sources such as the nationwide Cancer Surveillance, Epidemiology and End Results (SEER) Program may be applied to the entire area's population. The following assumptions shall apply:

- 50 percent of new cancer patients will require megavoltage therapy;

- 30 percent of new cancer patients who received megavoltage therapy will require retreatment;

- New, palliative, and returning patients will average 20 treatments;

- One megavoltage unit will average 6,000 treatments per year.

1/ "Arrangement" refers to an existing referral/consultation network which may be a conjoint radiation oncology center.

(b) A proposed megavoltage therapy unit shall show projected use by at least 300 cancer cases annually within three years after the beginning of operation.

(c) Existing and approved megavoltage units in a health service area shall be utilized at a rate of 6,000 treatments per year within three years after the proposed operation begins. This standard does not apply to:

(i) Older megavoltage equipment used on a back-up basis, or

(ii) Dedicated special purpose machines and high energy research equipment which have limited but important applications.

e. Critical Care Services (CCS)

A Coronary Intensive Care Unit (CCU) is a specific location in an acute care hospital designated and equipped for the management of patients with life-threatening arrhythmias, suspected myocardial infarctions, or other coronary conditions requiring intensive care. (Open heart surgery and cardiac catheterization are addressed in a separate section of this Plan.)

A general medical-surgical Intensive Care Unit (ICU) is a specific location in an acute care hospital designated and equipped to accommodate patients with serious medical conditions including trauma requiring immediate and aggressive intervention.

A Critical Care Unit is a combined coronary and intensive care unit.

A Critical Care Bed is a hospital bed equipped and designed for intensive/coronary care patients. Five or more ICU, CCU or critical care beds require designation as a unit with its own nurses' station.

A Step-Down (Intermediate) Unit is a specific location in an acute care hospital designed and equipped for coronary and intensive care patients whose risk has diminished but who still require monitoring.

An Emergency Life Support Station is a designated location in a basic service hospital or a mobile unit equipped to provide emergency life support to patients with suspected myocardial infarctions or life-threatening arrhythmias.

ICU-CCU or their combined Critical Care Units shall be distributed according to the population density and the hospitals' service intensity/specialization.

(1) An Emergency Life Support Station or emergency room should be located within 20 minutes driving time of at least 90 percent of the population.

(2) A Coronary Care Unit shall be located within 60 minutes driving time of each Emergency Life Support Station. Travel time should be measured with consideration of both ground and air transportation systems.

(3) Acute care facilities averaging 25 or fewer diagnosed myocardial infarction admissions per annum during the immediately preceding five-year period shall not commit to capital projects for the purpose of constructing, expanding or substantially remodeling a coronary intensive care unit.

(4) There shall be no new coronary care beds developed within a hospital planning area unless it is demonstrated that development of additional step-down beds is not an appropriate alternative.

(5) The minimum size of a newly-constructed ICU, CCU or critical care unit shall be four beds.

f. Cardiovascular Disease Services (CD)

Cardiovascular services include both cardiac catheterization and open heart surgery procedures. They also include coronary care unit services addressed in the Critical Care Services Section of this Health Facilities and Services Plan.

Cardiac catheterization includes diagnostic and therapeutic procedures involving the heart and the cardiac arteries which supply the heart. There are two categories of diagnostic procedures:

- Coronary arteriography - passage of a thin tube through major blood vessels and into the coronary arteries, followed by injection of an opaque fluid permitting x-ray visualization of the coronary arteries.
- Left or right catheterization - passage of a tube into one of the heart chambers to evaluate how well the heart is pumping.

The use of cardiac catheterization for therapeutic purposes includes injection of the enzyme streptokinase or other substances to break down blood clots formed in coronary

arteries. It also includes percutaneous transluminal coronary angioplasty (PTCA) which involves inflation of a balloon catheter at the site of narrowing of a coronary artery to dilate the artery. Current literature and professional opinion recommend stand-by open heart surgery capacity where PTCA is performed. The emerging trends in therapeutic cardiac catheterization need to be evaluated for efficacy, patient benefits, cost, and their potential to substitute for more invasive procedures.

A cardiac catheterization unit is a laboratory room in which cardiac catheterization procedures are performed.

A cardiac catheterization procedure includes all of the diagnostic and therapeutic interventions defined above performed on a single patient in a single day.

Open heart surgery units perform surgery requiring the use of a heart-lung bypass machine to perform the functions of circulation during surgery. Prior to the late 1960s, open heart surgery was primarily used to correct or palliate congenital or valvular heart disease. In the late 1960s, procedures for aorto-coronary artery bypass surgery were developed; in 1976, coronary bypass surgery accounted for 82 percent of all open heart surgery in Washington.

An open heart surgery unit is an operating room dedicated to the use of surgery using a heart-lung bypass machine.

Cardiovascular services, including cardiac catheterization, a specialized service, and open heart surgery, a tertiary service, shall be regionalized according to the following criteria:

(1) There shall be a minimum volume of 200 adult open heart surgery procedures (100 if pediatric) performed annually in each institution approved for open heart surgery within three years of initial operation. If institutions fall below 200 adult open heart surgery procedures, they should consider consolidation.

(2) New open heart surgery services shall not result in a number of open heart operating rooms that exceeds the maximum number of open heart operating rooms needed in the area by 1990 determined by multiplying the state's 1983 adult or pediatric open heart surgery use rate by the area's 1990 adult or pediatric populations, and dividing the result by the minimum capacity of adult or pediatric units (200 or 100, respectively.)

(3) There shall be no new open heart surgery operating rooms approved until all facilities providing open heart surgery in the planning area are experiencing at least 200 (100 for pediatric) open heart surgeries per year per open heart surgery operating room.

(4) Cardiac catheterization services shall be closely associated with open heart surgery programs, and shall be able to demonstrate, explicitly and in writing, association and referral arrangements with an existing surgery program.

(5) There shall be a minimum volume of 300 cardiac and noncardiac catheterization procedures per room (at least 100 of which should be cardiac catheterizations) performed annually in each institution approved for such services within three years of initial operation.

Proposed new cardiac catheterization services, adult and/or pediatric, should be able to project reaching this level within one year of operation.

g. End-Stage Renal Disease Services (ESRD)

End stage renal disease (ESRD) occurs when the kidneys suffer permanent loss of function. Two treatments are available to prevent the ESRD patient's death - kidney transplantation and maintenance dialysis. Maintenance dialysis is a process by which dissolved toxic impurities are removed from a patient's body by diffusion from the blood across a semi-permeable membrane into a dialyzing fluid. Maintenance dialysis in which the patient is connected to an artificial kidney machine for three to six hours, up to three times a week, is called hemodialysis. The other form of dialysis in common use is peritoneal dialysis, in which the patient's own abdominal membrane is used for diffusion.

A renal dialysis center is a hospital-based unit which furnishes the full spectrum (except renal transplantation) of diagnostic, therapeutic, and rehabilitative services required by ESRD patients. A renal dialysis facility is a free standing unit which furnishes maintenance dialysis to ESRD patients. Training for home dialysis and/or supervised self care may be provided by both free-standing and hospital based units upon federal certification.

A dialysis station with 100 percent utilization rate is defined as operating two shifts per day, six days a week, i.e., performing 12 dialyses per week and caring for four individual patients. A dialysis facility or center operating at an 80 percent utilization rate would perform 9.6 dialyses per station per week.

A renal transplantation center is a hospital unit which is approved to furnish kidney transplants and related services. These are located at University, Virginia Mason, Children's Orthopedic, and Swedish hospitals in Seattle and at Sacred Heart Hospital in Spokane. One hundred and three renal transplants were performed at Washington transplant centers in 1984.

Network Coordinating Council #2 (NCC #2) is an administrative organization designated and funded under Public Law 95-292 to assure adequate and quality ESRD services are available in Washington, Alaska, Idaho, Montana, and Oregon.

The ESRD service system shall be further developed in Washington State with the following characteristics:

(1) Transplant centers shall perform at least fifteen transplants annually by the fourth year of operation.

(2) Forecasted need for dialysis stations will be computed using health planning region-specific data and any regional goals for the percentage of patients on home dialysis (50 percent minimum goal).

(3) The number and location of dialysis facilities and centers shall be determined for each health planning region using the federal guidelines for unconditional status as follows:

    (a) Existing facilities and centers shall have an 80 percent utilization rate before approval will be granted for establishing a new facility or expanding an existing one within a reasonable driving time.

    (b) A proposed new dialysis facility or center within a standard metropolitan statistical area (SMSA) of 500,000 population or more shall have a minimum of six stations and 80 percent utilization rate of its outpatient dialysis units by the fourth year of its establishment. If located outside of an SMSA of 500,000 population or more, it should have a minimum of three stations and 33 percent utilization rate.

    (c) A proposed new dialysis center with 20 percent or less dialysis outpatients shall have a minimum of three outpatient stations and 33 percent utilization rate by the fourth year of its establishment.

(d) Approved dialysis facilities or centers proposing to add new stations shall achieve an 80 percent utilization for 52 weeks prior to expansion and should be able to estimate achieving this rate within two years of expansion.

(e) Based on the NCC #2 data, exceptions to (a)-(d) above are:

(i) each station on which at least six patients have been self/home trained annually shall be deducted from the approved stations on which the utilization calculation is made; and

(ii) the utilization rate may be reduced to 75 percent and 70 percent in facilities with 10 percent and 20 percent peritoneal dialysis patients respectively.

h. Facility Based Adult Rehabilitation Medicine Services (REHAB)

Patients' medical or surgical needs alone may not warrant inpatient hospital care, but hospitalization may nevertheless be reasonable and necessary because of their need for rehabilitative services. Patients are deemed to requie a hospital level of care if they require a relatively intense rehabilitation program involving a multidisciplinary, coordinated te approach to upgrade their ability to function as independent as possible.

There shall be a coordinated system of facility-based adult rehabilitation medicine services in Washington State with the following characteristics:

(1) Multidisciplinary services:

--physiatry or the guidance of a physician with at least two years of rehabilitation training (physical medicine);
--intensive skilled rehabilitation nursing care;
--social worker/discharge planner;
--physical therapy;
--occupational therapy;
--speech therapy; and
--psychology.

(2) Services required to qualify for Medicare/Medicaid reimbursement under the guidelines established by the Health Care Financing Administration. These include 24-hour physician availability, and appropriate rehabilitation services as indicated by patient needs.

(3) Operation in keeping with the guidelines established by a professional review organization under terms of Public Law 97-248 as amended by Public Law 98-21 and accepted by the Health Care Financing Administration. These guidelines shall include criteria for admission, patient care, and discharge.

(4) Written policies which are used to define types of patients admitted and referred.

(5) Participation in a communication and education network.

(6) Outpatient continuing care or make appropriate referral arrangements for this.

(7) Facilitate team communication and have documented procedures for same.

(8) Bed need forecast consistent with the Washington State Hospital Bed Need Forecasting Method for hospital total bed supply.

i. Computed Tomography Services (CT)

Computed tomography (CT) scanning is a radiologic procedure which produces cross-sectional x-ray images of internal parts of the body. These images are obtained by passing x-rays through the patient, measuring the unabsorbed radiation with detectors, mathematically reconstructing by computer a cross-sectional image and recording the image on photographic film. This records much smaller increments in tissue density than conventional x-ray films and, therefore, provides a clearer picture of many body abnormalities than conventional x-ray methods.

A CT scan is a series of tomographic images through the same area of diagnostic interest.

A head equivalent CT (HECT) unit is a single, unenhanced CT scan. A body scan with and without contrast amounts to 2.51 HECTs.

The development of CT scanning services will be guided by the following policies:

(1) CT scanners shall operate at a minimum of 2,800 head equivalent CT units (HECTs) for the second year of operation and thereafter.

(2) Facility-housed computer tomography scanners may operate at less than 2,800 HECT units per year, or facilities planning acquisition of a CT scanner may project less

than 2,800 HECT units per year, if it is found that the adjustment is justified because of one or more of the following: (a) the costs of transporting inpatients to another facility for CT scans would be equal to or exceed the average fixed costs of operating the scanner; (b) 90 percent of the clients served by the CT scanner would have to travel more than 90 minutes driving time under average road conditions to obtain CT scanning services from the next nearest CT scanner(s); (c) cost and charge levels of the scanner are (will be) comparable to costs and charges of scanning services in other facilities of the same peer group having scanners of approximately the same price and capabilities; (d) the scanner is (will be) servicing a designated special population.

(3) There shall be no additional scanners unless the utilization of each of the other facility-based CT scanners in the same and contiguous hospital planning areas equals or exceeds 2,800 HECT units annually during the last completed calendar year.

(4) Forecasted utilization of proposed CT scanners shall be based on that hospital's existing case mix as measured by their discharge diagnoses for the most recent 12 months.

(5) When more than one facility in the same hospital planning area is proposing CT scanning, a maximum of one CT scanner shall be installed initially, provided that the institution meets other policies in this section. The determination of which facility will initially provide CT scanning will be based on which facility has the highest volume of expected inpatient CT scans based on that hospital's discharge diagnoses for the prior twelve months.

j. Magnetic Resonance (MR)

Magnetic resonance is a technique that applies the atomic principle of magnetic spin and absorption of energy by atomic nuclei in the presence of radio waves to yield information about tissue being examined. The information may appear in spectroscopic form or as an image produced by magnetic resonance, the latter using computed tomography to produce the image. MR is clinically efficacious, according to criteria listed by the Office of Technology Assessment.

Present state law does not require a Certificate of Need review of magnetic resonance equipment located in physicians' offices or other non-hospital settings unless the service is proposed for inpatients and provided on equipment which costs more than the expenditure threshold.

A "patient visit" is defined as a single occurrence for a patient to visit the MR unit and be scanned. It is the equivalent to the American Hospital Association's "scan." One patient visit may require scanning several anatomical parts.

The development of MR services will be guided by the following performance standards:

1. Washington State should have an appropriate supply of MR services with adequate geographic distribution.

    a. Certificate of Need should be granted to an applicant who can demonstrate a demand for at least 2500 patient visits a year in the second year of operation. The method of estimating demand will be the one in most current use by the American Hospital Association (AHA). This may require the application purchase services from the American Hospital Association. Existing MRs that have a utilization of 2500 patient visits in the twelve months prior to filing an application have already met this standard.

    b. Preference will be given to applications that demonstrate they can best address the needs of inpatients.

    c. Special consideration will be given to children's hospitals since the AHA method is not applicable and theoretic capacity of the equipment is different.

2. All physicians and techonologists operating MR units shall have special training in diagnostic imaging.

    a. Physicians performing the clinical interpretation of MR shall meet the standards set by the American College of Radiology. In September 1985 these were:

        1) Three months training or six months experience in nuclear radiology; and

        2) Six months training in cross-sectional body imaging to include at least three months training in computed body tomography or one year experience in cross-sectional body imaging to include computed body tomography; and

        3) Three months training or six months experience in neuroradiology; and

        4) Sixty hours of documented instruction in magnetic resonance imaging physics, instrumentation, and clinical applications.

b. Technologists assisting in MR studies shall be certified by a national board in at least one of the following fields prior to initiation of MR operations: radiology technology, nuclear medicine technology, or ultrasound technology.

3. MR units which have Certificate of Need approval shall periodically provide data in the SHCC-developed format requested. Non CN-approved units are encouraged to provide data also.

k. Innovative Technologies (IT)

Innovative Technology is new, potentially useful equipment or procedures for the diagnosis and/or treatment of disease requiring capital or operating expenditures which exceed the Certificate of Need thresholds. Present state law does not require CN review of IT located in physicians' offices or other non-hospital settings unless service is proposed for inpatients.

The Food and Drug Administration (FDA), National Center of Devices and Radiological Health, controls the introduction of medical devices into commerce. Medical devices are segregated into three classes:

--Class I devices are subject to the minimum level of control. General controls include the Good Manufacturing Practice Regulations.

--Class II devices have been declared to require performance standards to assure their safety and/or effectiveness. They must also meet the controls of Class I.

--Class III devices require formal premarket approval from the FDA for each make and model of the device to assure its safety and effectiveness. The controls of Class I are also required.

Investigational stage is the period during which manufacturer of a Class III device is testing it according to an established protocol in order to obtain the FDA's pre-market approval. During this stage the manufacturer cannot charge the sites or patients who are subjects of the investigation a price higher than necessary to recover costs of manufacturing, research, development, and handling.

Patient benefit refers to the aggregate: where scientific studies demonstrate that a significant number of patients receiving the services experience improved therapy and/or outcome; or if diagnostic, the information generated is

valid and not available by other diagnostic methods or is available only by means which are less safe, more uncomfortable to the patient, or which entail more expensive procedures.

Each innovative technology shall be initiated in the state of Washington according to the following process:

(1) A Technical Advisory Committee (TAC) shall be appointed by the State Health Coordinating Council (SHCC) chair to provide guidance for CN review, taking into consideration the patient benefit to be derived from the IT.

(2) Each TAC shall contain persons knowledgeable in the application of the technology under consideration and at least three SHCC members, one SHCC member being the TAC chair.

(3) The director of the CN program shall alert the director of the SHCC regarding the need for initiating a TAC to address a specific new technology when he/she has reason to believe an application is forthcoming (i.e., consultation regarding the technology is requested, a letter of intent is received, etc.).

(4) In consultation with the CN program, the SHCC may revise or reject the TAC's recommendation.

(5) In consultation with the CN program, the SHCC will determine whether the original TAC should reconvene to develop guidance for subsequent CN review in light of experience with the first phase.

1. Ambulatory Surgery Services (AS)

Ambulatory Surgery is surgery for which an overnight stay in a health care facility is not anticipated as medically necessary. Also called outpatient surgery, short-stay surgery, in- and out-surgery, and same day surgery. Ambulatory surgery is performed in a variety of settings including a hospital surgery suite which is also used for inpatient surgery, a hospital unit designed and dedicated only for outpatient surgery use, and a free-standing facility which may be owned by ("part of") a hospital or owned by others.

Outpatient Operating Rooms are those in which ambulatory surgery is performed and may be dedicated to this.

Ambulatory Surgical Facility (as defined in WAC 248-19-220(4)) means a facility, not part of a hospital, which provides surgical treatment to patients not requiring inpatient care in a hospital. This term does not include a facility in the offices of private physicians or dentists, whether for indivi-

dual or group practice, if the privilege of using such facility is not extended to physicians or dentists outside the individu or group practice.

The development of operating room capacity in general and ambulatory surgical facilities in particular will be guided by the following policies:

(1) The area to be used in planning for operating rooms and ambulatory surgical facilities is the hospital planning area.

(2) Outpatient operating rooms should ordinarily not be approved in hospital planning areas where the total number of operating rooms available for both inpatient and outpatient surgery exceeds the area need.

(3) When a need exists in hospital planning areas for additional outpatient operating room capacity, preference shall be given to dedicated outpatient operating rooms.

(4) An ambulatory surgical facility shall have a minimum of two operating rooms.

(5) Ambulatory surgical facilities shall document policies to provide access to individuals unable to pay consistent with charity care standards established for hospitals affected by the proposed ambulatory surgical facility.

(6) Community costs for an expansion in operating rooms shall be assessed by applying the established Community Cost Estimating Method to the impacted hospitals' surgery cost centers. In hospital planning areas where the ratio of ambulatory surgery is less than 30 percent of total surgical volume, community cost shall include savings associated with shifting inpatient surgeries to outpatient surgeries so that the ratio of outpatient surgeries reaches 30 percent.

(7) The need for operating rooms will be determined by the method described in this plan.

m. Short Stay Psychiatric Services (PSYCH)

Short stay psychiatric hospital services are services in acute care general hospitals, in private psychiatric hospitals, or stays of 30 days or less in state mental hospitals or federal (Veterans Administration and military) hospitals, for severely and acutely mentally disabled persons who may be either civilly committed (Involuntary Treatment Act) or voluntarily admitted.

Short stay psychiatric residential services are services provided for persons experiencing acute psychiatric disorders

without medical complications (who may be civilly committed or voluntarily admitted), which are provided in residental programs with the following characteristics:

- Both residential care (room, board, skilled supervision) and treatment/stabilization are provided under a single administration.

- The residential facility either (a) is licensed by the Department of Social and Health Services (DSHS) as a boarding home or an adult residential treatment facility (ARTF); or (b) is certified by DSHS as an adult family home or child foster home; or (c) is within a licensed hospital, but operated as a separate residential program with separate financial accounting approved by the Washington State Hospital Commission.

Involuntary Treatment Act (ITA), Chapter 71.05 RCW, is the Washington State law governing involuntary civil commitment of individuals for psychiatric care.

The development of short stay psychiatric services in Washington State will be guided by the following policies:

(1) Short-term patients with more severe medical involvement, and those with more severe, violent behavior disturbances (especially if requiring restraint), should be in specialized programs which can meet their needs. Usually these programs are hospital based.

(2) Access to short stay psychiatric residential programs should be available to clients with private insurance coverage as well as those who are state paid (Medicaid or involuntary treatment) and those with sufficient personal resources to pay out of pocket.

(3) The county is a fundamental administrative unit for mental health services in Washington. Therefore the planning areas for computation of short stay psychiatric resource needs are counties, with the exception that the following groups of counties, which jointly operate their mental health services, should be considered single planning areas:

    - Benton and Franklin Counties
    - Chelan and Douglas Counties
    - Thurston and Mason Counties

(4) Because the hospital resources needed within the desired system of short stay psychiatric services are much more completely developed than the needed residential services, the following performance standards shall be in effect until replaced in this State Health Plan:

(a) During this period, the need for short stay psychiatric hospital services is determined to be 13 bed per 100,000 population for the state as a whole. The need for short stay psychiatric residential services is determined to be 8 beds/100,000 population. These are normative standards determined by the SHCC to be appropriate.

(b) Development of short stay psychiatric residential services should be a goal.

(c) In the interest of increasing equity in geographic access to needed psychiatric services, those mental health planning areas with the lowest ratios of short stay psychiatric resources in relation to population should be priority locations for short stay psychiatric residential programs.

In planning areas where there is no concrete evidence of residential program development, consideration should be given to making determinations of need for a greater proportion of hospital services within the total need for short stay psychiatric services. Examples of concrete evidence of program development may include committed funding, contracts, letters of intent, appropriately zoned sites, and the like.

(5) The need for short stay psychiatric hospital services in each mental health planning area shall be determined by the short-stay psychiatric service forecasting method within the most recent State Health Coordinating Council (SHCC)-approved version of the Washington State Hospital Bed Need Forecasting Method.

(6) Within acute care general hospitals, the following capacity shall be considered available to meet short stay psychiatric hospital needs:

- The number of beds in designated psychiatric hospitals units;
- In hospitals which do not have designated psychiatric units, the actual average daily census of psychiatric services provided during the data period which forms the basis for hospital bed need forecasting shall be counted.

(7) The capacities of state mental hospitals and federal hospitals to provide the level of short stay psychiatric services assumed in detailed forecasting methods should be confirmed as part of the forecast adjustment process, and re-examined as part of the next State Health Plan development cycle.

(8) The relative needs of children, aging individuals and other adults for services, and the relative availability of resources to meet their needs, should be considered in deciding the particular mix of hospital programs needed in an area, and the particular mix of residential programs.

(9) The MHD should inform interested agencies of all applications or letters of intent concerning development of short stay psychiatric residential programs, and should solicit HSA comment on the proposals before reaching a decision about ITA certification or funding.

4. LONG TERM CARE PERFORMANCE STANDARDS

a. Nursing Home Services (NH)

The term "nursing home" includes entities licensed or required to be licensed under the provisions of chapter 18.51 RCW, and equivalent facilities owned and operated by the state. A nursing home is any home, place, institution, building or agency or distinct part thereof 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 to properly 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 dressing and bandages, and carrying out of treatment prescribed by a duly licensed practitioner of the healing arts.

The term "nursing home" does not include a swing bed program.

(1) The areas used for planning nursing home services shall be: Clark and Skamania Counties combined, Snohomish County and Camano Island, Island County, excluding Camano Island and the other 35 individual counties in the state.

(2) The appropriate supply of nursing home beds in each area of the state shall not exceed the number of beds determined to be needed by the Washington State Nursing Home Bed Need Projection Method, except that certain nursing home projects which are undertaken as part of a qualifying continuing care retirement community may choose to be considered under the special provisions of Performance Standard B.4.c.(4).

(3) State approval to build, expand or acquire a nursing home shall not be given to owners or operators of existing nursing homes who, according to federal or this or another state's survey reports for at least the last three years, have had repeated and/or severe violations of standards of patient care.

(4) Operators proposing to build or expand a nursing home shall document: 1) joint planning with other health care and long-term care programs, 2) a commitment to placing clients in the least restrictive setting, and 3) services designed to assist clients to maintan maximum functional independence.

(a) Evidence of joint planning shall include written agreements with other providers for referral, consultation, service provision, and joint planning. It shall also include a list of other long-term care services informed about the project including at least the Area Agency on Aging, local home health agencies, the local Community Service Office (CSO) and the local hospitals.

(b) Evidence of a commitment to least restrictive placements shall include: 1) information provided to clients prior to admission on other long-term care services in the community. 2) the existence of a continuing patient assessment program for all clients regardless of their payment status, and 3) for existing nursing homes, a documented record of discharging clients to their homes or less intensive services and of maintaining no severe or repeated deficiencies cited in the discharge planning standard for the last three years.

(c) For existing nursing homes, evidence of adequate services to maintain client functional independence shall include documentation that for at least the last three years the nursing home has not had repeated and/or severe violations of standards of patient care.

(5) Important considerations for which preference in meeting the bed needs in a planning area may be given are presented below. Preference shall be given to the project which meets the greatest number of the following criteria for preference.

(a) Nursing home operators who have the policy of admitting patients without regard to their source of income or payment.

(b) Projects that include other institutional long-term care services or evidence relatively greater linkages to community-based long-term care services.

(c) Projects which improve the geographic distribution and/or provide access to nursing home beds in a currently underserved area.

(d) Nursing home operators having or proposing to have a Medicare contract in areas with less than the statewide proportion of Medicare nursing home beds to total nursing home beds.

(e) Nursing home operators serving or proposing to serve Medicaid clients.

(f) Nursing home operators proposing to serve additional heavy care patients in areas where CSO placement staff or hospital discharge planners document significant and continuing difficulties in placing heavy care patients in nursing homes.

(g) Existing nursing home operators in the state who are seeking to achieve a 100-bed minimum efficient operating size for nursing homes or to otherwise upgrade a facility with substantial physical plant waivers or exceptions, as determined by the State Aging and Adult Services Administration.

(h) Projects that propose to serve persons requiring mental health services and persons with dementias.

(6) Nursing home projects which are undertaken as part of a continuing care retirement community shall meet the additional performance standards of Section B.4.c of this plan.

b. Swing Bed Services (SB)

"Swing beds" are hospital beds, available to provide either acute care or long-term care/nursing care services as required, which meet the following conditions:

- They are in a rural hospital (i.e., outside of U.S. Census defined "urbanized areas");
- The hospital has under 50 licensed beds, excluding any critical care beds and infant bassinets and any beds in a Medicare and/or Medicaid certified distinct long-term care wing;

- The total number of swing beds in the hospital does not exceed five;
- Capital expenditures to establish the swing beds do not exceed the Certificate of Need capital threshold identified in WAC 248-19-220.
- Services meet minimum requirements established by Medicare for rural hospital swing beds.

(1) The establishment of a swing bed program, as defined above, shall not be subject to capital expenditure review unless it involves an increase in the hospital's total number of licensed beds.

(2) Swing beds shall be counted as hospital beds. They shall not be considered nursing home beds for the purpose of determining nursing home bed needs or available nursing home bed supply.

(3) Hospital programs providing long-term care/nursing care services which are not swing beds as defined above, shall be considered nursing home services. They shall be subject to capital expenditure review and all nursing home certification requirements, and shall be counted in the Nursing Home Bed Projection Methodology.

c. Continuing Care Retirement Communities (CCRCs)

Definitions

A "continuing care contract" means a contract to provide a person, for the duration of that person's life or for a term in excess of one year, shelter along with nursing, medical, health-related or personal care services, in exchange for payment of an entrance fee, periodic charges, or both. Continuing care contracts include (but are not limited to) life care agreements and mutually terminable contracts. The living space and services under a continuing care contract may or may not be provided at the same location.

A "continuing care retirement community" (CCRC) is any of a wide variety of entities providing shelter and services pursuant to continuing care contracts with its members. For clarity, three types of CCRCs are distinguished in this plan:

Type A CCRC - A "life care model" CCRC which provides its members (residents) with a contractually guaranteed range of services from independent living through skilled nursing, including some form of assistance with

activities of daily living. There must be no limits on days of medically needed nursing home care. With limited exceptions related to start-up periods, a Type A CCRC offers services only to contractual members. The member's financial responsibility is stated in contract, with the CCRC responsible for remaining costs. With the exception of insurance purchased by the CCRC or its members, no third-party -- including, after a limited start-up period, the Medicaid program -- is liable for costs of care, even if the member depletes his/her personal resources.

These characteristics of a Type A CCRC, as they apply to differential requirements for state approval of nursing home beds, are elaborated in Performance Standard (3) below.

Type B CCRC - A CCRC which does not meet all the requirements of Type A CCRCs, but does provide nursing home care or other facilities or services subject to state Certificate of Need review. A typical example would be a CCRC which operates an on-site nursing home, but contractually guarantees only a limited number of days of nursing care, after which additional payment is required of the member. Many Type B CCRCs have nursing home units which maintain Medicaid contracts and/or admit patients who are not CCRC members.

Type C CCRC - An entity offering continuing care contracts whose scope of services does not include state reviewable facilities or services. For example, a residential retirement community with long-term contracts which offers proximity to a separate nursing home, but no contractually guaranteed health services other than an on-call nurse to cover health emergencies, is a Type C CCRC.

A "member" of a CCRC is an individual who has signed a continuing care contract with the CCRC.

A "transition period" is a period not exceeding five years between the start-up of a Type A CCRC (i.e., the date its first member takes up residency under a Type A continuing care contract) and the date that it fully meets the requirements in Performance Standards (3)(b) and (3)(c) below for "self-containment" in financing and nursing home admission.

Introduction

CCRCs can provide a valued option in meeting the long-term residential, social and health needs of many of Washington's senior citizens. Continuing care contracts also have been acknowledged by the Washington State Legislature as distinct

from long-term care insurance (RCW 48.84.020(2)). However, consumers in Washington and nationwide have encountered serious, documented problems in dealing with some CCRCs, generally stemming from long-term financial instability of the community or insufficient disclosure to consumers. Based on the recommendations from a special advisory process*, the performance standards in this section have been developed to balance competing public needs and goals including:

- assistance in weighing the benefits and risks of CCRC membership for consumers who may have insufficient information for informed choice;
- the needs for nursing home care of both individuals who become CCRC members and those who cannot afford or do not choose this option;
- the cost containment interest of state government in encouraging those specific CCRCs which can give binding assurances that state funds will not be used to underwrite long-term care services for their members.

Current state Certificate of Need review processes deal with nursing homes and other specific types of health facilities and services, not with CCRCs as a whole (although Long Term Care Strategy 4.d(3) in Volume I of the State Health Plan recommends legislation which would establish independent oversight of CCRCs themselves). However, in order to correctly apply performance standards to a nursing home (or other reviewable activity) which is part of a CCRC, it must be reviewed differently from free-standing facilities because of its special characteristics:

- The nursing home is not a separate financial entity. Services are contracted, priced and paid for as a whole. The issue of cost containment cannot reasonably be addressed, from the consumer's point of view, for the nursing home service in isolation. Put another way,the consumer's price for the contract, if viewed as payment for nursing home services alone, would appear very high compared to charges for other new nursing home projects.

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*During 1985 and 1986, the State Health Coordinating Council and the State Council on Aging jointly sponsored a 16-member CCRC Advisory Group representing citizen members of the two councils; state legislative committees with jurisdiction over financial institutions and social and health services; and pertinent state agencies (DSHS, Governor's Office, Insurance Commissioner and Consumer Protection Division of the Attorney General's Office). CCRC developers, technical experts, and consumers participated actively in this extended period of discussion, hearings and written comment.

- Many CCRCs involve a large "insurance effect:" including both a large deposit payment which prepays benefits and expenses and extensive cross-subsidy among members of different ages or of similar age but differing health care needs. Consequently, issues of pricing, cost containment and financial feasibility require a long-term view, including actuarial perspectives not necessary for review of "regular" nursing home projects.

- The financial risks of CCRC failure fall on consumers and state government as well as on facility operators and their lenders. This is true because CCRC financing generally includes members' deposits, and state government (at least in the case of Type A CCRCs) is given assurances of savings. In the framework of actuarial cost analysis, the likelihood of such losses must be considered as a factor relevant to cost containment as well as financial feasibility.

- When functioning well, a CCRC (especially if Type A) enhances continuity of care - a quality consideration - through its very design.

For these reasons, Certificate of Need review of a nursing home project within a CCRC requires information about the CCRC as a legal and financial whole. The performance standards which follow, therefore, are different in many respects than they would be for a free-standing nursing home. However, with one exception -- the consideration of certain CCRC nursing home projects outside of the area-specific bed need standards established under the state's projection method - this differential treatment does not exempt CCRC-based projects from any of the usual review criteria. Rather, it (1) adds information requirements pertinent to the special legal and financial arrangements surrounding CCRCs, and (2) offers operators/ developers of certain kinds of CCRCs the option of having nursing home projects they propose considered under different need rules, related to characteristics of members rather than the local general population, if the CCRC meets special conditions including guarantees that state funds will be conserved.

If legislation is enacted establishing direct regulation of CCRCs for consumer protection purposes, this section of the Health Facilities and Service Plan should immediately be reevaluated to eliminate any redundant or conflicting requirements and to coordinate review processes.

Performance Standards for Health Service Projects of CCRCs

(1) All health facilities and services which would be reviewable if undertaken by another entity remain reviewable if undertaken by or as part of a CCRC of any type.

(2) Any nursing home project which is undertaken by or as part of a CCRC shall meeet all of the following performance standards.

(a) The project shall be financially and actuarially feasible, and shall contain costs, as demonstrated by all of the following:

(i) Submission of a feasibility study and financial plan based on marketing analysis, relevant literature, experience of other similar CCRCs, and specific actuarial study (ten-year minimum timeframe) which includes the components listed in Section 1 of Appendix B of this plan.

(ii) Submission of an actuarial opinion, written and signed by a qualified actuary as defined in 284-05-060 WAC, which indicates the likely feasibility of the project based on the feasibility study and financial plan (see (2)(a)(i) above) and the model contract (see (2)(c)(i) below).

(iii) Determination upon advisory review of the feasibility study and financial plan ((2)(a)(i)), the actuarial opinion ((2)(a)(ii)) and the model contract ((2)(c)(i)) by the Office of the Insurance Commissioner (or if this cannot be arranged, by an independent, qualified actuary contracted by DSHS), that the project is likely to be financially and actuarially feasible.

(iv) Submission of a written, legally binding commitment, supported by provisions of the model contract, that the CCRC shall maintain actuarially sound pricing structure and reserves or other mechanisms to assure future service obligations, based on actuarial restudy as necessary.

(v) Submission of an escrow plan, including identification of escrow agents and a copy of executed escrow agreements, and a statement of anticipated application of all escrows, which meets all requirements listed in Section 2 of Appendix B of this plan.

(b) The project shall provide consumers (members and prospective members) with an accurate basis for informed decisions about CCRC participation and purchase (through this means) of nursing home or other health services. This shall be demonstrated by submitting a written, legally binding commitment, supported by provisions of the model contract, to disclose all information listed in Section 3 of Appendix B to consumers prior to offering a contract for sale (or, in the case of current members who have not received a complying initial disclosure, upon receiving state approval of any service or facility change), with update disclosure of changes at least annually to members.

(c) In order to provide a firm basis for actuarial analysis and feasibility determination, and to document binding commitments to meet other performance standards, the project sponsor shall submit the following documentation related to contracts which are or will be used:

(i) A model continuing care contract (between the CCRC and the member) which contains the provision listed in Section 3 of Appendix B.

(ii) A model waiting list agreement covering deposit amounts; any other fees; refund amounts in the events of admission, rejection of application or withdrawal of application; the amount of interest (if any) to be paid on deposits; the maximum time within which a required refund will be given to the contractee; and provisions for obtaining information on the likely time before a vacancy will occur.

(iii) A written, legally binding commitment that the CCRC will continue to use either the model contract or, in the event of contract changes, future contracts which also satisfy all requirements in this section of Volume II of the State Health Plan as of the date of project approval; and that any contract for transfer of any part of the CCRC will require the transferee to comply with these requirements.

(d) If the project is a nursing home, it shall meet performance standards in Section B.4.a. of Volume II of the State Health Plan, with the exception

that Type A CCRCs approved under the provisions of CCRC Performance Standard (4) below, shall not be subject to the area bed need limits in Nursing Home Performance Standard B.4.a.(2).

(3) To be considered a Type A CCRC, a CCRC shall demonstrate that it meets the following performance standards (in addition to those in (2) above):

(a) From the start of operations (or the date of state project approval, if later), the CCRC shall contractually provide or arrange for at least the following specific services for its members:

- Residential (independent living) units.
- Nursing home care (including skilled nursing) without any limitation on days of care which is unrelated to medical need. This scope of nursing care must be provided for in the CCRC's contracts with members, but potentially could involve a higher monthly charge for persons receiving nursing care than for those living independently.
- Some form of assistance with activities of daily living.
- Services which are equivalent in scope to state chore services (including "individual provider" services) and to Medicaid home health services, for at least those members who otherwise would be eligible for such state-funded programs.

(b) By the end of a transition period not exceeding five years from the date the first CCRC member takes up residence in any CCRC area under a Type A continuing care contract (or, if sooner, from the date the first patient enters the nursing home unit), the CCRC:

- Shall not have a Medicaid contract for its nursing home unless this is a contract limited to continuation of payments for specific individuals who are not CCRC members and entered the nursing home unit during the CCRC's transition period as permitted in (3)(c).
- Shall not have a congregate care contract for any area which is licensed as a boarding home, unless this is a contract limited to continuation of payments for specific individuals who

are not CCRC members and entered the boarding home unit during the CCRC's transition period as permitted in (3)(c).

- Shall be providing, as required by (3)(a), services meeting needs of any members which otherwise would render those members eligible for state-supported chore services or Medicaid home health services.

(c) By the end of a transition period not exceeding five years, the CCRC shall admit to its nursing home services only members who have signed continuing care contracts. However, nonmembers admitted earlier during a transition period (see (e) below) shall be permitted to remain for as long as they have medical need for nursing home care.

(d) The CCRC shall provide written, legally binding assurances that conditions (3)(a), (b) and (c) will be met. These assurances must include a signed agreement with DSHS Aging and Adult Services Administration which either stipulates that a Medicaid contract will not be sought, or else limits any Medicaid contract to the restrictions in (3)(b).

(e) If a Type A CCRC wishes to exercise a transition period, it shall submit a transition plan which describes whether and for how long nonmembers will be admitted to the nursing home unit; whether and for how long a Medicaid contract will be sought for the nursing home unit; and whether and for how long a congregate care contract will be sought for any boarding home unit. If there will be a congregate care or Medicaid nursing home contract, the CCRC shall document arrangements for the continuing financial support of any nonmembers remaining as indigent patients after the end of the transition period. The transition plan shall include a written, binding assurance that every nonmember admitted to the CCRC's nursing home unit (during a transition period) shall be informed at the time of nursing home admission of the particulars of the transition plan and how they affect the person's rights and charges. The transition plan shall include a sample disclosure statement for this purpose, written in plain English.

(4) A nursing home project proposed by a Type A CCRC meeting all standards in (3) above, shall be considered, if the project sponsor requests, under the following special bed need standards:

(a) The project size (number of nursing home beds) shall meet all of these standards:

(i) The number of nursing home beds requested in a single project (whether initial or expansion) shall not exceed 60 beds.

(ii) No project shall result in a total CCRC nursing home capacity (including utilization of other facilities on contract) which exceeds one nursing home bed per four independent living units within the CCRC.

(iii) The CCRC shall justify the number of beds requested, not to exceed limits in (a)(i) and (a)(ii), based on actuarially sound forecasts of the expected age, sex and health characteristics of the CCRC's members in the ten years following the year of the application and evidence concerning demographically comparable nursing home use rates for the general public and within similar CCRCs.

(iv) In computing ratios for (4)(a)(ii), only independent living units of the CCRC which already exist or are scheduled for completion at the same time as the proposed nursing home beds, under the same financial feasibility plan, shall be counted.

(v) In computing demographic forecasts of CCRC membership for (4)(a)(iii), only independent living units and other living areas of the CCRC which already exist or are scheduled for completion at the same time as the proposed nursing home beds, under the same financial feasibility plan, shall be counted.

(b) Any nursing home project by a Type A CCRC, which is proposed under and meets the standards in (3) and (4)(a), is not subject to the bed need standard for the Nursing Home Planning Area in which the project is located (see Nursing Home Performance Standard B.4.a.(2) of this volume of the State Health Plan). However, the total number of nursing home beds approved under this provision which are currently in "transition status" (see standard (3) above) shall at no point in time exceed 300 beds statewide. If approval of a Type A CCRC project involving a transition period would lead to exceeding 300 nursing home beds in such transition periods at the same time, that project shall not be approved.

(5) Any Type A or Type B CCRC proposing a nursing home project may, at its discretion, designate it as an application against the special statewide pool of CCRC nursing home beds established under the Nursing Home Bed Need Projection Method (General Provision (f) ii and Step 2). No single project shall be considered simultaneously under both the CCRC statewide bed pool and the bed allocation of the Nursing Home Planning Area in which the project is located.

d. Home Health Agencies (HH)

Home health agency means an entity coordinating or providing the organized delivery of home health services.

Home health services means the provision of nursing services along with at least one other therapeutic service or with a supervised home health aide service to ill or disabled persons in their residences on a part-time or intermittent basis, as approved by a physician.

(1) The performance standards policies presented below are interim. The health planning system shall evaluate these standards and revise them as necessary, when data on the costs and use of home health services in the state are available.

(2) The following home health planning areas in each health planning region shall be used to determine population requirements for home health services:

Health Planning Region I

(a) Clallam/West Jefferson
(b) Whatcom
(c) Skagit
(d) San Juan
(e) Island (minus Camano Island)
(f) East Jefferson
(g) Snohomish/Camano Island
(h) King
(i) Pierce
(j) Kitsap

Health Planning Region II

(a) Grays Harbor/Pacific
(b) Thurston/Mason
(c) Lewis
(d) Cowlitz/Wahkiakum
(e) Clark/Skamania/Klickitat

Health Planning Region III

(a) Okanogan
(b) Chelan/Douglas
(c) Kittitas/Yakima
(d) Grant
(e) Benton/Franklin

Health Planning Region IV

(a) Ferry/Stevens/Pend Oreille
(b) Lincoln/Adams
(c) Spokane
(d) Walla Walla/Columbia
(e) Garfield/Asotin/Whitman

(3) The total annual number of home health visits needed in a home health planning area in the next year shall be estimated using the Interim Home Health Agency Need

Estimation Method described below. As utilization data become available, estimates used in this method shall be evaluated and adjusted.

(People under 65 x .005) x 10 visits
+ (People 65-79 x .044) x 14 visits
+ (People 80+ x .183) x 21 visits

= TOTAL VISITS

(4) The appropriate number of home health agencies in each home health planning area shall be determined based on the following policies:

(a) For planning purposes ten thousand (10,000) home health agency visits shall be considered to be the target minimum operating volume for a home health agency.

(b) Two home health agencies may be permitted in each home health planning area to allow competition and consumer choice. Where the projected aggregate need is less than 10,000 visits per year, the burden of proof shall be on a proposed new home health agency to demonstrate that competing agencies will result in greater levels of efficiency, effectiveness and equity in such an environment. In this regard, they shall address at least the considerations in Policies (5)(a)-(g) below.

(c) The maximum number of home health agencies permitted in a home health planning area shall not exceed the number of agencies derived by dividing the visits estimated under Step 3 above by the number 10,000.*

(d) For the purpose of determining the need for additional home health agencies in a home health planning area, existing home health agencies in the planning area are those agencies which can serve the area without further state approval and which provide service use and cost data requested by the health planning system.

(5) Considerations for which preference may be given in reviewing competing proposals to meet a limited need in a planning area are presented below. Preference shall be given to the project that meets the greatest number of the following criteria for preference:

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*Note: Fractional numbers derived under this calculation would be rounded down to the nearest whole number.

(a) The proposed agency will meet state certification requirements.

(b) The proposed agency will serve either directly or through formal agreements with other providers the entire planning area in which it is proposed to be located.

(c) The proposed agency has a written policy and budget to serve clients without regard to their source of payment.

(d) The agency has a lower charge per visit compared to similarly-organized agencies providing comparable services in the home health planning area. "Organization" refers to whether the agency is freestanding or hospital-based.

(e) The agency assures continuity of care by having documented formal linkages to other levels of care.

(f) The agency has arrangements to provide charity care to clients who are unable to pay for services.

(g) The agency demonstrates a mechanism for measuring and responding to community concerns.

e. Hospice Services (HS)

Hospice means a private or public agency or part thereof that administers or provides hospice care.

Hospice care means care supervised by the attending physician and provided by the hospice to the terminally ill. Hospice care is primarily palliative or medically necessary care provided by a hospice multidisciplinary team with care available 24 hours per day 7 days a week.

Hospice multidisciplinary teams means a team of individuals that provides or supervises care and services offered by the hospice and that is composed of at least a physician (consultant), registered nurse, social worker, and a pastoral, spiritual or other counselor.

Hospice services are provided in a coordinated program of care organized for the purpose of providing palliative and supportive care which is designed to meet the psychosocial, psychological, and spiritual needs of patients and their families (which includes those persons related by blood, marriage, or other significant relationship as designated by the patient). Bereavement services are an essential part of hospice care.

(1) The areas used for planning hospice services shall be: Clark and Skamania Counties combined, Snohomish County and Camano Island, Island County excluding Camano Island and the other 35 individual counties in the state.

(2) Until more complete utilization data of services provided by hospices are available, the potential population who may choose hospice care in each area shall be estimated using the following Hospice Need Estimation Method.

The need for hospice services shall be determined using the following method.

(a) Calculate the average annual number of cancer deaths for the past five years in the area.

(b) Multiply the average annual number of cancer deaths by 0.25 to obtain the number of potential hospice patients with a cancer diagnosis.

(c) Calculating the total number of expected hospice patients by dividing the number of cancer hospice patients by 0.90.

(3) Proposed new hospices or hospices proposing expansion shall have a predominant home care emphasis and shall use existing community services.

(a) Hospices proposing additional inpatient beds* for hospice patients shall ordinarily have an inpatient bed to hospice patient ratio that is equal to or less than the statewide average for existing hospices.

(b) Hospices shall use and integrate existing community services to meet client care needs. Affected provider and consumer groups shall be involved in planning, development and governance of proposed programs. Hospices shall not plan new community services unless they document that existing community services do not have the capability or are not willing to meet program needs.

(4) New or expanded hospices shall meet state hospice certification standards or minimum hospice quality standards, when such standards are developed.

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*Hospice beds may be located in a hospital, nursing home or free-standing facility.

(5) Preference in the development of new hospice care programs shall be given to programs which (a) have the policy of serving clients without regard to their source of payment, and (b) will serve geographic areas that do not have access to a hospice care program and/or a specific population without access to a hospice care program.

C. FORECASTING METHODS

1. INTRODUCTION

This section of the State Health Plan presents officially adopted methods for forecasting the need for operating rooms, nursing home beds and hospital beds. These methods are designed specifically to meet requirements for state review of proposed projects, but they are appropriate for other uses as well.

The operating room need determination method is new in this plan State Health Plan (SHP). Earlier versions of the other two methods were included in the 1980 SHP and incorporated by reference in the 1982 SHP. This plan brings the three methods together in one document. However, because of their complexity and length, they are separated from related performance standards for planning and review.

2. OPERATING ROOM NEED METHOD

a. SUMMARY

This method is the quantitative basis for reviewing proposals for ambulatory surgery facilities. It also will be used in reviews of proposed new hospital operating rooms when the project is costly enough for review.

As noted above, this is a new forecasting method. The general approach is for the health systems agencies to adopt a reasonable method for forecasting the number of surgeries and, if they wish, policies on the proportion of surgeries which could be done on an outpatient basis. The method in the SHP then calculates the number of inpatient and outpatient operating rooms (ORs) needed to perform these surgeries. The method follows the State Health Coordinating Council (SHCC)-adopted policy that all existing inpatient and outpatient capacity must be efficiently utilized before new ORs may be added.

In estimating the capacity of current ORs and the number of added ORs which would be needed to satisfy any future need, different assumptions are made about the number of surgeries which can occur in ORs dedicated to outpatient use as opposed to those providing surgery for hospital inpatients. This is necessary because outpatient surgeries tend to be simpler and less time consuming (on average), and because outpatient ORs tend to be scheduled for fewer hours per week. The method estimates these and other time factors (e.g., set-up time between patients, level of realistic capacity compared to the "theoretical" maximum) so that calculations can be carried out.

With the method itself are two examples showing application in urban and rural areas with various substitutions of better data in place of the method's general assumptions.

b. DETAILED METHOD

The need for operating rooms in a hospital planning area shall be determined using the following method:

Existing Capacity:

(1) Assume the annual capacity of one operating room located in a hospital and not dedicated to outpatient surgery is 94,250 minutes. This is derived from scheduling 44 hours per week, 51 weeks per year (allowing for five week day holidays), a 15 percent loss for preparation and clean-up time, and 15 percent time loss to allow scheduling flexibility. The resulting 70 percent productive time is comparable to the Hospital Commission's definition of "billing minutes" which is the time lapse from administration of anesthesia until surgery is completed. HSA policies may vary the desired scheduled time to fit urban and rural areas.

(2) Assume the annual capacity of one operating room dedicated to ambulatory surgery is 68,850 minutes. The derivation is the same as #1 except for 25 percent loss for prep/clean-up time and scheduling is for a 37.5-hour week. Divide the capacity minutes by the average minutes per outpatient surgery (see #7). Where survey data are unavailable, assume 50 minutes per outpatient surgery, resulting in a capacity for 1,377 outpatient surgeries per room per year.

(3) Calculate the total annual capacity (in number of surgeries) of all dedicated outpatient operating rooms in the area.

(4) Calculate the total annual capacity (in number of minutes) of the remaining operating rooms in the area, including dedicated specialized rooms except for 24-hour dedicated emergency operating rooms. Exclude cystoscopic and other special purpose rooms.

Future Need:

(5) Project number of inpatient and outpatient surgeries performed within the hospital planning area for the target year. This shall be based on the current number of surgeries adjusted for forecasted growth in the population served and adjusted for trends in surgeries per capita.

(6) Subtract the capacity of dedicated outpatient operating rooms (#3) from the forecasted number of outpatient surgeries. The difference continues into the calculation of #8.

(7) Determine the average time per inpatient and outpatient surgery from hospital planning area survey data. Where survey data are unavailable, assume 100 minutes per inpatient and 50 minutes per outpatient surgery. This excludes preparation and cleanup time and is comparable to "billing minutes."

(8) Calculate the sum of inpatient and remaining outpatient (from #6) operating room time needed in the target year.

Difference:

(9) If #8 is less than #4, divide their difference by 94,250 minutes to obtain the area's surplus of operating rooms used for both inpatient and outpatient surgery.

(10) If #8 is greater than #4, subtract #4 from the inpatient component of #8 and divide by 94,250 minutes to obtain the area's shortage of inpatient operating rooms. Divide the outpatient component of #8 by 68,850 to obtain the area's shortage of dedicated outpatient operating rooms.

(11) The percentage utilization of existing surgery suites can be calculated by dividing their annual billing minutes reported to the Hospital Commission by their annual capacity, adjusting for dedicated outpatient operating rooms.

EXAMPLE 1:

OPERATING ROOM NEEDS OETERMINATION METHOD

Example of Urban Hospital Planning Area (Central King) Using All Assumptions In Method Except Average Time Per Inpatient Surgery In Step 7

Discussion Of Outcome With Alternative Scheduling Times

Step 1

94,250 minutes per year = capacity of one inpatient operating room

Step 2

68,850 minutes per year or 1,377 surgeries per year = capacity of one dedicated outpatient operating room.

Step 3

10 dedicated outpatient rooms x 1377 = 13,770 capacity for outpatient surgeries.

Step 4

68 inpatient rooms x 94,250 = 6,409,000 minutes is capacity for inpatient surgeries.

Inventory derived by:

58 non-dedicated mixed rooms (inpatient & outpatient)
6 dedicated coronary OR
4 with approval for mixed use
68 rooms

Not counted in inventory:

1 24-hour emergency operating room at Harborview
7 unused for OR but could be made available with minimum capital expenditure
1 gastroenterology suite
2 special interventional radiology rooms
etc.

Step 5

1986 forecast using linear regression of King County surgeries Central King Hospital Planning Area as a percentage of this, trend in Central King outpatient surgeries.

By 1986: 21,266 outpatient surgeries (32% of total)
45,190 inpatient surgeries

Step 6

21,266 forecasted outpatient surgeries - 13,770 existing capacity = 7,496 deficit

Step 7

146.5 minutes per inpatient surgery
50 minutes per outpatient surgery

Step 8

45,190 inpatient surgeries x 146.6 minutes = 6,620,335 minutes needed by 1986
7,496 deficit outpatient surgeries x 50 minutes = 374,800 minutes needed by 1986

Step 9

Step 8 is greater than Step 4. There is a deficit.

Step 10

6,620,335 minutes - 6,409,000 = 211,335 minutes ÷ 94,250 = 2 inpatient operating rooms needed at 85% utilization.

374,800 minutes : 68,850 = 5.4 dedicated outpatient operating rooms needed at 85% utilization by 1986

DISCUSSION

Applying the method to the Central King Hospital Planning Area shows a deficit of 2 inpatient and 5.4 outpatient operating rooms. However, because the Central King hospitals schedule their operating rooms for use an average of 45.8 hours per week (instead of 44), each room has the productivity of 98,104 minutes. This eliminates the deficit of inpatient operating rooms and reduces the need for outpatient operating rooms to 4.7. There would be no deficit if the policy were to include in the inventory those operating rooms no longer used for surgery but which could meet licensing codes with a small capital expenditure.

EXAMPLE #2:

OPERATING ROOM NEEDS DETERMINATION METHOD

Example Of Use Of Operating Room Planning Method
For Rural Hospital Planning Area, With Discussion

Steps 1 & 2

Assume that there is a policy that all operating rooms in a rural hospital should be scheduled for use a minimum of 7.5 hours a day, five days a week, 51 weeks a year. Taking into account the small number of operating rooms in rural hospitals and allowing for scheduling flexibility, the policy is that 70 percent is an optimum utilization rate. In other words, no operating rooms are needed in a rural planning area where the average utilization rate is under 70 percent of the minimum scheduled time.

The minimum productivity of one room would be 80,325 minutes, including preparation and clean-up time. This is not comparable to the Hospital Commission's "billing minutes" which do not include preparation and clean-up time.

(7.5 hrs. x 5 days x 51 wks x 60 minutes x 70% = 80,325 minutes/yr)

Step 3

There are no dedicated outpatient operating rooms in the rural hospital.

Step 4

There are two operating rooms in this rural hospital. Both are used for inpatient and outpatient surgery and the outpatient surgery includes cystoscopic procedures which the hospital counts as surgical procedures in its reporting system. The hospital's surgical capacity is 160,650 minutes per year. (2 x 80,325)

Step 5

We observe the number of surgeries performed in the hospital over the past five years has been between 560 and 570, the population has remained stable, and we anticipate no more than 570 surgeries in 1990. Of these, about 40 percent have been outpatient surgeries and this proportion has remained stable. Thus we forecast 342 inpatient and 228 outpatient surgeries by 1990.

Step 6

There are no dedicated outpatient operating rooms.

Step 7

A survey of the hospital showed inpatient surgery required 150 minutes (120 for actual surgery + 30 for prep. & clean-up). Outpatient surgery required 90 minutes (60 surgery + 30 prep. & clean-up).

Step 8

342 inpatient surgeries x 150 minutes = 51,300 minutes
228 outpatient surgeries x 90 minutes = 20,520
TOTAL = 71,820 minutes needed by 1990

Step 9

160,650 minutes capacity - 71,820 minutes needed by 1990 = 88,830 minutes excess capacity

88,830 ÷ 80,325 = 1 surplus operating room

Step 10

Step 8 was not greater than step 4, therefore, no deficit.

Step 11

Not applicable since the annual capacity in step 4 includes preparation and clean-up time.

DISCUSSION

It is doubtful that an agency would go through these calculations since they would observe the 1984 utilization was only 31 percent.

1984 minutes include prep. and clean-up = 70,230 minutes
capacity at 100 percent utilization = 229,500

70,230 ÷ 229,500 = 31%

In this example, the preparation and clean-up time is accounted for in Steps 7 and 8 rather than in Steps 1 and 2.

3. NURSING HOME BED NEED PROJECTION METHOD*

a. SUMMARY

Methods for forecasting nursing home bed need were incorporated in the 1980 and 1982 State Health Plans. They were significantly revised in 1984, by amendment of the SHP, following exhaustive study by an advisory group including SHCC members, DSHS executives, directors of nursing home trade associations and representatives of the state's aging services network, including the State Council on Aging. The method was amended in May 1985 to clarify treatment of swing beds in rural hospitals, based on recommendations from another special advisory process set in motion by the SHCC. Finally, it was amended to its present text following a major advisory group similar to that of 1984.

These forecasts are used as the primary quantitative basis for reviewing nursing home projects. Bed needs for developmentally disabled persons are developed separately by DSHS, and DSHS has the option of defining other special populations (e.g., certain mentally ill persons) for separate need forecasting. The May 1985 amendment stipulated that small rural hospitals may operate up to five "swing beds," available for either acute care or nursing care as needed, which will not be counted as nursing home beds. The latest amendment set aside a statewide pool of beds for projects for retirement communities. Certain retirement communities also are exempt from the area need standard for nursing home beds.**

The method calls for preparation of statewide and area (essentially county) forecasts of nursing home bed need for a date three years in the future, for nursing home supply deliberation, plus a longer-range forecast also is prepared for general policy advisory purposes. The forecasts ordinarily are updated every three years, with the next update scheduled for the second half of 1989.

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* This 1987 revision of the nursing home beds projection method takes effect upon completion of DSHS preliminary decisions on Certificate of Need nursing home applications under review as of January 21, 1987. These review decisions are based on the previous method adopted in 1984.

**In 1985-86, an advisory group jointly appointed by the SHCC and the State Council on Aging developed recommendations on how to deal with nursing home beds within continuing care retirement communities. Further changes in the State Health Plan's nursing home policies have been made to implement those recommendations. See Long Term Care Performance Standard 4.c.

The statewide forecast for 1990 is based on a desired 1990 "target ratio" of 53.7 nursing home beds per thousand people age 65 or older, initially selected in 1984 and reaffirmed in 1987. While this ratio represents a reduction in the bed-to-population ratio which prevailed in 1984 (60.2 beds/1,000), it allows for the addition of over 900 beds during the 1984-1987 period and will permit approval of hundreds of additional beds between 1987 and 1990.

First priority in allocating the beds to counties is to bring all counties up to at least the bottom end of a "reasonable nursing home bed ratio range" defined in the method. This range is derived based on the 26th and 58th percentile points in the actual rank-order distribution of ratios (current beds per 1,000 target-year residents age 75+) for the state's counties. Remaining beds are divided among counties which have bed supplies within the reasonable bed ratio range in proportion to the number of beds each county would need to reach the top end of that range.

The method also contains ground rules for fine-tuning of the baseline forecasts by the Area Agencies on Aging and the DSHS Aging and Adult Services Administration. These adjustments, involving mutually agreed upon shifts and pooling of counties into larger areas, cannot increase the statewide total.

b. DETAILED METHOD

(1) Assumptions

(a) Nursing home bed need projections should reflect variations in nursing home use by different age groups of the population.

(b) Nursing home beds should ordinarily be located reasonably close to the people they serve.

(c) Equity in the availability and use of nursing home beds within the state should be increased by reducing the wide variation in ratios of nursing home beds to elderly population among areas of the state.

(d) Areas of the state that are underbedded, adequately bedded and overbedded should be identified and treated differently in the bed need projection process.

(e) The overall supply of beds in the state should represent a reasonable and appropriate state nursing home bed to elderly population ratio.

(f) Most current nursing home use in the state reflects an appropriate need for formal services that should be met by nursing home beds or other services in the long term care continuum.

(g) To be responsive to unique local circumstances, the nursing home bed need projection process should include local discretion in defining nursing home planning areas and bed allocations.

(2) General Provisions

(a) Nursing home bed need projections shall be developed for a three year period ending in the projection year and for at least one subsequent longer range period. Three year projections shall be the basis for nursing home bed supply decisions.

(b) Projections shall ordinarily be updated every three years during the last half of the third year. Bed need projections shall be revised if, in the determination of the State Health Coordinating Council or Department of Social and Health Services, significant nursing home bed supply problems have developed.

(c) The planning areas used for nursing home baseline projections shall be Clark and Skamania Counties combined, Snohomish County (with addition of Camano Island), Island County (excluding Camano Island), and the other 36 individual counties in the state.

(d) Prior to developing revised nursing home bed need projections, the Department of Social and Health Services, in consultation with the State Health Coordinating Council, the State Council on Aging and the State Nursing Home Advisory Council, shall review and affirm or modify projection method terms.

(e) The Department of Social and Health Services shall obtain, evaluate and respond to public comments prior to adopting revisions of the projection method or nursing home bed need projections.

(f) The bed needs of special population groups shall be projected separately, and necessary adjustments in base data shall be made to reflect these separate projections.

i. Special populations shall include the developmentally disabled, and may include a mental health population defined by the State Department of Social and Health Services.

ii. In addition to any other provision of the State Health Plan applying to continuing care retirement communities (CCRCs), a special statewide pool of beds shall be designated within the projection method for which only proposals for nursing home beds operated by CCRCs for their members shall be eligible to apply. The State Health Plan's definition of CCRCs shall apply.

iii. Any bed need projections for special populations shall be developed by the Department of Social and Health Services using projection methods developed for this purpose.

(g) Demonstration of nursing home bed need through application of the bed projection method is not sufficient evidence, by itself, to warrant the addition of nursing home beds. Even if there is a projected need for beds in an area, approval may be denied based on developer's not meeting state quality of care survey standards or based on other non-quality related conditions defined in explicit, measureable terms in applicable health plans and state rules.

(h) Swing beds shall be counted as hospital beds. They shall not be considered nursing home beds for the purpose of determining nursing home bed needs or available nursing home bed supply.

"Swing beds" are hospital beds, available to provide either acute care or long term care/nursing care services as required, which meet the conditions specified in Section B.4.b. of this volume of the State Health Plan.

(3) Specific Baseline Projection Method Steps and Provisions

NOTE: Figure 1 is a graphic presentation of these steps.

STEP 1: DETERMINE THE APPROPRIATE NUMBER OF ADDITIONAL BEDS IN THE STATE IN THE PROJECTION YEAR.

Step 1.a. Define a state target nursing home bed to elderly (65+) population rato for a target year.* (This ratio uses population age 65+ in

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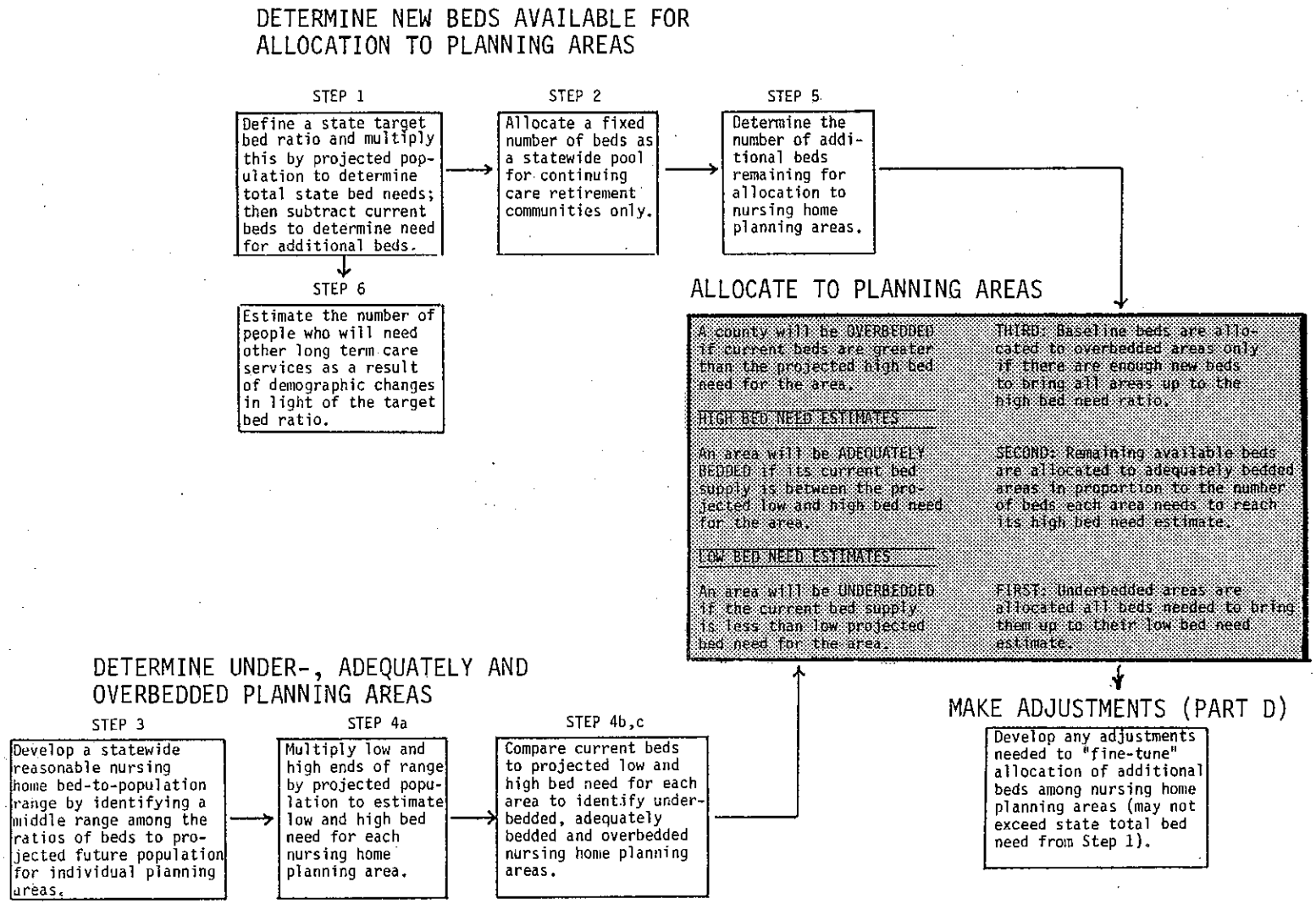
*Note that the target year for the state target bed ratio may not be the same as the projection year for which nursing home bed needs are developed.

FIGURE 1

GRAPHIC DESCRIPTION OF WASHINGTON STATE NURSING HOME BED NEED PROJECTION METHOD



the denominator because most comparative information from other states is in this form. Note that ratios with the age 75+ population as denominator are used for other purposes in this method.)

(1) The state target bed ratio shall constitute the number of beds needed for the appropriate use of nursing home beds in the state. Such target ratio shall be developed considering:

(a) The national bed ratio and the bed ratios of other states judged to have reasonable and progressive long term care policies, and

(b) state policy goals for the allocation of scarce resources between nursing home beds and other institutional and community based services in the long term care continuum, and

(c) the effects on nursing home bed needs of new health systems developments, such as hospital diagnostic related group (DRG) reimbursement and other changes in incentives stemming from governmental and private payment systems for acute and long-term care, and

(d) progress being made in developing other long term care services for the population at risk of nursing home placement (see Step 6 below).

(2) The state target bed ratio for 1990 shall be 53.7 nursing home beds per thousand people 65 years of age or older. The preliminary target for 1993 also shall be 53.7 beds per thousand people 65+, subject to review by the State Health Coordinating Council and DSHS following the 1989 legislative session.

Step 1.b. Determine the total number of appropriate beds in the state in the target year by multiplying the projected population 65+ in thousands by the state target bed ratio.

Step 1.c. Determine the total number of additional beds needed statewide in the target year by subtracting the current bed total from the total number of appropriate beds.

STEP 2: RESERVE A STATEWIDE POOL OF BEDS FOR CONTINUING CARE RETIREMENT COMMUNITIES.

Step 2.a. Determine a number of beds, not exceeding one-quarter of the total additional beds needed statewide (Step 1.c.), which shall be designated as a special statewide pool for applications from continuing care retirement communities (CCRCs) anywhere in the state requesting new or expanded nursing home capacity primarily for their members' use.

(1) In determining the number of beds in the pool, the effect of other provisions of the State Health Plan regarding CCRCs should be considered.

(2) For the period 1987 through 1990, 120 beds shall be set aside for this purpose.

(3) The eligibility of an applicant to apply for the CCRC beds shall be governed by definitions in the State Health Plan and DSHS administrative rules.

Step 2.b. Subtract the beds reserved for CCRC applications from the statewide need for new nursing home beds (from Step 1.c.), and allocate the remainder among nursing home planning areas as indicated in Step 5.

Step 2.c. Any adjustments of the baseline bed need forecast which would reallocate beds into or out of the CCRC pool shall require approval of the SHCC. (See (4) below on adjustments.)

Step 2.d. Any CCRCs qualifying under CCRC Performance Standard B.4.c.(4) of this volume of the State Health Plan for consideration of nursing home projects outside of the bed need projection method shall be counted as follows in developing projections of need for other nursing home beds:

(1) The beds of such CCRC nursing home units shall not be counted as available bed supply in determining net need for nursing home beds to meet general community needs.

(2) The members of such CCRCs (that is, all residents of all areas of the community, including the nursing home but also independent living and supported care residential units) shall be subtracted from the population of the state and of the nursing home planning area where the CCRC is located for purposes of computing total and net nursing home bed need under the projection method.

(i) Where age-specific population figures are used in the method, the same age groups shall be used in data collected from CCRCs on their members.

(ii) The estimates of future population and ages used in approved regulatory proposals (under Certificate of Need law and any future CCRC consumer protection legislation) shall be used as estimates of projection year membership/ages.

(3) The subtraction of beds and population of such CCRCs shall occur after the CCRC is approved as meeting all requirements for development.

Note that not all CCRCs qualify under Performance Standard B.4.c.(4). Other CCRCs may apply for nursing home beds from the statewide CCRC pool.

STEP 3: DETERMINE A STATEWIDE REASONABLE BED-TO-POPULATION RATIO RANGE.

Step 3.a. Rank order from low to high the ratio of base-year nursing home beds per 1,000 projection year population age 75+ for the various nursing home planning areas. Determine the percentile, or cumulative percent, of each successive point in the rank order.

Step 3.b. Define a statewide reasonable nursing home bed-to-population ratio range by identifying the low and high percentiles for the ends of the range.

(1) The low end of the range ("low reasonable bed ratio") shall constitute reasonable nursing home bed availability in all areas of the state, and generally

shall be deemed the minimum level at which the public need for nursing home beds is met.

(2) The high end of the range ("high reasonable bed ratio") shall be considered to represent a high level of nursing home bed availability in any area of the state, such that this ratio should not be exceeded without carefully weighing equity concerns.

(3) The low and high ends of the statewide reasonable bed supply ratio range shall respectively be set at the 26th and the 58th percentiles.

STEP 4: DETERMINE THE AREAS OF THE STATE THAT WILL BE UNDERBEDDED, ADEQUATELY BEDDED AND OVERBEDDED IN THE PROJECTION YEAR.

Step 4.a. Develop low and high bed need estimates for each area by multiplying the low and high statewide reasonable bed ratio from Step 3.b. by that area's projected population age 75+ in thousands.

Step 4.b. Determine the current number of beds in each area.

(1) The current bed count shall consist of licensed nursing home beds, beds in hospital long-term care units, and as yet unlicensed beds for which state approval has been granted. (See Definition (6)(d).)

(2) The current bed count shall be updated before each nursing home project review cycle.

Step 4.c. Compare the current beds in each area to projected low and high bed need estimates from Step 4.a. to identify areas that will be underbedded, adequately bedded and overbedded by the projection year.

(1) An area shall be deemed underbedded if the current supply of beds is less than the low nursing home bed need estimate for the area.

(2) An area shall be deemed adequately bedded if the current supply of beds is less than the high bed need estimate, but greater than the low bed need estimate for the area.

(3) An area shall be deemed overbedded if the current supply of beds is greater than the high bed need estimate for the area.

STEP 5: DETERMINE THE APPROPRIATE NUMBER OF BEDS IN EACH NURSING HOME PLANNING AREA IN THE PROJECTION YEAR.

Note: Figure 2 is a graphic presentation of this bed allocation process.

Step 5.a. Determine the number of beds to be allocated to each underbedded area by subtracting current beds from each area's low bed need estimate.

(1) The number of beds needed to bring underbedded areas up to their low bed need estimate shall be allocated to these areas.

Step 5.b. Allocate remaining beds available for underbedded and adequately bedded areas.

(1) Determine the remaining number of beds available for assignment to underbedded and adequately bedded areas by subtracting the beds apportioned to underbedded areas (in Step 5.a.) from the state's bed allocation (net of CCRC pool beds) for the projection year.

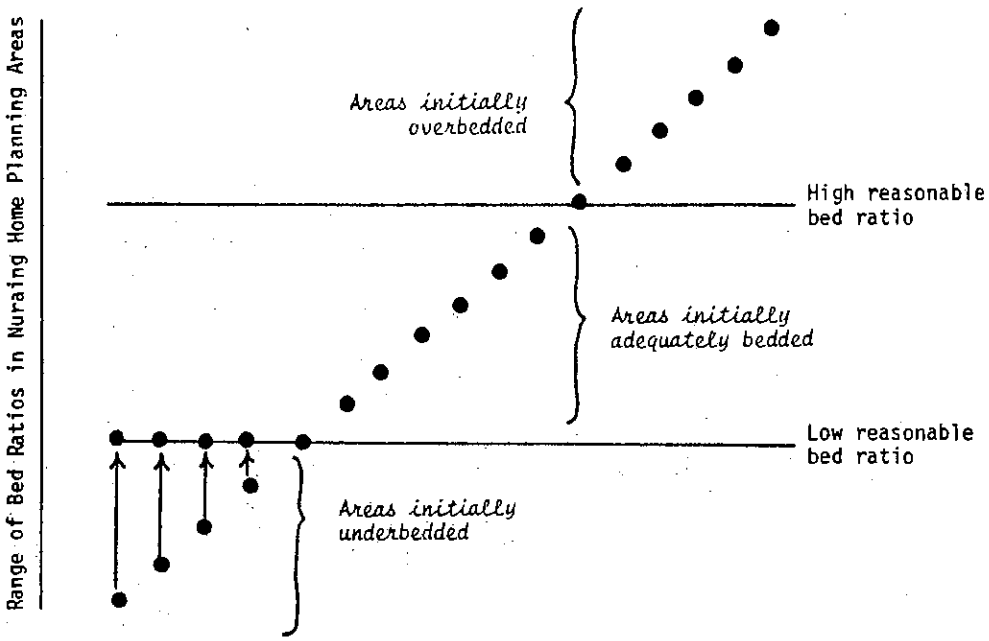
(2) Determine each area's total beds thus far in the allocation process, equal to current bed supply (from Step 4.b.) plus any beds assigned to the area (if underbedded) in Step 5.a.

(3) Determine how many more beds would need to be assigned to each area to bring it up to the high reasonable bed ratio in the projection year by subtracting total beds to this point in the calculation (Step 5.b.(2)) from the area's high bed need estimate (Step 4.c.).

FIGURE 2

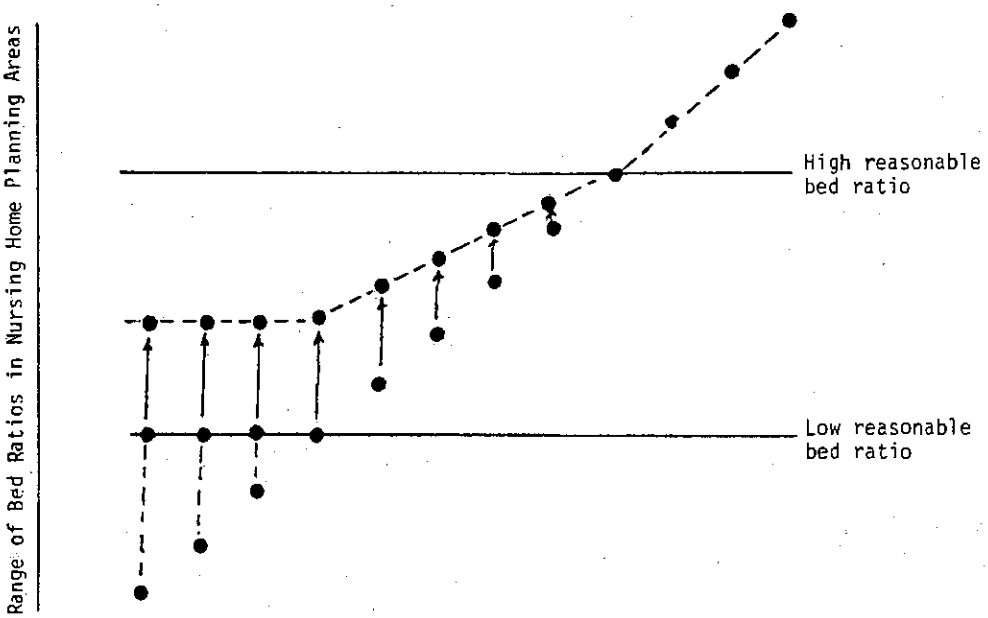
GRAPHIC REPRESENTATION OF ALLOCATION OF NURSING HOME BEDS AMONG AREAS IN THE BASELINE PROJECTION

Step 5.a.



Step 5.a. brings all areas to the low bed ratio.

Step 5.b.



Step 5.b. brings all areas not "overbedded" the same fraction of the way to the high bed ratio. For this step, "underbedded" areas start at the low bed ratio (to which Step 5.a. raised them).

(4) Divide the number of beds available for assignment (Step 5.b.(1)) by the total statewide bed requirement to bring all areas up to the high reasonable bed ratio (sum of individual area's needs from 5.b.(3)) to determine what proportion of that total bed requirement can be met.

(5) Assign each underbedded and adequately bedded area its proportional share of the remaining beds, equal to the proportion from Step 5.b.(4) times the area's need for additional beds to reach the high ratio (Step 5.b.(3)).

STEP 6: ESTIMATE FOR EACH AREA AGENCY ON AGING'S PLANNING AND SERVICE AREA (PSA) FOR THE PROJECTION YEAR THE NUMBER OF ADDITIONAL PEOPLE WHO WILL NEED OTHER LONG TERM CARE SERVICES AS A RESULT OF THE STATE TARGET BED RATIO.

Step 6.a. If age-specific use data are available, estimate base year statewide nursing home use rates for each age group.

Step 6.b. Estimate the patient days for the population at risk of nursing home placement in each age group in each PSA by multiplying the base year statewide use rate for each age group by that age group's projected population in thousands in the PSA.

Step 6.c. Estimate the average daily number of at risk individuals in the area by summing patient days across age groups, and dividing the result by 365.

Step 6.d. Estimate the number of nursing home beds that would be needed for the at risk population by dividing the average daily number of at risk individuals by the nursing home occupancy factor, which shall be 95 percent.

Step 6.e. Estimate the number of additional people who will need other long-term care services by subtracting the number of beds allowed each PSA from the bed need estimate from Step 6.d.

(4) Adjustment of Baseline Nursing Home Need Projections

(a) "Adjustments" (also called "bed reallocations") are authorized changes in the baseline nursing home bed need projections prepared under the step-by-step method above. Adjustments are shifts among planning areas of additional (incremental) beds allowed under the method's statewide total. The purpose of the adjustments is to "fine-tune" the more mechanical baseline, through a legitimate public process, without losing the positive features of the baseline calculation, including its definite statewide total and its guidance for improving geographic equity in bed distribution.

(b) In the absence of a complete set of SHCC-designated Regional Health Councils* which can perform adjustments as part of comprehensive health planning activities, nursing home bed need adjustments shall be developed by Area Agencies on Aging subject to DSHS approval, under the following process:

i. Area Agencies should develop any adjustments to the baseline bed need forecasts which they consider appropriate, following public input (see (f) below), in the form of bed reallocation plans which identify the new proposed distribution of beds and the changes from the baseline (or last adjustment) which it represents.

ii. Any shift of beds involving geographic areas represented by different Area Agencies must be supported by both Area Agencies.

iii. All bed need adjustments must be approved by the DSHS Aging and Adult Services Administration. The requirements in (f) must be met.

iv. No adjustment shall be approved which has the effect of exceeding the statewide total bed need under the baseline method.

In the event that funding for comprehensive Regional Health Councils is restored, the SHCC should immediately reevaluate what agencies should develop the adjustments.

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*The role of Regional Health Councils, as established in state law, was filled by four Health Systems Agencies which lost their federal funding as of November 1986.

(c) As part of the adjustment process, two or more nursing home planning areas for which baseline projections have been developed may be grouped into a single larger area. Where this is approved, the bed need for the entire pooled area shall be considered as a whole in reviewing specific project applications.

(d) In developing adjustments, the following issues, among others, should be considered:.

i. Patterns of movement of nursing home patients into and out of the area(s), including evidence from any available patient origin data.

ii. Any discrepancies between local forecasts of age-specific populations and the official Office of Financial Management population forecasts used in the baseline.

iii. The relative difficulty of arranging placement in different areas for patients needing nursing home admission.

iv. The relative availability of long-term care services which can offset some needs for nursing home supply.

v. Whether any overbedded areas are being awarded additional beds.

(e) Adjustments are part of the planning process and must be completed and approved prior to the start of the regulatory reviews which will use the adjusted numbers. DSHS shall identify a specific date prior to the start of each year's concurrent review(s) of nursing home project applications which will be the deadline for approval of all adjustments for use during that cycle of reviews.

(f) DSHS requirements for approval of bed reallocations plans (adjustments) shall include all the following:

i. An assurance, signed by the Area Agency director(s) concerned, that the bed reallocation plan was developed in a way which met the following process conditions:

a. The draft reallocation plan was distributed for review and comment by affected groups including nursing homes or nursing home associations, hospitals or hospital

associations, Regional Health Councils designated by the State Health Coordinating Council, and other local aging service providers and aging groups.

b. The review and comment period for the reallocation plan was at least 30 days.

c. At least one public hearing was held on the bed reallocation plan following completion of Area Agency staff deliberations.

d. Subsequent to the review and comment period and hearing, the Area Agency's governing board, or a designated committee, systematically considered all comments and weighed them against each other, in developing the final bed reallocation plan. A written explanation of disposition of comments is available upon request.

ii. The bed reallocation plan must conform to the State Nursing Home Bed Need Projection Method, including its statewide total bed need.

(g) The baseline projection shall be in effect in all areas unless replaced by approved reallocations.

(5) Data Sources and Methods

(a) Patient day data used in developing projections shall be those reported by nursing homes and verified by the Aging and Adult Services Administration.

(b) Total area patient days shall be determined by allocating patients back to their area of origin on the basis of the latest available patient origin data, when such data are available on a statewide basis.

(c) Patient age data used in developing use rate estimates shall be that collected by the Aging and Adult Services Administration.

(d) The source of population estimates and projections shall be official publications of the State Office of Financial Management.

(6) Definitions

(a) "Adjustments" mean approved shifts of nursing home beds among planning areas, developed as indicated in (4) above.

(b) "Base Year" means the year in which projections are developed, or, in the case of data, the most recent information then available.

(c) "Baseline projection" means the projection of need for nursing home beds, statewide and in each nursing home planning area, which is generated using the step-by-step method described.

(d) "Current bed count" means the total number of beds, at any point in time, which are considered available for public use (Step 4.b.). Some clarifications:

- "Distinct-part" long-term care units in hospitals are counted, even though they are covered under the hospital's license.
- Nursing home or long-term care beds in an HMO-operated hospital are counted.
- Swing beds are not counted.
- Nursing-level beds in state and federal institutions (including Veterans Administration Medical Centers and State Veteran Homes) do not have state licenses and are not counted.
- Licensed nursing home beds which are operated as specialized developmental disabilities facilities under federal ICF/MR rules (Intermediate Care Facilities for Persons with Mental Retardation and Related Disabilities) are not counted as available to the general population in need of nursing home care. (However, the same facility might be counted if it ceased to operate as an ICF/MR.)

(e) "Projection year" means the year which marks the endpoint of the three-year projection period.

(f) "Target year" means the year targeted for attainment of a specified ratio of nursing home beds to population identified as a health planning objective. (Step 1.a.)

4. HOSPITAL BED NEED FORECASTING METHOD

a. INTRODUCTION

This document is a revision of the "Guide to the Use of the Washington State Hospital Bed Projection Methodology," prepared in 1979. The former version of the Guide was adopted by the State Health Coordinating Council (SHCC) in its entirety as part of the 1980 State Health Plan (SHP). It later was incorporated by reference in the 1982 SHP.

This version differs from the original in three ways:

1) It contains several substantive policy changes, including trend-adjustment of the hospital utilization rate used in forecasting.

2) It is different in format and includes some editorial improvements. For example, the order of presentation has been changed and the formerly separate psychiatric bed need forecasts have been brought into the same document with less duplication.

3) Certain step-by-step calculation methods and examples which were part of the 1979 Guide will be made available in comparable detail but will not be part of the State Health Plan in order to permit timely minor revisions (e.g., improved data sources).

b. SUMMARY

This plan consolidates two earlier hospital forecasting documents, maintaining a similar general framework and method but changing a number of particulars. The general hospital bed need forecasting method and related principles were initially adopted by the SHCC in 1979 in the "Guide to the Washington State Hospital Bed Projection Methodology." This was printed in the 1980 SHP and incorporated by reference in the 1982 SHP. A separate document, the "Short-Term Hospital Psychiatric Bed Projection Method," was adopted by the SHCC in 1981 and included in the 1982 SHP. While consistent in general principles with the overall forecasting method, this method contained elements specific to psychiatric services.

The hospital bed need forecasting method is the primary quantitative basis for review of hospital projects which fall under the Certificate of Need law. Review is required for all new hospital beds and for some changes in use of existing beds (depending on what new services are proposed and how large a capital expenditure is entailed). Forecasts clearly address the issue of total bed need for each geographic area. However some specific services (uses of beds) are reviewable, but not specifically forecast as a subtotal of bed need. In such cases, other methods, not formally adopted in the SHP, must be used as part of the assessment of public need for the beds.

The methods in this plan produce two forecasts, one for short-stay psychiatric bed needs in nongovernmental hospitals and one for non-psychiatric bed needs in all hospitals within the state. The non-psychiatric forecasts are prepared for the entire state, the health planning regions and for each of the geographic hospital planning areas. The psychiatric forecasts are prepared for the entire state, each health planning region and each county (or multi-county) mental health planning area.

It is possible for hospitals, as corporate entities, to establish services which fall outside the scope of the forecasts - for example, a hospital can open a long-term care wing which is counted and licensed as a nursing home - but in general, any "bedded service" of a hospital is within this scope unless clearly defined to the contrary in the State Health Plan. To give a few examples, obstetric beds, adult rehabilitation service beds, alcoholism treatment beds and rural hospital swing beds all are part of the nonpsychiatric bed need total.

The nonpsychiatric forecast method starts with information on the use of hospital services in a "base year." Hospital use rates are calculated for the residents of each hospital planning area. These rates are stated in patient-days per 1,000 population for two age groups: 0-64 and 65 or older. Long-term trends in the hospital use rate (currently downward) are assumed to continue; therefore, each hospital planning area's use rates are adjusted in proportion to the rate of change in use rates over the past ten years. The statewide or health planning region trend is used, whichever shows the slower change. (An alternate adjustment is used in a few HPAs where increasing reliance on health maintenance organizations complicates trend anlaysis.)

The trend-adjusted hospital use rates are applied to the projected future ("target year") population of each hospital planning area. This calculation produces a forecast of the number of patient-days of hospital care which the residents of each hospital planning area will use in the target year. However, these days of care will occur in a variety of hospitals, not only those hospitals located in the HPA where the individuals live. Expected patient-days of hospital care are redistributed to the planning areas where services are likely to be provided. In general, it is assumed that the same patterns of patient movement occurring in the base year will remain stable through the target year.

Finally, for each planning area where services will be provided, the forecasted number of patient days is converted to a forecasted need for hospital beds. Patient-days are divided by an occupancy standard calculated for each HPA based on the mixture of different hospital sizes in the area.

The psychiatric method really involves combining two different forecasts. The statewide forecast of short-stay psychiatric bed need is determined by applying a desired bed-to-population ratio to the expected population in the target year. This ratio, 13 beds per 100,000 residents, is a

normative standard, chosen by the SHCC in consultation with the state Mental Health Division. The selection of this ratio is related to a policy decision to encourage development of residential (nonhospital) short-stay psychiatric programs.

The other component of the psychiatric bed method is a demand projection for each health service area and county. It is derived using a method analogous to the nonpsychiatric forecast method, except that there is no attempt to adjust use rates in relation to trends. The results of the demand projection are adjusted to match the statewide (target-ratio) forecast. This way the statewide total of beds will observe the desired ratio, while the distribution of beds throughout the state will agree with observed patterns of service use and patient movement.

Both the psychiatric and nonpsychiatric methods result in baseline forecasts of needed beds in a future target year. These baseline figures can be adjusted subject to guidelines in the forecasting method document.

The hospital bed need forecasting method, in its entirety, addresses many detailed issues which cannot be adequately summarized here. A glance at the detailed contents will help the reader to identify areas of special interest.

This plan includes a considerable volume of changes in the hospital forecasting methods guide. Many of the changes are editorial and organizational. Some of the more important substantive changes are:

- Trend-adjustment of the hospital use rates used in nonpsychiatric forecasts (previously, use rates were assumed to remain constant from the base year to the target year);
- Use of a normative bed-to-population ratio in psychiatric forecasts (previously, the base year use rate was applied to target year population);

- Definite separation of the psychiatric forecast (previously unclear), and clarification of the relationship between overall forecasts and service- or age-specific forecasts (previously unstated and ambiguous);
- Statewide use of the same occupancy standards, related to hospital size (previously, no standards were stated for use in rural areas);
- Age-specific use rates for at least two age groups, 0-64 and 65+ (previously, a single use rate was computed for residents of all ages and a separate adjustment was carried out in forecasting to estimate, based on national data, the effect of changes in the proportions of residents over and under 65).

c. CRITERIA AND STANDARDS FOR EVALUATION AND USE OF METHOD

(1) Definitions

Should: The use of the term "should" in this document implies that there is an expectation and a probability that the particular criterion or standard will be carried out.

Shall connotes an absolute directive and an expectation that a standard definitely will be carried out.

Base year: The most recent year about which data is collected as the basis for a set of forecasts.

Target year: The future year for which patient days, populations and bed needs are forecasted.

Future bed capacity: Beds which will or could be available in the target year. See Hospital Forecasting Criterion 12.

Net bed need or unmet bed need: Forecasted bed need minus future bed capacity, for some target year.

Note: Additional relevant definitions are found in the Glossary to this plan.

(2) General Principles:

1. Forecasting involves both interpretation of trends and the application of judgment concerning the continuation or alteration of trends. All forecasts include such judgments.

2. Forecasting of need for services is not necessarily identical to forecasting of demand. Any need forecast which is not based on predicted demand must be based upon explicit normative statements about the appropriate level of a resource, which have been formally adopted by the health planning system.

   (Explanation: The forecasting method for short-stay psychiatric hospital bed need incorporates elements of normative need. This principle establishes a policy base.)

3. In forecasting future use of hospital services, a clear distinction has to be made between what is, what will be, and what should be. Forecasts of what will be can be changed to reflect what should be only if there is an implementation strategy which realistically can accomplish that change.

4. Forecasts are not in themselves methods for eliminating shortages or surpluses of hospital services and facilities. Forecasts are evidence which can help in deciding whether shortages or surpluses

may develop. Given some evidence about the future, the health planning system has to decide whether it makes sense to try to change a potential surplus or shortage, has to decide whether it has the ability through some implementation strategy (e.g., the Certificate of Need process) to do so, and has to decide what type and degree of change it wants to accomplish.

5. The health planning system in the State of Washington does not have the ability to eliminate existing surpluses of capacity.

6. Hospitals within the state are encouraged to use this methodology. Of course, any hospital or other group within the state may challenge the methodology adopted by the planning system or the results of applying that methodology. Objections to forecasts or the forecasting methods should be stated as early in the planning process as possible, during the adjustment process at the latest.

7. Hospitals and the health planning system should jointly conduct the planning of hospital services in consultation with the Washington State Hospital Commission.

8. Hospitals are responsible for implementing specific services.

9. Starting in 1986 (using 1985 base year data)*, bed need forecasts should be prepared and adjusted at least every three years. The SHCC should decide annually if it is necessary to develop new forecasts in less than three years. This should be done only if it is determined that changes have occurred which would have a significant statewide impact on the forecasts.

   As part of its decision on the need for new forecasts, the SHCC should consider the percent deviation (plus or minus) from the old forecast which would result from using more recent data on population, use rates, etc. The new data must be for a full year (same quarters as used in computing the original forecast) - i.e., less than a year of data should be considered insufficient to justify a new forecast.

   If a new forecast is developed under this provision less than three years after the last full forecast/adjustment cycle, no changes should be made in the negotiated adjustment assumptions from the last full cycle.

*A baseline bed need forecast, which will not go through the adjustment process except for continuation of previously negotiated adjustment assumptions, will be prepared in 1985 or early 1986 using 1983 base year data. A 30-day period will be allowed after distribution of the baseline numbers for correction of any errors.

(3) Criteria and Standards

1. CRITERION: Planning for People

Hospital services and beds should be planned according to the needs of specific groups of people.

STANDARDS:

a. It is not appropriate to assume that the people within the areas use or should use the hospitals within the area, nor should they assume that hospitals in the area serve only the people in the area.

b. Hospital planning should be based on sound evidence about the actual patterns of use by the public. Since the public is free to choose physicians and hospitals regardless of location, plans for hospital services cannot assume that the people within a planning area use or should use only the hospitals within the area, nor should they assume that the hospitals in the area serve only the people in their area.

c. It is not necessary to assume that patterns of use, especially improper patterns of use, or lack of use, will continue. However, plans based on a change in forecasted use patterns should thoroughly document either why the patterns are expected to change or how the patterns will be made to change. In a case where a change in use patterns is assumed, both patient admission rates and lengths of stay should be examined.

d. To the degree that is practical, specific groups of people which use particular or special services not covered by service-specific or age-specific forecasts should have their need for beds calculated as a separate subset within overall forecasts (see Criterion 9).

e. Medical care organizations which serve a separate group of people, such as a Health Maintenance Organization or the Veterans Administration, should not assume that all of the needs of their people have to be met by separate services and facilities owned or controlled by those organizations.

2. CRITERION: Need for Multiple Criteria

Hospital bed need forecasts are only one aspect of planning hospital services for specific groups of people. Bed need forecasts by themselves should not be the only criterion used to decide whether a specific group of people or a specific institution should develop additional beds, services, or facilities. Even where the total bed supply serving a group of people or a planning area is adequate, it may be appropriate to allow an individual institution to expand.

STANDARDS:

a. The fact that a particular hospital has served a particular group of people in the past does not mean that the hospital will or should serve those people in the future. For a variety of reasons (e.g., the desire to develop a Health Maintenance Organization), the people may want to change the pattern of use.

b. Under certain conditions, institutions may be allowed to expand even though the bed need forecasts indicate that there are underutilized facilities in the area. The conditions might include the following:

- the proposed development would significantly improve the accessibility or acceptability of services for underserved groups; or
- the proposed development would allow expansion or maintenance of an institution which has staff who have greater training or skill, or which has a wider range of important services, or whose programs have evidence of better results than do neighboring and comparable institutions; or
- the proposed development would allow expansion of a crowded institution which has good cost, efficiency, or productivity measures of its performance while underutilized services are located in neighboring and comparable institutions with higher costs, less efficient operations or lower productivity.

In such cases, the benefits of expansion are judged to outweigh the potential costs of possible additional surplus.

c. Under certain conditions, existing institutions may be denied approval to expand facilities, beds, and inpatient services even though all facilities in an area are fully utilized. Some of these conditions might include the following:

- facilities in the area are not making maximum use of techniques and services which can increase the efficiency of the facilities; or
- project is not financially feasible, or
- it is determined that it is in the community's interest to develop an alternative type of service or facility rather than expand existing institutions; or
- use rates in the area are judged excessive.

In such cases, the benefits of denying development are judged to outweigh potential costs of possible service shortage.

d. The mere fact that a group of people has an unmet need for services or facilities does not mean that any particular hospital has a right to try to meet those needs. Hospitals, DSHS and State Health Coordinating Council should develop criteria, standards, and plans to guide decisions about which hospitals should serve unmet needs.

(Explanation: It is recognized that hospital bed need forecasting should not be the only criterion against which a project is evaluated. The financial feasibility, the proposed staffing, and the potential for cost containment of the project as well as those conditions listed above should all be taken into consideration.

In planning to meet the needs a group of people may have for services or facilities, consideration should be given to not only allopathic services, but to the special needs and circumstances of osteopathic hospitals and non-allopathic services. No forms of health care should be discriminated against during the development of plans for needed services.)

3. CRITERION: Age/Sex Categories

For the group of people being considered, patient day forecasts should, to the extent to which it is practical and to which data is available, be calculated separately for those age and sex groups which have significantly different use rates.

STANDARD:

a. To the extent possible, patient day forecasts should be calculated separately or adjusted for the following:

- people age 0 through 14
- people age 15 through 64 (or people age 15 through 44 and 45 through 64).
- people age 65 or more
- women of childbearing age (age 15 through 44)
- for psychiatric services, ages 0-17, 18-64 and 65 or more.

(Explanation: Currently the age groups 0-64 are used in all forecasting. Additionally, the age groups 0-17 and 18-64 are differentiated in short-stay psychiatric forecasting, because psychiatric treatment programs for children and adolescents very often are separate from programs serving adults.)

4. CRITERION: Target Date

Because medical terminology and standards of practice change rapidly, because medical facilities and equipment become obsolete quickly, because communities and their goals change, and because, in general, long-range forecasts are unreliable, forecasts should go only as far into the future as needed to answer the type of policy question being asked.

STANDARDS:

a. For most purposes, bed projections should not be made for more than seven years into the future. Each time forecasts are revised, a forecast target date should be agreed upon by the health planning system.

   (Explanation: In the 1985 forecasting cycle, the target year is 1990.)

b. For major policy questions, such as whether a community should have a hospital or additional hospitals, long-range forecasts should be prepared. For long-range forecasts, the health planning system may determine that a different method is preferable to the one used for short-term purposes. Any alternative method should be reviewed publicly and be adopted by the SHCC.

5. CRITERION: Population Forecasts

The most accurate population forecasts available at the time of forecasting should be used.

STANDARDS:

a. Where future growth or decline of population may change significantly, ranges of projected population should be used. The health planning system should specify the most probable population estimate and should use it as the basis for bed forecasts.

b. Population forecasts prepared by the Office of Financial Management (OFM) of the State of Washington, including age and sex-specific forecasts, should be the basic forecasts used. Other local forecasts may be used to deal with small areas, provided that totals equal the OFM forecast at the statewide and county levels.

c. Hospitals may employ other more local forecasts (e.g., those produced by the councils of governments), if accurate, for specific service areas and negotiate with SHCC/DSHS in the development of forecasts for use in developing the hospitals' own plans. Use of population forecasts should be resolved during the adjustment process.

d. If OFM issues updated county-specific population forecasts between hospital forecasting cycles, and the health planning system determines that these forecasts differ significantly from the baseline population forecasts used in the most recent bed need forecasts, revised hospital forecasts should be produced using the new population figures even if a new baseline forecast would not be necessary under General Principle 9. All other hospital forecasting data and assumptions (e.g., patient origin, market share, use rates) shall be unchanged. The revised population figures (only) shall be subject to adjustment.

6. CRITERION: Hospital Utilization Rates

The health planning system should determine the most appropriate future utilization rates* for use in bed need forecasting. A range of rates may be identified, if appropriate, so long as there is no ambiguity about what rates will be used.

STANDARDS:

a. Use rates should be forecasted for each of the major services (adult medical/surgical, pediatrics, and obstetrics) and for other specific services as identified in Hospital Forecasting Criterion 10. It is assumed that the base year's utilization rate will be projected forward to the target date, subject to adjustment for age (all services), changes in fertility rates and obstetric use patterns (obstetrics), and to anticipated changes in policy.

However, a service's use rates may be forecasted to be higher or lower than in the base year if a specific analysis of past trends in admission and lengths of stay is conducted and the health planning system or hospital documents reasons for anticipated continuation in or change to such past trends.

b. Based on analysis of annual data, for trends in patient days, admissions and lengths of stay, the forecasted use rates for the target year shall be determined by adjusting the base year non-psychiatric use rate upward or downward to reflect the slope of the ten-year use rate trend line. The trend for statewide or regional changes in use rate shall be used, whichever trend is

*The utilization rate is the number of hospital patient days per 1000 population.

The adult medical/surgical utilization rate is the number of medical/surgical patient days per 1000 population age 15 and older.

The pediatric utilization rate is the number of pediatric patient days per 1000 population ages 0 through 14.

The obstetric utilization rate is the number of obstetric patient days per 1,000 female population ages 15 through 44.

less pronounced (that is, whichever trend would result in the least change from the base-year use rates). This adjustment shall be carried out only if it is judged that the use rate trend will continue in the same direction.

(Explanation: A different procedure is used in certain hospital planning areas with high HMO enrollment and HMO-owned/operated hospital facilities. See step-by-step method for overall (non-psychiatric) forecasts, in this Guide.)

STANDARD

c. No planning area's utilization rate for non-psychiatric (medical/surgical/obstetric/pediatric) services shall be forecast lower than the statewide age-adjusted use rate for HMO enrollees, unless that area's actual base-year use rate was that low.

(Explanation: The procedures for the latest forecasting cycle specify that no hospital planning area shall have a forecasted 1990 use rate less than its actual 1983 use rate or the 1983 statewide hospital use rate for HMO enrollees, whichever is lower. This check is applied on an age-specific basis.)

Note: It has been shown that there is some substitution effect between hospital and nursing home beds. Impacts should be carefully monitored in planning areas where the supply of one or both types of beds is being effectively constrained by the policies in this Plan.

7. CRITERION: Use of Planning Areas

Planning areas are tools for dividing the population of a large area into convenient geographic units practical for planning.

STANDARDS:

a. Planning area boundaries should be defined by the health planning system and reviewed by provider and consumer groups.

b. Planning areas should not, to the extent practical, divide communities which share a common set of interests. However, there are groups of people who make use of special health care services for whom it is sometimes not possible to create separate exclusive small geographic planning areas, such as Health Maintenance Organization enrollees, veterans, members of the armed forces, etc.

c. Planning area boundaries should be drawn so that it is possible to make reasonable population estimates and projections. This means that the boundaries should follow census tract, county, and state boundaries.

d. Planning areas may contain a number of hospitals, or no hospitals at all. A planning area which does contain one or more hospitals may not have available within its boundaries many of the services which its population needs and/or uses.

e. There will often be considerable overlap between the market or service areas of the hospitals and the planning areas in which those hospitals are located. Despite any overlap, planning areas for groups of people should be distinguished from market or service areas of hospitals and specific services.

f. Planning areas for specific services should, if possible, be coterminous with the basic hospital planning areas. Planning areas for more specialized services (e.g., psychiatric units, burn centers, neonatal intensive care units, etc.) which SHCC, DSHS and hospitals have determined should be offered over a larger area or regionalized, should be composed of groups of the basic hospital planning areas.

8. CRITERION: Planning Area Hospital Bed Needs

The availability of hospital resources and the determination of resource requirements should be evaluated through an analysis of planning area bed needs.

STANDARDS:

a. DSHS should develop baseline patient day and bed need forecasts for each planning area, using the given hospital bed need forecasting method upon which appropriate adjustments for planning area bed needs can be made.

b. When necessary SHCC and DSHS in cooperation with area hospital councils, the Washington State Hospital Association, and hospitals within each planning area, should adjust the planning area baseline estimates using the given bed forecasting method to take into account mutually agreed upon or negotiated changes in population, use rates, market shares, out-of-area use, and/or upward revisions of the appropriate occupancy standards (as permitted in Hospital Standard 11.e). This adjustment process should ensure opportunity for participation and comment by the Hospital Commission, insurors, purchasers, labor and other interested parties.

c. Upon receipt of a new set of baseline forecasts (regular three year cycle), hospitals should present their recommended adjustments to the SHCC and DSHS and negotiate any differences in bed forecasts.

d. Separate planning area hospital bed need forecasts should be made in each planning area which contains both hospitals providing basic community-oriented services and hospitals providing region-

wide tertiary care services. The health planning system in consultation with affected hospitals should determine when and where these separate projections should be made.

(Explanation: Hospital patient day and bed need forecasts should be made for planning areas as a whole. These total forecasts would be made for planning areas not only with one facility, but also those with two, three, or more facilities. The baseline forecasts provide a common starting point for the analysis of planning area bed needs by the community, including consumers, planners, and providers.

Determining bed needs by planning area will foster an increasing shift toward thinking about the care needs of people within a community. It will also provide one starting point for long range and joint planning among the consumer, provider, and planning groups. While the SHCC and DSHS will provide the baseline patient day and bed need forecasts for each planning area, local councils and provider groups will have the opportunity to verify or suggest modification of these forecasts using the forecasting methodology. Where made, these changes might be the result of well-documented modifications to population estimates, use rates, market share, physician practice patterns, or out-of-area use.

Bed need forecasts for hospitals providing regional tertiary care services may need to be made separately from the forecasts for other hospitals in the planning area. These hospitals serve a relatively widespread clientele with a large proportion of their patients being drawn from outside of the planning area.)

9. CRITERION: Framework for Overall Forecasts and for Service Specific/Age Specific Forecasts

There is a distinction in bed need forecasting between services where the forecast is based at least in part on normative judgments about need, and those where the forecast is based exclusively on demand patterns and population changes. There also is a distinction between overall forecasts and sub-forecasts which are parts of an overall total.

STANDARDS:

a. The need for hospital services shall be forecast in two distinct parts: need for short-stay inpatient psychiatric services (partially based on normative need) and need for non-psychiatric hospital services.

b. Bed needs for non-psychiatric services, which are forecast on the basis of demand (utilization patterns) and population, shall be forecast as an aggregate. Specific service forecasts within this aggregate shall be treated as subsets of the total.

c. Unless otherwise explicitly stated in a service specific forecasting method, all forecasts for specific hospital services are subsets of the total forecast for non-psychiatric services (i.e., medical/surgical/obstetric/pediatric services).

A finding of net need for a specific service does not by itself provide justification for adding beds to meet this need. Conversion of the use of beds in one or more hospitals within the planning area must be considered. Beds shall not ordinarily be added to meet a specific service need unless they also are needed to address a general unmet need for non-psychiatric hospital beds in the area.

d. Specific services which are not individually forecast shall be considered part of the total forecast for non-psychiatric services. If an applicant to develop such services proposes to construct new hospital beds, there must be net unmet need for these beds within the area's total forecast of medical/surgical/obstetric/pediatric bed need.

e. If age-specific service needs are separately forecast (e.g., need for short-stay psychiatric inpatient services for children and adolescents), these forecasts shall be interpreted as subsets of the total forecast for all ages. A finding of net need for a particular age group does not by itself provide sufficient justification for adding beds to meet the need.

f. In the event of conflicting evidence about bed needs from overall bed need forecasts and service specific (or age specific) sub-forecasts, the overall forecasts ordinarily shall be considered binding. The sub-forecasts should be reduced in the adjustment process, if necessary, to avoid an excessive shift of an area's hospital capacity from general medical/surgical/obstetric/pediatric use to specialized units.

Explanation: It is theoretically possible for service specific and age specific sub-forecasts to add up to more than the total bed need for an area (overall forecast). This is true because occupancy standards have a different effect applied service-by-service than they have when applied overall at the planning area level. The overall occupancy standards used in forecasting (see Hospital Forecasting Standards 11.b. and 11.f) were chosen to allow sufficient leeway for hospitals to meet a variety of needs. Forecast need for a specific service therefore may overstate the number of beds which it is sensible to shift from general medical/surgical/obstetric/pediatric use to more specialized uses. The overall balance of general and specialized beds within an area is an appropriate topic for adjustments (so long as total area bed need forecasts are not exceeded) and for selective growth/

selective use planning. Regionalization plans developed by the health planning system for specific services also should influence this balance in certain instances.

10. CRITERION: Service Specific Resource Requirements

Forecasts of hospital resource requirements should recogize that all beds within a hospital or hospitals are not capable of providing nor are they intended to provide similar services.

STANDARD

a. The State Health Coordinating Council shall prepare service-specific baseline forecasts of patient days and bed needs for short-stay psychiatric hospital services. These forecasts are needed as guidance for review of Certificate of Need applications for addition, expansion or replacement of specific service units in hospitals.

Except for psychiatric services, service-specific forecasts shall be subsets of the overall forecast for non-psychiatric (medical/surgical/obstetric/pediatric) services. As such, they shall not affect the calculation of the total non-psychiatric patient days and beds forecast for each planning area.

(Explanation: Note that need for a specific service does not by itself address the question of whether beds should (or may) be added to meet this need. See Hospital Forecasting Criterion 9.

Hospital resource requirements should be determined on a service/specific (e.g., medical/surgical, obstetric, psychiatric) basis. Many planning and certificate of need decisions require the knowledge of both service-specific capacity and future requirements.

All decisions should recognize that beds, even those within a particular facility, and medical staffs may not be inter-changeable in the short term. For example, a patient in a medical/surgical unit probably could not be placed in an obstetric bed.

Service specific forecasts could assist hospitals in developing long range plans. They may provide some guidance to a facility on the resources which may be required in the future. Because different services have different resource and personnel requirements, an accurate assessment of future need is essential in planning for the development of an area's resources).

11. CRITERION: Occupancy Standards for Use in Forecasting

Hospital bed capacity should be utilized efficiently without compromising necessary access to service. Bed need forecasting methods should use occupancy standards chosen to achieve this dual goal.

STANDARD: Statewide occupancy expectations

a. Average annual occupancy rates for hospitals and specific services should not be less than:

- 75% statewide
- 75% for adult medical/surgical services statewide
- 55% for obstetric services statewide
- 55% for pediatric services statewide

STANDARD: Occupancy standards for individual facilities for use in forecasting

b. In developing baseline forecasts of future bed needs, the occupancy standards for existing hospitals in planning areas shall not be less than:

- 50% for hospitals with 1 through 49 beds.
- 65% for hospitals with 50 through 99 beds.
- 70% for hospitals with 100 through 199 beds.
- 75% for hospitals with 200 through 299 beds.
- 80% for hospitals with 300 beds or more.

(Explanation: These standards are for use in forecasting.)

STANDARD: Occupany standards for use in forecasting specific services

c. In developing baseline forecasts of future need for specific hospital services, the occupancy standards for specific services already existing in hospitals shall not be less than:

- 55% for services with 1 through 49 beds.
- 70% for services with 50 through 99 beds.
- 75% for services with 100 through 199 beds.
- 75% for services with 200 through 299 beds.
- 80% for services with 300 beds or more.

The minimum occupancy standards for some specific services may be higher. These are explictly stated as part of the service-specific forecasting methods (e.g., for short-stay psychiatric hospital services).

If forecasts are developed for alcoholism/substance abuse service bed needs, the same occupancy standards should be used as in short-stay psychiatric forecasts.

(Explanation: These minimum occupancy standards have not been changed since 1979. However, as of this plan edition, they are being applied to all planning areas, rather than only those in urban areas. Since the health planning system has responsibility to plan for specific services whether in urban or rural areas, occupancy standards must exist for forecasting use in all areas.)

STANDARD: Occupancy standards for use in resource forecasts

d. In evaluating the appropriate size (beds) for a proposed new facility or service, special facility-specific forecasts sometimes are needed. In these instances, forecasted volume (Average Daily Census, or ADC) is given and an appropriate bed complement must be determined. The following occupancy standards shall be used in these special resource forecasts.

d.1. New facilities: For the purposes of making resource forecasts, occupancy rates for proposed new hospitals shall not be less than:

- 50% for hospitals with an average daily census (ADC) of 25 or less.
- 65% for hospitals with an ADC between 26 and 65.
- 70% for hospitals with an ADC between 66 and 140.
- 75% for hospitals with an ADC between 141 and 225.
- 80% for hospitals with an AOC of 226 or more.

d.2. New services in hospitals: For the purpose of making resource forecasts, occupancy rates for proposed new specific services should not be less than:

- 55% for services with an ADC of 25 or less.
- 70% for services with an ADC between 26 and 65.
- 75% for services with an ADC between 66 and 140, and
- 75% for services with an ADC between 141 and 225.
- 80% for services with an ADC of 226 or more.

For services which have higher occupancy standards (see Standard 11.c above), the higher occupancy standards shall be used, but shall be applied to ADC rather than to beds.

STANDARD:

e. SHCC and DSHS may negotiate appropriate occupancy standards for individual hospitals which are higher than the minimums presented in Standards 11.a, b, c and d above. Once developed, these shall be used in future baseline forecasts, as applicable.

STANDARD:

f. The occupancy standard applied to each planning area or service within each planning area shall be based, for forecasting purposes, on the current weighted average of the appropriate occupancy standards for each facility in the planning area. This is calculated as the sum, across all hospitals in the planning area, of each hospital's occupancy rate times that hospital's percentage of total beds in the area. Where a specific service is concerned, the weighted average for all applicable service units is determined (weighted by unit size).

(Explanation: There is no change in this method since 1979).

12. CRITERION: Bed Capacity

In determining the future bed capacity which will serve a community, the count should include all beds which will be available or could be available for patient use. The count should not include beds which physically could not be used, and beds which will be eliminated within the span of the forecasts.

STANDARDS:

a. The count of future bed capacity should separately identify:

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

b. Occupancy standards for forecasting are computed based on beds which are licensed and physically could be set up, plus beds which do not physically exist, but which are authorized.

c. SHCC and DSHS consulting with individual hospitals should decide what beds should be counted in what part of current and future bed counts (see 12.a(1) through 12.a.(4) above).

(Explanation: The count of future bed capacity should be used in conjunction with the hospital bed projections to determine future need. This count assists in the identification of areas with potential deficits or surpluses in the availability of resources.)

STANDARD

d. For specific service categories, future beds are those which could be set up in an existing service unit, plus those authorized plus or minus any changes in service-specific capacity which do not require approval but which will occur prior to the target year. Definitions used in counting available beds are included in each service specific forecasting method.

(Explanation: This definition is necessary because not all changes in specific service capacity are subject to review. Forecasted net need for beds in a service should incorporate the best estimate of future capacity in all units within the planning area.)

13. CRITERION: Allocations to Individual Hospitals

The allocation of utilization to individual hospitals should be by a process which is reasonable, fair, and realistic.

STANDARD:

a. Calculations of the current "market penetration" by hospitals of one planning area into another planning area should be based on patient origin and destination data. Baseline forecasts of future utilization and bed needs generally should assume continuation of current market share patterns, subject to change if necessary during the formal adjustment process.

d. SPECIFIC METHODS

This section presents the detailed methods used to forecast hospital bed needs.

(1) Determination of Forecasting Policies and Availability of Methods Detail.

Policy decisions about how to forecast need for hospital resources are made by the State Health Coordinating Council, and adopted as part of the State Health Plan. However, there exists a level of technical detail which is administratively developed by SHCC staff, within the State Health Plan's policy framework.

Detailed explanations of how each calculation is carried out, including identification of data sources, shall be available from SHCC staff (DSHS).

Changes in procedure may be made at the technical (staff) level only to improve technical methods within policies adopted by the SHCC, or to improve clarity, or to add information previously unavailable. Any change which is not consistent with SHCC-adopted policy requires formal SHCC action (an amendment to the State Health Plan).

(2) Method for Overall Baseline Forecast of Non-Psychiatric (Medical/Surgical/Obstetric/Pediatric) Hospital Bed Needs.

Following is a step-by-step description of the method for forecasting the overall (aggregate) need for medical/surgical/obstetric/pediatric hospital beds. Many elements are elaborated in the Hospital Bed Forecasting Standards.

1. Develop trend information on hospital utilization

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

STEP 2: Subtract psychiatric patients days from each year's historical data.

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

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

2. Calculate baseline non-psychiatric bed need forecasts

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

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

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

Each hospital planning area's trend-adjusted use rate for every age group is tested against the statewide hospital use rate for HMO enrollees in the same age group. The trend-adjusted use rate is used in forecasting if it equals or exceeds the statewide HMO enrollees' hospital use rate. If not, forecasting will be done using the applicable statewide HMO enrollees' use rate or the hospital planning area's actual base-year use rate, whichever is lower.

STEP 7B: Alternate Adjustment: In lieu of Step 7A, in those hospital planning areas where:

1. HMO enrollees make up a significant and increasing portion of the population;
2. HMO enrollees are expected to use HMO-owned and operated hospitals;
3. base year HMO enrollment and hospital use (i.e., patient days) can be identified; and,
4. forecasts of the HMO future enrollment are made by or deemed reasonable by health planning system,

the following adjustment will be made instead of the hospital use rate trend adjustment, provided, the resultant hospital bed need forecast for the planning area is less than the use rate trend-adjusted hospital bed need forecast.

Step 7B.1: Subtract the forecasted HMO enrollment from the target year population.
Step 7B.2: Adjust the market shares of the hospital planning areas to exclude HMO hospitals.
Step 7B.3: Set the target year use rate equal to the hospital planning area's base year non-HMO use rate. The non-HMO use rate equals total patient days minus HMO patient days, divided by total population minus HMO enrollment.

(Explanation: The effect of HMOs' increasing market penetration and low hospital use rates in individual hospital planning areas is difficult to separate from other factors in the historical trends of declining area-wide use rates. In those planning areas where this effect is likely to continue, separate forecasting of HMO/non-HMO patient days and beds is a more appropriate approach than the trend adjustment used for other areas. Therefore, until data become available which would allow a more exact analysis of the trend components, the above special adjustment will be used for those specific hospital planning areas. For the 1985 forecast cycle, the following hospital planning areas meet the conditions of this adjustment: Southwest Snohomish and North, East, Central, Southwest and Southeast King).

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

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

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

Explanation: Psychiatric beds in general acute-care hospitals are included in occupancy calculations. The occupancy standards in Standard 11.b were selected to allow sufficient leeway for hospitals to meet a variety of needs, including psychiatric, and these assumptions have been applied in the past to hospitals having psychiatric services as well as to those which do not.

3. Determine total baseline hospital bed need forecasts

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

Make Adjustments

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

(Explanation: In applying this method in the 1985 and 1986 forecasting cycles, the age groups used throughout are 0-64 and 65+, except for the psychiatric bed need forecasts which consider ages 0-17, 18-64 and 65+.

The forecasting method assumes that out-of-state residents will continue to use the same percentage of each area's hospital services (patient days) as they did in the base year. Similarly, it assumes that Washington State residents will continue to seek care in areas outside the state to the same extent as in the base year. In some hospital planning areas these out-of-area use assumptions are quite significant and warrant careful consideration during the adjustment process).

(3) Methods for Service-Specific Forecasts Within the Overall Non-Psychiatric Forecast

At present there are no formally approved statewide methods for forecasting service-specific components of the non-psychiatric forecast. It is anticipated that such methods will be developed in the future.

(4) Short-Stay Psychiatric Bed Forecasting Method

(a) INTRODUCTION

This section of the hospital forecasting guide provides a description of the Washington State Short-Stay Psychiatric Hospital Bed Need Forecasting Method. It is part of the adopted Hospital Bed Need Forecasting Method, while recognizing factors which are unique to psychiatric bed needs in hospitals.

The short-stay psychiatric hospital bed need forecasts are developed independent of other hospital bed need forecasts presented in the Washington State Hospital Bed Need Forecasting Method.

(b) THE BED NEED FORECASTING PROCESS

There are three phases to the short-stay psychiatric bed need forecasting process. These three phases will allow a consistent forecasting method to be used across the state as well as allowing adjustments for local conditions and plans which could not be used statewide. The process also includes the development of selective growth policies within each health service area.

i. The baseline forecasting phase - The state agency develops a set of baseline bed need forecasts. The forecasts are developed using a uniform data base and assumptions and are consistent with the adopted psychiatric method.

ii. The adjustment and selective growth policy phase - The SHCC and the Mental Health Division work with interested parties including consumers and providers, and county governments, as appropriate, to note any adjustments (which must follow the adjustment guidelines of this plan). The adjustments should reflect local conditions and plans.

iii. The finalized forecasts phase - Once all Health Systems Agency adjustments have been reviewed and found to conform with the adjustment guidelines and selective growth policies developed, the state agency releases a finalized set of forecasts which are to be used in reviews, in developing future plans and for inclusion in the State Health Plan.

Each of these phases has a number of underlying assumptions and guidelines which are described in criteria and standards. Some of the criteria and standards apply to the methodology as a whole, some to individual phases, and others to specific steps within the projection method. Except where noted herein, criteria and standards contained in the Washington State Hospital Bed Need Forecasting Method are applicable to the psychiatric bed forecasts.

(c) DESCRIPTION OF THE STEP-BY-STEP METHOD

The method presented here shall be used to determine baseline short-stay psychiatric hospital bed needs. This method should be used in the context of the assumptions and guidance outlined in the criteria and standards. The forecasts should then proceed through the adjustments phase of the forecasting process. Any adjustments considered must be applicable to particular steps within this method. The adjustments phase is further described in Section IV.B of this hospital forecasting guide.

Summary of method: Forecasts for short-stay psychiatric hospital bed need are calculated so that the total short-stay beds available for state residents would equal a desired statewide normative bed-to-population ratio of 13 beds per 100,000 persons. It is assumed that federal hospital use will continue current demand patterns (use rate, patient origin), while needs for short stay psychiatric inpatient services in community and state hospitals are adjusted from base year use rates to achieve the desired overall bed target.

Hospital psychiatric bed need is forecasted for each mental health planning area (counties, with the exception of dual-county areas: Chelan/Douglas, Benton/Franklin and Thurston/Mason). The underlying demand forecasts (before adjustment to the target bed

ratio) are based upon age-specific use rates (for ages 0-17, 18-64 and 65+) and county market shares from the base-year patient origin study. The patient origin data base includes all discharges from community hospitals with a psychiatric primary diagnosis; all stays of 30 days or less in state mental hospitals (excluding criminal and sexual psychopath commitments); and all psychiatric discharges from federal (VA and military) hospitals with length of stay of 30 days or less. Group Health enrollees are included.

Forecast Based on Current Demand Patterns

Step 1: Using the latest patient origin data and Division of Mental Health-provided state mental hospital discharge data, allocate patient days (PDs) generated in each county's hospitals back to the county where the patient lives.

Step 2: Compute each county's age specific use rates (ages 0-17, 18-64 and 65+) by dividing the PDs generated by each age group by that age group's base year population.

Step 3: Assuming that each county's residents' demand for short stay psychiatric hospital services remains constant, calculate the number of PDs that would be generated by the residents of each county in the target year by multiplying each county's age specific use rates by its projected population in each age group. Total PDs equal the sum of PDs for the three age groups.

Step 4: Using the same patient origin data used in Step 1, and using the projected PDs from Step 3:

a. Calculate the number of PDs which would be generated in each county's hospitals, in the target year, based upon the market shares for hospitals in that county;

b. Calculate the number of PDs which would be generated in the state hospitals, in the target year, based upon those hospitals' market shares; and

c. Calculate the number of PDs which would be generated in the federal hospitals, in the target year, based upon those hospitals' market shares.

Step 5: Calculate the projected average daily census (ADC) for each county's non-governmental hospitals and for the state and federal hospitals by dividing the number of PDs which would be generated in each county and each government hospital (from Step 4) by 365.

Step 6: Calculate the counties' and the state and federal hospitals' demand for beds in the target year by dividing their ADCs (from Step 5) by an appropriate occupancy standard:

a. For counties or state/federal hospitals with a short stay psychiatric ADC of 10 or less, the occupancy standard is 70 percent;

b. For counties or state/federal hospitals with a short stay psychiatric ADC of 11 or more, the occupancy standard is 85 percent.

Note: These demand projections do not include demand by out-of-state residents. This is corrected in Step 10.

Adjustment of Demand Forecast to Desired Target Bed-to-Population Ratio

Step 7: Calculate the statewide short stay psychiatric hospital bed supply needed in order to achieve the desired normative bed-to-population ratio of 13 beds per 100,000 persons in the target year by multiplyng the projected statewide population in the target year by 13 and dividing the product by 100,000.

Step 8: Subtract from the statewide normative bed need (calculated in Step 7) those beds projected as needed in federal hospitals (calculated in Step 6). The remainder is statewide normative need for short stay psychiatric beds in non-federal hospitals.

Step 9: Calculate a factor to adjust statewide demand for non-federal beds to match the statewide normative need for such beds. This adjustment factor equals the remainder from Step 8 (statewide normative bed need for non-federal hospital beds) divided by the projected demand for beds in non-governmental hospitals and state hospitals (from Step 6).

Step 10: Using patient origin data, adjust each county's projected demand for non-governmental beds (Step 6) to account for patient flow into that county from out-of-state. It is assumed that the percentage of out-of-state use (PDs) in the hospitals in each mental health planning area will remain constant.

Step 11: Calculate each county's normative adjusted need for non-governmental hospital beds for short stay psychiatric services by multiplying the county's unadjusted demand for non-governmental beds (Step 10) by the normative adjustment factor calculated in Step 9.

Note: This forecast method assumes that federal hospitals and state mental hospitals will maintain sufficient short-stay psychiatric capacity to meet their share of total short-stay need. Federal hospitals are assumed to maintain their base year use rate and patient origin patterns. The state mental hospitals' short-stay use rates are assumed to decline slightly (by the same percentage as community hospital use rates are assumed to decline; see Steps 9 and

11), as a result of expanded short stay residential programs. The ability of federal and state hospitals to provide these service levels (ADCs) will be verified as part of the forecast adjustment process.

Step 12: Each county's net need for non-governmental short-stay psychiatric hospital beds is equal to the county's adjusted non-governmental bed need (from Step 11) minus the county's future non-governmental bed supply (as defined in Hospital Forecasting Criterion 12.d). Non-governmental short-stay psychiatric beds are those identified in Short Stay Psychiatric Services section of this plan.

(d) CRITERIA AND STANDARDS

The primary policy guidance for this forecasting method is Short Stay Psychiatric Services Section of the Plan. Other applicable standards are found in the general criteria and standards for hospital bed need forecasting, in the Guidelines for Adjusting Psychiatric Bed Need Forecasts and below.

General Criteria and Standards for Psychiatric Forecasting

The following criteria (and related standards) have broad significance beyond any single phase of the psychiatric forecasting method.

1. Planning Services for the Population

Short-stay inpatient psychiatric services should be planned on the basis of the needs of the population.

a. Standard. The need for short-stay psychiatric inpatient/residential resources is specified in Planning and Review Policy 3.3.2.4 of the State Health Plan.

b. Standard. In areas where the state agency (Mental Health Division) projects a change in the patterns of use due to state policy initiatives, interested agencies of the affected areas should provide a review and comment on the projected impact of policy initiatives. After analysis of comments, the state agency should provide the final decisions on the projected impact of the policies used in baseline bed need forecasts.

c. Standard. To the degree to which it is practical, specific groups of people which use special services or facilities should have their needs for beds calculated separately through the use of selective growth policies. When selective growth policies have been applied, the total number of beds forecasted as needed must sum to no more than the total number forecasted in the finalized

forecast phase. Special subgroups should include children, adolescents, adults, involuntary, and voluntary patients, to the extent that separate facilities or programs are needed to serve these groups. (See Selective Growth Policies).

2. Areas for Planning Services

   a. Standard. The planning area for short-stay psychiatric hospital services is the county, with the exception of formal multi-county mental health authorities noted in short-stay psychiatric services section of this Plan.

Criteria and Standards for the Psychiatric Baseline Forecasting Phase

3. Psychiatric Use Rate

   Forecasting of the need for psychiatric service resources should be based upon the best estimation of the appropriate utilization of those resources.

4. Occupancy Standard for Residential Programs

   a. Interim standard: For forecasting purposes, the occupancy standard for short-stay psychiatric residential programs shall be 85 percent (county-wide weighted average for all residential programs). This will be changed if necessary based on experience with the program.

Criteria and Standards for the Adjustments and Selective Growth Policy Phase of Short-Stay Psychiatric Forecasting

5. Documented Use Rate Variations

   Short-stay psychiatric hospital resource need forecasts should reflect current and proposed federal and state initiatives and policies which would result in changes in the use rate of the population.

   a. Standard. The Mental Health Division should, at least biennially, list federal and state initiatives where such a change is documentable and quantify the impact of such initiatives. The State Health Coordinating Council in consultation with the state agency should make final decisions on the appropriateness and validity of proposed revisions.

   b. Standard. All forecasts incorporating impacts of state and federal policies and initiatives should be reevaluated as part of each full forecast/adjustment cycle to ascertain the effectiveness, feasibility, and appropriateness of

those policies and initiatives. The projected impacts of the policies and initiatives should also be re-evaluated to determine accuracy. Policies and initiatives which are no longer valid should be factored out of the forecasts. More frequent re-evaluation may be undertaken if justified based on General Principle 9 in this guide.

c. Standard. Under the auspices of the SHCC and DSHS hospitals and other interested parties within each planning area should jointly adjust, if necessary, the baseline forecasts to account for local (nonpolicy) impacts. All adjustments to population, use rates, market shares, and out-of-area use should be well documented. Guidelines for local adjustments are contained in Sections IV.A and IV.B of this forecasting guide.

d. Standard. Adjustments to the baseline forecasts should include consideration and analysis of the impacts on the utilization or potential utilization of psychiatric services by the under- and inappropriately served population in all short-stay service settings.

6. Psychiatric Service Selective Growth Policies

Psychiatric service selective growth policies should be developed.

(Explanation: There is a need for a selective growth policy for hospital inpatient psychiatric services which outlines the placement of beds within mental helath planning areas, the number of beds to be placed in hospitals, the levels of psychiatric service to be provided by the various hospitals, and the population groups to be served by the hospital psychiatric beds. Selective growth policies should be developed as part of the adjustments phase of the forecasting method).

a. Standard. Selective growth policies should reflect local circumstances and values toward acute inpatient/residential psychiatric care.

b. Standard. During and after analysis of federal and state policies and proposed policies and adjustments in the adjustments phase of the method, selective growth policies should define:

(1) the placement of short-stay inpatient/residential beds in the following types of facilities:

(a) hospitals with or without designated psychiatric units,
(b) free-standing psychiatric hospitals,
(c) nursing homes,

(d) boarding homes,
(e) other residential living sitautions.

(2) the location of short-stay hospital psychiatric beds within mental health planning areas.

(3) the relative priority and numbers of hospital psychiatric beds needed to provide service of the following types:

(a) beds needed to serve
(i) voluntary commitments,
(ii) involuntary commitments;

(b) beds needed for population groups
(i) children,
(ii) adolescents,
(iii) adults (ages 20 through 64),
(iv) elderly (ages 65 and over);

(c) beds in facilities providing multiple levels and types of mental health care and having formal linkages with other community services providing less intensive care.

(4) terms governing the meeting of priority needs (e.g., circumstances under which lower priority needs should be approved in the absence of competing applications for higher priority beds). These terms should include the meeting of needs through both hospitals and alternative settings.

c. Standard. Resource availability or limitations for inpatient psychiatric services should be considered in the development of selectie growth policies.

d. Standard. Selective growth policies should indicate conditions under which (1) institutions could be allowed to expand or establish facilities, beds, or services even though forecasts show that there would be underutilized resources in the area, and (2) institutions could be denied approval to expand or establish facilities, beds, or services even though there may be a demonstrated need for such facilities, beds, or services.

e. Standard: If there is lack of evidence of development of short-stay psychiatric residential programs, a bed allocation plan may allow for short-stay psychiatric hospital beds exceeding the normative adjusted bed need forecast (from Step 11 of the Short Stay Psychiatric Hospital Bed Forecasting Method) but not exceeding the demand for beds using unadjusted base-year psychiatric use rates (from Step 6 of this method).

e. GUIDELINES FOR ADJUSTING FORECASTS

(1) General Adjustment Guidelines

INTRODUCTION

This section serves to detail the types of adjustments which may apply to the baseline hospital patient day forecasts and outline the documentation which would be required to make these adjustments. The factors discussed here should be considered when adjusting the baseline patient day forecasts. Any adjustments should be the result of negotiations between the hospitals and DSHS, with opportunity for participation and comment by the Hospital Commission, insurors, purchasers, labor and other interested parties.

The discussion of adjustment factors is organized into the four components influencing total patient days. These factors are:

- population
- use rate
- market share
- out-of-area use

POPULATION

There are three population components to be considered in analyzing the affects of population on total patient days - the planning area population, the projected subscriber population using a Health Maintenance Organization (HMO) hospital, or the projected federal population. Changes in any of these components could affect the population forecasts used to calculate patient days. Each of these changes is discussed below.

Factors Affecting Population

1. Changes in the Projected Planning Area Population:

   Population projections are based on a number of assumptions regarding net migration, fertility rates and mortality rates. A change in any of these factors would therefore affect the projected planning area population.

   For example, land use policies designed to strictly control the growth of rural areas or fuel shortages would probably decrease migration to rural areas. This situation would result in an increase in the projected population of urban planning areas.

2. Changes in the Projected Planning Area Subscriber Population Using an HMO Hospital:

HMO population forecasts for a geographic area are usually based on historic trends and the HMO's growth policy. However, opening a new clinic or hospital in an area might increase an HMO's enrollment faster than anticipated and decrease the population projected to use community hospitals. If a ceiling on HMO penetration in an area were reached, the HMO enrollment might not grow as fast as anticipated. This situation would increase the population projected to use community hospitals.

3. Changes in the Projected Planning Area Population using Federal Hospitals:

Currently, there is some difficulty in obtaining precise data on the number of persons using VA and military hospitals, particularly on a planning area basis. However, even if the population using federal hospitals is not subtracted, changes in this population will affect the number of persons using community hospitals. For example, an expansion in the number of persons eligible for services at a VA Hospital could increase the population using federal hospitals and decrease the population using community hospitals. However, elimination of obstetric services at a military hospital would increase the projected population using community hospitals for this service.

Documentation for Adjusting Population Estimates and Projections

In order to adjust a population forecast, it is important to first establish that the initial method of projecting the population does not account for the anticipated change. If it does not, then it is important to find a substitute population projection which better explains the factors affecting population in an area.

Similarly, documenting that the number of enrollees using an HMO hospital in an area will be different from that projected by the HMO must be based on evidence of changes in the assumptions underlying the HMO projection. That is, it would be necessary to cite the reaons why the HMO enrollment in an area is not expected to grow according to historic trends.

Documenting changes in the federal population requires information from the military or the Veterans Administration on expected changes in eligibility requirements and/or expected changes in covered services. It is also important to establish that this is a permanent change rather than a temporary one in order to document the need to adjust the population component of the patient day projections.

USE RATE

Use rate is defined as the rate at which residents of an area use inpatient hospital services and is expressed as the number of patient days per 1,000 population. Because patient days are determined by the number of admissions and length of stay, changes in either of these variables would affect use rate.

A change in the use rate will usually change the total number of patient days which planning area residents spend at all hospitals, not just at hospitals within their own planning area. Many changes affect both use rate and market share. The six factors discussed below have a significnat impact on use rate. Factors affecting market share are discussed in the next section of this guide.

Factors Affecting Use Rate

1. Demographic Changes in the Planning Area Population:

   When the composition of a planning area's population changes, this is likely to result in a change in the rate at which area residents use hospital services. For example, if the average age of an area's population is increasing, both length of stay and the number of admissions are likely to increase, resulting in an increase in the area's use rate.

2. Changes in Provider Practice Patterns:

   Changes in the way medicine is practiced would affect the rate at which residents of an area use inpatient services. Several types of changes in provider practice patterns may occur:

   a. Inpatient to Outpatient Services or Vice Versa:

      For example, the trend toward doing more surgery on an outpatient basis has decreased inpatient use rates.

   b. Develoment of New Program:

      For example, the development of a home-based hospice program might result in more terminally ill persons receiving care at home and decrease hospital use rates.

   c. Changes in Diagnostic Technology:

      For example, the extent to which CT scans reduce the need for exploratory surgery would decrease use rates.

d. Changes in Economic Access:

For example, changes in third party reimbursement patterns or adoption of new health insurance programs may alter existing use rates.

5. Changes in Government Regulations:

Several government regulatory programs are aimed at decreasing hospital use, primarily by decreasing the number of admissions and the length of stay. The principal example is the peer review program (PRO-W) which is intended to decrease hospital use by federally-funded patients.

6. Changes in Preventive Care Programs:

The development of new or the expansion of existing preventive care programs could reduce the number of inpatient days and decrease use rates. For example, implementation of a widespread blood pressure detection program is presumed to result in the prevention of heart attacks and therefore to decrease hospital use rates.

Documentation for Adjusting Use Rate

Before adjusting use rates it is necessary to document that there has been a change in the way persons use hospital services, not just a change in the use of one hospital.

To justify the adjustment of use rates, it is first necessary to demonstrate changes in a hospital's admissions and/or length of stay. If the number of admissions from an area is observed to be increasing, it is necessary to establish that this increase is greater than the projected population increase. If it is, an explanation for the increase needs to be found among the factors affecting use rate. For example, one explanation might be that the increased admissions are due to the recent expansion of coverage for inpatient alcoholism services by major employers in the area (factor #4) and to a change in consumer attitudes toward alcoholism treatment (factor #3).

A second way of justifying the adjustment of use rates is by documenting a change in the factors affecting use rate. Based on data which show that elderly persons use hospital services at five times the rate of non-elderly persons, planning area use rates may be adjusted to reflect expected changes in the proportion of elderly persons residing in each area.*

*Note that age-specific use rates are used in most baseline forecasting methods, greatly reducing the need for additional age-related use rate adjustments.

It is important to note that it is particularly difficult to document the impact of changes in accessibility on use rate, due to the fact that unmet needs must first be demonstrated. For example, in order to argue that the closure of a hospital is going to decrease an area's use rate, it must be shown that persons formerly served by the closed hospital will not seek care at other hospitals.

A final way of justifying the adjustment of use rates is by using data and information gained from the experience of other areas. This is particularly useful when arguing that a trend will end. For example, if an area's declining use rate is due to a downward trend in a length of stay, it may be presumed that this trend will continue unless the experience of other areas indicates that the length of stay will not fall below a certain minimum level.

MARKET SHARE

Market share is defined as the portion of a population's inpatient days which are met by a hospital or a group of hospitals. Any increase in the market share of one hospital, therefore, reflects an equal decrease in the market share of other hospitals.

A hospital's market share is determined by a number of circumstances over which the hospital has varying degrees of control. For example, a hospital usually cannot change the number of other hospitals which locate in the area. However, a hospital can determine its role, service mix, management style, and efficiency which when taken together affect the hospital's general attractiveness to physicians and the community. Hospitals consequently can alter their competitive position and thereby increase or decrease their market share. Six factors affecting market share are identified below.

Factors Affecting Market Share

1. Demographic Changes in the Population:

   Changes in the composition of an area's population will affect area hospitals' market share of inpatient days just as it will affect use rates. This characteristic results from some socio-economic groups using hospital services within the area more than do the general population. Similarly, other groups are more likely to go out-of-area for hospital services. For example, patient origin studies indicate the elderly are more likely to "stay at home" for hospital services. Thus, if the proportion of elderly persons in a planning area increases, the result may be an increased market share for local hospitals.

2. Changes in the Number and Types of Physicians in a Planning Area:

   The number and types of physicians in a community determines the size of local hospitals' physician referral base. The addition of

new physicians to the area may reduce the need of local residents to seek care out-of-area and should increase the local market share of the hospitals in the area.

3. Changes in Hospital Services:

Similarly, the addition of new types of hospital services reduces the need for local residents to seek care out of the area. For example, the development of a rehabilitation service at an area hospital will probably decrease the number of area residents going to out-of-area hospitals for this service and will increase the local hospital's market share of area residents.

4. Changes in Hospital Capacity:

A hospital's ability to treat people is limited by its capacity. An increase in local capacity can increase local hospitals' market share if some residents have been going out of the area during peak capacity situations.

Changes in capacity can be in the form of new beds, a change in room mix (i.e., relative number of single to multiple bedrooms) or in general operating efficiency.

5. Changes in a Hospital's Attractiveness to Practitioners:

A hospital's style of operation and resources affect its attractiveness to practitioners. These are characteristics over which hospitals have a fair degree of control, and include:

- available services;
- proximity to physicians' offices;
- hospital's compatibility with physician treatment style;
- support services within hospital;
- efficiency of hospital;
- restrictions on practice (e.g., utilization review, bylaws, requirements for staff privileges), and
- physical plant.

To the extent that the attractiveness of a hospital changes and physicians admit patients who were previously hospitalized elsewhere, market share will be increased.

6. Changes in Consumers/Purchasers' Preferences for Hospital:

Although physician preference has been the primary determinant, consumers and, to an even greater extent, third party payers are likely to increase their role in deciding where acute care is purchased. In the near future, third party payers and consumers are likely to give greater attention to hospital efficiency and charges. Further, consumers are increasingly becoming interested in the hospital's general approach to care, responsiveness to patient/community desires, location, and physical plant.

For example, in some parts of the country, Blue Cross has issued guidelines that will only permit reimbursement for open heart surgery at hospitals meeting minimum volume standards. This restriction will probably decrease the market share of hospitals which do not meet these standards.

7. Small Sample Problem with Market Share Data:

A factor which needs to be considered in examining market shares is whether the sample from which a hospital's market share was determined is of sufficient size to not be distorted by chance events. Thus, it is important to examine the base data to ensure that random events during the sample period did not seriously affect the market share conclusion. For example, if a major accident results in a large number of residents being hospitalized out of the area during the same period, the study data would not accurately represent local hospitals' actual market share.

Documentation for Adjusting Market Share

The best justification of the need to adjust market share is an observed change in a hospital's market share over time. This type of documentation is only available through an areawide patient origin study.

If a hospital wants to document that this observed change indicates a trend which can be expected to continue, it is also necessary to explain the factors which brought the change. For example, if this increase was due to an increase in the number and types of physicians in the area (factor #2), it is necessary to document that the number and types of physicians in the community is expected to continue to increase and that area residents who were previously going out of the area for physician services are not staying at home. Thus, it is also important to indicate where these patients were previously going and which hospital's market share should be adjusted downward.

It is more difficult to document the need to adjust market share where the changes have not yet been observed. Unobserved changes should be discussed in terms of changes in the hospital's competitive position either as instigated by the hospital or as the result of changes in the competitive position of other hospitals.

Documentation should focus on changes in the number and types of physicians in the community or on the hospital's staff, and on changes in the hospital's service mix, capacity, and attractivenss to residents and third party payers.

An additional method of documenting the need to adjust market share is by obtaining verification from other hospitals that their market share of patients from a particular area is decreasing. This might occur, for example, in an instance whre a referral hospital is near capacity and chooses to send out-of-area patients back to their home community for part of their hospital stay.

The weakest case for the need to adjust market share is a description of a hospital's marketing strategy to improve its attractiveness to physicians, third party payers, and the community. Although it is important to include this type of documentation, it is not enough to substantiate the need for a major expansion program.

Finally, it should be noted that the best way for a hospital-based HMO to document changes in market share is by using actual enrollment figures.

OUT OF AREA USE

Out-of-area use is defined as the number of days spent at planning area hospitals by persons residing outside the planning area. There are two types of out-of-area use: (1) use of planning area hospitals by persons who do not reside in the planning area but do reside within the health planning region, and (2) use of planning area hospitals by persons who do not reside within the health planning region. In the first case, out-of-area use is calculated by multiplying the planning area hospitals' market share of the other planning area by the other area's projected population. Thus, the computation of out-of-area use already takes into consideration any changes in use due to changes in population.

It should also be noted that out-of-area use includes both random use by visitors to an area and non-random use by out-of-area persons who are referred to or choose to use area hospitals. The first three factors discussed below affect non-random use; the fourth affects random use.

Factors Affecting Out-of-Area Use

1. Factors Affecting Market Share (See previous section)

   Most of the factors which affect a hospital's market share of planning area residents could also affect its market share of out-of-area residents. For example, a change in hospital services such as the development of a rehabilitation service might attract out-of-area residents as well as area residents.

2. Changes in the Competitive Position of Hospitals in Other Planning Areas:

   Just as initiatives area hospitals take may increase their market share of out-of-area residents, initiatives out-of-area hospitals take may decrease area hospitals' attractiveness to out-of-area patients. For example, the development of a rehabilitation service in a hospital in another planning area might decrease out-of-area use of area hospitals.

3. Changes in Physician Referral Patterns:

   Physician referrals are responsible for much of the use of area hospitals by out-of-area residents. Changes in physician referral patterns will, therefore, affect out-of-area use. For example, the development of an affiliation agreement between an urban and rural hospital would probably result in more referrals to the urban hospital and thereby increase its out-of-area use.

4. Changes in Visits to the Area by Out-of-Area Residents:

   Changes in the volume of visits to an area can influence the number of patient days generated on a random basis by persons from outside the area. For example, the development of a new recreational facility in an area may increase the number of tourists using local hospitals. Out-of-area use of local hospitals would also be expected to increase if there were an increase in the number of migrant workers coming to the area.

Documentation for Adjusting Out-of-Area Use

The best documentation of the need to adjust out-of-area use is an observed change in a hospital's market share of out-of-area patients. For persons residing outside the health planning region, this documentation can be provided by a hospital's own patient origin data. For persons residing in other planning areas within the region, the areawide patient origin study is needed to document this change and to provide the information necessary to adjust the market share of other hospitals within the region. In addition, this documentation of an observed change in a hospital's market share of out-of-area patients should be accompanied by a description of the factors which have caused the change and of the reasons why this trend is likely to continue.

Changes in out-of-area use which are anticipated but which have not yet been observed are more difficult to document. Unobserved changes should be discussed in terms of changes in a hospital's competitive position or in physician referral patterns.

(2) Psychiatric Bed Need Forecast Adjustments

This section presents guidelines as to the types of adjustments that may be applied to the baseline short-stay psychiatric hospital bed need forecasts and outlines the documentation needed to justify any adjustments. Any adjustments should occur during the the negotiations/adjustments phase and should be the result of discussions between community hospitals and DSHS.

These adjustment guidelines are organized into the four components influencing total patient days. These factors are:

- population
- use rate
  - influence of state and federal policy
  - availability of short-stay psychiatric services (beds) in other settings
  - other
- market share
- out-of-area use

1. Population

Factors affecting population are covered in Section IV.A. of this Guide.

2. Use Rate

a. Changes in federal or state policy (adjustments to steps 4c, 5 and 6 of the step-by-step method).

Any changes in programs or regulations will likely affect admission rates and average length of stay. These program changes could either increase or decrease the utilization of inpatient psychiatric services. Examples of programs and their intended effects are listed below:

- policies aimed at moving patients out of the state hospitals - these programs would tend to increase the utilization of community hospitals.
- development of short-stay psychiatric residential programs and other alternative services (such as emergency shelters, improved nursing home care for the mentally ill, and enhancement of the CCF program) would tend to decrease the hospital use rates. Budget restrictions or restrictive program changes in these areas would tend to increase the hospital use rate.

- programs involving improved preplacement screening, discharge planning, and case management should tend to decrease to hospital use rate. Impacts here, however, depend heavily on placement criteria and on the availability of community services which can serve as an alternative to hospitalization.

- programs promoting the use of mental health services and/or improving casefinding and general community resources may tend to increase the use rate. For example, an intensive program aimed at mentally ill children may increase the very low hospital use rate for persons in that age group.

- changes in the involuntary treatment laws may either increase or decrease the use rate depending upon the nature of the statutory change.

- changes in the state and federal budget will have a variety of impacts. Copayment increases in the Medicaid program may tend to decrease the use rate. Reductions in the mental health program budget, however, may tend to increase the use rate.

Documentation. Before adjusting use rates, justification of a change or expected change in use rates as a result of the initiation of a program should be provided. The mere desire to initiate a program or produce an intended effect is not sufficient to justify an adjustment of use rates. Documentation of a change should include and be based upon two factors:

- evidence that a program will be initiated, continued, revised, etc. The program must have a budget, staff, appropriate commitments, or other resources sufficient to demonstrate that the proposed change will actually occur.

- effects of the program. Documentation should quantify the expected effects of program initiation or change. Adjustments should be based on past experience, pilot studies, follow-up research, or analysis of the effects of similar programs in other states.

b. Availability of psychiatric services in other settings (adjustment to steps 4b, 4c, 5 and 6). The planned or future availability of short-stay psychiatric services in settings other than a hospital will likely affect utilization of these services in the hospital. Patients who may have used services at the hospital in the past may instead seek services at the other setting. In this instance, hospital utilization may decrease in the future, and a demand-based method would overestimate the need for hospital beds.

In some areas, the addition of short-stay psychiatric services in alternative settings may not decrease utilization of hospital services. Instead, the additional services may pick up much of the latent demand for an area which previously had a substantially depressed use rate.

Documentation. See a. above.

c. Local factors affecting the use rate. These factors are addressed in detail elsewhere in this plan.

All of these adjustment factors are addressed in detail in earlier in this plan. Special attention should be given to market share changes for psychiatric services since the opening, closing, or expansion of a facility will tend to have a greater effect for this service than for most other hospital services.

4. Out-of-Area Use

Addressed in detail in elsewhere in this plan.

APPENDICES

APPENDIX A

IN-HOSPITAL CANCER REHABILITATION PROGRAM

Summary of Services and Staffing Standards Established by the Committee on Rehabilitation, Fred Hutchinson Cancer Research Center.

STANDARD I: Hospitals of all sizes which provide cancer diagnosis and treatment services should have a rehabilitation program which includes as a minimum eight basic service or staffing components.

1. Availability of patient and public information materials including Cancer Information Service (CIS).

2. List of the resources for cancer rehabilitation in the community and in the referral area (e.g., ACS office, state vocational rehabilitation service agencies, transportation, etc.), plus a knowledge of the resources.

3. Awareness by physicians, nurses and administrators of needs in cancer rehabilitation.

4. Availability of cancer specialists plus other needed medical specialists in the hospital, on call, or by referral.

5. Discharge planning and referral arrangements with home health care agencies.

6. Assurance of appropriate training in cancer rehabilitation for team coordinator.

7. Inclusion of the discussion of continuing care and the rehabilitation in review of cancer cases at tumor boards and other hospital meetings.

8. Opportunity for staff to participate in inservice training or continuing education programs in cancer rehabilitation.

STANDARD II: Hospitals of at least 100 beds which provide cancer diagnosis and treatment should provide the eight basic service or staffing components and the following:

1. Referral arrangements with physiatrist, maxillofacial, prosthedontist, dentist or dental hygienist, speech pathologist, occupational therapist, physical therapist, enterostomal therapist, dietitian and clergy.

2. Nurse, social worker or other staff designated as a coordinator for cancer rehabilitation (at least part-time) with a formal job description.

STANDARD III: Hospitals of at least 200 beds which provide cancer diagnosis and treatment should provide the eight basic service or staffing components and the following:

1. Referral arrangements for a physiatrist, maxillofacial prosthedontist, dentist or dental hygienist, speech pathologist, physical therapist, occupational therapist, enterostomal therapist, dietitian and clergy.

2. Designation of a medical director for the rehabilitation team.

3. At least one nurse and one social worker designated as responsible for coordinating the hospital's cancer rehabilitation programs; procedures for appropriate referral of cancer patients to the coordinator; arrangements for these members of the staff to meet as a group at regular intervals with the attending physicians and patients who have been referred to the cancer rehabilitation team.

STANDARD IV: Hospitals of at least 500 beds which provide cancer diagnosis and treatment should provide the eight basic service or staffing components and the following:

1. Physiatrist, maxillofacial prosthedontist, dentist or dental hygienist, speech pathologist, physical therapist, occupational therapist, enterostomal therapist, dietitian and clergy on hospital staff.

2. Designation of a medical director for the rehabilitation team.

3. At least one nurse and one social worker designated as responsible for coordinating the hospital's cancer rehabilitation programs; procedures for proper referral of cancer patients to the coordinator; arrangements for these members of the staff to meet as a group at regular intervals with the attending physicians and patients who have been referred to the cancer rehabilitation team.

APPENDIX B

REQUIREMENTS FOR CONTINUING CARE RETIREMENT COMMUNITY PROJECTS

SECTION 1: REQUIREMENTS FOR CCRC FEASIBILITY REPORT/FINANCIAL PLAN

1. The expected demographics (including numbers, age, sex, health and financial means) of CCRC members for at least a ten-year period;

2. Expected utilization levels and costs of contractually guaranteed services, in total and in relation to demographic categories, in each year of the study;

3. The proposed financing of construction and startup, including amounts and uses of any deposits applied to these expenses;

4. The proposed plan for securing future service obligations through one or a combination of: designated reserves; reinsurance, such as stop-loss insurance; bonding; and/or contractually-mandated purchase by CCRC members of group or individual long-term care insurance;

5. A proposed pricing plan, including amounts of initial and periodic fees, necessary increases in fees over at least a ten-year period to assure continued financial feasibility, and the anticipated application of reserves or other methods in 4 to safeguard future service obligations;

6. All other actuarial, financial, service use and cost assumptions necessary to derive the conclusions of the study.

SECTION 2: REQUIREMENTS FOR CCRC ESCROW PLANS

1. Safeguards all deposits received from consumers (members or prospective members), including initial membership fees, so that obligations for refunds and/or application of these funds to CCRC reserves and expenses according to the plan can be assured;

2. Identifies conditions under which each escrow shall be released, including provisions which assure that pre-construction deposits shall not be released (except for the purpose of refunds) until the following conditions have been achieved:

   - the CCRC is 50 percent subscribed (i.e., has received signed contracts and required deposits which constitute 50 percent of the total amount which would be received in deposits if all units were subscribed); and

   - commitments have been obtained for both construction and long-term financing; and

- funds at least equaling the total cost of construction and startup have been received, committed or (in the case of members' deposits) pledged.

3. Documents provisions in the model contract (see CCRC Performance Standard (2)(c)(ii)) which legally bind the CCRC to follow the escrow plan.

SECTION 3: REQUIREMENTS FOR CONTINUING CARE CONTRACTS

1. Contracts shall be in plain English.

2. Contracts shall identify all fees and charges which will be imposed, specify the amount of any initial payment(s) and the initial amounts of all periodic payments, and describe all methods by which the CCRC may change or add fees.

3. Contracts shall list all services to be provided, including the extent and limitations of all service benefits with particular attention to the nature and duration of health and nursing care benefits and the boundaries between covered and uncovered services.

4. Each contract shall identify the specific living unit contracted for and specify provisions governing issues of tenancy including transfers among living units, reoccupancy of units after an illness or other absence, and what will happen, in cases of dual tenancy, if one of the two residents dies, withdraws, is dismissed or needs to be transferred to a health facility.

5. Contracts shall describe all procedures by which a member may be evicted or otherwise required to leave a residence unit, or the contract terminated by the CCRC. Dismissal and contract termination shall be limited to good cause, and eviction or other retaliation against a member due to complaints against the CCRC shall be contractualy prohibited.

6. Contracts shall clearly state all rights of cancellation by the member.

7. Contracts shall explain all refund policies, including those pertaining to situations where the member has cancelled the contract during the cooling-off period or probationary period (see 8), has withdrawn at a later time, has been dismissed, or has died.

8. Contracts shall provide for a pre-occupancy cooling-off period of not under seven days and a post-occupancy probationary period of not under ninety days, during which the new member may cancel with or without cause with a full refund less reasonable costs determined by a method specified in the contract.

9. Contracts shall specify the circumstances under which members will be permitted to remain in the CCRC if unable to pay fees, including any use of benevolent funds and any circumstances under which continuation of services would requie the member to use public assistance or Medicaid funds.

10. Contracts shall guarantee residents the right to organize a resident council, including the right to collectively represent the concerns of residents in dealings with the CCRC's administration.

11. Contracts shall include provisions which bind the CCRC to adhere to commitments made under the following Performance Standards for CCRCs in Volume II of the State Health Plan.

    a. Escrow plan requirements (see CCRC Performance Standard (2)(a)(v) and Section 2 of this Appendix).

    b. Consumer disclosure (see CCRC Performance Standard (2)(b) and Section 4 of this Appendix).

    c. Actuarially sound pricing and reserves or other mechanisms to assure future service obligations (see CCRC Performance Standard (2)(a)(iv)).

    d. If a Type A CCRC, scope of services (see CCRC Performance Standards (3)(a)).

    e. If a Type A CCRC exercising a transition period, the timely termination of contracts for Medicaid nursing home reimbursement or congregate care payment (see CCRC Performance Standards (4)).

SECTION 4: DISCLOSURE REQUIREMENTS FOR CCRC'S

1. The names, business addresses, legal/corporate forms, experience in establishing or operating CCRCs, nursing homes or other health facilities, and other existing and proposed CCRC properties, of the provider and of each individual constituting, owning an interest in, serving on the governing board of, or managing the CCRC.

2. Whether any of the persons in (1) has been convicted, enjoined or judged liable for damages as the result of a criminal or civil action claiming fraud, embezzlement, fraudulent conversion or misappropriation of property, or has had any state or federal license or permit revoked in connection with any business activities.

3. Whether the provider is, or is affiliated with, a religious, charitable or other non-profit organization, and the extent (if any) to which any such affiliated organization is responsible for any financial service liabilities of the CCRC.

4. A description of all services provided or proposed by the CCRC under its continuing care contracts, including the extent to which nursing, medical, health-related or personal care is furnished, the present or proposed costs of all services, and a description of any services made available by the CCRC at an additional charge (beyond initial and periodic fees in the contract).

5. A description of all fees required of residents, including initial and periodic charges, apartment resale fees, and special service fees; the manner by which the CCRC may adjust fees; the history of fee increases for at least five years for the CCRC (if in operation) and for any other CCRCs which the provider or manager operates; the circumstances under which members will be permitted to remain in the CCRC, including any use of benevolent funds, if the member is unable to pay charges; whether continuation of services may in any circumstances require the member to use pubic assistance or Medicaid funds; and the method of calculating fees that will be charged if the member marries while in the CCRC.

6. A description of health and financial conditions required to be accepted as a member and to continue membership, including provisions for the period between the date the continuing care contract is executed and the member occupies a living unit.

7. Income statements and balance sheets for the three most recent fiscal years (if in operation that long), plus a pro-forma income statement for the next fiscal year and a statement of any changes in operations or management that are expected to substantially affect financial position over the next three years.

8. If operation of the CCRC has not begun, a statement of the anticipated sources and application of funds to be used in the purchase or construction and startup of the CCRC; a description of any mortgage, loan or other long-term financing and its terms and conditions; an estimate of the total entrance fees to be received from members at or prior to the commencement of operations; and an estimate of any startup losses.

9. Professional summaries of accounting, audit and actuarial opinions received by the CCRC as part of professional accounting and actuarial studies or reports.

10. The general nature of any anticipated cost-shifting and cross-subsidization among CCRC members.

11. The term and renewability of the contract.

12. Unless demonstrably untrue, a statement to the effect that the individual contracts of various CCRC members may over time be different as to services and fees due to contract changes resulting from changing conditions.

13. Any other information necessary to understand the nature of the agreement and the risks involved in CCRC membership.

14. A list of the regulatory agencies with responsibility over various aspects of CCRC operation and their areas of responsibility.

NOTE: Periodic disclosure of changes under CCRC Performance Standard (2)(b) applies to all areas of disclosure above.

GLOSSARY OF TERMS

Acute Care - Acute care services focus on the diagnosis and treatment of medical problems generally, but not always, in a hospital setting, for persons with severe, short-term health problems. They are provided by physicians, nurses, and other skilled health personnel working as a team or individually, depending upon the severity of the problem. Acute care services generally are categorized into three types: primary, secondary and tertiary care. Secondary care services are often in a hospital setting and include medical/ surgical, pediatric, obstetric, radiology, and laboratory services. Tertiary care consists of complex diagnostic and therapeutic services requiring highly specialized personnel and equipment. In addition, tertiary services tend to be directed at emergency conditions, utilize high cost equipment, and are subject to rapid technological change.

Ambulatory Surgery Facility - A facility, either free-standing or hospital-based, where outpatient surgery is performed. An intermediate level of surgical care for procedures that are too complex to be done in a physician's office, but do not require inpatient hospitalization.

Case Management - A process that consists of a comprehensive assessment of an individual's needs and development of a detailed plan of services and related activities for the purpose of achieving and maintaining the maximum level of health and independence of which the person is capable at the appropriate minimum level of care. In the dual case management system now employed by DSHS, adults initially receive a standardized assessment conducted jointly by Community Services Office (CSO) staff and Information and Assistance (I and A) staff of Area Agencies on Aging (AAAs). Then, individuals referred to community care have their cases managed by I and A staff, and cases referred to residential care are managed by CSO.

Certificate of Need - Public regulatory approval for certain capital expenditures and additions, changes or terminations of health services as required under RCW 70.38.

Corporate Strategic Planning - Planning undertaken by a corporate entity in order to support internal decision making in pursuit of organizational goals which typically include (in a health services organization) the provision of services of adequate or better quality; financial success (at minimum, solvency); and sometimes expansion. Such planning usually occurs in a competitive environment.

Cost-based Reimbursement - A method of provider reimbursement based on the actual costs incurred in providing services.

Cost Shifting - The practice by which a provider redistributes the difference between normal charges and lesser amounts received from certain payers by increasing charges made to other payers.

Credentialing - The statutory regulation of a health profession by registration, certification or licensure. Proposals to credential new categories of allied health occupations in Washington are reviewed under RCW 18.120.040.

Dedicated Rooms - Spaces for a specific use. For example, dedicated outpatient operating rooms would not ordinarily be used for inpatient surgery.

Diagnosis Related Groups (DRG's) - A classification system that groups patients' hospital stays according to principal diagnosis, presence of a surgical procedure, age, presence or absence of significant comorbidities or complications, and other relevant criteria.

Health Care Facilities Authority - The Health Care Facilities Authority was established in 1980. Its authority and powers are defined in RCW 70.37. The Authority is empowered to issue municipal revenue bonds "for the construction, purchase, acquisition, rental, leasing or use by participants of projects for which bonds to provide funds therefore have been approved by the authority" and to loan the proceeds to qualified, non-profit hospitals. Since the income from these bonds is not currently subject to the same federal taxation rates as are corporate bonds, qualified hospitals benefit from lower interest rates (up to 3 1/2 percentage points less).

Health Maintenance Organization (HMO) - This term is defined specifically in the Health Maintenance Act of 1973 (P.L. 93-222) as a legal entity or organized system of health care that provides directly or arranges for a comprehensive range of basic and supplemental health care services to a voluntarily enrolled population in a geographic area on a primarily prepaid and fixed periodic basis. Can be sponsored by the government, medical schools, hospitals, employers, labor unions, consumer groups, insurance companies and hospital medical plans.

Health Planning System State Health Coordinating Council (SHCC), Department of Social and Health Services (DSHS) regional health councils designated under RCW 70.38.085, and other local agencies specified by the State Health Coordinating Council, acting together through the processes of RHC plan development and project review.

Health Planning Region - A multi-county area identified by SHCC and DSHS for health planning and resource development purposes. Initially these regions are the health service areas defined under federal law.

Horizontal Integration - In traditional economic usage, an extension of economic control to include additional entities producing or selling the same good or service: in lay terms, "absorbing the competition." An example of "classical" horizontal integration in health care would be formation or enlargement of a chain of primary care clinics, a chain of nursing homes, etc. The term also is used, in health care, to denote economic control over health services which provide similar services: e.g., purchase or initiation of a free-standing diagnostic imaging center by a hospital or group of hospitals. (See also Vertical Integration in glossary.)

Hospital - A facility requiring licensure under RCW 70.41 and/or required to report to the Washington State Hospital Commission. The definitional scope of services within a "hospital" is determined for licensure purposes by the Department of Social and Health Services, and for purposes of budget and rate review, by the Hospital Commission.

Hospital Planning Areas - Those geographic areas designated by SHCC and DSHS for population-based planning of hospital services.

Inpatient - A person receiving health care services with board and room in a health care facility on a continuous twenty-four hour a day basis.

Managed Health Care System - An organization or entity with the following features: a) provision for insurance and responsibility for the delivery of health care services through the same organization, b) financial risk to the managed health care system through capitation payment, and c) utilization management of enrollees.

Medicaid (Title XIX) - Program administered by the states under provisions of Title XIX of the Social Security Act and rules of the federal Health Care Financing Administration (HCFA). It makes payments for approved health services provided by hospitals, other health service agencies and private practitioners to persons eligible for Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), and certain other persons whose income does not exceed maximum welfare benefits. Medicaid is funded on a state-federal shared basis. It should not be confused with Medicare (Title XVIII).

Medicare (Title XVIII) - A federal health insurance program that covers some of the costs of hospitalization and selected medical care for persons 65 or older, for physically disabled persons meeting certain requirements, for certain other citizens needing specific treatment (e.g., chronic renal dialysis for irreversible kidney ailment) and for some eligible beneficiaries.

Ordinarily - This word has a specific meaning in this State Health Plan which is clarified in the particular policies in which it is used.

Policy - A definite course (or method) of action selected by management from alternatives to determine present and future decisions.

Preference - Priority or higher ranking given in review to health facilities and services having those characteristics specified in the preference statement, when: 1) two or more health facilities or services are competing to meet a limited need in an area (i.e., a need that is not sufficient to justify all health facilities or services proposed in an area), and 2) the competing health facilities or services substantially conform to all other applicable standards.

Principle - A statement of the highest ideals toward which the health system should move.

Prospective Payment System - A payment system in which health service payment rates are based on expected classes and volumes of patients and are set before services are rendered.

Regional Health Council - An organization defined under the terms of RCW 70.38.085.

Regionalized Hospital System - A plan which organizes hospital services in a specific geographic region into a coordinated network of services. The services and facilities range from the simplest to the most complex with coordinated referral agreements among the participating institutions. The supply of services, especially tertiary services, is determined by the amount of demand which would use each service efficiently.

State Housing Finance Commission - A public body established under the terms of RCW 73.180 for the purpose of issuing bonds and participating in federal, state and local housing projects.

Sliding Fee Scale - A schedule of charges (fees) for specific health and/or social services which are keyed to a person's ability to pay, based on income level or some other type of means test.

Vertical Integration - In traditional economic usage, a shift in the economic organization, ownership, etc., of enterprises which places inputs for production of a good or service under the economic control of the same entity which controls production of end-products (or of other "intermediate products" which are closer in the chain of production to the consumer). An example of "classical" vertical integration of health care services would be the purchase of a pharmaceutical or hospital supply firm by a proprietary hospital chain. The term also is used in health care to denote economic control of additional levels of care through which a patient might pass: for example, purchase or initiation of home health services by a nursing home or a hospital. (See also Horizontal Integration in glossary.)

ACRONYMS

AAA - Area Agency on Aging

BAAS - Bureau of Aging and Adult Services

BNHA - Bureau of Nursing Home Affairs

CoN or CN - Certificate of Need

CSO - Community Services Office

DCD - Department of Community Development

DMA - Division of Medical Assistance

DSHS - Department of Social and Health Services

HMO - Health Maintenance Organization

HPA - Hospital Planning Area

L & I - Department of Labor and Industries

LTCPG - Long Term Care Planning Group

MCH - Maternal and Child Health Services

OFM - Office of Financial Management

OSPI - Office of the Superintendent of Public Instruction

RCW - Revised Code of Washington

SBOH - State Board of Health

SHCC - State Health Coordinating Council

SHP - State Health Plan

SHPDA - State Health Planning and Development Agency

WAC - Washington Administrative Code

WSHC - Washington State Hospital Commission

APPENDIX I

State of Washington Department of Health certificate of need #1516
for University of Washington Medical Center – issued 18 November 2013

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STATE OF WASHINGTON
DEPARTMENT OF HEALTH

November 18, 2013

CERTIFIED MAIL #2000 1570 0000 5081 8678

Stephen P. Zieniewicz, FACHE
Executive Director
University of Washington Medical Center
1959 North East Pacific Street
Seattle, Washington 98195-6151

Dear Mr. Zieniewicz:

Enclosed is Certificate of Need #1516 issued to University of Washington Medical Center for addition of 79 medical/surgical beds to the hospital in Seattle within King County.

The certificate is not approval for any other local, federal, or state statutes, rules, or regulations. Such a project may also need Department of Health approval for a construction plan and facility licensing or certification, as well as other federal or local jurisdiction permits.

The Certificate of Need is valid for two years. The project must begin during this time. If there is substantial and continuing progress, we may extend the certificate for one six month period. For an extension, you must submit an extension request at least 120 days before the expiration. You cannot begin a project after the expiration date.

This decision may be appealed. Any affected person with standing may request an adjudicative proceeding to contest this decision within 28 calendar days from the date of this letter. The notice of appeal must be filed according to the provisions of Revised Code of Washington 34.05 and Washington Administrative Code 246-310-610. A request for an adjudicative proceeding must be received within the 28 days at one of the following addresses:

Mailing Address:
Adjudicative Service Unit
Mail Stop 47879
Olympia, WA 98504-7879

Other Than By Mail
Department of Health
Adjudicative Service Unit
111 Israel Road SE
Tumwater, WA 98501

We monitor projects until completed or the expiration date, whichever occurs last. We do this with quarterly progress reports. At least 30 days before the report's due date, you will receive a form to complete and return.

If you have any question, please contact Janis Sigman, Manager of the Certificate of Need Program at (360) 236-2955.

Sincerely,

Steven M. Saxe, FACHE
Director

Enclosure

cc: Shannon Walker, Office of Investigations and Inspection
Karen Stricklett, Department of Health, Customer Service Office

Washington State Department of Health

This Certificate is granted under the authority of RCW 70.38. Issuance of this Certificate does not constitute approval under any other local, federal or state statute, implementing rules and regulations. Examples where additional approval may be necessary include, but are not limited to, construction plan approval through the Construction Review Unit of the Department of Health, facility licensing/certification through the Department of Social and Health Services or Department of Health, and other federal or local jurisdiction permits.

Certificate of Need #1516 is issued to:

Legal Name of Applicant:	University of Washington Medical Center
Address of Applicant:	1959 North East Pacific Street Seattle, Washington 98195-6151
Type of Service:	Acute Care Hospital
Facility Name:	University of Washington Medical Center
Facility Address:	1959 North East Pacific Street Seattle, Washington 98195-6151

ISSUANCE OF THIS CERTIFICATE OF NEED IS BASED ON THE DEPARTMENT'S RECORD AND EVALUATION OF NOVEMBER 5, 2013, (App #13-09).

Project Description:

This application proposes the addition of 79 medical surgical beds to UWMC's current 450 bed licensed capacity. The project will be completed in two phases. The project will not change the services currently provided by the University of Washington Medical Center.

Phase One

The first phase includes the completion of two of the shelled floors and will add a total of 56 beds, including a new 24 bed intensive care unit, to the license. This Phase is expected to be completed in 2015.

Phase Two

The second Phase includes the completion of the final shelled floor and will add another 23 acute care beds. This Phase is expected to be operational in 2017 (or earlier if demand warrants), and at project completion, UWMC will be licensed for 529 beds, of which 444 will be available for acute care use.

Continued on page 2

Service Area
King County

Approved Capital Expenditure
The approved capital expenditure associated with this project is $70,771,363.

This Certificate authorizes commencement of the project from November 18, 2013, to November 18, 2015, unless extended, withdrawn, suspended, or revoked in accordance with applicable sections of the Certificate of Need law and regulations.

Date Certificate Issued: November 18, 2013

Steven Saxe
Director

This Certificate is not transferable.

Project Description (Continued)

The number of approved beds is summarized below:

Type of Service	Phase 1	Phase 2
General Medical/Surgical	421	444
Level 2 intermediate care nursery	15	15
Level 3 neonatal intensive care unit	35	35
Psychiatric (PPS exempt)	16	16
Rehabilitation, Level 1 (PPS exempt)	19	19
Total	**506**	**529**

Condition:

Approval of the project description as stated above. University of Washington Medical Center further agrees that any change to the project as described in the project description is a new project that requires a new Certificate of Need.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

November 5, 2013

CERTIFIED MAIL # 7011 2000 0000 5081 8661

Stephen P. Zieniewicz, FACHE
Executive Director
University of Washington Medical Center
1959 NE Pacific Street
Seattle, Washington 98195-6151

RE: CN 13-09

Dear Mr. Zieniewicz:

Thank you for the Certificate of the Need (CN) application submitted by the University of Washington Medical Center posing to add 79 acute care beds to the existing hospital.

We have completed review of the Certificate of Need (CN) application submitted by the University of Washington Medical Center posing to add 79 acute care beds to the existing hospital. For the reasons stated in the enclosed decision, the department has concluded that the project as described below is consistent with the applicable CoN review criteria. The Department is prepared to issue a CoN for this project provided University of Washington Medical Center agrees to the following in its entirety:

Project Description:

This application proposes the addition of 79 medical surgical beds to UWMC's current 450 bed licensed capacity. The project will be completed in two phases. The project will not change the services currently provided by the University of Washington Medical Center.

Phase One

The first phase includes the completion of two of the shelled floors and will add a total of 56 beds, including a new 24 bed intensive care unit, to the license. This Phase is expected to be completed in 2015.

Phase Two

The second Phase includes the completion of the final shelled floor and will add another 23 acute care beds. This Phase is expected to be operational in 2017 (or earlier if demand warrants), and at project completion, UWMC will be licensed for 529 beds, of which 444 will be available for acute care use.

The number of approved beds is summarized below:

Type of Service	Phase 1	Phase 2
General Medical/Surgical	421	444
Level 2 intermediate care nursery	15	15
Level 3 neonatal intensive care unit	35	35
Psychiatric (PPS exempt)	16	16
Rehabilitation, Level 1 (PPS exempt)	19	19
Total	**506**	**529**

Condition:

Approval of the project description as stated above. University of Washington Medical Center further agrees that any change to the project as described in the project description is a new project that requires a new Certificate of Need.

Approved Costs:

The capital expenditure for this project is $70,771,363.

You have two options, either accept or reject the above in its entirety. If you accept the above in its entirety, your application will be approved and a Certificate of Need sent to you. If you reject any provision of the above, you must identify that provision, and your application will be denied because approval would not be consistent with applicable Certificate of Need review criteria. Please notify the Department of Health within 20 days of the date of this letter whether you accept the above in its entirety.

Your written response should be sent to the Certificate of Need Program, at one of the following addresses.

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

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

Sincerely,

Steven M. Saxe, FACHE
Director

Enclosure

APPENDIX H

Virginia Mason Medical Center First Hill Campus
Compiled Major Institution Master Plan document – 5 February 2014

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Virginia Mason Medical Center

First Hill Campus

Compiled Major Institution Master Plan

TEAM MEDICINE™

This Compiled Major Institution Master Plan (MIMP) for the Virginia Mason Medical Center has been prepared by Virginia Mason, URS Corporation, SRG Partnership, Weinstein A+U, Makers Architecture & Urban Design and Steinbrueck Urban Strategies, for submittal to Seattle's Department of Planning and Development in compliance with Seattle Municipal Code (SMC) 23.69.032 D, Development of a Master Plan.

This Compiled MIMP for the Virginia Mason campus was created using the following regional planning efforts and guidelines as guiding principles, policies and requirements:

The Washington State Growth Management Act (originally adopted in 1990) and codified as RCW 36.70A
City of Seattle Ordinance 120691, adopted December 17, 2001, enacting regulations for the location, uses, and size of Seattle Major Medical and Educational Institutions
The City of Seattle Comprehensive Plan
The City of Seattle Transportation Strategic Plan
The First Hill Neighborhood Plan
The City of Seattle Transit Master Plan
The Blue Ring Center City Open Space Plan
The City Parks and Recreation 2011 Development Plan
The City of Seattle Bicycle Master Plan
The City of Seattle Pedestrian Master Plan
Puget Sound Regional Council's VISION 2040

The Seattle City Council approved the MIMP on December 16, 2013. The Council's Findings, Conclusion and Decision (Clerk File 311081) contains 64 conditions of approval (pages 15 to 29). The Council's Findings, Conclusion and Decision are included in their entirety as Appendix F to this Compiled Master Plan. Future development of the Virginia Medical Center is subject to those conditions.

Contact

Betsy Braun
Administrative Director, Facilities Management
Virginia Mason Medical Center
Blackford Hall, Room 309
1100 9th Avenue
P.O. Box 900, Mail Stop: R3-DCPM
Seattle, Washington 98111-0900
Tel: 206-341-0941
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Compiled Major Institution Master Plan

February 5, 2014

Aerial View, 1961

Aerial View, 1965 - Interstate 5 in construction

Aerial View, 1978 - with Freeway Park

Aerial View, 1989 - with convention center

A. INTRODUCTION

1. Background and Purpose

Virginia Mason Medical Center is an integral part of a diverse, evolving neighborhood on First Hill in Seattle and is a major health care service provider to the region. As the neighborhood and the region have grown, so has Virginia Mason. Since its beginning in 1920 on First Hill, Virginia Mason has expanded its original campus, decentralized many business operations and opened clinics in surrounding communities to accommodate the growing regional population with primary and specialty care services. Virginia Mason is expanding its provision of services through strategic alliances with regional health care providers such as Group Health Cooperative of Puget Sound, Evergreen Health, Wenatchee Valley Medical Center and Pacific Medical Centers.

This growth has occurred over a 90-year time frame that has seen a revolution in lifestyles, urbanism and neighborhood character. In the 1920s, First Hill was still a mix of single-family houses, small commercial businesses and a few five- to -six-story residential apartment buildings. Virginia Mason's first building fit within this scale, with its six-story original hospital wing. Over the next 50 years, this community, which was built at the scale of the pedestrian, horse and buggy, was transformed by the rise of the automobile. In the 1960s, Interstate 5 (I-5) was constructed through Seattle, cutting off First Hill from downtown Seattle. Buildings turned their backs upon the street and shifted from a pedestrian orientation to an automobile orientation. They also grew upward, establishing a new scale on First Hill that was redefined with the construction of approximately 15 story high-rise residential towers and comparably sized religious, office and medical buildings.

Seattle is now redefining itself and developing towards a future that is refocused much more on the pedestrian experience, the opportunities for transit connections and a much greater density in areas defined as urban centers, such as First Hill. The community is challenging developers to build in ways that promote health, an active lifestyle, sustainable buildings, convenience and diversity.

The next generation of 300 foot tall (25- to 30-story) residential towers allowed under current zoning and tall commercial buildings may once again transform First Hill. This density is needed to accommodate the rapidly growing population of people who are seeking out lifestyles that are no longer as dependent upon the automobile and looking for a more urban lifestyle. Within the last 10 years, Seattle's residential population on First Hill has increased by nearly one-sixth, from approximately 52,000 residents in 2000 to over 60,000 residents in 2011. This trend is expected to continue. Thirty-seven percent of the residents also work in downtown Seattle. This growing population is younger, well-educated and diverse and is transforming Seattle into one of the most lived-in cities in the United States, with nearly 22,000 residents per square mile in the downtown.[1]

[1] Downtown Seattle Association 2012 State of Downtown Economic Report.

View from Pine & Terry looking north, 1907


View of the downtown waterfront, 1952


View of Harborview, 1949

Historic photographs courtesy of The Seattle Public Library

Virginia Mason's First Hill campus needs to be redeveloped to meet the health care demands of this regional growth, to provide for advancements in technology and patient care practices and to replace aging facilities. It also needs to reflect this new sense of urbanism by redeveloping in ways that:

- Create an environment for our patients, their families and visitors, our employees and volunteers, and our neighbors, that reflects the quality of care we provide.
- Provide a safe, attractive and engaging campus with lively streetscapes.
- Exemplify good stewardship of scarce resources.
- Modernize and expand facilities to accommodate new technologies and embrace the future.

This process begins with the renewal of Virginia Mason's Major Institution Master Plan (MIMP), which expired in 2004. Virginia Mason submitted its Notice of Intent to prepare a new Master Plan on August 9, 2010, and the MIMP Application/Concept Plan on December 7, 2010. Virginia Mason completed the last project approved under the previous Master Plan, the new Floyd & Delores Jones Pavilion, in 2011. The recent acquisition by Virginia Mason of the 1000 Madison block creates the opportunity to allow critical inpatient services to be replaced while maintaining full operations in the existing hospital. Virginia Mason is asking that its Major Institution Overlay (MIO) be expanded to include this block. The MIO process will ensure that the replacement buildings will contribute to the quality and the activity of the neighborhood.

Virginia Mason is also looking to the future to create a campus that is developed with a density comparable to the underlying zoning. This density allows Virginia Mason to be a good steward of the scarce resource of land on First Hill and minimizes its footprint on the surrounding community by reducing its need to expand further.

2. First Hill Neighborhood

The First Hill neighborhood is an extensively studied urban environment. Its planning efforts are built upon a foundation of sound city, county and regional plans aimed at defining the vision and accommodating the needs of a rapidly growing region.

This vision starts with a regional framework provided by the Puget Sound Regional Council's "VISION 2040," adopted by the Council in April of 2008. VISION 2040 provides clear and specific guidance for the distribution of population and employment growth into types of places defined as "regional geographies." The largest share of growth is distributed to metropolitan and core cities - places with designated regional growth centers that are already connected by major transportation corridors and high capacity transit.[2] This broad framework sets out the importance of the interrelationship between systems such as land uses, transportation, community facilities and the underlying ecology. The vision emphasizes the cooperative goals needed for a successful community to flourish in the long term. Of direct relevance to the First Hill neighborhood's role in the region, it emphasizes the development of regional growth centers and compact urban communities to accommodate the additional 1.7 million new inhabitants of Puget Sound and 1.2 million new jobs anticipated within the next 35 years.

[2] VISION 2040 executive summary, 2008

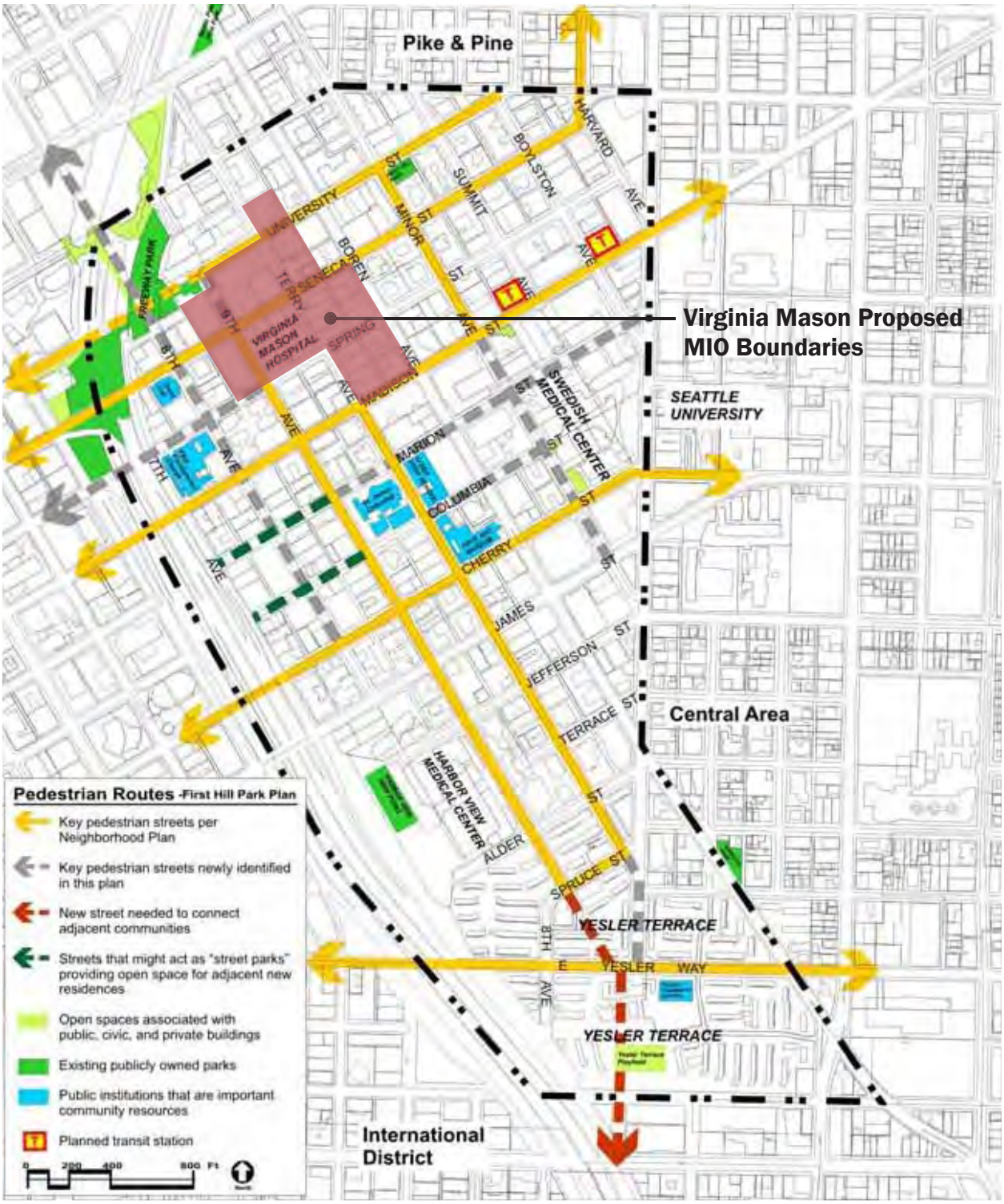

Figure 1 Virginia Mason Proposed Major Institution Overlay District on the "Pedestrian Routes Diagram"

Source: First Hill Urban Center Park Plan, City of Seattle, 2005

Neighborhood Context: Urban Center Village

First Hill's place within the region is first defined by its designation as one of six Urban Centers in Seattle. This designation envisions a bright, multidimensional future for First Hill that includes a full range of community amenities, including a vibrant pedestrian streetscape, a range of housing options, employment opportunities and a diversity of community services. These community services encompass open space, retail, commercial, multifamily residential, social, religious and educational services, an art museum, and other institutions and experiences.

The designation as an Urban Center Village has, as a foundational element, the expectation that the community will be planned to support a higher density of housing and employers than other communities. It is a critical difference between First Hill and other Seattle communities. First Hill is identified as a suitable area to accommodate urban density because it is already at a density greater than many of the surrounding neighborhoods, because of its proximity to Downtown, its access to transportation, and its many community services, institutions, jobs and residences. This increased density is essential if First Hill is to grow and support its role in the region as both a residential and an employment center.

The planning defines a community where auto, transit and pedestrian corridors connect and concentrate commercial activities within pockets of high-rise residential development. The major arterials include Madison Street, Broadway, James Street, Boren Avenue, and the Pike/Pine Street corridors. Other streets have been targeted to be excellent pedestrian environments, including University Street, Seneca Street, Terry Avenue south of Madison Street, Eighth Avenue, Ninth Avenue and Minor Avenue (see Figure 1).

Within these major arterial boundaries nestle pockets of residential neighborhood, educational and medical development. The land use edges are not well integrated, and residential, commercial and freeway uses relate to each other in sometimes awkward ways.

Neighborhood Texture

Virginia Mason is below the crest of First Hill in the area known as the West Slope, with topography that descends toward downtown Seattle. Virginia Mason's campus is adjacent to the Horizon House continuing care retirement community to the northwest, a variety of residential developments to the northeast and southwest, the commercial district along Madison Street and Boren Avenue to the southeast and Freeway Park to the west. Terry Avenue and University Street are designated as "Neighborhood Green Streets" as they pass through the Virginia Mason Campus. This designation provides incentives for certain street improvements and pocket parks in exchange for increased floor area sizes and allows improvements in the right-of-way in collaboration with the City of Seattle.

The character of development on First Hill is enormously varied and reflects a neighborhood that is undergoing dynamic change. It ranges in scale from single-family homes to high-rise residential towers, and from small commercial buildings to office towers, universities, cathedrals and hospitals. The urban texture is uneven, with parking lots, one-story buildings or undeveloped sites abutting new high-rise developments. There has been significant recent retail development along the Madison Street corridor and along James Street, but the recent economic downturn has had a negative impact on the small

businesses in the community, and there are empty storefronts. A sprinkling of retail establishments is scattered throughout First Hill and provides important amenities to the community.

Major Institution Hub

First Hill is host to four Major Institutions, with an emphasis on health care, life sciences and higher education. These institutions are bolstered by, and have been foundational incubators to, other internationally acclaimed organizations like the Fred Hutchinson Cancer Research Center and the University of Washington Global Health program. They are a training and proving ground for developing regional and global expertise, fueling the economic engines of research and development in organizations like Amgen, Zymogenetics, the Bill & Melinda Gates Foundation, the Seattle Biomedical Research Institute, Cell Therapeutics, Seattle Science Foundation, Dendreon, Seattle Genetics and many others.

The First Hill institutions train a significant percentage of the health care and research practitioners in the Puget Sound region. In their partnerships with the University of Washington, Seattle Pacific University, Seattle University and Seattle Community College, they provide a substantial role in the development and retention of the intellectual capital of the region. Their ability to attract national and international talent, grants, research funding and venture capital places Seattle within the top five regional centers of innovation in the nation.

These four Major Institutions collectively generate over 77,220 jobs, provide over $4.9 billion in salaries and benefits and provide one out of every six Seattle jobs.[3] Their secondary effects are directly and indirectly responsible for another 160,000 Seattle jobs, and the number of jobs is anticipated to continue to grow at an average rate of 5% a year. This growth has ranked Seattle #1 in high-tech growth based on long- and short- term growth numbers, according to Forbes, beating out even Silicon Valley. [4]

3. Goals, Objectives and Intent of Major Institution Master Plan

Virginia Mason is now updating its Vision for its First Hill campus. The goal of this effort is to fully understand the capacities and constraints inherent in the redevelopment of the existing properties, to collaborate with the surrounding neighborhood on how to best accommodate this growth and to smooth the development process.

As a critical first step in planning for this growth, Virginia Mason has entered into the City of Seattle's MIMP process to partner with its First Hill neighbors to collaboratively develop a vision for the future. From Seattle Department of Neighborhood's website: *"Seattle's hospitals, universities and colleges are important assets of the region and Seattle therefore allows their development to exceed many of the zoning standards that would apply to nearby development. Unique zoning rules are crafted for each major institution through the adoption of a Major Institution Master Plan that: 1) identifies a boundary (Major Institution Overlay District) within which the revised rules applies; and 2) identifies the specific rules that will apply to development within this boundary. The objectives of the plan are to balance the*

[3] Downtown Seattle Association Economic Impact of Seattle's Major Institutions, 2012

[4] Seattle Times, November 21, 2011

needs of major institution development with the need to preserve adjacent neighborhoods." [5]

Virginia Mason representatives have been actively involved in the numerous recent planning efforts on First Hill, including the First Hill Neighborhood Plan, the West Slope First Hill Plan, the planning for siting the Sound Transit First Hill station, the planning for the First Hill Streetcar, the development of other MIMPs, the Downtown Seattle Association plans, First Hill Improvement Association activities, Design Review Board meetings, and the activities of the Freeway Park Association. This involvement has deepened our perspective on the neighborhood's collective goals, concerns and plans, and how Virginia Mason can best grow within this unique community.

This participation, the hard, dedicated work of the Citizens Advisory Committee, and input from many neighbors and other businesses on First Hill have culminated in the development of a shared set of goals and objectives for the redevelopment of the campus.

[5] City of Seattle Department of Neighborhood website: http://www.seattle.gov/neighborhoods/mi/miac/, 3/17/2012

Table 1 Goals and Objectives

GOALS	OBJECTIVES
CAMPUS BUILDINGS	
Design the edges of the campus to contextually relate to the adjoining properties in scale, style and massing	• Maintain the existing setbacks of the underlying zoning to shape building masses, except where deviations are needed to accommodate hospital bed floors
Design buildings, including rooftops and street level facades, with consideration of how they will appear to viewers from surrounding residential buildings, nonmotorized travelers at street level, and motorized travelers	• Consider the placement of mechanical equipment and how it can be shielded • Consider views into new facilities from neighboring buildings • Create interest at street level from a pedestrian scale • Integrate mechanical equipment into the architecture of the building
Acknowledge the diversity of scales and styles in neighboring buildings, from high-rise to single-family	• Shape the buildings and towers to respond to their context • Incorporate measures that respond to the scale and character of adjacent buildings • At the larger scale, consider visual interest through articulation of facades, fenestration patterns, and larger scale architectural moves • Use materials that are compatible with the neighboring development • Create a style that is compatible with residential instead of an institutional style
The scale of the pedestrian streetscape is important	• Create street level facades that respond to the pedestrian scale and add interest from a pedestrian perspective
Protect public view corridors	• Consider the use of setbacks to maintain and open up public east-west views • Design skybridge structures to minimize view blockage • Consider massing buildings in an east-west direction to reduce the impacts on the views of uphill neighbors
Provide shared spaces that community members can also use	• Consider locating cafeterias, coffee shops, gift shops, conference centers, meeting areas, auditoriums and gathering places near entries for easy community sharing

GOALS	OBJECTIVES
LANDSCAPING AND OPEN SPACE	
Maintain plantings and street trees	• Replace trees that need to be moved or removed for development
Enhance campus greenery, open space	• Use thoughtful site planning and landscape design, working at a campuswide and site specific level • Make use of multiple scales of plant materials, pocket parks, plazas, median strips, setbacks and roof decks • Add plantings and other features to attract birds, pollinators and other desirable fauna to the gardens
CAMPUS MOBILITY	
Maintain and improve the mobility of pedestrians and other nonmotorized travelers to move through the Virginia Mason MIO boundaries (don't become a closed-off campus)	• Address steep slopes with steps, handrails and ramps • Extend overhangs, awnings, or other weather protection features to protect pedestrians from rain along designated pedestrian corridors where feasible • Use "Crime Prevention Through Environmental Design" principles to enhance safety of the pedestrian experience
Improve sidewalks and streetscapes to enhance the pedestrian and other nonmotorized user experience	• Use three-dimensional plantings, artwork, pedestrian-scale lighting and street furnishing to enrich the pedestrian experience
Make entries easy to find, welcoming and accommodating	• Improve accessibility of entries • Locate entries to facilitate pedestrian egress
Enhance ease of pedestrian flow, improve circulation, accessibility, wayfinding, connectivity, visual interest	• Reveal activities within buildings at street level with an interactive sidewalk edge, transparency of street-level facades
Enhance the ability of people to pass through the larger buildings via interior and exterior "streets" that are combinations of entries, major corridors and skybridges	• Expand the existing network of skybridges to create interior and exterior pedestrian connections across the entire campus • Consider developing tunnels where feasible to move materials "off-stage" from the public

GOALS	OBJECTIVES
Provide attractive nonmotorized connections across the campus to Downtown and other Seattle neighborhoods	• Continue the Pigott Corridor extension up University for the half-block northwest of Terry • Consider the use of lighting that is the same or similar to that used elsewhere on First Hill (such as in Freeway Park)
Create open spaces in ways that tie together the public spaces of the neighborhood	• Locate open space in areas on campus that enhance or complement open space located off campus (such as adjacent to the Pigott Corridor or across from the Sorrento Hotel)
NEIGHBORHOOD VITALITY AND CHARACTER	
Contribute to the economic vitality of First Hill that exists from the interdependence of residential, commercial, and the educational and health care institutions	
Maintain the residential character of First Hill	• Replace any housing loss on First Hill per City requirements • Locate noisy trash hauling and dock functions away from residential neighbors
Honor and protect designated historic structures	• With development, perform historic resources studies of older buildings on campus • Protect landmarks through City Landmarks process • Design new facilities to complement and enhance existing landmarks, like the Sorrento, the Baroness and the Archbishop's residence • Where possible salvage historic elements from demolished buildings and reuse them in new construction. (Note: this item is a post-workshop update to the goals and objectives.)
Maintain and support opportunities for retail that serve both Virginia Mason and the residential community	• Identify locations on Virginia Mason blocks where retail uses will contribute to neighborhood vitality • Work with neighborhood on desirable types of retail to serve the broader population • Provide direct access to retail from the street

GOALS	OBJECTIVES
ENVIRONMENTAL STEWARDSHIP	
Employ Environmental Stewardship in the design and practices of buildings, grounds, and operations	• Pursue healthy living with design principles • Use new energy-efficient technologies that help reduce energy usage and create a cleaner environment • Use each block to its highest and best use • Balance open space and setbacks with high density and tall structures to maximize capacity of each block
Build facilities that are resource-efficient	• Participate in the Seattle 2030 District challenge
Minimize glare, noise, wind effect and shading	• Design strategies for microclimate, local conditions • Prioritize public spaces when considering shading • Consider the location of noise-creating activities to least impact neighborhood residents • Minimize the effects of artificially lit interiors during the night on surrounding residential areas. (Note: this item is a post-workshop update to the goals and objectives.)
TRANSIT, TRAFFIC AND PARKING	
Continue to encourage the use of transit over driving to Virginia Mason by making transit an easy and enjoyable way to get to and from the Virginia Mason campus and adjacent First Hill neighborhoods	• Improve bus stops with enhanced lighting, shelters, landing areas and wider sidewalks • Advocate for enhanced transit coverage for First Hill, especially connections that tie it to other Seattle neighborhoods and downtown • Work with Seattle Police Department “Crime Prevention Through Environmental Design” principles to enhance bus stop safety and use • Be aware of pedestrian routes that connect to transit stops as part of the transit system’s quality and level of safety
Continue to reduce peak-commute trip single-occupancy vehicle use and encourage alternative modes of transportation, including walking, bicycling, mass transit, shuttles and carpools	• Continue and enhance the existing Transportation Management Plan (TMP) to reduce the number of drive-alone commutes to the VMMC campus
Build parking to meet but not exceed present, future need, sequence parking development	• Distribute the location of structured parking and access to lessen neighborhood impact

GOALS	OBJECTIVES
CONSTRUCTION IMPACTS	
Minimize construction impacts on the larger community	• Construct new buildings in phases • Develop and implement a construction management plan and communicate with the community about the plan
Maintain traffic and pedestrian flow	• Limit the use of street area for construction, or time street closures to minimize disruptions to neighborhood traffic • Limit sidewalk closures
Maintain the viability of retail	• To the extent feasible, provide temporary locations for retail displaced by Virginia Mason construction

4. Virginia Mason's Mission

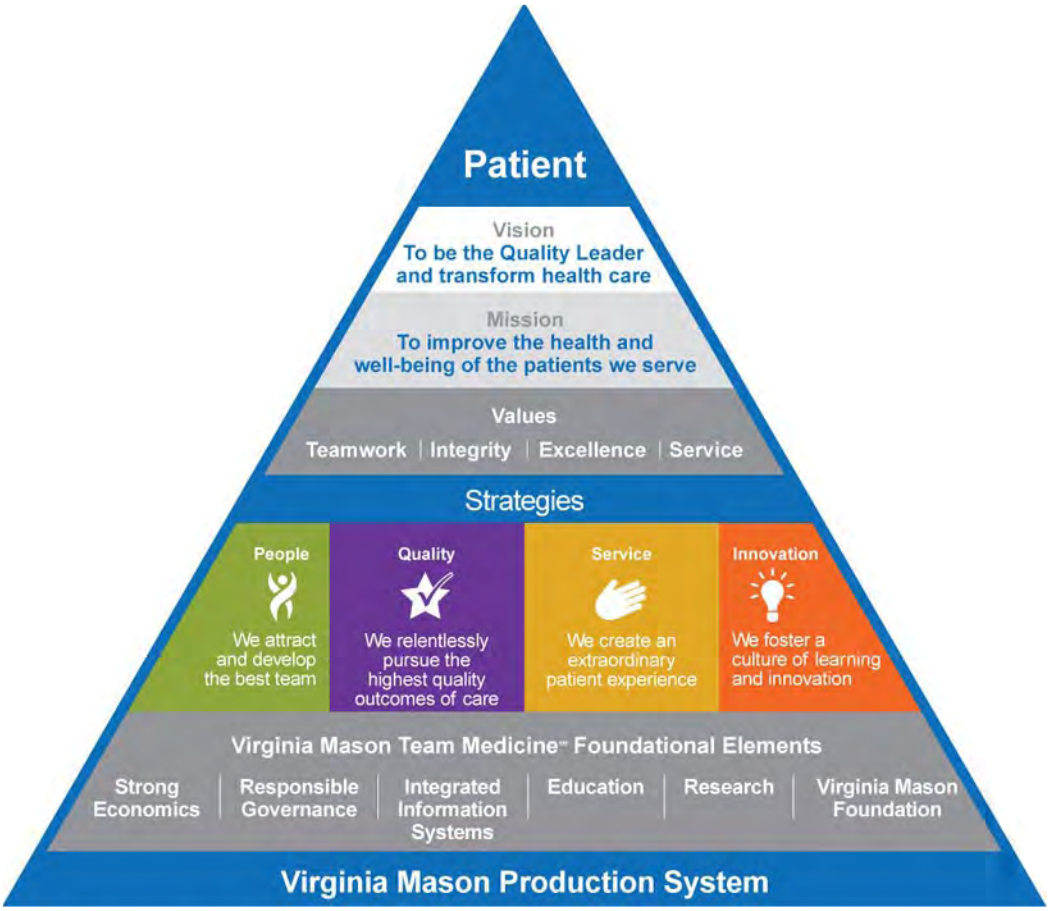

Figure 2 Virginia Mason's Strategic Plan Pyramid

Virginia Mason: Patients First

Patients are the reason Virginia Mason exists. Therefore, patients are at the center of all Virginia Mason's considerations and decisions. All facilities and operations are designed to enhance the overall experience of the patient.

Virginia Mason's mission is to improve the health and well-being of the patients served. Virginia Mason aspires to be the Quality Leader and transform health care by leading the way to improve health care quality and patient safety. Everything Virginia Mason does is ultimately to improve patient health and well-being. This is accomplished by hiring the finest physicians and staff, achieving the best clinical outcomes, providing unsurpassed service and the safest, most efficient facilities for patients and their families.

Virginia Mason embraces advances and innovations in health care delivery to meet the ever-changing needs of patients. Today, this means providing hospital facilities that offer the technological and design advancements vital to patients in the 21st century. Virginia Mason is also committed to providing a broad range of services that improve one's sense of well-being and prevent illness. Virginia Mason is acclaimed for its expertise in providing services in Digestive Disorders, Neurosciences, Heart Care, Cancer Care, Orthopedics and Sports Medicine, and Urology.

Virginia Mason Vision: To be the Quality Leader and Transform Health Care

To become the Quality Leader and transform health care, Virginia Mason set out first to change the way health care is delivered. The Virginia Mason concept of quality is all-encompassing and includes both clinical results and the service components of all interactions with patients. Virginia Mason strives to provide the best outcomes available anywhere. Virginia Mason is transforming health care delivery by eliminating waste, standardizing work and providing extraordinary care and service.

Virginia Mason Production System (VMPS)

Virginia Mason has achieved remarkable transformational results by focusing on the process of change through its management method, the Virginia Mason Production System, or VMPS. Modeled on the Toyota Production System, Virginia Mason has embraced lean manufacturing processes to scrutinize health care delivery at every level of the organization. This relentless focus on structured process improvement has eliminated waste at every level of the organization, increasing patient safety and satisfaction, reducing cost, and improving quality of care. VMPS provides specific methods for designing processes, facilities, and the environment of care, focusing on patient centeredness, improved flow and delivery of the highest quality care.

Figure 3 Leapfrog Award

Virginia Mason: Demonstrating Quality and Value

In 2010, the Leapfrog Group awarded Virginia Mason its Top Hospital of the Decade award, recognizing Virginia Mason's decade-long, sustained drive to improve the value of its services to its patients. The Leapfrog Group is a coalition of large organizations who buy health care services for their employees and who are working to initiate breakthrough improvements in safety, quality and affordability. The Leapfrog Group defines value by identifying organizations that provide the best quality of care at the lowest cost.

Figure 4 Leapfrog Top Hospital of the Decade 2001 - 2010

The Top Hospital of the Decade award followed six consecutive years (2006-2011) of the Leapfrog Group naming Virginia Mason a Top Hospital. The Top Hospital recognition has been awarded to Virginia Mason each year since the award's inception in 2006. The Top Hospital designation is based on results from the Leapfrog Hospital Survey, the nation's premier hospital evaluation tool that provides consumers and health care purchasers with up-to-date assessments of hospitals' quality and safety programs and outcomes.

Virginia Mason also received the highest overall scores in the Pacific Northwest region in the Leapfrog Group's 2010 Hospital Quality and Safety Survey. No hospital in Washington has outranked Virginia Mason on this annual survey since the Leapfrog Group began measuring hospital quality and safety in 2001.

In 2008 through 2012, Virginia Mason also received the HealthGrades Patient Safety Excellence Award and was named a Distinguished Hospital for Clinical Excellence. Only 263 hospitals in the nation received this honor for being in the top 5% for patient safety. HealthGrades, a leading independent health care ratings organization, evaluated 5,000 hospitals across the country for clinical performance.

Virginia Mason Organization

Virginia Mason Medical Center is a nonprofit comprehensive regional health care system in Seattle that combines a primary and specialty care group practice of more than 460 physicians with a 336-bed acute-care teaching hospital. Virginia Mason operates a network of clinics throughout the Puget Sound area providing primary care, specialty and outpatient surgical services, and Bailey-Boushay House, a skilled-nursing facility and chronic care management program for people with HIV/AIDS and for those suffering from life-threatening illnesses.

Virginia Mason is governed by a board of community volunteers. The medical center is a tax-exempt organization under Section 501(c)(3) of the Internal Revenue Code. The board has adopted governance policies and practices to help guide fulfillment of its commitment to the community and the patients served.

The medical center is affiliated with the Virginia Mason Institute (VMI), which provides education and training in the Virginia Mason management method - known as the Virginia Mason Production System (VMPS) - to other health care providers and organizations. VMI includes the Center for Health Care Solutions, whose work is to improve quality and access to care while reducing cost for employers and health plans for the most common and costly medical conditions. The medical center is also affiliated with the Benaroya Research Institute at Virginia Mason (BRI), which is internationally recognized in autoimmune disease research, and the Virginia Mason Foundation. The Virginia Mason Foundation engages in fundraising in support of the mission of the medical center and BRI.

The First Hill campus is composed of the acute care hospital, BRI, and a full complement of primary care and specialty clinics. The Bailey-Boushay House is located in the Madison Valley east of downtown Seattle and is approximately two miles outside of Virginia Mason's Major Institution Overlay district.

Virginia Mason also serves the larger region through a network of seven satellite medical facilities in Federal Way, Issaquah, Bellevue, Kirkland, Lynnwood, Sand Point and Winslow/Bainbridge Island. Virginia Mason also has three supporting facilities: the medical records and warehouse facility in Georgetown, administrative offices in the Metropolitan Park West building in downtown Seattle, and a call center in Canyon Park, Bothell.

Virginia Mason has affiliations with Group Health Cooperative of Puget Sound, Pacific Medical Centers, Evergreen Health, Wenatchee Valley Medical Center and other regional health care providers.

Virginia Mason Staff

Virginia Mason employs more than 5,500 people. Over 460 physicians are employed by Virginia Mason and many provide services at more than one location. Virginia Mason also benefits from the contributions of almost 970 volunteers who donated more than 22,768 hours in 2011.

Virginia Mason's First Hill campus facilities run around the clock, providing continuous care to the community. The regional clinics are open Monday through Friday, with some clinics and surgical services also open on Saturday. Because of this, the employees generate activities that enliven neighborhoods throughout the week and contribute a significant economic benefit to the surrounding neighborhoods that extends past the traditional lunch-hour crowds.

Virginia Mason Patients

Over 626,791 health care provider visits were made in 2011 at Virginia Mason's First Hill campus. In 2011, 16,330 patients were admitted to the hospital, 10,000 outpatient surgeries were performed, and over 15,700 patients were treated at the Emergency Department.

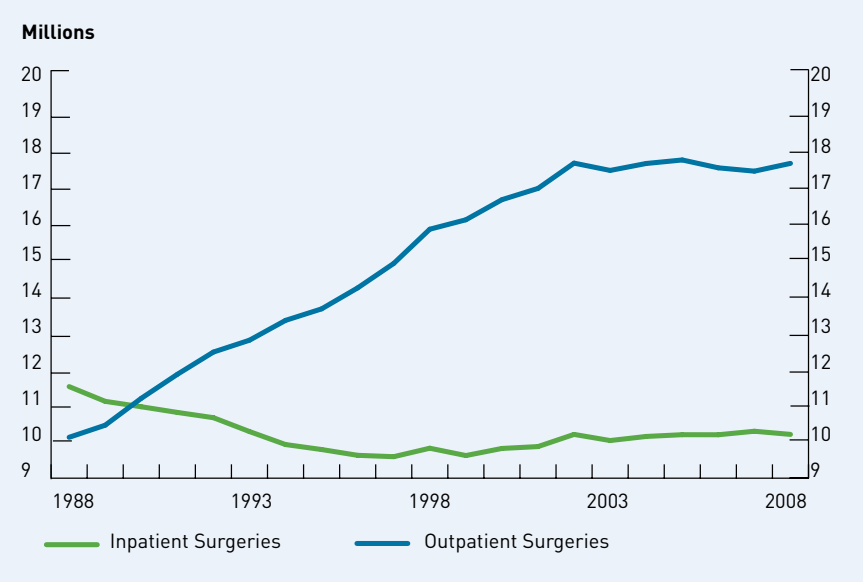

Figure 5 Inpatient and Outpatient Surgeries at U.S. Community Hospitals

Source: American Hospital Association

The increasing proportion of outpatient visits reflects a significant trend in health care innovation as more and more procedures that previously required hospitalization can now be done in an outpatient setting, and the patient can go home the same day. Virginia Mason is decentralizing some of these procedures to its regional outpatient surgery centers in Issaquah, Federal Way and Lynnwood to free up capacity on the First Hill campus for patients whose illnesses are more acute and who require specialty or hospital care. The First Hill campus continues to see increasingly complex, sicker patients whose illnesses require a teamed specialty approach to care and facilities specially designed for this purpose.

Virginia Mason Commitment to the Community

Virginia Mason is proud to be an important part of the First Hill neighborhood and recognizes that the institution and its neighbors are crucial partners in a quality neighborhood. Virginia Mason's commitment to the community extends well beyond patient care. Virginia Mason believes it is essential to contribute at many levels to the communities where patients and staff members work and live. The organization has acted on that belief by contributing time, energy and money to efforts that benefit the community in the areas of improving health, providing free and subsidized care, and supporting health professional education and research.

Virginia Mason's commitment is described in more detail in Section D.13, page 88.

5. Regional Growth and Health Care Needs

Regional Population Growth

The population of the Puget Sound area within King, Snohomish, Pierce and Kitsap Counties continues to steadily increase every year. From 2000 to 2010, the regional population increased by more than 400,000 people, or an 11% increase, from 3.2 million people to 3.69 million people, according to the 2010 census. If this rate of growth holds steady over the next 20 years, the region's population could conservatively increase by another 1 million or more people. Rising land costs, limited availability of undeveloped land, land use planning and good stewardship of scarce natural resources will direct much of this growth to growing urban cores and into multiunit housing, like the First Hill neighborhood.

Regional growth is not likely to slow in the next 20 years - the abundant natural resources, vibrant and diverse economy and links to the Pan-Pacific markets are likely to continue to grow well into the future. The growth framework for Virginia Mason's First Hill campus must find the best use of every parcel, to contain its footprint and concentrate its density, while at the same time providing the highest quality care for its patients, now and in the future.

Aging Population

This steadily growing population increases the demand for health care services at all levels of service delivery, including prenatal and maternal care; pediatric and adult care; geriatric and specialty care like skilled nursing, Alzheimer's and hospice; tracking and treatment of chronic diseases; and hospitalization for acute care episodes at all ages.

In addition, the steadily aging population exerts its own stress upon the regional health care system. The Social Security Administration now states that if a person lives to age 65, they are likely to live to an average of 83 years of age. One in four 65 year olds will live to age 90, and one in 10 will live to 95. The Baby Boomers (born between the years of 1946 and 1957) are going to add significant demand for specialty services. As they downsize their lifestyles and move into more convenient and compact urban neighborhoods like First Hill, they will want easy access to quality specialty care, such as that provided at Virginia Mason.

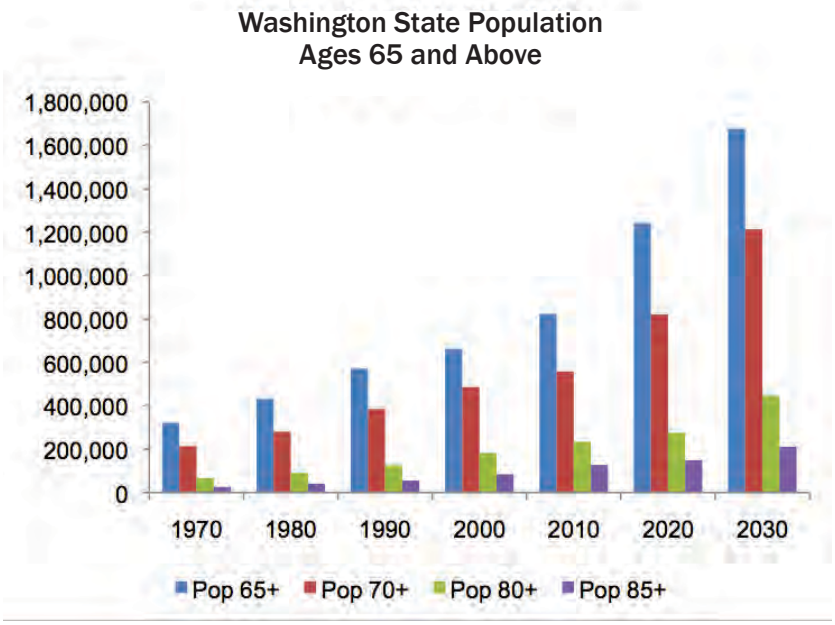

Figure 6 Washington State Population Ages 65 and Above

Source: State of Washington Office of Financial Management Forecasting Division November 2012 State Population Forecast

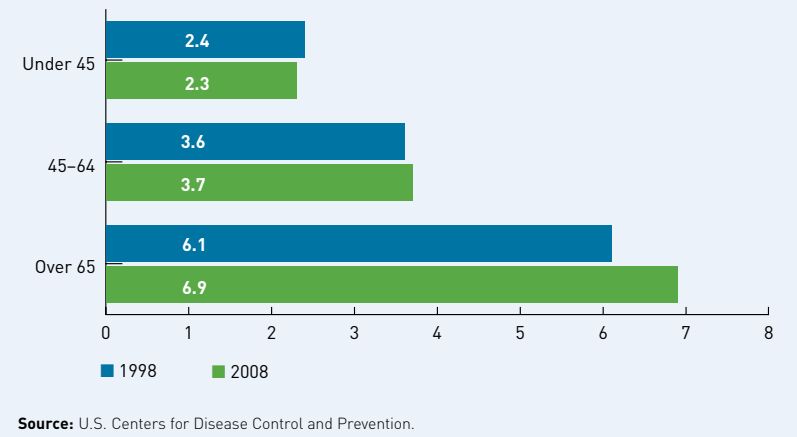

Figure 7 Annual Rate of Physician Office Visits by Age Group, 1998 versus 2008

Source: US centers for Disease Control and Prevention

Older adults use a higher percentage of health care services than younger, healthy adults, as they frequently have multiple chronic conditions that require testing, monitoring and treatment to maintain the best health possible. In 2005, 133 million American, almost 1 out of every 2 adults, had at least one chronic illness. One in five have multiple chronic conditions.[6] The Centers for Disease Control and Prevention note that chronic diseases are the leading cause of disability and death in the United States. The Urban Land Institute states that *"those over 65 years of age have three times as many office visits per year as people under 45."*[7] Virginia Mason's plans for the near future anticipate a significant increase in demand for specialty services, coupled with team-based, integrated care management to provide the best value for these older patients.

Decentralization and Regional Presence

Virginia Mason is reaching out to these growing, aging populations by expanding its primary care and specialty care services to its regional ring of clinic locations in Bellevue, Federal Way, Issaquah, Kirkland, Lynnwood, Northeast Seattle/Sand Point, and Winslow/Bainbridge Island. This regional growth needs to occur in conjunction with growth of Acute Care services at the First Hill campus, and with an expanded portfolio of skilled nursing and home health care.

Virginia Mason's new alliance with Evergreen Health will leverage Evergreen's capacity in Home Health care to augment Virginia Mason's hospital services.

For parents who need to get to work but who have a mildly ill child who must be kept out of school or day care, Virginia Mason offers Tender Loving Care (TLC). TLC provides child care for children ranging in age from 1 year to 12 years old, offering parents the reassurance that their sick child will be well cared for while they work. TLC is located on the First Hill campus close to employers in downtown Seattle.

This regionalization of services is described in more detail in Section D.12, page 87.

[6] (Gen Intern Med. 2007, December; 22 (Suuppl 3): 391-395)

[7] The Outlook for Health Care, by Gary Shilling, 2011

Increasing Complexity of Care

Virginia Mason will continue to focus hospital care at the First Hill campus. The patients at the First Hill campus are being seen for more complex and invasive procedures that are in large part the drivers behind the need to replace the facilities at the First Hill campus. More complex care means more medical devices and more sophisticated monitoring, a heavier reliance on information systems infrastructure, and more heat from equipment requiring more air conditioning, more power and more space.

Team Medicine, as practiced by Virginia Mason, uses a concentrated team of specialists to act collaboratively to deliver optimal care. Higher acuity care requires larger, integrated teams composed of an array of specialists directed by a care manager. The care also includes more active participation in care by the patient and their families. These larger teams of caregivers are hard to support efficiently within the built constraints of the existing campus. Looking to the future, Virginia Mason is employing strategies to move the highest acuity care into the new Jones Pavilion and to rebuild its core hospital services on the 1000 Madison block.

Virginia Mason does not anticipate an increase in its Bed License under the State of Washington's Certificate of Need process at this time, although it may do so within the life of this Master Plan if the growth of such services requires it. If additional hospital beds are proposed in the future, they would replace outpatient services and not add to the area projections within this plan. They would therefore reduce the demand for parking, utilities, traffic, etc., as inpatient hospital services have lower demand for these than outpatient services. Virginia Mason is currently seeing its ability to provide more and more procedures in an outpatient setting, the increasing ability of telemedicine and remote monitoring to provide health care services closer to home, and reductions in average lengths of stays keeping pace with service growth.

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View of Madison from Broadway, 1889

View of First Hill from Denny Hill, 1882

View from Denny Hill, 1890

Historic photographs courtesy of The Seattle Public Library

B. EXISTING CAMPUS

The existing Virginia Mason Medical Center First Hill campus is a study in regional medical growth. The original hospital was built in 1920 as a six-story concrete frame building housing 65 hospital beds. The first addition was made to the hospital in 1928. Since the beginning in 1920, there have been 26 additions or new buildings constructed within the First Hill campus. The most recent, the Floyd & Delores Jones Pavilion, was completed in 2011.

This growth parallels the growth of Seattle. From its start as a rugged frontier town, First Hill has reinvented itself about every 20 to 30 years, from forests and farms to wood frame Victorian-era housing, to St. James Cathedral and Harborview Medical Center towering over the neighborhood to brick apartment buildings to postwar midrise apartment buildings. The most recent wave of new development is pushing First Hill skywards into an urban center of tall, densely developed high-rise apartments, Major Institution development and office buildings.

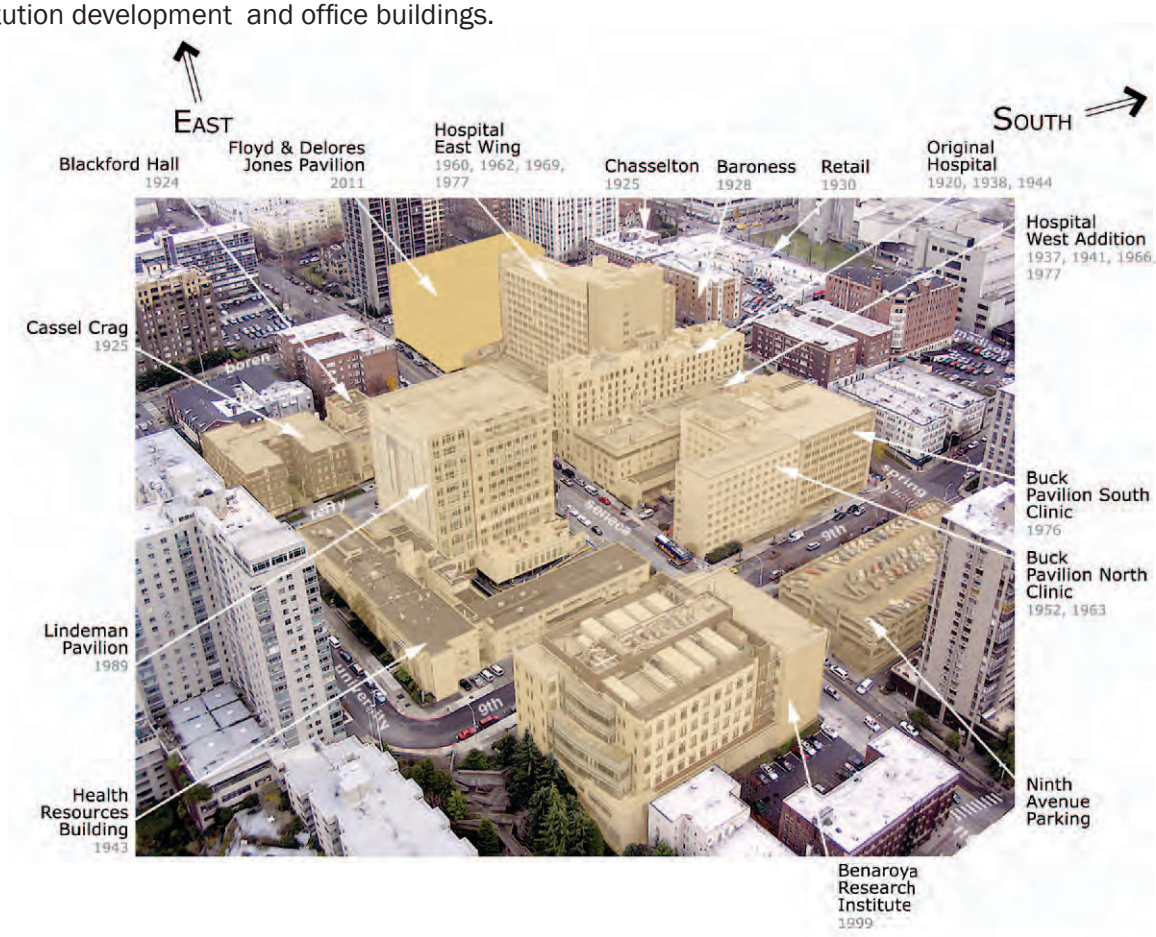


Figure 8 Virginia Mason Campus, Looking Southeast

Figure 8 depicts how the campus has grown, with a major building addition added every three to 10 years. Each year, a substantial number of smaller renovation projects are done to upgrade existing services, accommodate new technologies, provide routine maintenance or replacement of services, and keep pace with the changing needs of health care.

1. Virginia Mason Property

Virginia Mason owns all of the property within the MIO district with the exception of the public rights-of-way. The total land area of the Virginia Mason First Hill campus is approximately 8.5 acres or 369,550 square feet over eight contiguous city blocks (including the 1000 Madison block and alley). See Appendix A for detailed property ownership and legal descriptions.

Existing/Approved Development

The existing Virginia Mason facilities of the First Hill campus include 12 buildings and total approximately 1.23 million building gross square feet (BGSF), as identified in Figure 8 on page 23 and detailed in Table 2 below. This includes the new Floyd & Delores Jones Pavilion but excludes properties on the 1000 Madison block and subterranean development. The 1992 MIMP allowed development of Virginia Mason facilities up to 1.66 BGSF.

Table 2 Existing Virginia Mason Development

Existing Facility	Description of General Uses	Total Above Grade Building Gross Square Feet (BGSF)
Cassel Crag / Blackford Hall / MRI Building	Offices, research	66,085
Lindeman Pavilion	Offices, clinic, support space	157,246
Health Resources Building	Offices, support space	59,405
Benaroya Research Institute	Offices, research	109,550
Ninth Avenue Parking Garage	Parking	69,786
Main Hospital / East Wing/ West Addition /Buck Pavilion Clinics	Inpatient, clinic, offices, support space	531,734
Inn at Virginia Mason	Hotel, restaurant, offices, support space	48,445
Jones Pavilion	Inpatient, support space	185,193
University/Terry Parking Lot	(Surface parking only)	0
Total Existing Virginia Mason Development		**1,227,444**

Approximately 95,870 BGSF of development currently exist on the 1000 Madison block, as detailed in Table 3 on page 25. Total existing development within the proposed MIO boundary therefore amounts to approximately 1.32 million BGSF, above grade.

Table 3 Existing Development Within 1000 Madison Block

Existing Facility	Description of General Uses	Total Above Grade Building Gross Square Feet (BGSF)
Baroness Apartment Hotel	Hotel, offices	34,070
Chasselton Court Apartments	Apartments	37,170
1000 Madison retail	Retail (multiple)	24,630
Total Existing Development on 1000 Madison Block		**95,870**

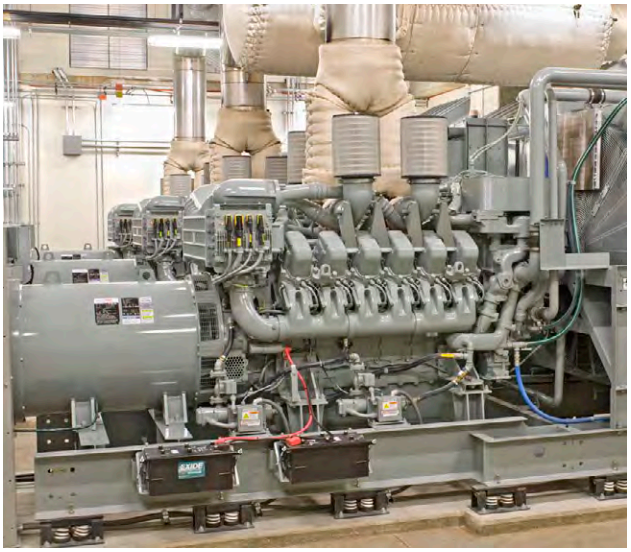
Aging Infrastructure

Hospital needs are constantly evolving. Much of Virginia Mason's existing campus is aging and needs to be replaced to meet modern health care requirements. Here are some examples:

- Patient privacy and disease control require single-patient rooms. A significant percentage of Virginia Mason's existing inpatient capacity is in double rooms.
- More and more complex equipment is brought to the bedside, for faster, more efficient and more convenient treatment, requiring additional utility support.
- Increased participation by family members brings them into the patient care areas.
- Larger care teams need more support space.
- Seismic, fire and life safety codes have expanded to better protect patients and staff.

There have been various assessments done identifying the near-term costs to upgrade to achieve new code requirements for health care occupancies. For many of the buildings, the cost to replace them with new is less than the cost to upgrade, especially taking into consideration the cost of disruption of patient care services.

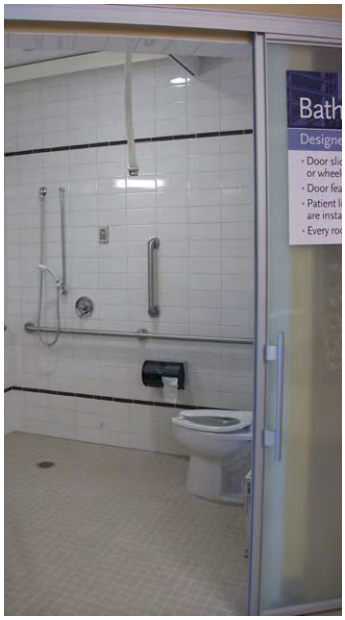
In addition, the spaces needed to provide medical services continue to get larger. A typical hospital inpatient room in the 1980s was about 140 net square feet per bed, with some efficiency gained in multiple bed rooms. New, modern rooms can be two times as large. Toilet rooms have tripled in size; exam rooms have doubled in size. Some of this is due to the Americans With Disabilities Act (ADA), some due to the increasing size of the average American, some due to infection control concerns, and some due to patient preferences for single-patient rooms. Mechanical infrastructure needed to provide services to a medical facility also continues to increase in size and can now consume nearly 20% of a building's total area.



One of four 1500 KVA generators in the Jones Pavilion

Patient and medical treatment room sizes have increased to meet new standards:

- ADA-accessible bathroom sizes have increased from 20 square feet to 50 to 60 square feet.
- Clearances around hospital beds have increased from 3 feet to 5 feet.
- Operating rooms have increased in size from 300 square feet to over 600 square feet.
- Recent regional hospitals have a range of area needed per bed: Providence Everett Colby – 2,833 BGSF/bed; Swedish Issaquah Hospital – 3,142 BGSF/bed; Seattle Children's expansion – 3,500 BGSF/bed
- We are projecting a need for approximately 2,492 BGSF/per bed for hospital replacement.



Jones Pavilion orthopedics room

The Jones Pavilion is an important first step in the replacement of the hospital core. The first floors opened in 2011, and when complete, approximately one-third of the existing inpatient beds will be replaced with new, state-of-the-art rooms and space designed for providing Virginia Mason's unique production system of patient health care delivery. This still leaves two-thirds of the hospital inpatient capacity to be replaced elsewhere along with clinic, support and other space replacement and growth needs.

2. Programmatic Needs

Virginia Mason continues to be a leader in the innovation of health care services. This innovation is occurring on two fronts: first, Virginia Mason's medical teams are pushing the boundaries of medical knowledge daily with innovative new techniques and procedures, and the rigorous pursuit of and application of best practices in medicine. Second, health care reform measures are demanding new service delivery methods that fundamentally change the incentives used to provide care. Bundled Payments, Medical Homes and other proposals will drive the realignment of services into new configurations that are as yet unknown.

Virginia Mason envisions its First Hill campus to be the location where the most acutely ill and most complex patients are seen. The expertise needed to treat this patient population requires a certain critical mass of facilities. Expert coverage is required on all shifts; and costs must be distributed to maintain significant infrastructure like food services, a full-service 24-hour laboratory and emergency back-up systems; and to provide efficient utilization of expensive technologies like magnetic resonance imaging (MRI) equipment and Linear Accelerators. While the regional presence for ambulatory services continues to expand, Virginia Mason expects that the most acutely ill patients will continue to be seen at the First Hill campus.

In order to fully implement the Virginia Mason Production System, spaces must be designed to help support the innovative care developed at Virginia Mason. The design of the new Floyd & Delores Jones Pavilion includes the following features that will become the model for the redeveloped First Hill campus:

- The latest life-saving medical technologies
- A new Emergency Department, Procedural and Operating Rooms that enhance flow
- Streamlined admissions
- Specially designed space for family members in each patient room
- Internet access, education rooms and refreshments
- Innovative floor designs that reduce walking for staff
- Enhanced infection control measures
- Quiet and calm patient care areas with “off-stage” staff workflows

All of these changes make defining specific building programs a challenging process. Virginia Mason will need a significant increase in area to just replace its existing buildings, without growth. The goal is to balance increases in efficiency and quality of care against this increase in area.

Certain core hospital functions need to be replaced as a group because of their need for immediate adjacency. The core functions require approximately 422,000 square feet of contiguous area. Other hospital functions do not require this immediate adjacency, and can be relocated elsewhere on campus.

- Seconds transporting patients save lives. The inpatient beds, operating rooms, Emergency Department and specialty diagnostic areas like Cardiac Catheterization need to be as close as possible to each other.
- Supporting services like laboratories, food services, inpatient pharmacy, loading docks and sterile instrument processing also need to be located as close to these functions as possible to provide the most efficient delivery to our patients.

There are very few locations on campus where the contiguous core functions can be replaced.

- Within the existing campus MIO, constructing 422,000 square feet of contiguous hospital space would require spanning over Terry Avenue.
- The 1000 Madison block, the area proposed for an expanded campus boundary, is the only site large enough to accommodate this area without crossing over a city street.

Our increasing, aging population requires expanded clinic, specialty space and research facilities:

- Puget Sound Regional Council forecasts that population of the four-county region (King, Pierce, Snohomish and Kitsap) will grow 34% between 2010 and 2040.
- As Baby Boomers age, the demand for medical services will increase – Washington's Office of Financial Management calculated the population of those aged 65 and older in 2010 at 823,357 and predicts this number to more than double by 2030 to approximately 1.7 million, as people live healthier lives extending their life spans, and as new cures are found for diseases.
- Clinic and specialty care space must grow to meet demand – we are projecting a 2.8% annual growth rate – requiring an additional 691,523 square feet over the next 30 years.
- Benaroya Research Institute at Virginia Mason continues to grow, bringing innovative treatment into clinical use through its translational research programs. Additional research space needs are projected to be approximately 177,000 square feet over the next 30 years.

A summary of the space needed to replace aging facilities and to respond to increased need for clinic, research and support needs is provided in Table 4 on page 29.

The existing campus and the 1000 Madison block contain 1,324,273 square feet. Redeveloping the campus would include:

- 35% of the existing space meets current guidelines and would be retained = 464,992 square feet
- The total projected need is approximately 3 million square feet:
    - 15% of the new total space (464,992 square feet) would be made up of existing space that meets current health care guidelines and would be retained
    - 38% of the projected total would be required to replace existing outdated facilities and to bring them to current health care guidelines
    - 47% of the projected total would be required to meet projected growth needs for clinic, specialty care and research

Additional growth in "Support and Miscellaneous" may include additional hotel, storage, office and other medical-related uses.

Table 4 Major Institution Master Plan Area Summaries

Use	Total Current Area (A)	Space to be Retained (B)	Area Needed to Replace Core Hospital Functions (C)	Total Area Needed to Replace Existing Aging Facilities(D)	Area Needed for Service Growth (E)	Total Area Needed by Year 2040 (B + D + E)
Hospital	525,757 SF	164,624 SF	422,000 SF[1]	672,589 SF		837,215 SF
Clinic	410,024 SF	125,797 SF		201,200 SF	691,523 SF	1,018,520 SF
Research	109,550 SF	109,550 SF			177,392 SF	286,942 SF
Support and Miscellaneous[2]	65,341 SF	30,250 SF		181,185 SF	471,160 SF	682,595 SF
Above-ground Parking	69,786 SF					0 SF (all parking to be located below ground)
Hotel	82,015 SF	33,570 SF		48,445 SF		82,015 SF
Housing	37,170 SF					0 SF (housing replacement to be located off campus)
Retail[3]	24,630 SF	1,200 SF		40,630 SF	80,450 SF	122,280 SF
TOTAL	**1,324,273 SF**	**464,992 SF**	**422,000 SF**	**1,144,050 SF**	**1,420,525 SF**	**3,029,567 SF**
Percentage of Total Area		**15%**		**38%**	**47%**	**100%**

1 The 422,000 SF of contiguous space needed to replace core hospital functions is included within the total of 889,143 SF needed to replace existing aging facilities.

2 "Support" includes office, food service, storage, maintenance area, physical plant, loading docks and similar uses.

3 "Retail" includes pharmacy, optical, coffee shops and similar uses on existing campus and neighborhood retail proposed for 1000 Madison block.

3. Community-Campus Integration

Virginia Mason's campus is an integral part of the First Hill experience. Virginia Mason staff shop and do their banking in the neighborhood, obtain their health care, and frequent the many neighborhood restaurants, parks, churches and food service venues. Neighbors and hotel guests eat in Virginia Mason's inexpensive and high-quality cafeteria and restaurant. Neighbors and patients have visitors and family members sleep in the Virginia Mason hotels, frequent the restaurants and coffee bars and come to Virginia Mason's Emergency Department when they are in need. Nearly 300 Virginia Mason employees live within two miles of the First Hill campus, and over 2,100 live in Seattle. A significant percentage of Virginia Mason's patients live or work in downtown Seattle and select the First Hill location for its convenience and accessibility.

Virginia Mason recognizes that its campus functions both for its own purposes and as part of the fabric of the neighborhood and the connections within and beyond the neighborhood. The opportunities to re-build Virginia Mason's facilities also create the ability to improve the quality of the streetscape and open spaces used by neighborhood residents and visitors as well as by Virginia Mason's patients and staff.

4. Future Evolution of First Hill

The planning for First Hill continues to evolve. The current community dialog includes debate on items such as: the location, nature and quantity of street-level retail uses; pedestrian-targeted street improvements (such as woonerfs and green streets); open space; transit development; bicycle routes; parking needs; and traffic management. As new plans are developed and adopted by the First Hill neighborhood and City Council, Virginia Mason may update the accompanying Design Guidelines over time to incorporate the new ideas and directions. Virginia Mason will use the Standing Citizens Advisory Committee and its public meetings to review proposed updates with the community.

C. DEVELOPMENT STANDARDS

1. Existing Underlying Zoning

Virginia Mason Medical Center's existing First Hill campus includes one existing underlying zoning district: High-rise Multi-family Residential (HR). The base height limit is 160 feet with the ability to go to a maximum of 300 feet if the applicant satisfies conditions for extra floor area. The previous MIMP established a 240-foot maximum height limit overlay onto the entire campus, although recent buildings were not built to the full height allowed by the MIO. Figure 9 illustrates the existing zoning designations.

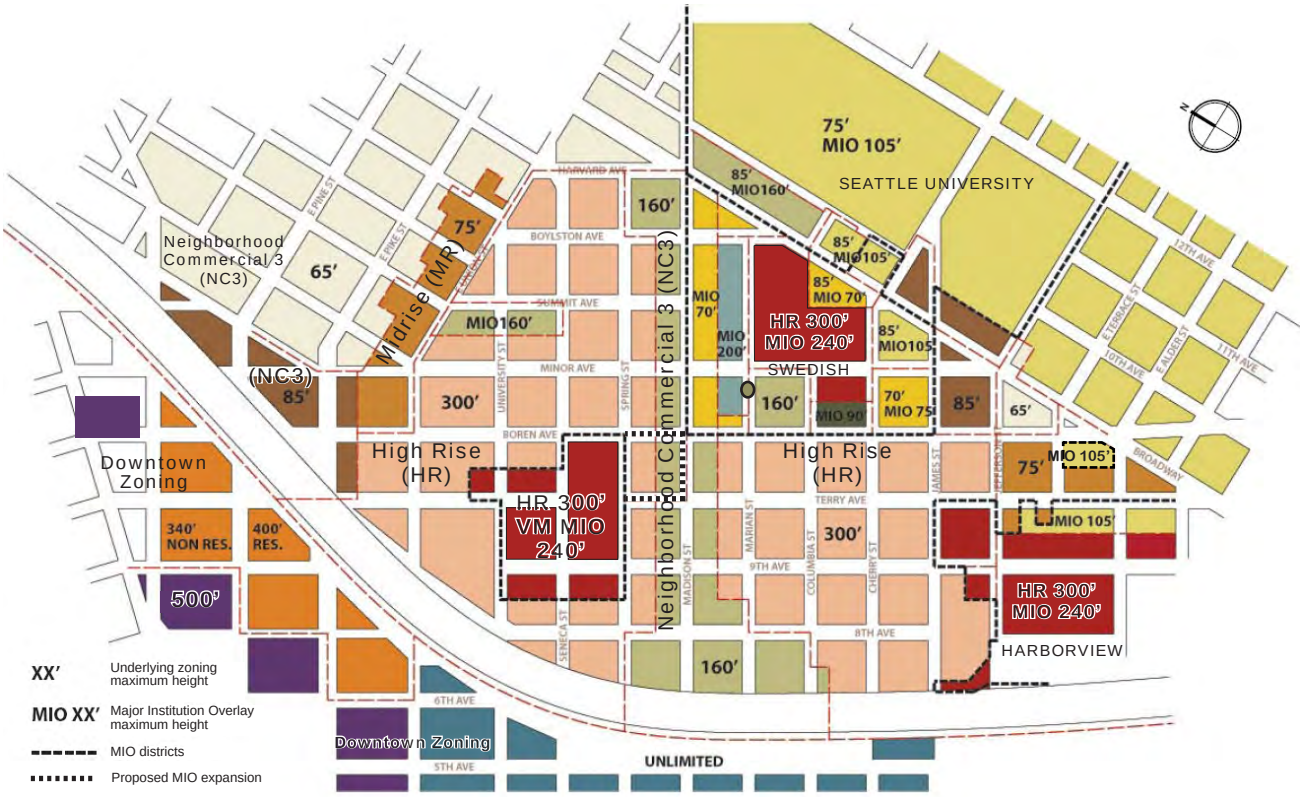


Figure 9 Existing Zoning

2. Proposed Expansion Areas

Virginia Mason is proposing two expansions of the existing campus boundary:

(1) An expansion of the existing campus is requested to include the block bordered by Boren Avenue on the east, Madison Street on the south, Terry Avenue on the west, and Spring Street on the north. This block, known as the 1000 Madison block, includes two existing underlying zoning districts: Neighborhood Commercial (NC-3P 160' base height limit) along the southeast half of the block fronting Madison Street, and HR on the northwest half of the block. The Madison Street corridor is a designated principal pedestrian street, and certain street level uses are required (SMC 23.47A.005).

(2) An administrative correction is requested to be made to the existing MIO district boundary map to accurately reflect Virginia Mason property ownership. The parcel includes Lots 9 and 12 plus a 20 foot portion of Lot 8 of Block 112. This correction was approved in the previous MIMP and needs to be carried forward in this update. The portion of Lot 8 is not correctly shown graphically within the MIO boundary on the current city zoning maps. See Appendix A.

3. Proposed Structure Setbacks

Virginia Mason is proposing to meet or exceed underlying zoning setbacks from property lines in all areas of the campus for new construction.

Section 23.45.518 of the Seattle Land Use Code lists the required setbacks for development in HR zones:

- Along street frontages, the development standards require an average setback from the property line of 7 feet and a minimum setback of 5 feet for portions of building 45 feet or less in height, and a minimum of 10 feet in setback for building facades above 45 feet in height.
- Along alleys, no setback is required for portions of structures 45 feet or less in height, and a 10-foot minimum setback is required for structures above 45 feet.
- For lot lines that abut neither a street nor an alley, the development standards require an average setback from the property line of 7 feet and a minimum setback of 5 feet for portions of building 45 feet or less in height (except no setback is required for portions of buildings abutting an existing structure built to the abutting lot line, and a minimum of 20 feet in setback for building facades above 45 feet in height).

Along most street frontages, Virginia Mason is proposing to set buildings back 7 to 10 feet from the property line for the first 45 feet of elevation. Above that height, Virginia Mason is proposing an additional 10 feet in most locations, so the setback would be twice what would otherwise be required by the Land Use Code for a residential development. Along Madison, Virginia Mason is proposing to set the upper portion of the building (above approximately 45 feet) back an additional 30 feet, for a total of 40 feet from the property line (see Table 12 on page 45), and greater setbacks are proposed for portions of the central hospital block (see Tables 9, 10 and 11 on pages 41, 42 and 43).

The future building to be located on the Ninth Avenue Garage redevelopment site will have a maximum depth (east/west) of 93 feet. The east and west lower and upper level building setbacks shall be based on the merits of the building design and by balancing the needs of the residents to the west and the

needs of the pedestrian experience on 9th Avenue. A minimum setback of seven feet shall be required for portions of the building 45 feet or less in height and 12 feet for portions of the building above 45 feet in height.

Proposed setbacks are shown for each block in Figures 10 through 18 on pages 34 through 44 and summarized in Tables 5 through 12 on pages 36 through 45. See Figure 10 on the following page for a composite figure identifying all proposed setbacks for the campus.

Architectural features, structural projections, weather protection, window overhangs and similar elements may extend into the public right-of-way as long as safety clearances are maintained as determined by Seattle Department of Planning and Design during project permitting.

Setbacks and building massing for the future building that will replace the Health Resources Building will follow the setbacks specified in the agreement reached with Horizon House during the previous MIMP. No changes are proposed other than the potential reconfiguration of the open space on the northwest corner of the block, per Horizon House's request.

4. Width and Floor Size Limits

Virginia Mason is requesting a modification to the provisions in HR zones that limit building facade widths and floor size to allow major medical institution development to occur to the maximum space available with configurations found efficient for health care delivery within the above proposed setbacks.

The provisions that Virginia Mason is requesting to modify include the following:

- Elimination of the requirement in the HR zoning that portions of structures above a height of 45 feet are limited to a maximum facade width of 110 feet. (Virginia Mason is proposing that unmodulated facades be limited to a maximum facade width of 110 feet.)
- Elimination of the provision that the average gross floor area of all stories above 45 feet in height not exceed 10,000 square feet in order to reach or exceed a maximum facade width of 130 feet.
- Elimination of the building separation requirements specified in subsection 23.45.520. (Virginia Mason has included a goal of bringing daylight into staff working areas and public areas where feasible as a design strategy. See Design Guidelines. A. Context; 1. Natural Context and Environment; a. Design with natural systems in mind; Solar conditions.)

5. Existing and Proposed Height Limits (MIO Heights)

The existing MIO district for the entire Virginia Mason First Hill campus is designated as MIO-240, with a 240-foot height limit. It extends generally along Boren Avenue, Spring Street, University Street and Ninth Avenue, as shown in Figure 18 on page 44. The Virginia Mason-acquired 1000 Madison block is outside the existing MIO district. It is proposed to be included within the Virginia Mason MIO boundaries in the proposed MIMP (Alternative 6b) with a MIO-240 designation.

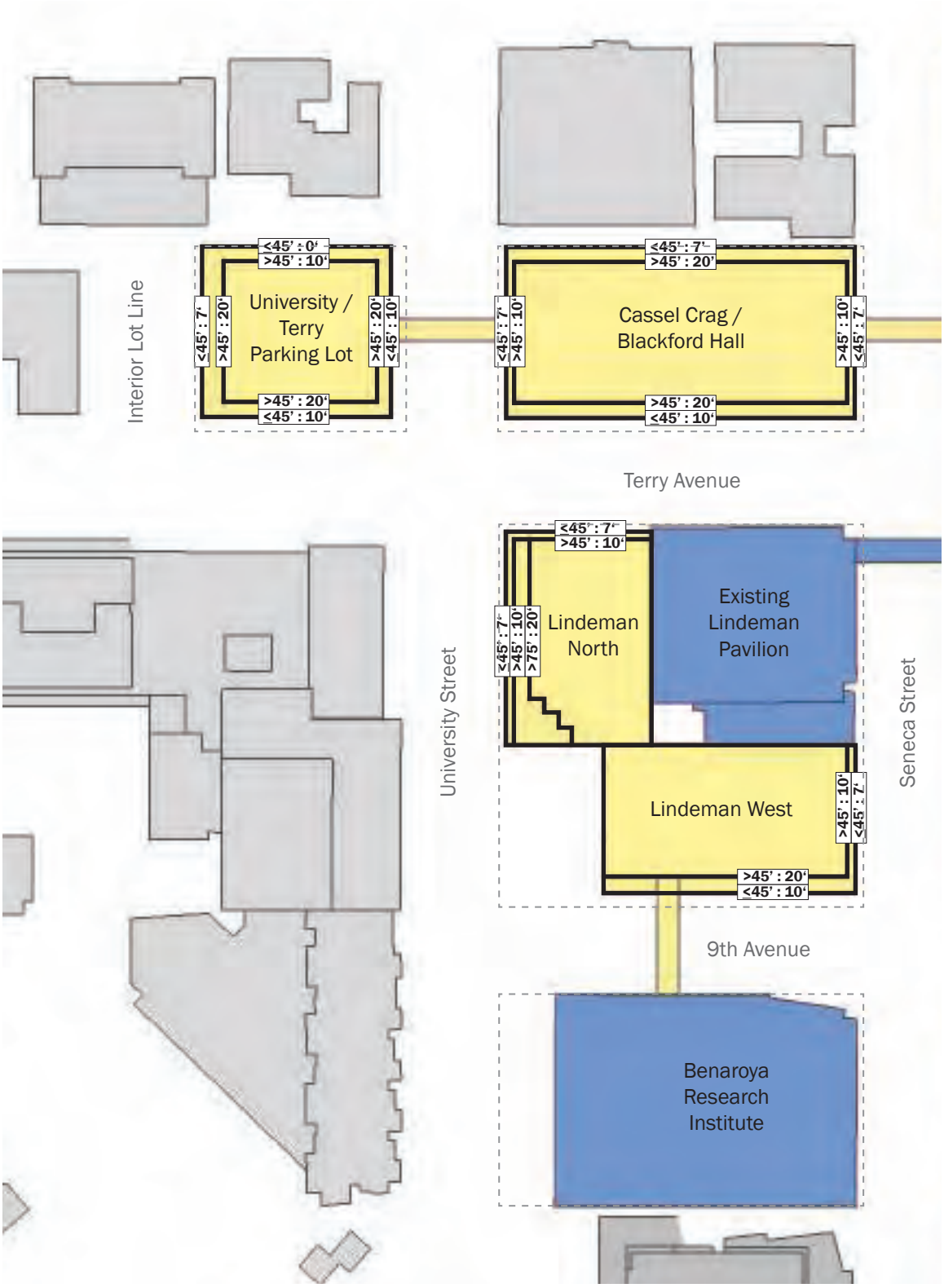
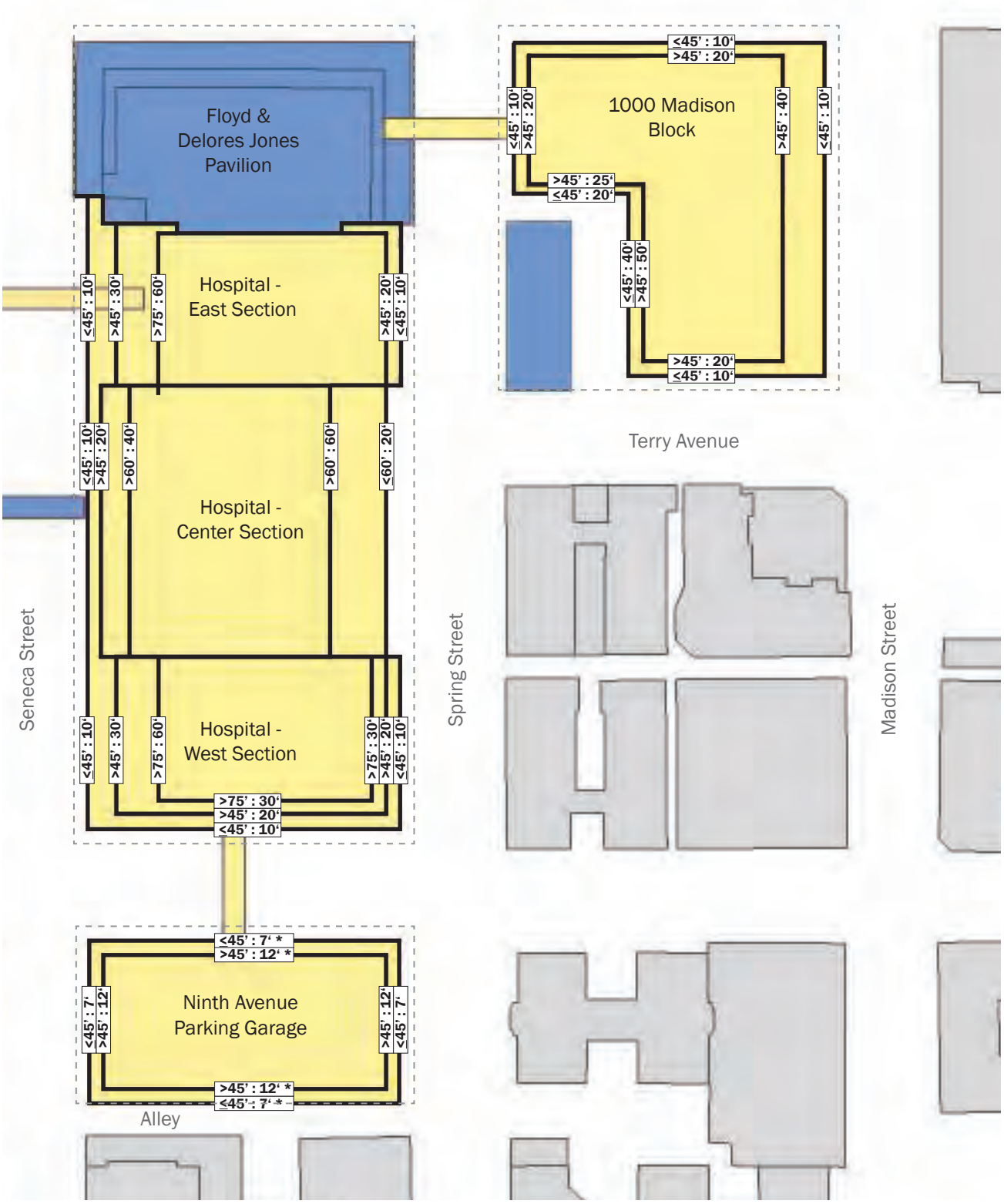


Figure 10 Proposed Building Setbacks – Virginia Mason Campus



* 7' and 12' setbacks are the minimum required (See Council Condition 17 in Appendix F)

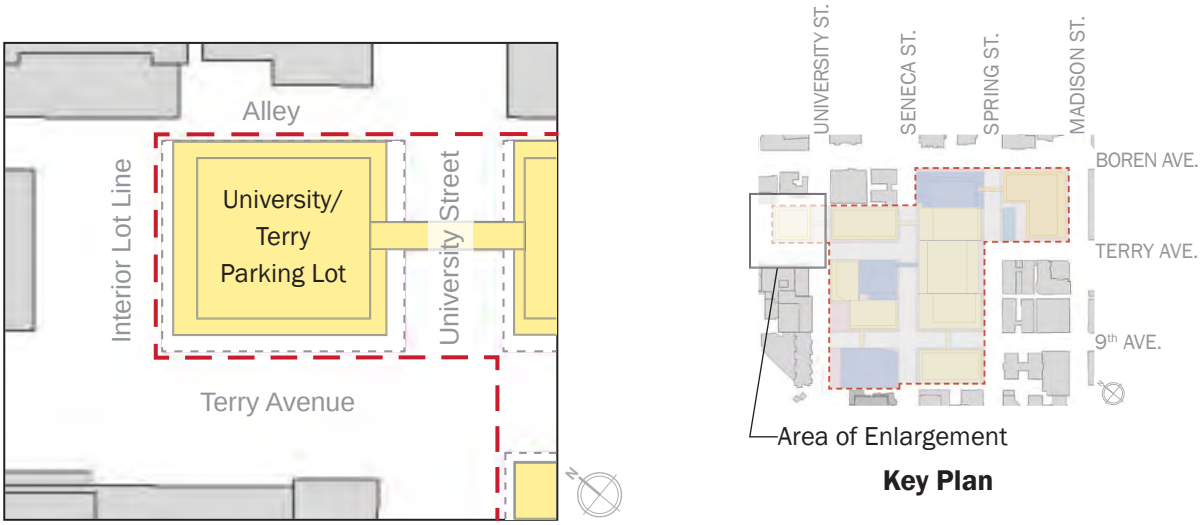


Figure 11 Proposed Building Setbacks – University/Terry Parking Lot Block

Table 5 Proposed Building Setbacks – University/Terry Parking Lot Block

Location	Street/ Avenue	Campus Location	Virginia Mason's Proposal		Complies With Underlying Zoning Setback?	Modification Requested?
			Portions of structure ≤ 45'	Portions of structure > 45'		
Abutting a Street	*Land Use Code requires 7' average/5' minimum setback for portions of buildings <45' in height and 10' for portions of buildings >45' in height*					
	University	University/Terry Parking Lot – north side of University between Terry and alley to the east	10 feet	20 feet	Yes	No
	Terry	University/Terry Parking Lot – east side of Terry north of University Street	10 feet	20 feet	Yes, exceeds	No
Abutting an Alley	*Land Use Code requires 0' setback for portions of buildings <45' in height and 10' for portions of buildings >45' in height*					
	Alley	University/Terry Parking Lot – east side of lot	0 feet	10 feet	Yes	No
Abutting an Interior Lot Line	*Land Use Code requires 7' average/5' minimum setback for portions of buildings <45' in height and 20' for portions of buildings >45' in height*					
	Interior lot line	University/Terry Parking Lot – north side of lot	7 feet	20 feet	Yes	No

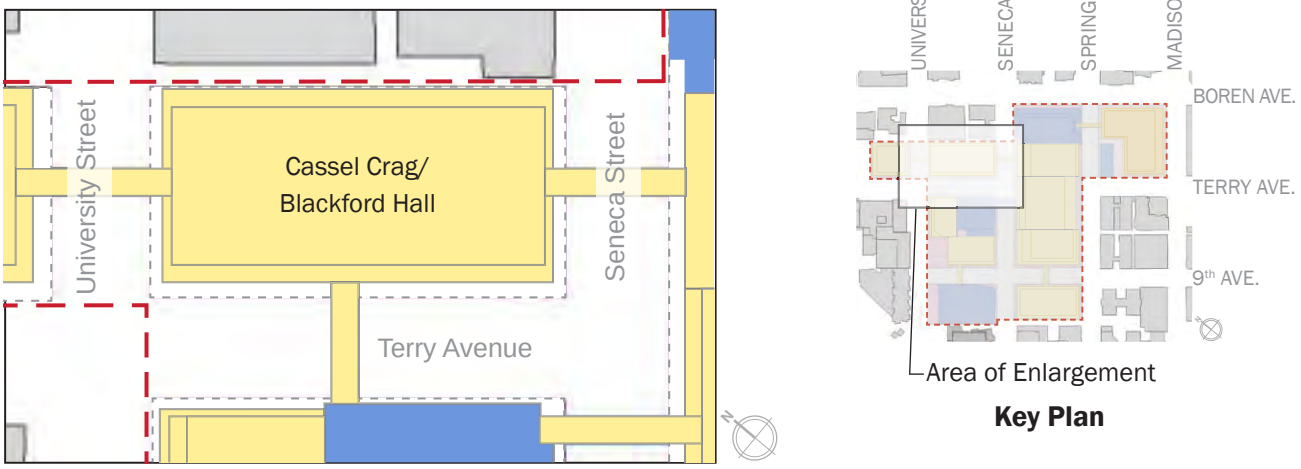
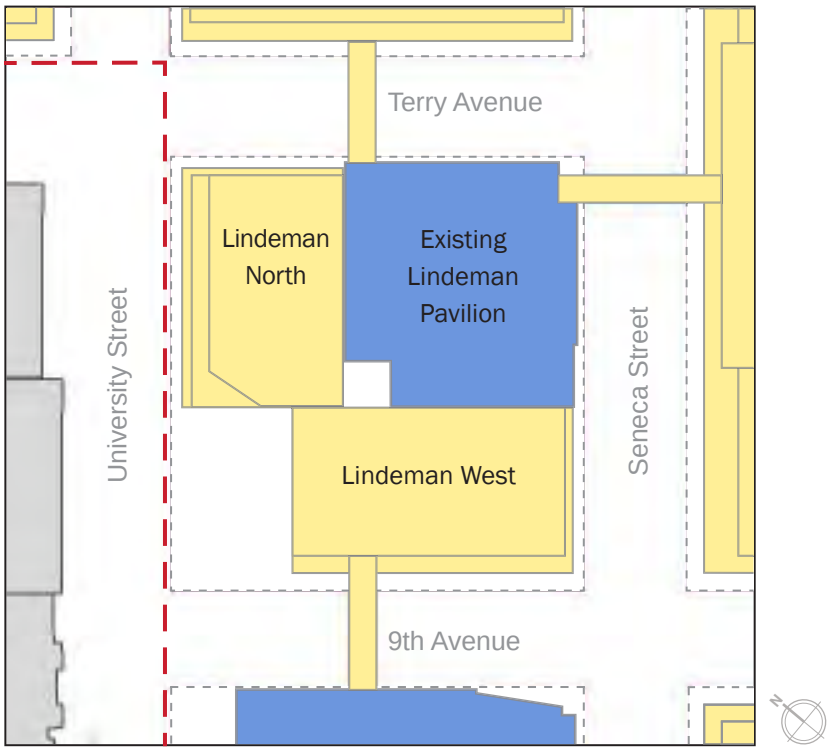
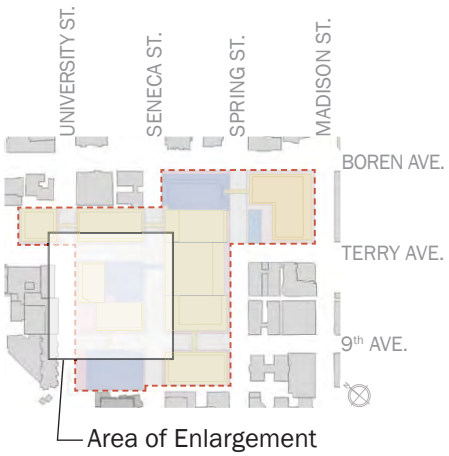


Figure 12 Proposed Building Setbacks – Cassel Crag/Blackford Hall Block

Table 6 Proposed Building Setbacks – Cassel Crag/Blackford Hall Block

Location	Street/ Avenue	Campus Location	Virginia Mason's Proposal		Complies With Underlying Zoning Setback?	Modification Requested?
			Portions of structure ≤ 45'	Portions of structure > 45'		
Abutting a Street	*Land Use Code requires 7' average/5' minimum setback for portions of buildings <45' in height and 10' for portions of buildings >45' in height*					
	University	Cassel Crag/Blackford Hall Block – south side of University	7 feet	10 feet	Yes	No
	Terry	Cassel Crag/Blackford Hall Block – east side of Terry	10 feet	20 feet	Yes, exceeds	No
	Seneca	Cassel Crag/Blackford Hall Block – north side of Seneca	7 feet	10 feet	Yes	No
Abutting an Interior Lot Line	*Land Use Code requires 7' average/5' minimum setback for portions of buildings <45' in height and 20' for portions of buildings >45' in height*					
	Interior Lot Line	Cassel Crag/Blackford Hall Block – between University and Seneca Streets	7 feet	20 feet	Yes	No





Key Plan

Figure 13 Proposed Building Setbacks – Lindeman Block

Table 7 Proposed Building Setbacks – Lindeman Block

Location	Street/ Avenue	Campus Location	Virginia Mason's Proposal		Complies With Underlying Zoning Setback?	Modification Requested?
			Portions of structure ≤ 45'	Portions of structure > 45'		
Abutting a Street	*Land Use Code requires 7' average/5' minimum setback for portions of buildings <45' in height and 10' for portions of buildings >45' in height*					
	Terry	Lindeman Block – west side of Terry between University and Seneca Streets	7 feet	10 feet	Yes	No
	University	Lindeman Block – south side of University	7 feet	10 feet 20 feet for structure >75' in height	Yes, exceeds	No
	Ninth Avenue	Lindeman Block – east side of Ninth Avenue between University and Seneca Streets	10 feet	20 feet	Yes, exceeds	No
	Seneca	Lindeman Block – north side of Seneca between Ninth and Terry Avenues	7 feet	10 feet	Yes	No

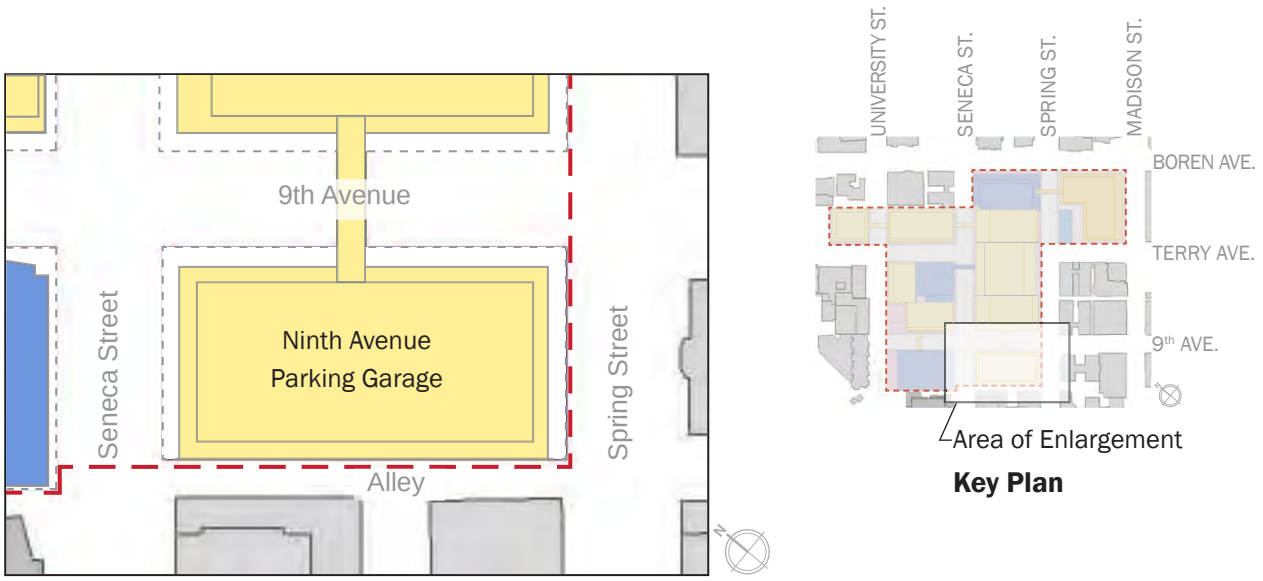


Figure 14 Proposed Building Setbacks – Ninth Avenue Garage Block

Table 8 Proposed Building Setbacks – Ninth Avenue Garage Block

Location	Street/ Avenue	Campus Location	Virginia Mason's Proposal		Complies With Underlying Zoning Setback?	Modification Requested?
			Portions of structure ≤ 45'	Portions of structure > 45'		
Abutting a Street	*Land Use Code requires 7' average/5' minimum setback for portions of buildings <45' in height and 10' for portions of buildings >45' in height*					
	Seneca	Ninth Avenue Garage Block – south side of Seneca west of Ninth Avenue	10 feet	20 feet	Yes, exceeds	No
	Ninth Avenue	Ninth Avenue Garage Block – west side of Ninth Avenue between Seneca and Spring Streets	7 feet *	12 feet *	Yes, exceeds	No
	Spring	Ninth Avenue Garage Block – north side of Spring west of Ninth Avenue	10 feet	20 feet	Yes, exceeds	No
Abutting an Alley	Land Use Code requires 0' setback for portions of buildings <45' in height and 10' for portions of buildings >45' in height					
	Alley	Ninth Avenue Garage Block – west side of site	7 feet *	12 feet *	Yes	No

* 7' and 12' setbacks are the minimum required (See Council Condition 17 in Appendix F)

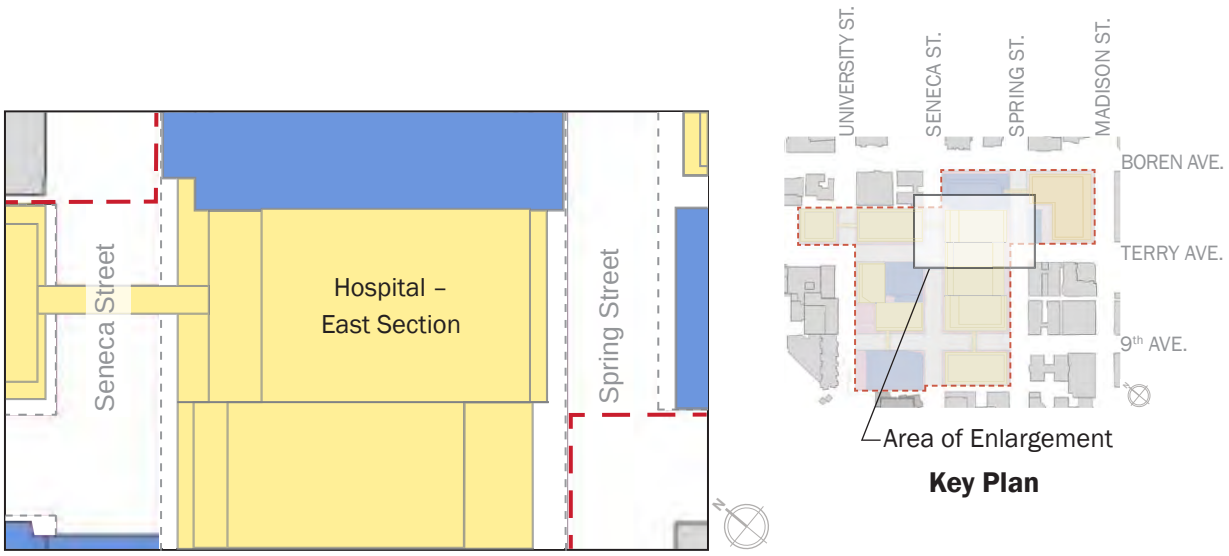


Figure 15 Proposed Building Setbacks – Central Hospital Block – East Section

Table 9 Proposed Building Setbacks – Central Hospital Block – East Section

Location	Street/ Avenue	Campus Location	Virginia Mason's Proposal		Complies With Underlying Zoning Setback?	Modification Requested?
			Portions of structure ≤ 45'	Portions of structure > 45'		
Abutting a Street	*Land Use Code requires 7' average/5' minimum setback for portions of buildings <45' in height and 10' for portions of buildings >45' in height*					
	Seneca	Central Hospital Block, East Section – south side of Seneca	10 feet	30 feet for structure > 45' in height 60 feet for structure> 75" in height	Yes, exceeds	No
	Spring	Central Hospital Block, East Section – north side of Spring	10 feet	20 feet	Yes, exceeds	No

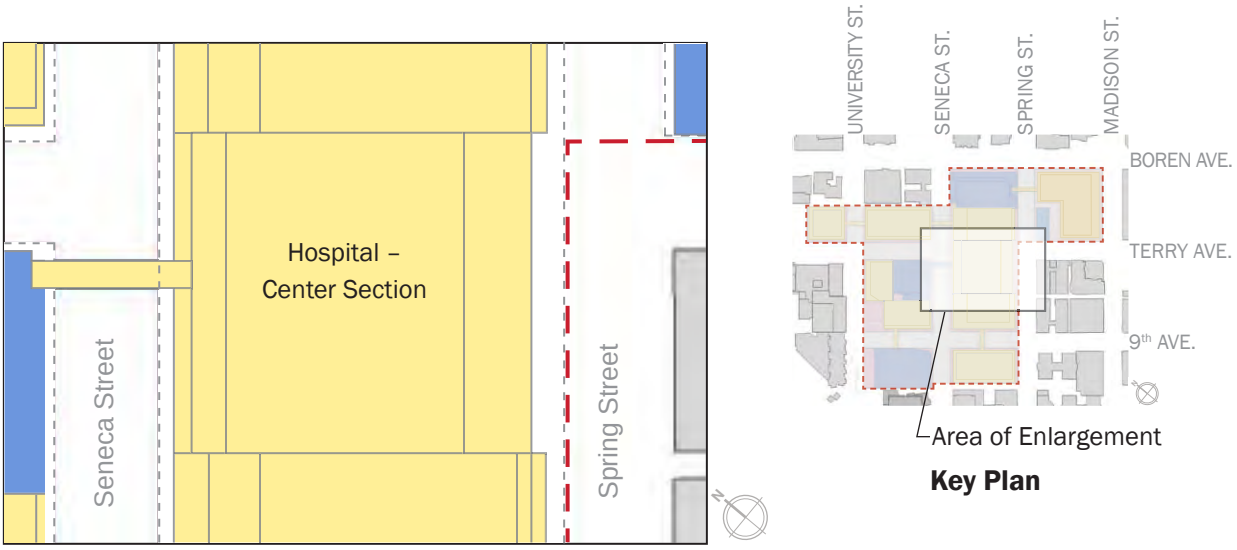


Figure 16 Proposed Building Setbacks – Central Hospital Block – Center Section

Table 10 Proposed Building Setbacks – Central Hospital Block – Center Section

Location	Street/ Avenue	Campus Location	Virginia Mason's Proposal		Complies With Underlying Zoning Setback?	Modification Requested?
			Portions of structure ≤ 45'	Portions of structure > 45'		
Abutting a Street	*Land Use Code requires 7' average/5' minimum setback for portions of buildings <45' in height and 10' for portions of buildings >45' in height*					
	Seneca	Central Hospital Block, Center Section – south side of Seneca	10 feet	20 feet for structure > 45' in height 40 feet for structure > 60' in height	Yes, exceeds	No
	Spring	Central Hospital Block, Center Section – north side of Spring	20 feet	20 feet for structure > 45' in height 60 feet for structure > 60' in height	Yes, exceeds	No

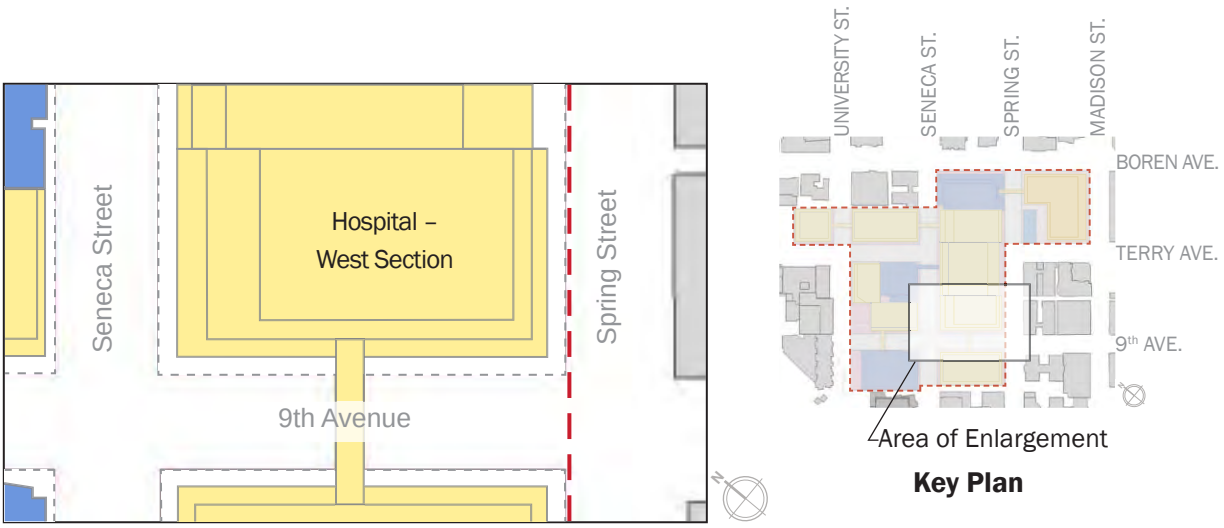


Figure 17 Proposed Building Setbacks – Central Hospital Block – West Section

Table 11 Proposed Building Setbacks – Central Hospital Block – West Section

Location	Street/ Avenue	Campus Location	Virginia Mason's Proposal		Complies With Underlying Zoning Setback?	Modification Requested?
			Portions of structure ≤ 45'	Portions of structure > 45'		
Abutting a Street	*Land Use Code requires 7' average/5' minimum setback for portions of buildings <45' in height and 10' for portions of buildings >45' in height*					
	Seneca	Central Hospital Block, West Section – south side of Seneca	10 feet	30 feet for structure > 45' in height 60 feet for structure > 75' in height	Yes, exceeds	No
	Ninth Avenue	Central Hospital Block, West Section – east side of Ninth Avenue between Seneca and Spring Streets	10 feet	20 feet for structure > 45' in height 30' for structure > 75' in height	Yes, exceeds	No
	Spring	Central Hospital Block, West Section – north side of Spring	10 feet	20 feet for structure > 45' in height 30 feet for structure > 75' in height	Yes, exceeds	No

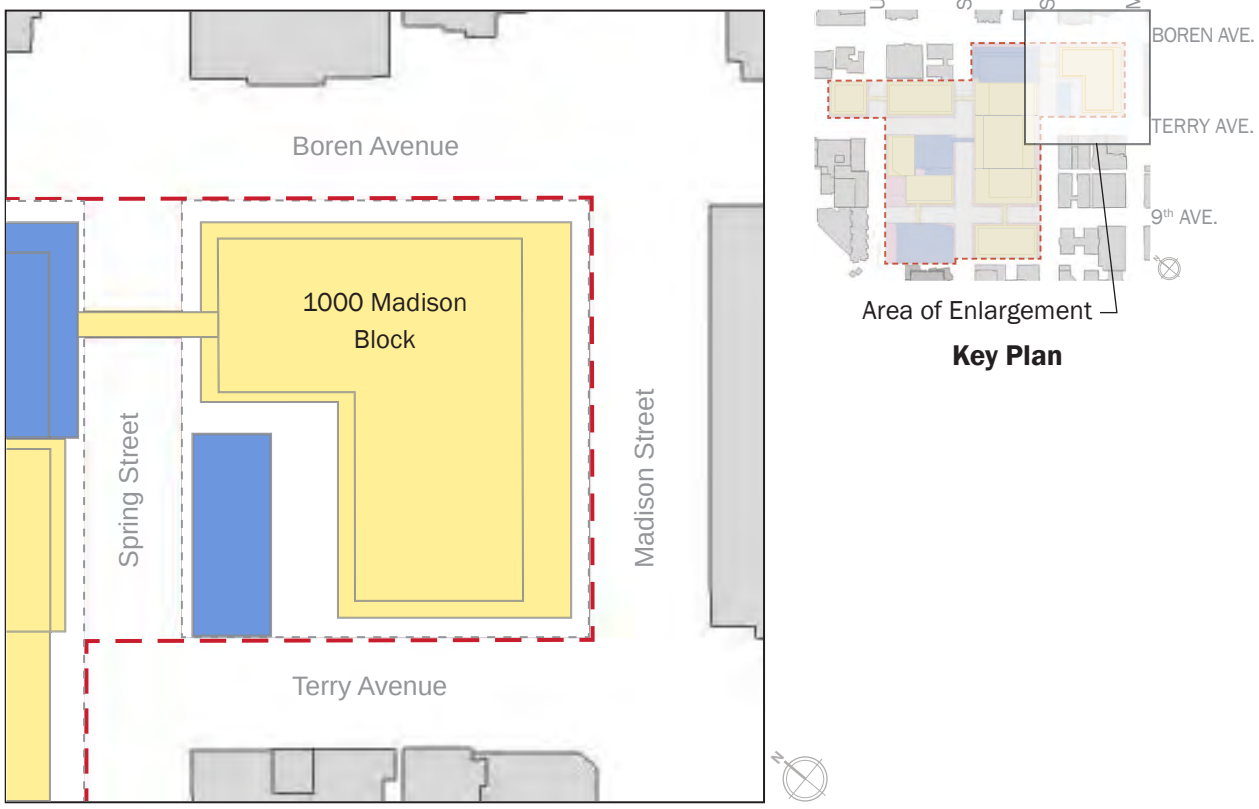


Figure 18 Proposed Building Setbacks – 1000 Madison Block

Table 12 Proposed Building Setbacks – 1000 Madison Block

Location	Street/ Avenue	Campus Location	Virginia Mason's Proposal		Complies With Underlying Zoning Setback?	Modification Requested?
			Portions of structure ≤ 45'	Portions of structure > 45'		
Abutting a Street	*Land Use Code requires 7' average/5' minimum setback for portions of buildings <45' in height and 10' for portions of buildings >45' in height*					
	Boren	1000 Madison Block – west side of Boren between Madison and Spring Streets	10 feet	20 feet	Yes, exceeds	No
	Madison	1000 Madison Block – north side of Madison between Boren and Terry Avenues	10 feet	40 feet	Yes, exceeds	No
	Terry	1000 Madison Block – east side of Terry between Madison and Spring Streets and north of University Street	10 feet	20 feet	Yes, exceeds	No
	Spring	1000 Madison Block – south side of Spring between Boren and Terry Avenues	10 feet	20 feet	Yes, exceeds	No
Abutting an Alley	*Land Use Code requires 0' setback for portions of buildings <45' in height and 10' for portions of buildings >45' in height*					
	Alley	1000 Madison Block – east side of Baroness Hotel	20-foot setback from Baroness	25 feet	Yes, exceeds alley setback requirements. Alley to be vacated	No
Abutting an Interior Lot Line	*Land Use Code requires 7' average/5' minimum setback for portions of buildings <45' in height and 20' for portions of buildings >45' in height*					
	Interior lot line	1000 Madison Block, building to be located south of Baroness	40-foot setback from Baroness (to allow for garage access)	50 feet	Yes, exceeds	No

Figures 19 and 20 and Table 13 identify both the MIO height districts listed in SMC 23.69.004, and show in parenthesis lower heights that Virginia Mason has agreed to maintain for the duration of the MIMP. Those lower heights are denoted as "conditioned heights." For the four existing buildings that will be retained (BRI, Lindeman, Jones Pavilion, and the Baroness) some existing mechanical equipment exceeds the "conditioned heights." For new construction, Virginia Mason is proposing that rooftop mechanical space/penthouses will be included within and limited to the MIO height or conditioned height, whichever is lower.

Figure 19 Existing Major Institution Overlay Districts
*** Conditioned heights shown in parentheses**

The Seattle Municipal Code in Section 23.69.004 designates nine MIO districts and requires that all land within an MIO District Overlay be designated with one of those nine MIO height limits.[8] As noted above, all land within Virginia Mason's existing campus is designated as MIO-240. Virginia Mason is proposing to maintain the MIO-240. The proposed MIO districts are as shown on Table 13 on page 48 and illustrated on Figure 20. Virginia Mason is proposing that the significant mechanical equipment, penthouses and rooftop structures, with the exception of minor plumbing and ventilation stacks, all be located within the MIO height districts described in Table 13 on the following page.

[8] The nine MIO height districts designated in SMC 23.69.004 are MIO-37 (37 feet), MIO-50 (50 feet), MIO-65 (65 feet), MIO-70 (70 feet), MIO-90 (90 feet), MIO-105 (105 feet), MIO-160 (160 feet), MIO-200 (200 feet) and MIO-240 (240 feet).

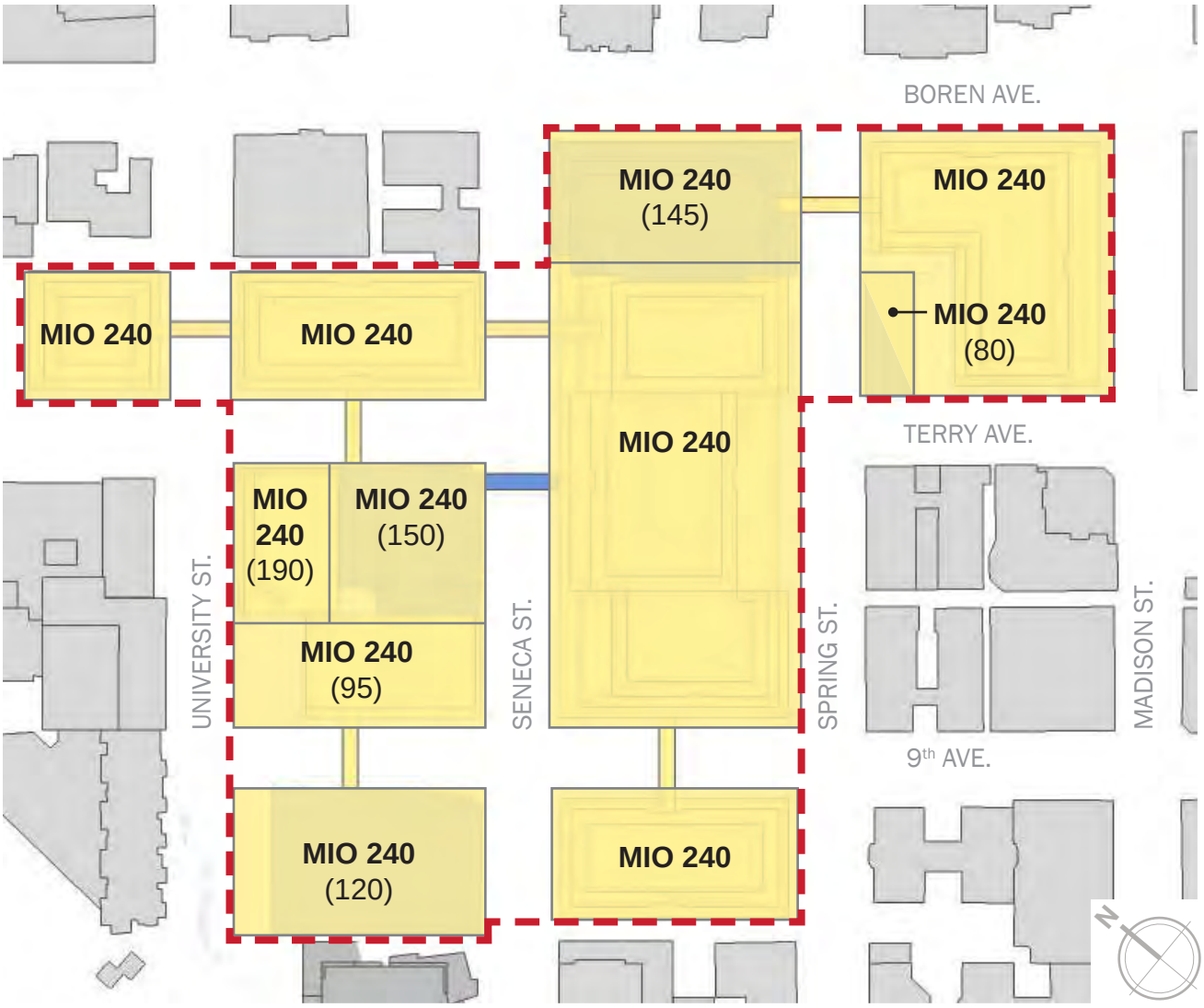


Figure 20 Proposed Major Institution Overlay Districts
*** Conditioned heights shown in parentheses**

Table 13 Existing and Proposed MIO Height Limits

Virginia Mason Campus Location	Underlying Zoning and Height Limit	Existing MIO Height	Proposed MIO Height District
University/Terry Parking Lot on northwest corner of University and Terry	HR 160-300'	MIO-240	MIO-240
Cassel Crag and Blackford Hall (half block on west side of Terry between University and Seneca)	HR 160-300'	MIO-240	MIO-240
Lindeman Block (full block between University, Ninth, Seneca and Terry)	HR 160-300'	MIO-240 (conditioned to 95', 150' and 190')	MIO-240 (conditioned to 95', 150' and 190')
BRI (half block west of Ninth and north of Seneca)	HR 160-300'	MIO-240 (conditioned to 120')	MIO-240 (conditioned to 120')
Jones Pavilion (half block west of Boren between Seneca and Spring)	HR 160-300'	MIO-240 (conditioned to 145')	MIO-240 (conditioned to 145')
Existing Hospital (super block west of Jones between Seneca and Spring, east of Ninth)	HR 160-300'	MIO-240	MIO-240
Ninth Avenue Garage (half block west of Ninth between Seneca and Spring)	HR 160-300'	MIO -240	MIO-240
1000 Madison Block	HR 160-300' NC-3 160'	N/A	MIO-240 (conditioned to 80' on the Baroness Hotel)

For new development, rooftop mechanical space/penthouses will be included within and limited to the MIO height limits or conditioned height, whichever is lower.

6. Exemptions from Gross Floor Area

The calculation of gross floor area considers exemptions and exclusions for calculating the FAR. Spaces that are entirely below grade and above and below grade parking are typically exempt from the calculation of gross floor area. Consistent with other Major Institution MIMPs, SMC 23.86.007 and SMC 23.45.510, Virginia Mason is requesting that the following spaces be exempt from the calculation of gross floor area:

- Above and below-grade parking
- Rooftop mechanical space/penthouses
- Interstitial space that is not occupiable (mechanical floors/levels)
- As an allowance for mechanical equipment, in any structure more than 85 feet in height, 3.5 percent of the gross floor area that is not exempt under subsection 23.45.510.E.
- Below-grade space
- Ground floor commercial uses meeting the requirements of 23.45.532, if the street level of the structure containing the commercial uses has a minimum floor to floor height of 13 feet and a minimum depth of 15 feet
- Skybridge and tunnel circulation space within the public right-of-way
- Other unoccupiable spaces similar to the uses identified in the list above as approved by the Director of the Department of Planning and Development.

Where rooftop mechanical equipment would be visible to high-rise viewers from outside the Virginia Mason campus, Virginia Mason will seek to locate the equipment and screen it from view to the extent that ventilation or exhaust would not be obstructed. The future designs of proposed projects presented to the Standing Citizen Advisory Committee will include mechanical equipment so that the committee can review and comment on its appearance and possible means of screening.

7. Existing and Proposed Lot Coverage for Entire Campus

The underlying zoning does not regulate lot coverage. The setbacks and open space proposed in the MIMP define the maximum building envelope that can be built on any site, and therefore the lot coverage. As with other Major Institutions, the maximum lot coverage standard is calculated against the entire campus rather than against individual project sites. The prior MIMP required a minimum of 1% of the campus to be set aside as open space, an area of approximately 3,081 square feet. The existing campus-wide lot coverage is approximately 98%, with approximately 1.9% of the campus in open space. Virginia Mason is proposing that a minimum of 4% of the campus be provided as dedicated open space, with a resulting lot coverage of 96%. See Section C.3 for proposed structure setbacks.

8. Street-Level Uses and Facades in NC Zones

Virginia Mason is proposing to expand its MIO boundary to include the block bordered by Boren Avenue on the east, Madison Street on the north, Terry Avenue on the west, and Spring Street on the south. The southern half of this block is zoned NC-3. The Madison Street frontage and the portions of Boren and Terry Avenues within the NC zoning are designated pedestrian streets.

SMC 23.69.008C3 states where the underlying zoning is a pedestrian-designated zone, the provisions of Section 23.47A.005 governing street-level uses shall apply. Those standards require that one or more of the following uses are required along 80 percent of the street-level street-facing facade in accordance with the standards provided in subsection 23.47A.008.C: a. General sales and services; b. Major durables retail sales; c. Eating and drinking establishments; d. Lodging uses; e. Theaters and spectator sports facilities; f. Indoor sports and recreation; g. Medical services; h. Rail transit facilities; i. Museum; j. Community clubs or centers; k. Religious facility; l. Library; m. Elementary or secondary school; and n. Parks and open space. If the proposed expansion to include the 1000 Madison block is approved, Virginia Mason intends to consider any of the following uses for potential location at street level along Madison and the portions of Boren and Terry Avenues within the NC-3 zoning and would be in compliance with the underlying zoning: medical services such as optical, eating and drinking establishments, retail sales and services, indoor sports and recreation, or perhaps lodging uses or additional open space.

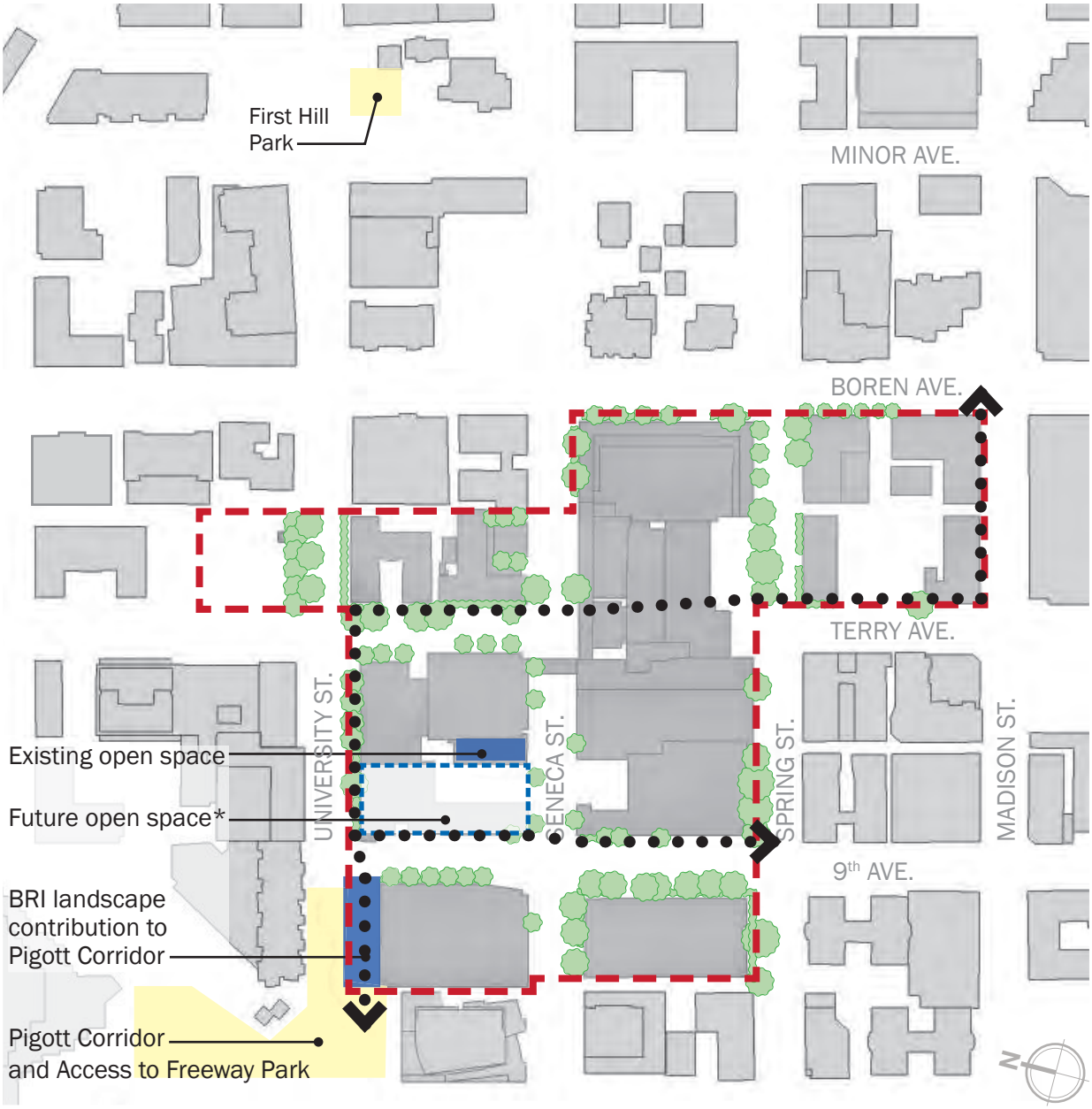
Section 23.47A.008A2 places limits on blank facades that would apply to future development by Virginia Mason. A facade segment is considered blank if it does not include at least one of the following: windows; entryways or doorways; stairs, stoops or porticos; decks or balconies; or screening and landscaping on the facade itself. Blank segments of the street-facing facade between 2 feet and 8 feet above the sidewalk may not exceed 20 feet in width. The total of all blank facade segments may not exceed 40% of the width of the facade of the structure along the street. Virginia Mason's proposed MIMP will comply with this development standard. Virginia Mason is proposing that the design of street-level facades along Madison Street and Boren Avenue be articulated in a way that can accommodate a variety of store sizes and entries, as retail use needs can change substantially over time.

9. Existing and Proposed Landscaping and Open Space

The focus of the open space and landscaping of the Virginia Mason Master Plan is to improve the quality of the urban streetscape connections within the public right-of-way surrounding the campus. The location benefits from the adjacent Freeway Park and the nearby First Hill Park (one block to the east).

The Seattle Land Use Code provides definitions for both "landscaping" and "open space."

"Landscaping" means live planting materials, including but not limited to trees, shrubs, vegetables, fruits, grass, vines, ground cover or other growing horticultural material. Landscaping may also include features intended to enhance a landscaped area, including water features, pathways or materials such



Approximate locations of existing campus landscape elements

Existing public open space

Existing Virginia Mason open space (open to public)

Future public open space (* ~10,000 square feet (combination of existing 3,400 plus 6,600 new) at street level, location to be determined)

Virginia Mason proposed key pedestrian corridors

Figure 21 Existing and Future Landscape/Open Space Plan

as wood chips, stone, permeable paving or decorative rock.

"Open space" means land and/or water area with its surface predominantly open to the sky or predominantly undeveloped, that is set aside to serve the purposes of providing park and recreation opportunities, conserving valuable natural resources, or structuring urban development and form. "Open space" is further defined as "landscaped," and "usable." An additional two definitions, "open space, common" and "private usable," apply only to occupants of residential structures and would not pertain to Virginia Mason.

- "Open space, landscaped" means exterior space, at ground level, predominantly open to public view and used for the planting of trees, shrubs, ground cover and other natural vegetation.
- "Open space, usable" means an open space that is of appropriate size, shape, location and topographic siting so that it provides landscaping, pedestrian access or opportunity for outdoor recreational activity. Parking areas and driveways are not usable open spaces.

Virginia Mason is proposing three categories to describe planned landscaping, open space and public amenities:

- Existing and proposed landscaping within Virginia Mason's boundaries
- Existing and proposed open space (including landscaped open space) within Virginia Mason's boundaries
- Existing and proposed public amenities located within or adjacent to street rights-of-way

Figure 21 on page 51 locates the existing and future landscape and open space features on campus.

Existing and Proposed Landscaping Within Virginia Mason's Boundaries

SMC 23.45.524 sets out the landscaping standards for the underlying HR zoning. Landscaping that achieves a Green Factor score of 0.5 or greater, as set forth in Section 23.86.019, is required for any lot with development containing more than one dwelling unit in HR zones. Virginia Mason would comply with this standard should housing be included in a future development within the MIO boundary.

The southern half of the 1000 Madison block is zoned NC-3. SMC 23.47A.016 sets out the landscaping standards for the underlying NC zoning. Landscaping that achieves a Green Factor score of 0.3 or greater, as set forth in Section 23.86.019, is required for any lot with development containing more than four dwelling units, development containing more than 4,000 square feet of new nonresidential use, or any parking lot containing more than 20 new parking spaces in NC zones. Virginia Mason is proposing to comply with the requirements for landscaping and pedestrian-designated street frontages, including limits on blank facades and the inclusion of street level uses.

Within the Virginia Mason boundaries, existing landscaping is located in planting areas adjacent to existing buildings, in the courtyard entrance to the Cassel Crag Building, and within the landscaped open space area adjacent to the Pigott Corridor. The landscaping includes a variety of shrubs, Pacific Northwest varieties such as azaleas, rhododendrons, roses, and other planting material.

Virginia Mason has just completed, via a partnership with Horizon House and Seattle Parks, a plan to reinvigorate and make safety improvements to the Pigott Corridor as recommended in the "New Vision for Freeway Park" (Project for Public Spaces, January 2005) and will participate as appropriate in plans

to improve and maintain the public amenity. Virginia Mason continues to jointly maintain the landscaping with Horizon House under an agreement with the City of Seattle Parks Department.

Virginia Mason is embarking upon a multiyear project to significantly upgrade its landscaping. The planning for these improvements is occurring in collaboration with regionally respected landscape architects and designers. Virginia Mason's goals are to create green spaces that use native noninvasive plants, reduce water and fertilizer consumption, align with good urban landscaping design practices and enliven the urban pedestrian experience. This design will be presented to the CAC for their input as it evolves. In addition to the planned upgrade of existing landscaping, future landscaping will be designed for locations within the building setback areas identified above in Section C.3 and considered for rooftops (green roofs) and building terraces where feasible. Unless designated as usable open space, access landscaped rooftops may be limited to coincide with the building hours of operation and/or due to security policies in effect at the time.

Existing and Proposed Open Space Within Virginia Mason's Boundaries

Virginia Mason's prior Master Plan required a minimum of 1% of the campus be set aside as open space. Based on the existing combined lot area of 308,110 square feet, the required open space would be 3,081 square feet, which can be provided at ground level or on upper level plazas. Virginia Mason exceeded this requirement through its participation in the creation of the Pigott Corridor to Freeway Park and the plaza on the west side of the Lindeman Pavilion. Over 6,000 square feet of the northern end of the BRI parcel contributes to the Pigott Corridor, which is a key route that links First Hill with downtown through Freeway Park. The setback area is defined as "dedicated open space" of the Virginia Mason MIO district and will be protected and preserved. The existing plaza on the west side of the Lindeman Pavilion contributes an additional 3,400 square feet of publicly accessible open space.

In the underlying HR zoning, open space is considered as part of an "amenity area." The HR zoning requires that a minimum of 5% of a structure in residential use shall be set aside as amenity area, defined to include space that provides opportunity for active or passive recreational activity for residents of a development or structure, including landscaped open spaces, decks and balconies, roof gardens, plazas, courtyards, play areas and sport courts. No more than 50% of the amenity area may be enclosed. Parking areas, vehicular access easements, and driveways do not qualify as amenity areas, except that a woonerf may provide a maximum of 50% of the amenity area if the design of the woonerf is approved through a design review process pursuant to Chapter 23.41. "Woonerf" means a common space shared by pedestrians, bicyclists and vehicles, used for vehicular access, in which amenities such as trees, planters, and seating serve to impede vehicular movement and provide opportunities for outdoor use by occupants of abutting structures. A woonerf is intended and designed to prioritize pedestrian movement and safety through features such as pavers and pervious ground surfaces that slow vehicular movement.

Virginia Mason is not proposing structures for residential use. The 5% requirement of the HR zoning for "amenity area" would only apply to residential development were it to occur.

Virginia Mason is proposing that a minimum of 4% of the area of the campus be provided as dedicated open space. This is an amount equal to approximately 16,000 square feet of the expanded MIO district at full build out of proposed Alternate 6b. The open space area includes the retention of the 6,000 square feet of landscaped open space and a new plaza proposed for either the north corner of Ninth

Avenue and Seneca Street or a linear plaza along the east side of University Street when Phase 2 of Lindeman Pavilion is designed and constructed. Virginia Mason will provide a public open space plaza incorporating the existing 3,400 square feet just west of the Lindeman Pavilion with an additional 6,600 square feet for a total area of 10,000 square feet. The exact location and configuration of this space within the larger area shown on Figure 21 will depend upon decisions concerning parking entrances and other factors. Virginia Mason will work with both Horizon House and the Standing Advisory Committee to identify the location, design, and accessibility, of this important open space feature. See Figure 21 on page 51 Existing and Future Landscape/Open Space Plan.

In addition to these identified open space areas, as Virginia Mason develops designs for future buildings, they intend to identify opportunities for other open space plazas and rooftop gardens, but such improvements would be in addition to and beyond meeting the open space development standard of 4% of the campus area.

Virginia Mason will apply Crime Prevention Through Environmental Design (CPTED) principles to the development of its open space and public amenities to enhance the safety and security of the areas.

Existing and Proposed Public Amenities Located Within or Adjacent to Street Rights-of-way

A requirement within both SMC 23.45.524 (HR) and SMC 23.47A.016 (NC) is the provision and retention of street trees. Virginia Mason proposes to comply with those requirements. The existing street tree canopy on Virginia Mason's campus includes a variety of trees of varying ages and in varying degrees of health. Virginia Mason is committed to maintaining mature street trees where possible and replacing trees as needed over time. Virginia Mason intends to maintain the street trees that are healthy and do not pose safety hazards. The institution will replace trees when they are removed and as developments require their relocation. Where rows of trees create an identifiable streetscape, that identity will be maintained where feasible.

As described in Section C.13, Virginia Mason is proposing two pedestrian corridors through the campus, both connecting to the Pigott Corridor and Freeway Park located on the west edge of the Virginia Mason MIO boundaries. The intent of the pedestrian corridors is to provide pedestrian-oriented street-level connections from the First Hill neighborhood through the Virginia Mason campus to downtown Seattle.

One corridor would connect the east end of the Pigott Corridor (at the corner of University Street and Ninth Avenue) with the corner of Madison Street and Boren Avenue. The corridor would extend east along University Street to Terry Avenue, south along Terry Avenue, through a breezeway or other pedestrian connection across the central hospital block, and then continue along Terry Avenue to Madison Street, and then east along Madison Street to the corner of Madison Street and Boren Avenue. The second corridor would connect the east end of the Pigott Corridor along Ninth Avenue to Madison Street. Both pedestrian corridors are shown on Figure 21 on page 51 Existing and Future Landscape/Open Space Plan.

Both Terry Avenue and University Street are classified as "Neighborhood Green Streets." Within these pedestrian corridors, Virginia Mason is proposing wide sidewalks and planting strips created by setting the buildings back ten feet from the property line, street trees and other landscaping, pedestrian-scaled lighting, street furniture, awnings or other forms of weather protection, special paving, art and wayfinding (signage). Curb bulbs will be provided where there is on-street parking. While driveways are

not encouraged along Neighborhood Green Streets in order to create a continuous sidewalk, it may not be possible to avoid driveways on Terry Avenue and Ninth Avenue due to limitations on other street frontages. Where driveways are necessary, they will be designed to minimize impacts to pedestrians to the extent feasible. The corridor amenities would be provided along street frontages with new project development, or when opportunities arise with existing landscape or sidewalk replacement.

In addition, Virginia Mason proposes to improve other streetscapes, including along Seneca Street, Spring Street and Ninth Avenue, with street trees and other pedestrian amenities when adjacent property redevelopments occur.

All open space and public amenity improvements will be designed to accommodate the special user needs of the physically frail, medically challenged/handicapped, elderly and less mobile populations. Features will seek to reduce barriers and make the amenities truly accessible and usable to all, including application of ADA requirements, whichever version is current at the time of development.

10. Loading and Service Facilities

Seattle Municipal Code 23.54.035 describes the required number of loading berths based on the size of a facility and its demand. Hospitals are considered to be “high demand” uses (see Table 23.54.035A), whereas medical services and offices are considered to be “low demand” uses. At full 3 million square feet build out of the proposed MIMP (Alternative 6b), the Land Use Code would require more than 22 loading berths of 35 to 55 feet in length unless the requirement is waived or modified.

Virginia Mason currently has four loading areas: (1) a loading dock at the hospital on the south side of Seneca, (2) Lindeman Pavilion, (3) Spring Street and (4) BRI. There are four berths at the loading dock on Seneca, and two of them are used for a compactor and a dumpster, respectively. The loading dock at Lindeman Pavilion has two truck bays, which are limited in length and can accommodate trucks up to 30 feet in length. The Spring Street dock is used for food delivery and can accommodate one truck. The loading dock serving the BRI is on Seneca Street adjacent to the garage access. It can accommodate one truck.

Virginia Mason has engaged in numerous studies and improvement events to streamline and maximize the flows of delivery of materials across its docks. These “Lean” events using VMPS have significantly reduced batching of large deliveries of materials, employing Just In Time delivery principles and contracts with key supplier partners to optimize the number of docking berths needed to supply the campus. The existing docks are sufficient to meet the current campus demand, and additional improvements in materials flow and waste management may reduce this demand even further.

The Director of DPD can waive or modify loading berth requirements during specific project reviews when multiple buildings share a central loading facility, the loading is proposed to occur on site, and goods can be distributed to other buildings on site without disrupting pedestrian circulation or traffic. As provided for in SMC 23.54.035, a modification to loading berth requirements and space standards is requested by Virginia Mason. Multiple campus buildings share common central loading/supply/waste facilities. Virginia Mason is proposing that these be intertied with below-grade service/tunnel connections for efficient distribution and delivery to point of use.

Materials management and physical plant activity for hospitals require 24-hour operation. The Land Use Code-required number of berths may not apply due to the extended operations and efficiently scheduled distribution of activity. The VMPS prepackaging of regularly used "kits" eliminates multiple vendor deliveries of separate items and reduces on-site materials handling. Other exceptions for width, length and clearance of loading berths may be required because of the unique medical facility operations and the types of vehicles providing service.

Installing additional loading berths would not be required until new projects are designed and permit applications are submitted. Loading and unloading for businesses on the 1000 Madison block will occur from an internal loading dock, and not from any adjacent street. With each project, an analysis of loading needs will be performed, including potential traffic impacts, and the location and number of loading berths required to adequately serve that building's uses. If appropriate, a waiver request will be made for a specified number of berths. It would be at the discretion of the DPD director, in consultation with the director of the Seattle Department of Transportation, as to whether the waiver would be granted.

11. Preservation of Historic Structures

The existing Virginia Mason campus is composed predominantly of buildings that are more than 25 years in age, and that therefore will be reviewed for landmark status under current statutes (see SMC 25.12.350 Standards for Designation). Should these change during the period of the MIMP, Virginia Mason will comply with current requirements at the time of development.

An object, site or improvement which is more than twenty-five (25) years old may be designated for preservation as a landmark site or landmark if it has significant character, interest or value as part of the development, heritage or cultural characteristics of the city, state, or nation, if it has integrity or the ability to convey its significance, and if it falls into one (1) of the following categories:

A. It is the location of, or is associated in a significant way with, an historic event with a significant effect upon the community, city, state, or nation; or

B. It is associated in a significant way with the life of a person important in the history of the city, state, or nation; or

C. It is associated in a significant way with a significant aspect of the cultural, political, or economic heritage of the community, city, state or nation; or

D. It embodies the distinctive visible characteristics of an architectural style, or period, or of a method of construction; or

E. It is an outstanding work of a designer or builder; or

F. Because of its prominence of spatial location, contrasts of siting, age, or scale, it is an easily identifiable visual feature of its neighborhood or the City and contributes to the distinctive quality or identity of such neighborhood or the City.

The Baroness Apartment Hotel (1930) was nominated and the exterior of the building is now designated

a Seattle landmark as of December 7, 2010, per the City of Seattle website showing the ordinance's signature date by the Mayor (Ordinance No. 123487). The nearby Cassel Crag Apartments (1925), Chasselton Court Apartments (1925) and the Rhododendron Restaurant/Inn at Virginia Mason (1928) were also nominated to determine their status but were determined to not be landmarks on February 6, 2008, August 19, 2009, and October 7, 2009, respectively. The following adopted controls and incentives apply only to the Baroness Apartments.

Controls

The following controls are imposed on the features and characteristics of the Baroness Apartment Hotel that were designated by the Board for preservation: the owner must obtain a Certificate of Approval issued by the Board pursuant to SMC chapter 25.12, or the time for denying a Certificate of Approval must have expired, before the owner may make alterations or significant changes to the following specific features or characteristics: the exterior of the building.

No Certificate of Approval or approval by the City Historic Preservation Officer (CHPO) is required for the following: Any in-kind maintenance or repairs to the exterior of the building; and the installation of exterior security lighting, video cameras and security system equipment.

CHPO review is available for the following: the addition or elimination of duct conduits, HVAC vents, grilles, fire escapes, pipes, and other similar wiring or mechanical elements necessary for the normal operation of the building; signage; exterior painting; installation of exterior light fixtures not already excluded from the Certificate of Approval process; and alterations to the canopies on the south elevation.

The historic facades of the Baroness would be retained per City Ordinance requirements. Virginia Mason is proposing to set new development away from the Baroness by a minimum of 20 feet on the east side and 40 feet on the south side, with additional setbacks proposed for upper levels of the new development. The alley facade or the southeast side of the south facade, may offer opportunities to add pedestrian entrances to provide access between the Baroness and the new structure on the 1000 Madison block, subject to the controls of the historic designation. Any proposal to make a connection or modification to the building would be subject to approval by the Landmarks Board.

The Baroness Hotel provides a significant benefit to Virginia Mason patients and is currently aligned with the hospital's business interests. If, in the future, conditions change that alter this relationship, Virginia Mason may replace the use with other functions.

12. View Corridors

For view impact analysis in Seattle, five considerations apply pertaining to impacts on City-designated viewpoints and parks, designated scenic routes, designated downtown view corridors, designated Space Needle viewpoints and views of historic structures.

Development associated with Virginia Mason Medical Center's proposed MIMP would not affect territorial views from designated viewpoints or parks with the exception of potential impacts to views from First Hill Park - a small park, located on the southeast corner of Minor Avenue and University Street one block east of the MIO - that provides corridor views along Minor Avenue toward Lake Union and corridor views

along University Street of the downtown skyline and Elliott Bay.

There are two designated scenic routes in the vicinity of the Virginia Mason Medical Center campus - Boren Avenue and Interstate 5. Boren Avenue affords views looking north toward Lake Union and west toward Elliott Bay. Proposed development on the 1000 Madison block would not extend into the Boren Avenue right-of-way, nor would it affect northerly views. The north and south facades of the future buildings are proposed to be set back from the property lines by 7 to 10 feet at ground level (depending on location) and 20 feet above a height of 45 feet. No building facades would extend into the westerly view corridors from Boren Avenue. There is an existing skybridge across Seneca Street and additional skybridges are proposed to connect future development. The EIS includes visual simulations of the potential skybridges. With each future skybridge permit application, a more detailed analysis of whether Elliott Bay views from Boren would be diminished and mitigation measures proposed if needed such as increasing the transparency, increasing the height above the street, or moving the location farther up or down the hillside. Interstate 5's view corridor looks west and south. Virginia Mason Medical Center's campus is located to the east of this route.

Resolution No. 30297 (adopted in 2001) addresses the City's Street Vacation Policies and identifies certain downtown street rights-of-way in which westerly views are to be protected. While all the identified view corridors are located west of Interstate 5, the importance of these viewing corridors is also a consideration for development east of Interstate 5. Proximate to the Virginia Mason Medical Center campus, four streets are designated view corridors west of Interstate 5: University, Seneca, Spring and Madison Streets. To preserve and enhance westerly views from Boren through the Virginia Mason campus, Virginia Mason is proposing to comply with or exceed the underlying HR and NC-3 building setback requirements along the streets of Madison, Spring, Seneca and University east of Terry Avenue (see Figures 10 through 18 and Tables 5 through 12 on pages 36 through 45 for setback information on a block-by-block basis).

There are 10 designated viewpoints associated with the Space Needle. Only one of the viewpoints, however, is located on Capitol Hill - Volunteer Park, which is approximately 1.25 miles north of the Virginia Mason Medical Center campus. As such, Virginia Mason Medical Center is outside the designated view corridors from Volunteer Park to the Space Needle.

Preliminary analysis indicates that there are four designated landmark structures in the general vicinity of Virginia Mason Medical Center's existing campus: the Baroness Apartment Hotel, the Sorrento Hotel, the Dearborn House and the Stimson Green Mansion. Both the Dearborn House and the Stimson Green Mansion are located on Minor Avenue roughly one block east of the Virginia Mason Medical Center campus. As such, views of these two buildings would not be affected by development alternatives associated with Virginia Mason Medical Center's proposed MIMP. New development on the 1000 Madison block is proposed to be set back from the Baroness Hotel (20 feet on the east side and 40 feet on the south side) and set back from the abutting streets by a minimum of 10 feet with additional setbacks proposed at upper building levels. Street level views of the Baroness and the Sorrento Hotel would not be affected. However, existing upper-level views of the Baroness and the Sorrento Hotel over the existing one-story development could be affected by the proposed MIMP development.

The Final Environmental Impact Statement (FEIS) includes an analysis of potential impacts on the identified views.

13. Pedestrian and Bicycle Circulation Within and Through the Campus

The conditions of the bicycle and pedestrian facilities in the vicinity of the Virginia Mason Campus are well-documented in the Seattle Pedestrian Master Plan of 2009 and the 2007 Seattle Bicycle Master Plan. The Master Plan addresses its compliance with these plans in Appendix C to this MIMP.

The First Hill Neighborhood Plan identifies "Key Pedestrian Streets" in the vicinity of Virginia Mason as shown on Figure 1 on page 4. Within Virginia Mason's existing and proposed expanded boundaries, University, Seneca and Madison Streets are shown as providing east-west pedestrian connections, and Ninth Avenue provides a north-south connection from the Pigott Corridor to Madison Street. Terry Avenue also extends through the Virginia Mason central hospital as a public pedestrian pathway know as the Breezeway, connecting the Pigott Corridor to the Madison Street commercial corridor. The City of Seattle's Blue Ring Center City Open Space Plan also identifies Eighth Avenue to serve as a First Hill pedestrian connector.

First Hill is divided from the downtown core by Interstate 5. The few connections across Interstate 5 include the Pigott Corridor/Freeway Park; overpasses on Pike, Seneca, Spring and Madison Streets; and underpasses farther south connecting with Cherry and James Streets, and to Boren Avenue to the north. Traffic entering the community from Interstate 5 or the downtown is channeled to these few paths, creating local congestion. With the exception of Freeway Park, the connections are uncomfortable places for pedestrians and need enhancing to improve the pedestrian linkages to downtown and to overcome their psychological sense of separation.

Bicyclists are required to walk their bikes when using the Pigott Corridor. The Seattle Bicycle Plan identifies the need for improvements for bicyclists on Seneca and Spring Street within the boundaries of the Virginia Mason MIO, including the placement of sharrow markings. Sharrow markings have recently been applied to Spring Street. The extreme elevation change along Spring Street east of Ninth Avenue limits its usefulness for bicyclists traveling in an easterly direction through the campus boundaries.

To the north, east and south the steep slopes of the hill interrupt the pattern of the street grid, offering challenging transitions for pedestrian and bicycle access, and constricting arterial traffic to Boren and Broadway Avenues and Yesler Way. The Seattle University campus creates a porous transitional edge on the west side of its campus where the street grid intersects Broadway, and some streets are replaced with pedestrian pathways through its campus.

To improve connections for pedestrians, Virginia Mason is proposing to strengthen existing pedestrian connections at street level through the campus with focus on two pedestrian corridors between the corner of the Pigott Corridor at the corner of University/Ninth Avenue and Madison/Boren, and between the Pigott Corridor along Ninth Avenue to Madison Street as shown in Figure 21 on page 51. As individual blocks or frontages develop along any of the streets within the MIO, any pedestrian facilities (sidewalk plus planting strips) that do not meet established city standards that exist at the time of redevelopment will be brought up to those standards. An evaluation of accessibility will be performed as part of this analysis and measures included for ADA accessibility where feasible.

One pedestrian corridor would extend from the east end of the Pigott Corridor west to east along University, north to south along Terry to Madison (through an interior connection in the redeveloped central block, similar to the current breezeway, and then east along the face of Madison to Boren. A second pedestrian corridor would be north-south along Ninth Avenue between the east end of the Pigott Corridor and Madison Street.

The Breezeway (pedestrian corridor) between Seneca and Spring Streets is open 24 hours per day, 7 days a week, 365 days per year at Terry Avenue, per "Covenant with Respect to Pedestrian Pass-Through and Walkway" referenced in the Terry Avenue Street Vacation Ordinance (Ordinance 101874). Other future internal passages will be subject to the hours of operation of the buildings in which they are located. The other pedestrian corridors shown on the map are exterior and located on public sidewalks not subject to hours of closure.

The intent of the pedestrian corridors is to provide pedestrian-oriented street-level connections from the First Hill neighborhood through the Virginia Mason campus to downtown Seattle. Within these proposed pedestrian corridors, Virginia Mason is proposing street trees and other landscaping, pedestrian-oriented lighting, street furniture, special paving, art and wayfinding (signage).

Virginia Mason offers a combination of amenities for bicyclists. For the public, there are bicycle racks at each major entrance.

Virginia Mason's existing and proposed Transportation Management Plans include the following measures to support bicycle use among its staff:

- Locked bike cages with weather protection located in three of the parking garages on campus
- A minimum capacity of 75 bicycle parking spaces
- Shower facilities and lockers in multiple locations on campus and in each major building for staff who commute by bicycle
- Support for the Virginia Mason Bicycle Club to improve bike storage, security, shower facilities, and benefits for frequent riders and to encourage ridership.

As each new building is added, the need for additional bicycle amenities and bicycle access will be considered as part of the programming effort.

14. Transit Access

Virginia Mason is served by a variety of transit options. Buses traveling along Madison Street, Seneca Street, Ninth Avenue and Boren Avenue provide links to downtown, Seattle neighborhoods and suburban cities. The transit stops within or adjacent to Virginia Mason's property are shown on Figure 22 on page 61. Virginia Mason intends to work with Metro Transit to identify ways in which Virginia Mason could improve landscaping, lighting, wayfinding or other pedestrian-scale amenities around the bus stops within the boundaries of Virginia Mason property to enhance the transit rider's experience. These improvements would be implemented as street frontages are redeveloped, or as routine landscaping or sidewalk maintenance is performed.

Madison Street is identified in SDOT's Right of Way Manual as a "Major Transit Street." To provide for high pedestrian volumes, Virginia Mason is proposing to set the building back 10 feet from the property line. Combined with the existing 8.5-foot sidewalk, this will create a new 18.5-wide space between the building face and the curb. As described on page 54 in "Existing and Proposed Public Amenities Located Within or Adjacent to Street Rights-of-way", Virginia Mason is proposing to include street trees, landscaping, pedestrian-scaled lighting, street furniture, awnings or other forms of weather protection, special paving, art and wayfinding. Bike parking will be provided at major building entrances. Virginia Mason is proposing to vacate the alley on the 1000 Madison block and to locate driveway access on Terry Avenue and Spring Street. This would eliminate vehicular crossings of the sidewalk at mid-block.

A streetcar line is under construction along Broadway connecting the light rail station on Capitol Hill near Seattle Central Community College on the north end to the Yesler Terrace/International District on the south end with downtown Seattle. The nearest stop to Virginia Mason would be at Broadway Avenue and Marion Street, approximately four blocks southeast of Virginia Mason. A Bus Rapid Transit line is proposed on Madison Street, which was identified as a high-priority transit corridor in the City of Seattle's recently adopted 2012 Seattle Department of Transportation Transit Master Plan.

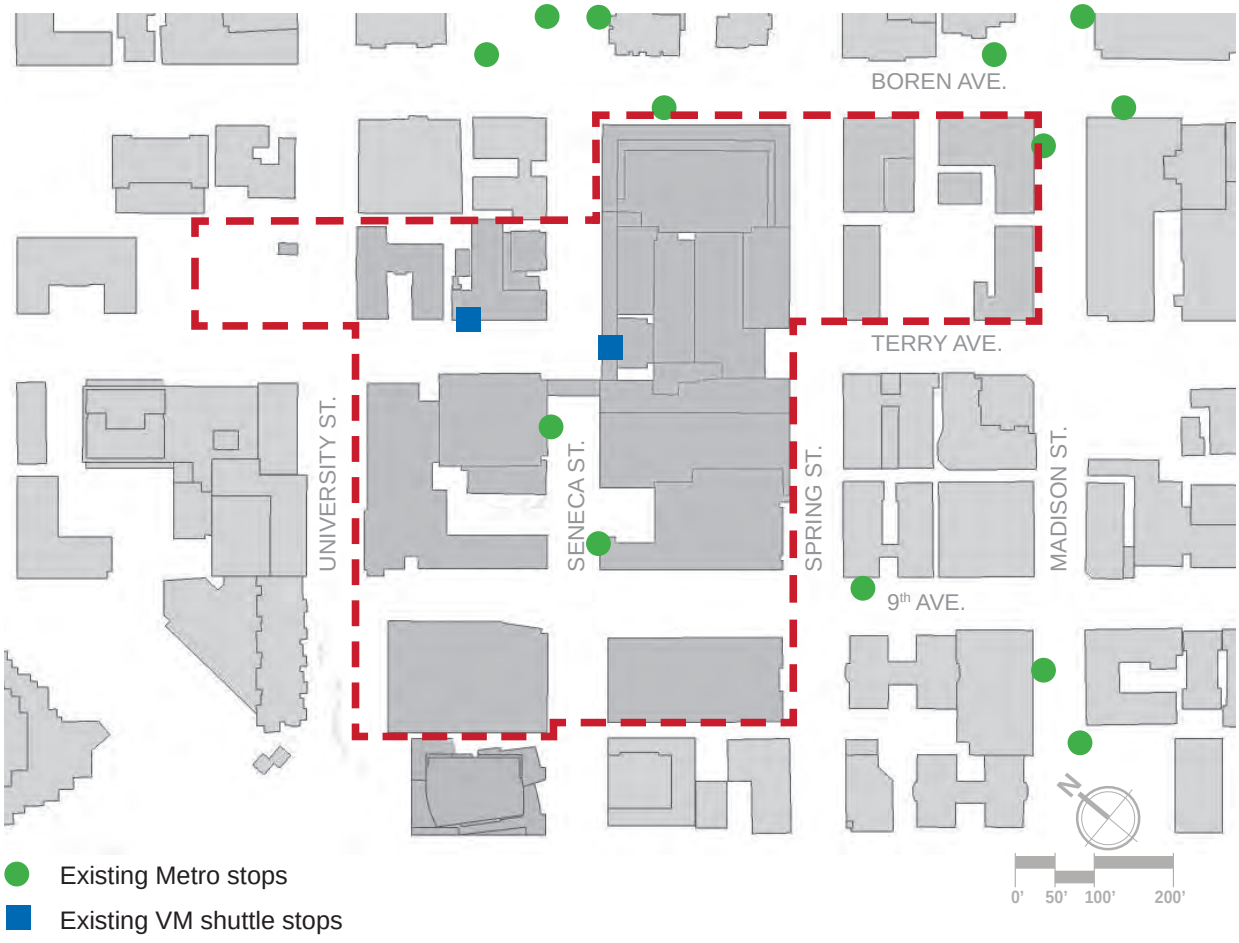


Figure 22 Existing Metro Bus and Virginia Mason Shuttle Bus Stop Locations

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D. DEVELOPMENT PROGRAM

1. MIMP Alternatives

Virginia Mason has evaluated several configurations of how to potentially distribute the area needed for its future growth on the First Hill campus with its Citizens Advisory Committee (CAC) and neighbors, and has held a workshop to set the criteria and preferences for how to best manage its growth, while balancing its needs with the needs of the neighborhood.

The preferred option, Alternative 6b, is now being carried forward in this Master Plan. This option proposes to expand Virginia Mason's MIO boundaries to include the 1000 Madison block, located to the south of the campus and bordered by Boren and Terry Avenues on the east and west, and Spring and Madison Streets on the north and south. The CAC's preference was to shift the area toward the Madison Street commercial corridor and to have increased setbacks and improved pedestrian-focused streetscapes throughout the campus.

The 1992 MIMP provided for an open space at the northeast corner of Ninth Avenue and Seneca Street. The CAC preferred to shift this to the north and extend Freeway Park and the Pigott Corridor. Two potential configurations of this open space are shown - one concentrating it at the intersection of University Street and Ninth Avenue, and one widening the setback along Ninth Avenue. Both of these options are proposed to be carried forward into the Final Master Plan as an allowance for open space on this block, with the final configuration to be developed at the time the block is developed with community input.

The proposed MIO boundaries and MIO height districts are shown on Figure 20 on page 47 in Section C.5. The Land Use Code stipulates that the Major Institution will prepare a Major Institution Overlay and then condition down to its proposed heights where applicable. Therefore, the Major Institution Overlay is to be 240 feet, with specific conditions set as shown for each site. Figure 23 on page 64 shows the proposed heights of existing, planned and potential development. Where heights shown in Figure 23 are less than 240 feet, they are proposed to be conditioned down to the heights shown.

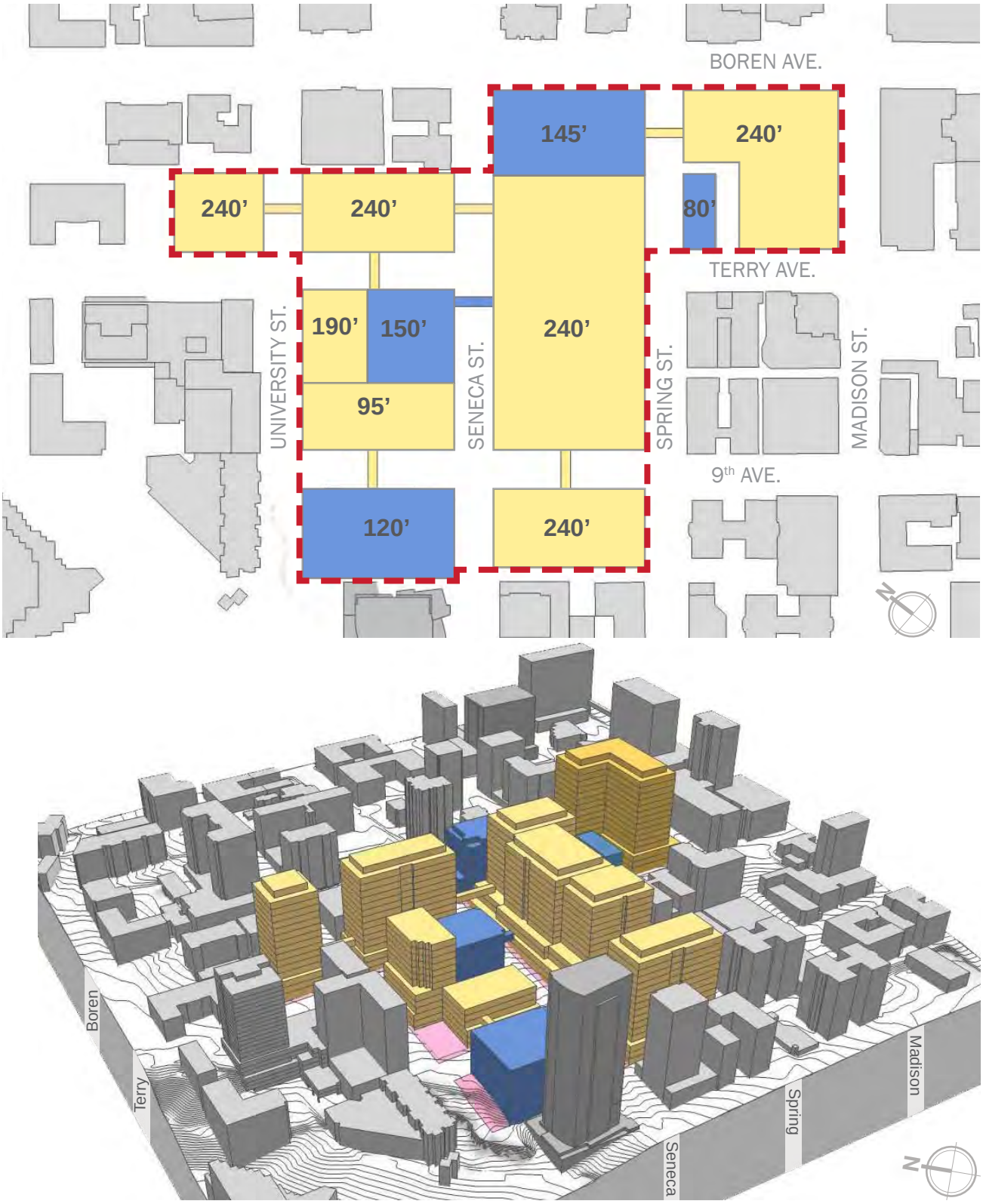


Figure 23 Alternative 6b – Proposed Building Heights

The amount of building area is described under development density as floor area ratio (FAR). Alternative 6b would include approximately 3 million square feet at full build out and would result in an FAR of 8.1. The Master Plan is proposing that this FAR is a campus FAR, with the setbacks describing the maximum allowable building envelope proposed on any site.

The Seattle Land Use Code defines gross floor area (GFA) to mean the number of square feet of total floor area bordered by the inside surface of the exterior wall of the structure as measured at the floor line. Areas that are entirely below existing grade and above and below-grade parking are typically excluded from the calculation of GFA for Major Institutions. Please refer to page 47, Section C.6 for what is included and excluded.

The total above-ground building area of the existing Virginia Mason buildings measures approximately 1.23 million square feet, as measured to the outside surface of the exterior wall. Existing development on the 1000 Madison block contains approximately 95,370 square feet, also measured to the outside surface of the exterior wall. Together with the Virginia Mason-owned 1000 Madison block, the existing development totals approximately 1.32 million square feet.

Virginia Mason refined the alternates considered to two alternatives that are carried forward into the Environmental Impact Statement:

- Alternative 5a - a City of Seattle-required “no boundary expansion” alternate, which adds approximately 1.7 million square feet, for a total GFA of approximately 3 million
- Alternative 6b - the proposed alternative, which expands the MIO boundary to include 1000 Madison block and adds approximately 1.7 million square feet, for a total GFA of approximately 3 million

One of Virginia Mason’s key goals in updating its Master Plan is to plan for the replacement of the existing hospital inpatient core. The buildings that comprise the core include the original Main Wing, the west additions to it, the East Hospital tower and the numerous small additions to these structures. A careful evaluation of this core area revealed four criteria that drove the development of the Master Plan options:

- The core hospital services include approximately 422,000 SF of area that needs to be contiguous
- This contiguous core hospital area needs to be located as close as possible to the Floyd & Delores Jones Pavilion, which now houses the Emergency Department.
- The existing hospital core areas need to remain fully functional while the replacement hospital is being built.
- An inpatient bed floor requires approximately 22,000 SF for optimum efficiency.

There are no sites on the existing Virginia Mason campus large enough to accommodate all four criteria. Alternative 5a was explored as a no boundary expansion way to enlarge the needed footprint by bridging over Terry Avenue to connect the Lindeman and Cassel Crag/Blackford Hall sites to create enough contiguous area to replace the core hospital functions. It would require building up to 300 feet in height on the central hospital block and would require more intense development on the Lindeman block than the previous Master Plan allowed with a potential 9.74 FAR.

This solution was not preferred by the CAC or Virginia Mason. A comparison of the features and potential environmental impacts of Alternative 5a with Alternative 6b is provided in the Final EIS.

Alternative 6b – Boundary Expansion to 1000 Madison, Develop to MIO 240'

Alternative 6b would:

- Expand the existing campus MIO boundaries to include the 1000 Madison block.
- Correct the MIO district boundary map to accurately reflect Virginia Mason property ownership by moving the boundary 20 feet to the north. See Appendix A.
- Maintain the MIO district heights at the existing MIO-240 and place a MIO-240 on the 1000 Madison block as shown on Table 13 in Section C.5 on page 48.
- Further condition heights below the MIO height districts as shown on Figure 23 on page 64 for the Jones Pavilion (145 feet), BRI (120 feet), and Lindeman block per the Horizon House Agreement, as adjusted to reflect the changed open space location.
- Maintain the historic-designated features of the Baroness Hotel.
- Demolish the Chasselton Court Apartments and existing retail on the 1000 Madison block for redevelopment into medical and retail use.
- Demolish and replace the hospital buildings except for the Floyd & Delores Jones Pavilion.
- Demolish the Health Resources Building and Buck Pavilion buildings, and expand the Lindeman Pavilion.
- Demolish and redevelop the site of Cassel Crag, Blackford Hall and the MRI building.
- Develop the parking lot at University Street and Terry Avenue.
- Demolish and redevelop the Ninth Avenue Garage with major medical or medical research use.
- Vacate the alley on the 1000 Madison block to enable new development to be placed midblock for efficient use of space and reduction in potential massing at the edges of the block.
- Connect new development with tunnels and skybridges as shown in Figure 29 on page 77.
- Add approximately 1.7 million square feet.
- Result in a total GFA of approximately 3 million.

Alternative 6b, because it includes the expansion to the 1000 Madison block, would likely create more intense development on the south and east sides of the campus and lessen the intensity of development on the north and west sides of the campus. Alternative 6b is illustrated in Figure 23 on page 64.

Section Views of Alternative 6b

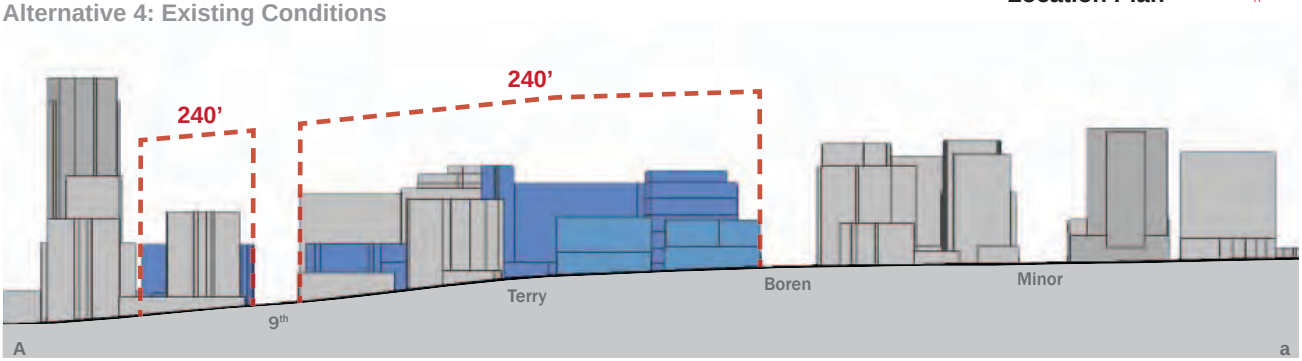
On the following pages, Figures 24 and 25 on pages 67 and 68 provide the height of Alternative 6b when viewed in section. Figure 24 shows the heights of proposed Alternative 6b development when viewed from Madison Street, looking north.

Figure 25 shows the potential heights of the proposed Alternative 6b development when viewed from Boren Avenue, looking west. Theoretical Virginia Mason massing is illustrated in context with potential maximum heights of adjacent neighboring properties (shown in grey).

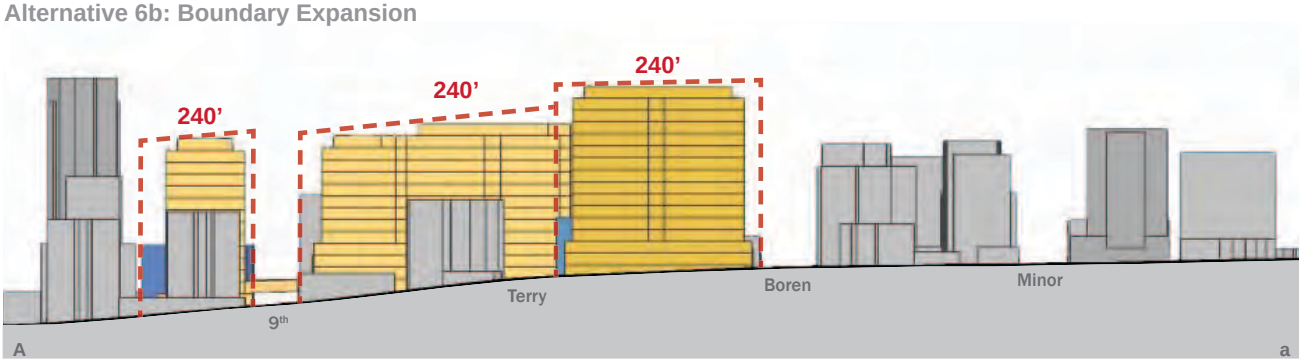
The heights shown in these sections are relative to the individual buildings noted from street to top of building and take into consideration the slope of the hill.

Location Plan

Alternative 4: Existing Conditions



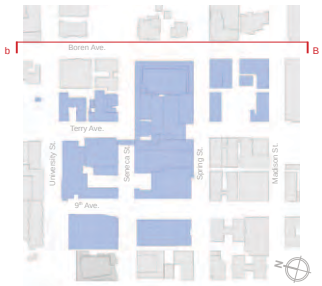
Alternative 6b: Boundary Expansion



Existing buildings VM theoretical massing Maximum MIO height

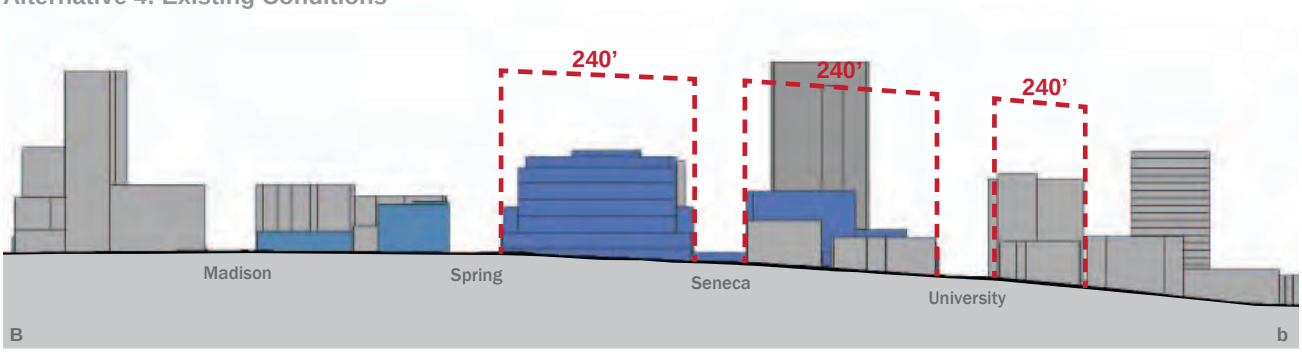
(Note: Height measurements taken at designated development site locations.)

Figure 24 – Comparative Sections, Madison Street Looking North

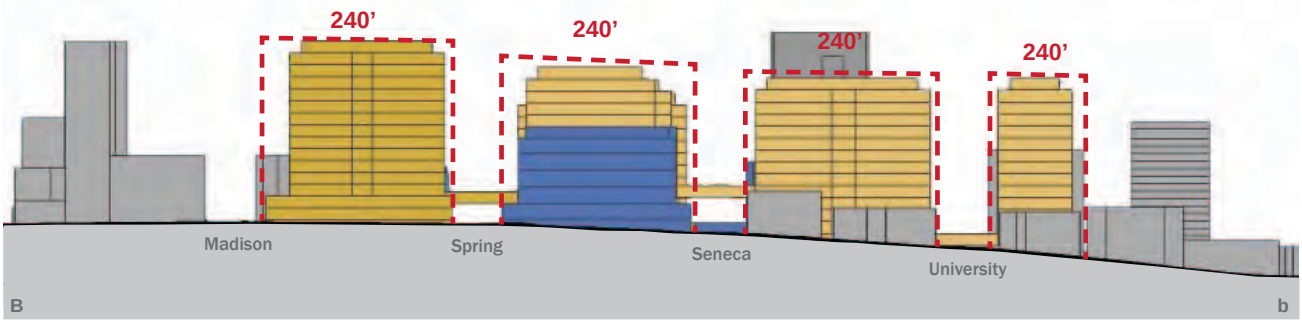


Location Plan

Alternative 4: Existing Conditions



Alternative 6b: Boundary Expansion



Existing buildings | VM theoretical massing | Maximum MIO height

(Note: Height measurements taken at designated development site locations.)

Figure 25 Comparative Sections, Boren Avenue Looking West

2. Density, Development Capacity and Floor Area Ratio (FAR)

The 1992 MIMP allowed development to 1.66 million square feet, or an effective FAR of 4.3 across the 7.07-acre campus. Alternative 6b proposes the addition of the 1000 Madison block, so the land basis would become 369,550 or 8.48 acres, including the alley. The development total and corresponding FAR for Alternative 6b is listed in Table 14 below.

Table 14 Development Capacity and FAR

	Land Basis	Total Gross Square Feet (GSF)	Floor Area Ratio (FAR)
Existing Development	308,110 GSF 7.07 acres	1.23 million existing	3.99 existing 4.3 allowed by expired MIMP
Underlying NC3-160 zoning (applies only to south half of 1000 Madison block)			Maximum of 5 for single use
Underlying HR zoning (applies to entire campus with the exception of south half of 1000 Madison block)			Base of 7 – 8 depending on lot size Maximum of 13 for structures 240' or less in height; 14 for structures over 240' with provision of incentives
Alternative 6b	369,550 GSF 8.48 acres	3.0 million proposed	8.1 proposed

The development program building area that is defined for the entire Virginia Mason campus MIO district may be located or transferred to any on-campus site as long as all applicable development standards are satisfied. Total development capacity and FAR applies to the entire MIO district and not to individual land parcels or sub-areas (SMC 23.69.030 E2). No differences in impact would occur since the maximum building envelope "worst case" condition was evaluated in the Final EIS, and appropriate mitigation was identified. There are no project area limitations or use or function restrictions by individual site other than the height limits and setbacks prescribed by each alternative and analyzed in the Final EIS.

Please see Section C.6 on page 49 for a discussion regarding space that is exempt from gross floor area calculations.

3. Maximum Number of Allowed Parking Spaces

Virginia Mason today provides approximately 1,426 parking spaces, including 884 spaces on campus, 175 spaces at Tate Mason, 60 spaces on the Virginia Mason-owned 1000 Madison block and 307 spaces that are leased from nearby property owners. The number of leased spaces fluctuates over time based on the availability of parking from neighboring parking garages. Three hundred seven spaces (307) was the count in 2010. A significant percentage of Virginia Mason patients and visitors arrive at the campus by using public transit or walking. As shown on Table 16 on page 97 in Section E.1, the existing number of parking spaces is below the Land Use Code minimum for major institutions of 1,667 spaces.

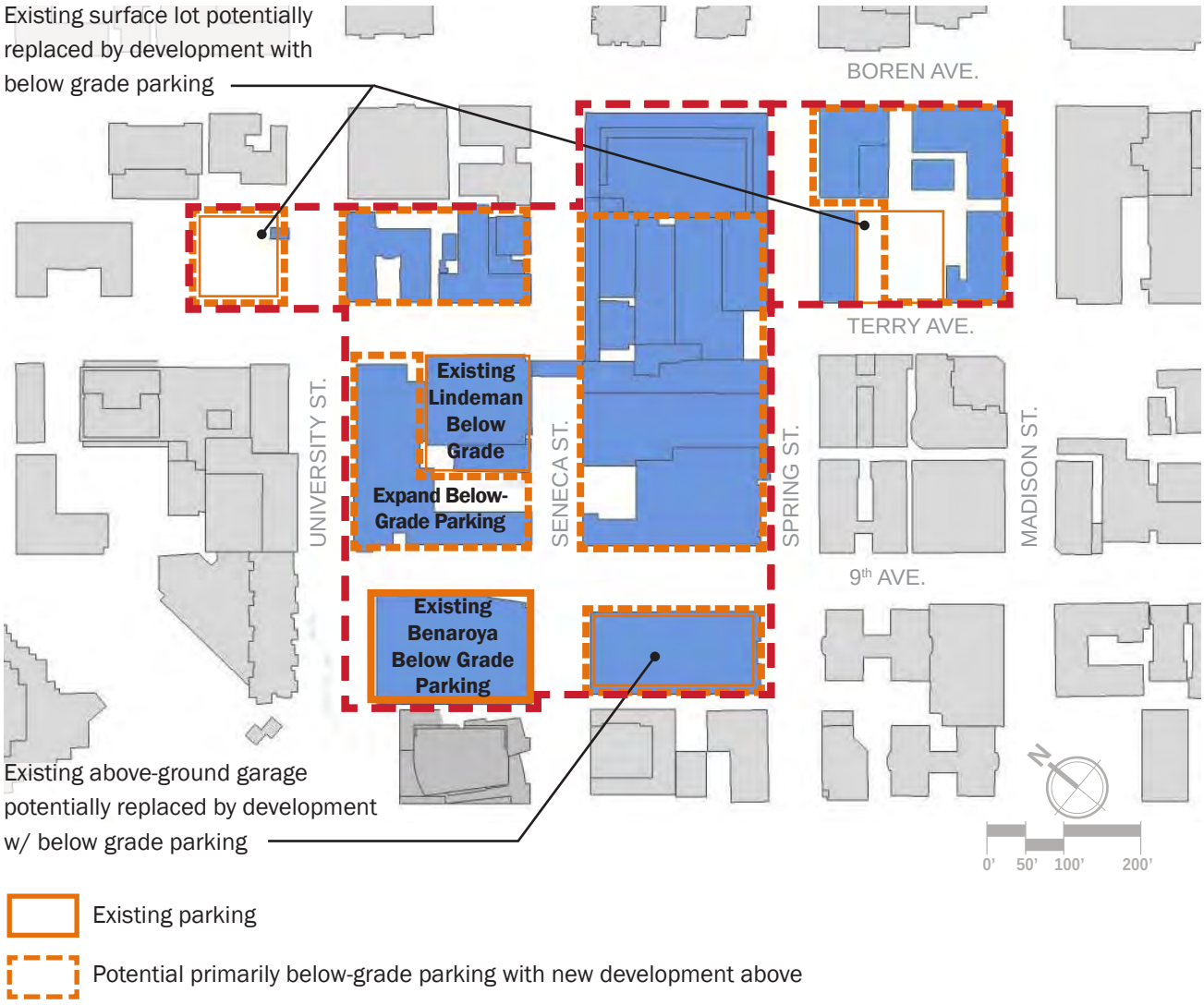


Figure 26 Existing and Planned Parking Areas

Existing and proposed planned campus parking areas are shown on Figure 26 on page 70. In addition, see Section D.5 below and Figure 27 on page 72 for the location of leased parking.

A parking calculation has been performed for Alternative 6b, as shown on Table 17 on page 98 in Section E.1. Based on calculated demand, the estimated number of recommended parking spaces for Alternative 6b is below the Land Use Code maximum allowable parking supply by 41 spaces. These demand numbers are being refined and are anticipated to be reduced, and Virginia Mason is not requesting a modification of the parking standards at this time. As each project is programmed and developed, a separate traffic study will be performed as part of SEPA to revalidate the parking demand, and will adjust the parking needed to reflect then-current conditions, codes and transportation patterns.

4. Existing and Planned Future Development

With regard to future development, the development program component shall describe planned physical development, defined as development that the Major Institution has definite plans to construct. The development program may describe potential physical development or uses for which the Major Institution's plans are less definite. The development program may be amended according to the provisions of Section 23.69.035 without requiring amendment of the development standards component.

At this time, Virginia Mason is proposing "planned development" on the Cassel Crag/Blackford Hall site (medical office and clinic), the Ninth Avenue Parking Garage site (medical research), the Lindeman 2 site (medical office and clinic), and 1000 Madison (hospital). Replacement of the core hospital building and the Terry and University parking lot site (office/medical) may come later, and the exact use will be dependent on future demand. These two sites are considered "potential development."

The range of planned and potential future development including street configuration is illustrated in Figure 23 on page 64. Existing development is shown in Figure 8 on page 23 in Section B.

Figure 21 on page 51 in Section C.9 locates existing landscaping and open space as well as potential areas that would be added with adjacent building construction.

Please see Figure 26 on page 70 illustrating the location of existing and planned parking areas and structures.

5. MIO District Properties and Leased/Owned Properties Within 2,500 Feet

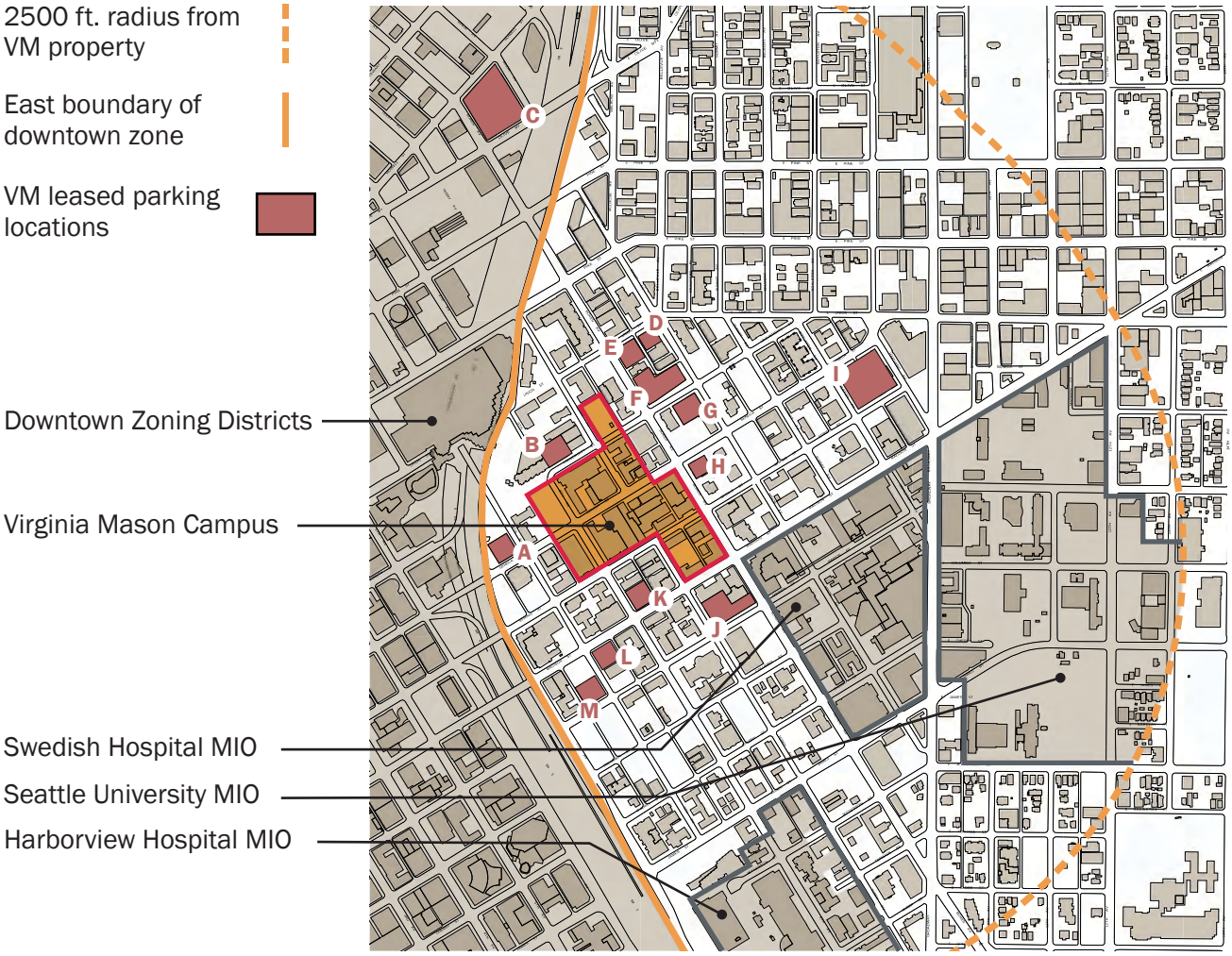
Virginia Mason owns all of the property within its existing MIO boundary and all of the property within both areas proposed for the expansion of the MIO boundaries (a 20-foot portion of Lot 8 of Block 112 and all of the property on the 1000 Madison block).

Virginia Mason leases parking at the following garages: Tate Mason, Avanti Apartments, Cabrini Towers, Cassel Crag, Copperfield, Exeter House, Horizon House, Landes, M Street Garage, Panorama House,

Sorrento Hotel and Stimson Green Mansion, as shown in Figure 27 below.

Metropolitan Park North and West facilities also provide leased space and parking to Virginia Mason. (Metropolitan Park is in a downtown zone. Space leased by a Major Institution in a downtown zone is exempt from the 2,500-foot concerns regarding parking or leasing, per SMC 23.69.022, section C.)

Virginia Mason also leases space from the First Baptist church at 1111 Harvard Avenue for the Bright Horizons Child Care Center, and leases space from Polyclinic for their playground on Spring Street between Boylston Avenue and Harvard Avenue. Bright Horizons runs a day care program for the children of Virginia Mason employees at this location.



VM leased parking sites:

- A Exeter House
- B Horizon House
- C Metropolitan Park
- D Copperfield
- E Avanti Apts.
- F Panorama House
- G Stimson Green
- H Tate Mason
- I First Baptist Church
- J Cabrini Towers
- K Sorrento Roof
- L M Street
- M Landes

Figure 27 Location of Leased Parking

6. Height, Bulk and Form of Existing and Planned Physical Development

Potential project heights are indicated on Figure 23 on page 64 for both planned and potential development.

7. Planned Infrastructure Improvements

There are no planned infrastructure improvements at this time. Existing utilities appear to have the capacity needed to provide services to the campus. However, the adequacy of utilities will also be re-evaluated as part of the SEPA review process for each individual project as it is brought forward.

8. Planned Development Phases and Plans

Planned and potential projects would occur throughout the life of the Master Plan. No Master Plan term is proposed and timing is only an estimate. The planned uses include hospital replacement, clinic replacement, research, infrastructure, parking and other mixed uses related to Virginia Mason's campus functions.

The Virginia Mason MIMP proposal includes multiple projects that may evolve as programming and planning are developed. It is possible that the planned projects could be completed by 2025, and the proposed projects could be completed by 2035.

Phasing of Planned Development

Alternative 6b includes expansion to the 1000 Madison block. There are two major development sequences and some minor projects that may occur with Alternative 6b, with one sequence focused first on replacing hospital space, and the second sequence focused first on replacing clinic space. For these, the planned and potential development sequencing would be as follows and illustrated on Figure 28 on page 74.

Construction of the buildings shown on Figure 28 on the perimeter of the compus (1H-1000 Madison block, 1C-Cassel Crag and Blackford Hall, and possibly the R-Ninth Avenue Garage site and the M-University/Terry Parking Lot site), could potentially begin within the first ten years after adoption of the Master Plan. Development of buildings designated as 2C or 2H would likely occur in the second ten years, and the redevelopment of the central hospital core (3C, 4C and 3H) would occur within the later phase of the Master Plan.

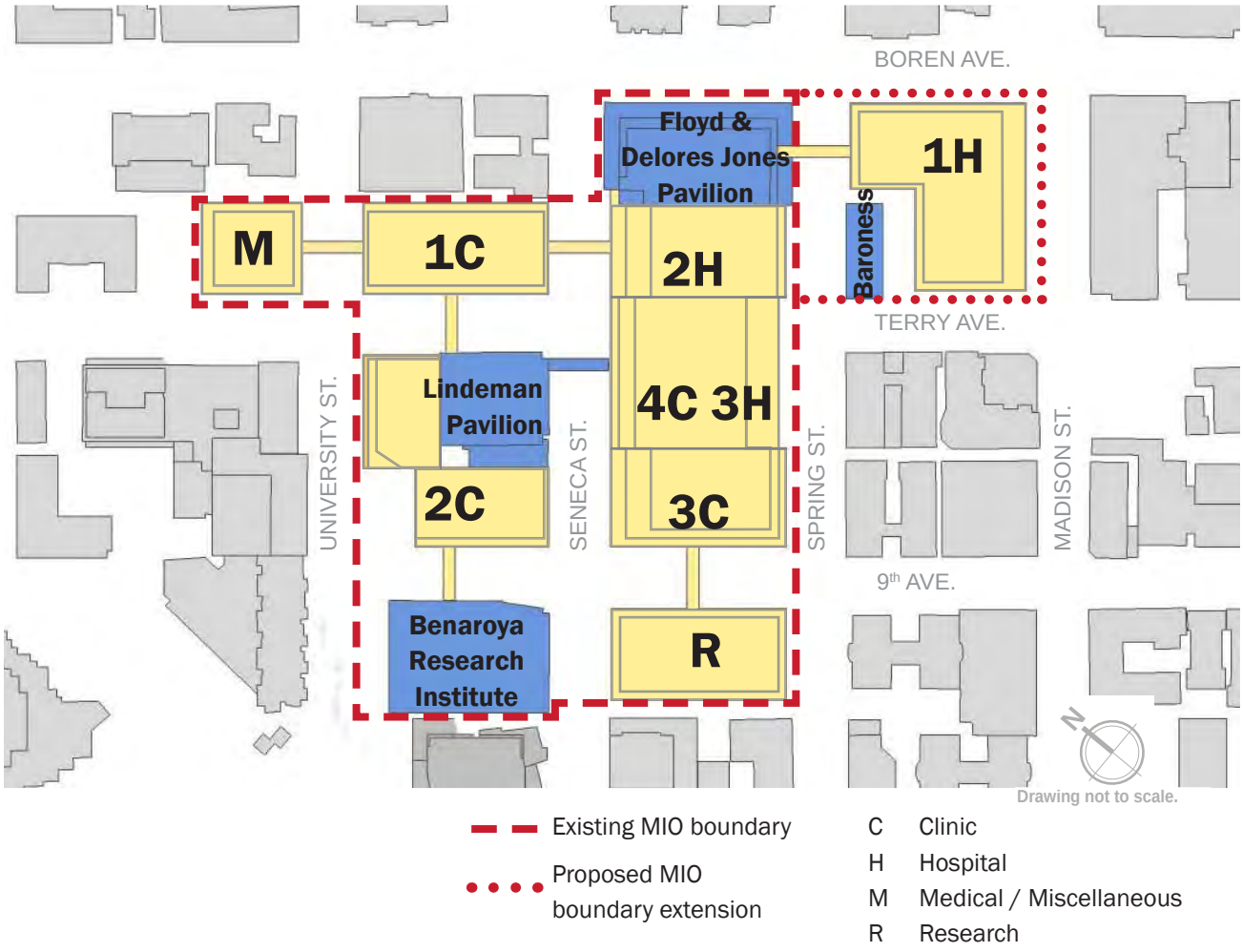


Figure 28 Alternative 6b – Potential Construction Sequences

1. A development sequence focused on replacing hospital space would start on the 1000 Madison block, bordered by Boren and Terry Avenues and Madison and Spring Streets, delineated as "1H" on Figure 28 above.

    - Redevelopment of this block retains the existing Baroness Apartment Hotel at the corner of Terry Avenue and Spring Street.
    - A skybridge and tunnel would connect the block to the new Floyd & Delores Jones Pavilion.
    - The Chasselton Court Apartments would be replaced through housing mitigation, and the retail businesses would be relocated. Development on this site would allow Virginia Mason to move inpatient services from the existing hospital buildings into the new facility so the older structures could be renovated and/or replaced.

2. A development sequence focused on replacing clinic space would start with the redevelopment of the half block between University and Seneca Streets, east of Terry Avenue and south of the alley.

    - Existing functions would be relocated to off-site rental space or within the rest of the First Hill facilities, and the Cassel Crag, Blackford Hall and MRI buildings would be demolished to allow for redevelopment (delineated as "1C" on Figure 28 on page 74).
    - Displaced functions, some clinic growth and parking would be relocated in the new development and consolidated with the medical and office functions currently housed in the Health Resources Building.
    - The Health Resources Building would be demolished to allow the planned project known as the North Pavilion Phase 2 building to occur (delineated as "2C" on Figure 28 on page 74). The Lindeman Pavilion would remain.
    - Tunnels and/or skybridges may connect the new buildings together as shown on Figure 29 on page 77 in Section D.9.
    - Completion of the North Pavilion Phase 2 would create new space for the clinics currently located in the Buck Pavilion, which would relocate into the North Pavilion Phase 2 building.
    - The Buck Pavilion buildings would then be renovated or replaced with additional clinic space (delineated as "3C" on Figure 28).

3. Once sufficient parking has been created, the planned project to redevelop the Ninth Avenue Parking Garage could occur. The project would replace the existing garage with underground parking, add medical research space and medical/office space on top of the garage, and connect to the existing BRI and Buck Pavilion buildings with skybridges and/or tunnels. This development is delineated as "R" on Figure 28.

Phasing of Potential Development Projects

The Terry and University parking lot site and the existing core hospital site are considered "potential development" as their redevelopment will likely occur after the other development takes place.

4. Development of the core hospital block cannot occur until the hospital space is replaced on the 1000 Madison block (see "1H") and the existing clinic space in the Buck Pavilion is moved to the Lindeman Pavilion block (see "2C"). The core hospital block would likely be developed in three phases, beginning either with the demolition and redevelopment of the building immediately west of the Jones Pavilion for hospital use (shown as "2H" on Figure 28 on page 74), or the renovation or replacement of the Buck Pavilion for clinic use (shown as "3C" on Figure 28). The center portion of the block would likely be developed for either hospital or clinic use (depending on the need at that time), or a combination of both. That development is shown as "4C" and "3H" on Figure 28.

5. The block at the intersection of Terry Avenue with University Street also could be developed once sufficient parking has been created. Its use would be dependent on what use may be needed at the time of development. This site is shown as "M" for "Medical/Miscellaneous" on Figure 28.

Maintenance and Minor Projects

Some minor projects are being considered that would slightly alter the total campus area and may occur at any time. Projects to replace the existing Seneca Street entrance and to reconfigure the old existing Emergency Department entrance on Spring Street are being considered.

Lastly, the existing buildings require maintenance, including window replacements and exterior wall repairs, awning and canopy renovations, and other minor modifications that have the potential to alter the measured areas of existing structures. These projects could occur at any time.

9. Planned Alley Vacations, Skybridges and Tunnels

No street vacations are proposed. The 1000 Madison block alley is proposed for vacation. The north-south alley now extends between Spring and Madison Streets. Vacating the alley would enable hospital and mixed use development on that block, as hospital inpatient bed floors require a certain amount of area for efficient operations. A half-block is insufficient to provide enough area.

The vacation of the alley at 1000 Madison is triggered by the development of the 1000 Madison block. The Master Plan has defined massing limits within which a future building could be developed, and setbacks that offer certain opportunities for mitigation. Features that are proposed by this massing and setbacks include:

- An open buffer between the new development and the Baroness Hotel that could serve as an entry and access point for both buildings
- A minimum 15.5' wide sidewalks and landscaping on the Madison and Boren sides of the block, and 10' wide sidewalks and landscaping on the Terry and Spring Street sides, with a sensitive transition to the narrower sidewalk widths in front of the Baroness [9]
- Improved wayfinding throughout the MIO expansion area, consistent with the wayfinding provided elsewhere on campus
- Improved pedestrian lighting, transit stops, bicycle facilities, pedestrian crossings and the opportunity for public art within the MIO expansion area
- Access for the provision of services into the future building from an entirely off-street loading dock facility within the new development
- Development consistent with the Design Guidelines

Since this building is still very conceptual in nature, Virginia Mason is proposing that the details of the development of the site, and the specific public benefits associated with the alley vacation be proposed at the time the detailed design commences, and that the benefits be concentrated on this block. Specific mitigation will need to be negotiated separately from the MIMP approval with the alley vacation process.

[9] The building face would be set back a minimum 15.5 feet from the curb on Madison if the City proceeds with street widening. If the widening does not occur, the distance from the curb to the face of the building would be 18.5 feet. On Boren, the building face would be set back a minimum 15.5 feet from the curb if the City proceeds with street widening. If the widening does not occur, the distance from the curb to the face of the building would be 20 feet.

Virginia Mason is not seeking approval for specific skybridges or tunnels at this time. Skybridges and tunnels will be needed to connect patient and materials circulation between the new and existing Virginia Mason facilities. If deemed needed at the time of new development, Virginia Mason will submit applications for skybridges and/or tunnels in conformance with SMC 15.64 Skybridge Term Permits, SDOT Director's Rule 2-06 Skybridge Permits, Client Assistance Memo 2207 Skybridge Permitting Process and Client Assistance Memo 2207 Term Permit Fee Methodology, or as those documents may be amended or superseded in the future.

The regulatory compliance agencies governing healthcare services hold medical environments and pathways to very high standards, including controlling airflow direction and air changes, prevention of patient exposure to airborne contaminants, and separation of clean and soiled flows of materials and patients. There are

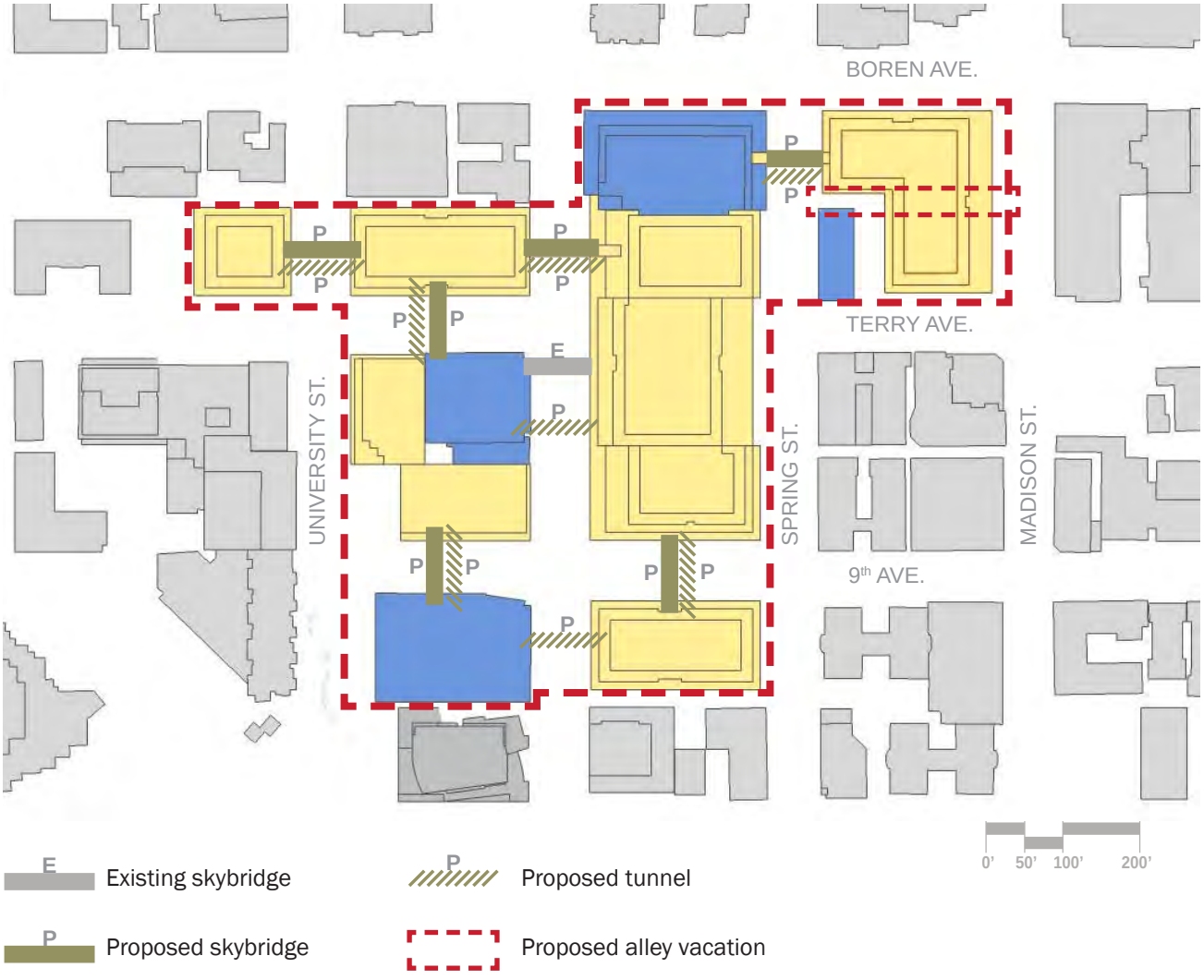


Figure 29 Street and Alley Vacations

numerous codes defining these relationships, including the Washington State Department of Health WACs, the NFPA fire codes, the ASHRAE mechanical system requirements, City of Seattle building codes, and others.

The concept of controlled environment also extends to the various items that potentially could come in contact with the patient, like a medical provider's clothing, medical supplies and equipment. These items also need to be managed to minimize potential contamination from environmental hazards, or the risk of theft or tampering. Numerous regulations, policies, procedures and guidelines govern the flows of medical staff and supplies. This work is grounded in epidemiologic studies and incident investigations that have tracked infections and adverse outcomes back to their source, and once found, have recommended revisions in the environment of care to eliminate the risk.

Some examples of these practices include: Staff who works in Operating Rooms cannot go outside in their surgical attire, or must change their attire prior to re-entering the Operating Room suite to reduce post-surgical infections. Supplies that have been unpacked at the loading dock to prevent their external wrappings from bringing contaminants into the care environment cannot be re-exposed to environmental contaminants by being moved back outside to be transported across a city street or alley. Pharmaceuticals must have a strictly controlled path of delivery from initial receipt to final dosing. Laboratory samples must be appropriately handled and transported to prevent degradation or contamination of the specimens and to provide a rapid diagnosis.

One of the goals of the Master Plan is to improve the environment of care by replacing older buildings that are no longer compliant with current codes or best practices where upgrades are not feasible. Current work-arounds to accommodate these grandfathered environments include transporting inpatients or clean supplies across city streets in ambulances or trucks where no skybridge or tunnel exist, rewrapping or repackaging materials for secondary transport, multiple apparel changes or additional removable layers of protective clothing. Virginia Mason is also relocating higher-acuity services into newer buildings to improve the environment of care and reduce the waste of rework and work-arounds.

Since these codes, policies and practices are continuously being updated, it will be necessary at the point in time that the skybridge or tunnel permits are requested to provide an analysis of the codes in effect as part of the justification.

Many patients have diverse multiple comorbidities.[10] It is not efficient/cost-effective to duplicate all patient care services, like operating rooms, MRIs and Radiologic treatment in every building on every block. This medical building archetype therefore either generates very large contiguous buildings that cover several city blocks (such as UW Medical Center, Harborview, Swedish Cherry Hill and Virginia Mason's existing hospital) or buildings that maintain the pedestrian passage and city streetscape by spanning across it with skybridges (such as Harborview, Swedish First Hill, and Virginia Mason's existing skybridge across Seneca Street).

The skybridges also link the neighborhood by increasing the porosity of the campus, as many are open to the public during business hours and offer an out of the weather path through the city. They also create a path that is accessible for people with disabilities, enabling them to climb otherwise impassable

[10] Comorbidities are diseases or conditions that coexist with a primary disease but they also stand on their own as specific diseases.

hillsides. The path from the Convention Center through Freeway Park, Pigott Corridor, HRB, the Lindeman Pavilion, the Central Hospital and the Terry Avenue breezeway creates an ADA-accessible link from the heart of downtown Seattle to Madison Street's commercial core.

Virginia Mason is proposing a combination of these two strategies (patient protection and neighborhood connections) in our MIMP. Their potential locations are shown in Figure 29 on page 77. Approval for future skybridges and tunnels will be secured through term permits that will be obtained at the time a potential project requiring such a connection is developed. The skybridge review and approval process the City of Seattle requires is robust and detailed, and includes both a review by local neighbors and a review by the Seattle Design Commission.

The existing skybridge over Seneca Street just west of Terry Avenue would be maintained. Virginia Mason has identified all potential locations where a future skybridge or tunnel may be needed. Not all of the planned skybridges and tunnels may be executed, depending on the sequencing of projects and their eventual occupants and amenities. The decision as to whether to request permit approval for individual skybridges or tunnels cannot be made until decisions are made by the City Council on the proposed expansion of the MIO boundaries and the approval of the requested areas and height limits.

The following criteria has been identified as an initial screening as to whether a future skybridge or tunnel would be needed:

- Would a skybridge or tunnel connect patient services requiring controlled environments that are separated from each other by a city street?
- If yes, which connections are most appropriate to facilitate the planned movement? (Both may be required, as the campus is vertically complex and certain flows cannot be commingled.)
- Would a skybridge increase the campus porosity and ADA accessibility for the public traveling between downtown Seattle and the Madison Street commercial area?
- Would a tunnel reduce or eliminate the need for multiple loading docks, thereby reducing traffic?

10. Housing Demolition and Replacement

Virginia Mason acquired the Chasselton Court Apartments as part of its purchase of the 1000 Madison block. In order to efficiently develop the 1000 Madison block for major medical use and to connect a future medical building on the 1000 Madison block with the Jones Pavilion, it will be necessary to demolish this building. The Seattle Landmarks Preservation Board voted to deny the motion designating the Chasselton Court Apartments as a Seattle landmark.

If the boundary expansion proposed within this MIMP is adopted, Virginia Mason will provide for housing replacement in conformance with the Seattle's Land Use Code.

The Chasselton Court Apartments consist of 62 apartments. The majority of the apartments are studio apartments (55 units), with seven one-bedroom apartments. There is a small parking garage structure on the south side of the building. There are no Section 8 or other subsidized housing units in the building. The average rent for a studio unit in March 2012 was $799 per month, and the average rent for a one-bedroom unit was $1,173 per month, which is comparable to rental rates for other similar

apartment buildings of its era on First Hill. There are approximately 1,615 apartments on First Hill of similar age and size to the Chasselton Court Apartments, per a 2011 market survey by Dupre + Scott Apartment Advisors, Inc., and 3,351 rental apartments on First Hill of varying age and cost.

Virginia Mason's housing replacement shall:

- Providing a minimum number of units equal to the number of units in the Chasselton Court apartments (62 units)
- Provide no fewer than seven one-bedroom units and no units smaller than the size of the studio units in the Chasselton Court apartments
- Include a minimum of 31,868 net rentable square feet, equivalent to that in the Chasselton Court apartments
- Be of a construction quality equal to or greater than that in the Chasselton Court apartment units
- Be located within the greater First Hill neighborhood, defined as the area between Interstate Highway 5 on the west, Pike Street on the north, 12th Avenue and Boren Avenue on the east, and the south boundary of Yesler Terrace on the south, as shown outlined in a broken black line on Figure 1 at page four of the MIMP

11. MIMP Consistency with Seattle Land Use Code (23.69.006)

SMC 23.69.006 Application of regulations requires:

> A. All land located within the Major Institution Overlay District shall be subject to the regulations and requirements of the underlying zone unless specifically modified by this chapter or an adopted master plan. In the event of irreconcilable differences between the provisions of this chapter and the underlying zoning regulations, the provisions of this chapter shall apply.

Virginia Mason has proposed compliance with all of the development standards of the underlying HR and NC-3 zoning, with the exception of floor area ratios (FAR), tower separation maximum floor-plate size and maximum facade width required to enable construction and operation of a hospital, design review (to be performed by SAC), and parking access. The adopted MIMP will become the regulations under which Virginia Mason's development will be allowed.

Table 15 Consistency With Applicable Land Use Code Standards

Underlying Zoning Standard (SMC Section)	Is Virginia Mason's Proposal Consistent?	Is a Modification to the Zoning Standard Requested?
The following zoning code standards apply to HR-zoned lands and are applicable to all blocks within Virginia Mason's existing campus and to the north half of the 1000 Madison block proposed for expansion.		
23.45.508 **General Provisions – HR**	***Yes, consistent***	***No modification requested***
23.45.510 **Floor Area Ratios – HR** Base FAR: 8 on lots 15,000 square feet or less in size; 7 on lots larger than 15,000 square feet. Maximum FAR with provision of incentives: 13 for structures 240' or less in height; 14 for structures over 240'.	***No***	***Yes,*** *Virginia Mason has a need of up to 3 million square feet and is proposing expansion to acquire additional land on the 1000 Madison block. Virginia Mason is requesting that their proposed FAR of 8.1 be applied across the campus.*
23.45.514 **Structure Height – HR** Base height of 160' Maximum height limit if extra residential height is gained – 240' to 300' **Development standard is superseded by** **23.69.020.C Structure Height – Major Institutions** Maximum structure heights for structures containing Major Institution uses may be allowed up to the limits established pursuant to Section 23.69.040 through the adoption of a master plan for the Major Institution. A rezone shall be required to increase maximum structure height limits above levels established pursuant to Section 23.69.040.	***Yes,*** *Virginia Mason will comply with the 240' MIO heights established in the adopted Master Plan.*	***No modification requested***
23.45.518 Setbacks – HR For lot lines abutting a street in the HR Zone: For portions of a structure 45 feet or less in height: 7-foot average setback; 5-foot minimum setback, except that no setback is required for frontages occupied by street level uses or dwelling units with a direct entry from the street. Greater than 45 feet in height: 10-foot minimum setback.	***Yes, consistent***	***No modification requested***

Underlying Zoning Standard (SMC Section)	Is Virginia Mason's Proposal Consistent?	Is a Modification to the Zoning Standard Requested?
23.45.518 Setbacks – HR For lot lines abutting a street in an NC zone: Street-level street-facing facades shall be located within 10 feet of the street lot line, unless wider sidewalks, plazas or other approved landscaped or open spaces are provided.	***Yes, consistent***	***No modification requested***
23.45.518 Setbacks – HR For lot lines abutting an alley in an HR zone: For portions of a structure 45 feet or less in height, no setback is required. For portions of a structure greater than 45 feet in height, a 10-foot setback is required.	***Yes, consistent***	***No modification requested***
23.45.518 Setbacks and Separations – HR For lots lines that abut neither a street nor an alley in an HR zone: For portions of a structure 45 feet or less in height: 7-foot average setback; 5-foot minimum setback, except that no setback is required for portions abutting an existing structure built to the abutting lot line. For portions of a structure greater than 45 feet in height: 20-foot minimum setback.	***Yes, consistent***	***No modification requested***
23.45.518 Separations – HR HR zones. Where two or more structures or portions of a structure above 85 feet in height are located on one lot, the minimum horizontal separation between interior facades in each height range is as provided in Table D for 23.45.518: 0 – 45' No separation required >45' – 160' 30-foot separation >160' 40-foot separation	***No***	***Yes,*** *Virginia Mason is requesting a modification to remove the required horizontal separation on interior facades to allow for efficient hospital design.*

Underlying Zoning Standard (SMC Section)	Is Virginia Mason's Proposal Consistent?	Is a Modification to the Zoning Standard Requested?
SMC 23.45.520 **Width and Floor Size Limits – HR** Portions of structures above a height of 45 feet are limited to a maximum facade width of 110 feet. A maximum facade width of 130 feet is permitted, provided that the average gross floor area of all stories above 45 feet in height does not exceed 10,000 square feet.	***No,*** *Virginia Mason is proposing that future hospital and medical buildings may have facade widths in excess of 110 feet, and may also have in excess of 10,000 square feet per story.*	***Yes,*** *Virginia Mason is requesting a modification to remove the limitation on facade width in order to allow for the floor plates needed for modern hospital layouts. Virginia Mason is proposing that unmodulated facades be limited to a maximum facade width of 110 feet.*
23.45.524 Landscaping Standards – HR	***Yes, consistent***	***No modification requested***
23.45.529 Design Standards – HR	***No***	***Yes,*** *Virginia Mason is requesting that this requirement be replaced with the design guidelines developed as part of the Master Plan. A proposed set of Design Guidelines is included as Appendix E to this MIMP.*
23.45.532 Standards for Ground Floor Commercial Uses in MR and HR Zones Commercial uses are limited to ground floor, and limited in size to 4,000 square feet, or up to 10,000 square feet for multipurpose commercial uses.	***Yes.*** *Institutional commercial uses such as cafeteria, optical shop or other related uses may be located on floors other than the ground floor and be greater than the sizes shown. Any non-institutional-related commercial uses would be located in compliance with the code requirements.*	***No modification requested***

Underlying Zoning Standard (SMC Section)	Is Virginia Mason's Proposal Consistent?	Is a Modification to the Zoning Standard Requested?
23.45.534 Light and Glare Standards – HR A. Exterior lighting shall be shielded and directed away from adjacent properties. B. Interior lighting in parking garages shall be shielded to minimize nighttime glare on adjacent properties. C. To prevent vehicle lights from affecting adjacent properties, driveways and parking areas for more than two vehicles shall be screened from abutting properties by a fence or wall between 5 feet and 6 feet in height, or a solid evergreen hedge or landscaped berm at least 5 feet in height.	***Yes, consistent***	***No modification requested***
23.45.536 **Parking Location, Access and Screening - HR**	***Partially,*** *Virginia Mason is proposing to comply with all parking location, access and screening requirements under HR zoning with the exception of:* *C. Access to parking.* *1. Alley access required. Except as otherwise expressly required or permitted in subsections C or D of this Section 23.45.536, access to parking shall be from the alley if the lot abuts an alley and one of the conditions in this subsection 23.45.536.C.1 is met.*	***Yes,*** *Parking studies done for the MIMP have proposed access locations and are reviewing these locations with the CAC and community via the EIS accompanying the MIMP.* *Virginia Mason is requesting that parking access be as shown in the MIMP, or as determined by DPD and SDOT during subsequent review of each specific building design.*
The following zoning code standards apply to NC-zoned lands and are applicable to only the south half of the 1000 Madison block proposed for expansion.		

Underlying Zoning Standard (SMC Section)	Is Virginia Mason's Proposal Consistent?	Is a Modification to the Zoning Standard Requested?
23.47A.005 Street-level Uses One or more of the following uses are required along 80% of the street-level street-facing facade in accordance with the standards provided in subsection 23.47A.008.C: a. General sales and services; b. Major durables retail sales; c. Eating and drinking establishments; d. Lodging uses; e. Theaters and spectator sports facilities; f. Indoor sports and recreation; g. Medical services; h. Rail transit facilities; i. Museum; j. Community clubs or centers; k. Religious facility; l. Library; m. Elementary or secondary school; and n. Parks and open space.	***Yes, consistent***	***No modification requested***
23.47A.008 **Street-level Development Standards – NC** A.2. Blank facades. a. For purposes of this section, facade segments are considered blank if they do not include at least one of the following: (1) Windows; (2) Entryways or doorways; (3) Stairs, stoops or porticos; (4) Decks or balconies; or (5) Screening and landscaping on the facade itself. b. Blank segments of the street-facing facade between 2 feet and 8 feet above the sidewalk may not exceed 20 feet in width. c. The total of all blank facade segments may not exceed 40% of the width of the facade of the structure along the street.	***Yes, consistent***	***No modification requested***
23.47A.008 **Street-level Development Standards – NC** A.3 Street-level street-facing facades shall be located within 10 feet of the street lot line, unless wider sidewalks, plazas, or other approved landscaped or open spaces are provided.	***Yes, consistent***	***No modification requested***
23.47A.008 **Street-level Development Standards – NC** B.2. Transparency. a. 60% of the street-facing facade between 2 feet and 8 feet above the sidewalk shall be transparent.	***Yes, consistent***	***No modification requested***

Underlying Zoning Standard (SMC Section)	Is Virginia Mason's Proposal Consistent?	Is a Modification to the Zoning Standard Requested?
23.47A.008 **Street-level Development Standards – NC** B. 3. b. Nonresidential uses at street level shall have a floor-to-floor height of at least 13 feet.	***Yes, consistent***	***No modification requested***
23.47A.008 **Street-level Development Standards – NC** C. In pedestrian-designated zones, the provisions of subsections 23.47A008.A and 23.47A.008.B and the following apply: 1. A minimum of 80% of the width of a structure's street-level street-facing facade that faces a principal pedestrian street shall be occupied by uses listed in 23.47A.005.D.1. The remaining 20% of the street frontage may contain other permitted uses and/or pedestrian entrances.	***Yes, consistent***	***No modification requested***
23.47A.012 **Structure Height – NC-3 160** A. The height limit for structures in the NC-3 zone is 160 feet, as designated on the Official Land Use Map, Chapter 23.32. Structures may not exceed the applicable height limit, except as otherwise provided in this Section 23.47A.012. **Development standard is superseded by 23.69.020.C Structure Height – MI** Maximum structure heights for structures containing Major Institution uses may be allowed up to the limits established pursuant to Section 23.69.040 through the adoption of a master plan for the Major Institution. A rezone shall be required to increase maximum structure height limits above levels established pursuant to Section 23.69.040.	***Yes,*** *Virginia Mason is proposing to extend MIO-240' to the 1000 Madison block.*	***No modification requested***

Underlying Zoning Standard (SMC Section)	Is Virginia Mason's Proposal Consistent?	Is a Modification to the Zoning Standard Requested?
SMC 23.47A.013 **Floor Area Ratio – NC-3 160** A. Floor area ratio (FAR) limits apply to all structures and lots in all NC zones and C zones. B. Except as provided in subsections C, D and E of this section, maximum FAR allowed in C zones and NC zones is shown in Table A for 23.47A.013. 1. Total permitted for a single-purpose structure containing only residential or nonresidential use for 160' height is a 5 FAR.	***No,*** *Virginia Mason is proposing a FAR of 8.1 for its proposed development (Alternative 6b)*	***Yes,*** *Virginia Mason has a need of up to 3 million square feet and is proposing expansion to acquire additional land on the 1000 Madison block. Virginia Mason is requesting that their proposed FAR of 8.1 be applied across the campus.*
23.47A.014 Setback Requirements – NC Setbacks are required for NC-zoned lots abutting or across the alley from residential zones. For Virginia Mason, the only location that this would be applicable to would be the 1000 Madison block where NC-3 zoning on the south half of the block abuts HR zoning on the north half of the block.	***No***	***Yes,*** *Virginia Mason is requesting that the setback requirements of 23.47.014 be waived in order to allow development of single structures to occur across the block if the requested MIO expansion is approved.*
23.47A.016 Landscaping Standards – NC	***Yes, consistent***	***No modification requested***
23.47A.022 Light and Glare Standards – NC	***Yes, consistent***	***No modification requested***
23.47A.030 **Required Parking and Loading – NC** A. Off-street parking spaces may be required as provided in Section 23.54.015, required parking. B. Loading berths are required for certain commercial uses according to the requirements of Section 23.54.035. Section 23.54.035 allows the Director of DPD to waive or modify loading berth requirements during specific project review when multiple buildings share a central loading facility, the loading facility is proposed to occur on site, and goods can be distributed to other buildings on site without disrupting pedestrian circulation or traffic.	***Yes,*** *pursuant to 23.54.035, Virginia Mason is requesting that the loading berth requirements be established by the Director of DPD during specific project review and that the code required number of loading berths per project be waived.*	*Virginia Mason provides loading facilities that are shared for multiple buildings.*

Underlying Zoning Standard (SMC Section)	Is Virginia Mason's Proposal Consistent?	Is a Modification to the Zoning Standard Requested?
23.47A.032 Parking Location and Access – NC A.1.c. If access is not provided from an alley and the lot abuts two or more streets, access is permitted across one of the side street lot lines as determined through 23.47A.032.C, and curb cuts are permitted pursuant to Section 23.54.030.F.2.a.1).	***Yes, consistent***	***No modification requested***
23.47A.032 **Parking Location and Access – NC** A.2. In addition to the provisions governing NC zones in 23.47A.032.A.1, the following rules apply in pedestrian-designated zones, except as may be permitted under subsection 23.47A.032.D: a. If access is not provided from an alley and the lot abuts two or more streets, access to parking shall be from a street that is not a principal pedestrian street.	***Yes, consistent***	***No modification requested***
23.47A.032 **Parking Location and Access – NC** B. Location of parking. 1. The following rules apply in NC zones, except as provided in subsection 23.47A.032.D. a. Parking shall not be located between a structure and a street lot line (Exhibit A for 23.47A.032). b. Within a structure, street-level parking shall be separated from street-level street-facing facades by another permitted use. This requirement does not apply to access to parking meeting the standards of subsection 23.47A.032.A.	***Yes, consistent***	***No modification requested***
23.47A.032 **Parking Location and Access – NC** B. Location of parking. 2. In pedestrian designated zones, surface parking is prohibited abutting the street lot line along a principal pedestrian street.	***Yes, consistent***	***No modification requested***

12. Virginia Mason Decentralization Plans

Virginia Mason embarked upon a regionalization of its services in the 1980s with the acquisition of sites in Federal Way and Lynnwood. The Federal Way site was built first and contains a full range of outpatient treatment services including an outpatient day surgery facility that meets hospital licensing requirements.

These two buildings were the first in a series of expanded clinics that now include seven outpatient treatment facilities throughout Puget Sound. They are:

- Federal Way Clinic
- Issaquah Clinic
- Bellevue Clinic
- Kirkland Clinic
- Lynnwood Clinic
- Sand Point Pediatric Clinic
- Bainbridge Island – Winslow Clinic

Virginia Mason has also decentralized some of its supporting services, including a significant portion of its computing, purchasing, training and financial staff to Metropolitan Park West office tower in Seattle, its medical records facility to Georgetown and its call center to Canyon Park in Bothell.

The goal of these decentralizations has been to make primary care and certain specialty services more convenient to our patients. Higher acuity services continue to be centralized on First Hill, including specialty services and inpatient hospitalizations greater than 24 hours.

Virginia Mason operates the Bailey-Boushay House on the east side of Capitol Hill in Madison Park, approximately two miles east of the First Hill campus. Bailey-Boushay House is a nationally recognized facility offering residential care and chronic care management programs for people living with AIDS and to those living with other life-threatening illnesses. These are patients who are not sick enough to be hospitalized, but who require 24/7 nursing care or hospice care.

The Adult Day Health program at Bailey-Boushay House is an internationally acclaimed role model for managing the complex physical, social, spiritual and psychological issues that accompany a diagnosis

of HIV. The Adult Day Health program patients are provided a bundle of services that help them manage their health in ways that keep them in their homes, out of the hospital, and in good health and good spirits.

Virginia Mason also provides services on the First Hill campus with Group Health Cooperative of Puget Sound and Pacific Medical Centers, who refer patients to the First Hill campus from their locations throughout the region for specialty or inpatient care. Group Health and Pacific Medical Centers staff are members of Virginia Mason's hospital medical staff, work at the First Hill campus and are integrated into Virginia Mason's program of services.

Also located on the First Hill campus is Tender Loving Care (TLC). TLC provides child care for mildly ill children ranging in age from 1 year to 12 years old, offering parents the reassurance that their sick child will be well cared for while they work.

Virginia Mason owns all of the property in the 1000 Madison block and is currently leasing the property to a variety of commercial and residential tenants. At this time, Virginia Mason is not proposing to lease space or otherwise locate a use at street level in a commercial zone, outside of, but within 2,500 feet of the MIO boundary, with the exception of the continuation of the leased parking shown on Figure 26 on page 70, and for the Bright Horizons Child Care Center. Virginia Mason leases space from the Polyclinic First Baptist Church at 1111 Harvard Avenue for the Bright Horizons Child Care Center and leases space for their playground on Spring Street between Boylston Avenue and Harvard Avenue. Bright Horizons runs a day care program for the children of Virginia Mason employees at this location.

13. Applicable Goals, Policies and Public Benefits

See Appendix B for information on how Virginia Mason will address goals and applicable policies under Education and Employability and Health in the Human Development Element of the Comprehensive Plan.

Community Contributions

Development enabled by this MIMP will allow Virginia Mason to continue to provide exceptional care to the region and to grow its services to meet the anticipated increase in regional demand.

Virginia Mason's contribution to the community extends well beyond patient care. Virginia Mason believes it is essential to contribute at many levels to the communities where patients and staff members work and live. The organization has acted on that belief by contributing time, energy and money to efforts that benefit the region in the areas of improving health, offering free and subsidized care, and providing health professional education and research.

As a nonprofit organization, Virginia Mason uses its income to support the delivery of high-quality, safe care, investing in charitable care, equipment, facilities, electronic medical records and other innovations. Virginia Mason is committed, as its mission statement puts it, to improving "the health and well-being of the patients we serve." The organization does not have owners or shareholders who receive earnings from operations. Everything Virginia Mason earns over and above its costs goes back into the organization, and a portion is used to provide services that benefit the community.

Uncompensated Care

As a nonprofit organization, Virginia Mason is committed to serving patients who are uninsured, underinsured or otherwise unable to pay for their medical care. The Uncompensated Care program assists thousands of uninsured and underinsured members of the community every year.

Under Virginia Mason's Uncompensated Care policy, free or reduced-cost medically necessary care (after all health insurance has been exhausted) is provided to individuals making up to 300% of the federal poverty level in keeping with the Washington State Hospital Association voluntary guidelines on billing the uninsured.

Subsidized Health Services

Every community needs certain health care services that typically cost more to deliver than the provider of these services receives. These "subsidized health services" are part of Virginia Mason's mission because they are needed in the community and otherwise would not be available to meet patient needs. They include:

- Emergency room care that is provided to all, irrespective of their ability to pay.
- Bailey-Boushay House, where a significant percentage of the residents are unable to fully pay for the care they receive and receive subsidized health services.
- Partnership with Public Health – Seattle & King County Health Care for the Homeless Network and other area hospitals who provide a respite expansion program for homeless adults in King County.

Community Health Improvement Services

Improving health and quality of life extends beyond diagnosis and treatment. It also requires community health education and outreach services. Health improvement and outreach services provided by Virginia Mason include the following:

- Community health education, such as classes in the Buse Diabetes Teaching Center
- Free health screenings in the community including skin cancer screening and the YWCA Health Fair, where over 1,000 people were screened
- Free flu shots and health screenings for the homeless in conjunction with United Way of King County's Community Resource Exchange
- Sponsorship of many professionally facilitated support groups, including brain tumor, Parkinson's disease, breast cancer, gastric bypass surgery and prostate cancer groups
- Bereavement support through its Separation and Loss Services
- Leadership roles in several community organizations that focus on health care
- The Day of Caring at Visions House, the Wintonia, the Franciscan and the Seattle Science Materials Center

Virginia Mason sponsors numerous community activities that support healthy lifestyles and that gener-

ate donations for its research efforts including the Seafair Benaroya Triathlon, the Seattle Marathon, the Boeing Classic Golf Tournament and other community activities.

Education

Virginia Mason strongly supports medical education to ensure its patients and the community benefit from advances in medical care and in the development of future providers:

- Virginia Mason is a premier teaching hospital that offers postgraduate education programs through its Graduate Medical Education (GME) Department. All GME postgraduate training programs are fully approved by the Accreditation Council on Graduate Medical Education (ACGME). Virginia Mason trains more than 110 residents and fellows annually.
- Numerous Virginia Mason Medical Center physicians have faculty appointments at the University of Washington, publish original research and speak at conferences nationally and internationally on their areas of expertise.
- Virginia Mason serves as an internship site for students in a variety of other health programs, such as nursing, pharmacy, respiratory therapy and laboratory technology.
- Virginia Mason's GME program is partnered with Public Health – Seattle & King County Health Services Division, providing 12 residents for the Eastgate Public Health Center, as well as providing residents at the Carolyn Downs Family Medical Center, Pike Market Medical Clinic and North Public Health Center.
- Virginia Mason provides a 0.5 FTE faculty member every fall, winter and spring quarter for undergraduate clinical nursing instruction for the University of Washington School of Nursing.
- Virginia Mason Institute, or VMI, provides education and training in the Virginia Mason management method, known as the Virginia Mason Production System (VMPS), to other health care providers and organizations. VMI's aim is to advance quality, safety and value by sharing VM's knowledge and experience in VMPS. VMI's education and training services cover a wide range of needs, from a basic understanding of the principles and practices that underlie VMPS, to in-depth education and hands-on work in applying VMPS methods that can transform an organization. VMI services include site visits to Virginia Mason, training in tools and methods, on-site assessments and education, and short term and in-depth engagements.

Research

Virginia Mason also conducts medical research through its affiliate, the Benaroya Research Institute at Virginia Mason (BRI). BRI is a nonprofit biomedical research institute that works to unlock the mysteries of the immune system. Its team of world-renowned scientists is focused on identifying causes and cures for devastating diseases including diabetes, arthritis, heart disease and cancer. The research institute houses more than 200 researchers and staff. BRI provides a full range of research and development services from "wet bench" research to clinical trials and translational research at the First Hill campus and regional satellites, and through other community outreach programs.

Environmental Efforts

In 2007, Virginia Mason broadened its efforts to be more environmentally friendly by focusing on recycling initiatives, waste reduction, energy conservation and organizational sustainability through its environmental stewardship initiative called EnviroMason. EnviroMason provides the framework for making unique energy and waste management decisions such as setting policies on reliability and use, making efficiency improvements, supporting capital planning and infrastructure design, and encouraging employee participation and innovation. EnviroMason focuses on seven principles:

- Leadership alignment and commitment
- Compliance assurance and pollution prevention
- System integration
- Public communication and public involvement
- Measurement and continuous improvement
- Industry leadership
- Environmental stewardship

Virginia Mason has realized hundreds of thousands of dollars in cost savings and revenue generation through energy conservation, waste reduction and innovative recycling efforts. EnviroMason programs and successes include expanding our recycling efforts to our parking lots, eliminating Styrofoam and reducing water use in the cafeteria, recycling construction waste, reducing mail center junk mail, enhancing our green commuting options for Virginia Mason staff (see Section E, TMP), recycling operating room plastics, recycling hazardous waste, providing Zipcars and electric car charging stations, and establishing community partnerships for long-term resource management solutions.

Since EnviroMason was implemented, Virginia Mason has accomplished:

- Virginia Mason's Boeing Classic event was awarded the 2011 Recycler of the Year, with 98% of all waste generated during the event being recycled
- Piloted Styrofoam recycling in 2011
- Initiated programs to recycle most of its pharmaceutical and laboratory waste, including solvents

- Developed a program to reuse and recycle computer components and salvage precious metals
- Recycled more than 679 tons of materials on the First Hill campus, including 60 tons of construction materials
- Reduced food service waste by 75% and water use by 72% in the kitchen
- Saved 160,000 gallons of water each year through composting, and an additional 2 million gallons of water a year by upgrading more than 1,200 plumbing fixtures on the First Hill campus
- Diverted 144 tons of food waste from public sewer systems by avoiding use of garbage disposals, and pulping compost waste to reduce the size of material needing to be hauled, with an additional savings of $24,000 from pulping
- Saved $72,000 in three years through increased recycling at the main First Hill campus
- Reduced trash hauling from six to five days a week
- Increased cardboard recycling by 300%
- Invested more than $3 million in energy conservation measures including efficient lighting, advanced chiller plant installations and upgrades, and extensive water and energy conservation measures

Virginia Mason was the title sponsor for the Go Green 2011 and 2012 Seattle conferences and continues to pursue innovations at all levels of environmental stewardship. Virginia Mason's campus today is the assembly of decades of incremental physical plant additions and multiple sets of building systems. Redevelopment of the campus under the Master Plan offers the opportunity to streamline, upgrade and replace this aging and piecemeal infrastructure with new consolidated physical plant systems that are significantly more energy efficient and reliable. This process has already commenced with the relocation of the main generators serving the hospital core to the Floyd & Delores Jones Pavilion. Additional improvements are being investigated through the recently completed Wood Harbinger Utilities survey and master plan.

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Sarah Patterson, Executive Vice President, Chief Operating Officer and avid bicyclist on the May 20, 2011 Bike to Work Day

E. TRANSPORTATION MANAGEMENT PROGRAM

1. Transportation Systems

Existing and Planned Parking

Virginia Mason encourages multiple modes of travel to its First Hill campus facilities. Campus parking is predominantly intended for Virginia Mason patients and their families with daytime limitations for employee use. With few exceptions, employee-driven single-occupancy vehicles (SOVs) are not allowed to park on site during periods of peak demand (typically 9 am to 4 pm) to encourage use of other travel modes and ensure adequate parking for patients. Shuttle service is provided between Virginia Mason and Metropolitan Park, where some employee parking is provided, and to transport staff to and from the buildings for business purposes. Virginia Mason participates in a collaborative agreement with Metro to subsidize bus service from the King Street train station and the ferry terminal to its campus. Virginia Mason strives to maintain the minimum parking supply necessary to support operations while minimizing impacts to the surrounding community.

Existing Parking

The existing parking supply consists of 1,426 stalls distributed between 23 parking lots and structures. The utilization of this supply is high, with more than 90% of the stalls being occupied during the late morning when parking demand is at its peak.

City code requirements for Major Institutions establish the minimum and maximum number of parking stalls allowed based on selected factors. The following table summarizes the parking requirements based on 2010 staff population and patient visits. The current supply of 1,426 spaces is approximately 240 spaces below the minimum required by the zoning code. It is also approximately 100 spaces below what is needed to accommodate the calculated peak demand.

Table 16 Parking Requirements Based on 2010 Staff and Patient Visits

Zoning Code Category	Unit	Unit Factor	Stall Requirement
Long-term Parking			
Peak hospital based doctors	228	.8	182
Peak staff doctors	66	.25	16
Peak # of other employees	3,035	.3	911
Short-term Parking			
# of hospital beds	272	.17	46
Average daily outpatients	2,246	.2	485
Fixed seats in auditorium	268	.1	27
Minimum Required Parking Spaces			**1,667**
Maximum Allowed Parking Spaces (1.35 x Minimum)			**2,250**
Existing Parking Supply			**1,426**

Planned Parking

Analysis of existing parking utilization and proposed Master Plan Alternative 6b indicates that the proposed parking supply of approximately 4,000 stalls would be sufficient to meet Virginia Mason's operational requirements to ensure patient access to facilities and still minimize the amount of parking provided for employees.

The potential access locations to future parking supplies are illustrated in Figure 30. These locations are conceptual at this level of planning and reflect the current understanding of vehicular circulation patterns and potential safety issues. Some of the accesses are located on streets where alley access is also available. Current code requires alley access, with certain exceptions. As projects are developed, parking structures and the location of accesses will be evaluated for operational performance, safety, and consistency with code requirements in place at the time of project review.

Changes in transportation travel modes due to light rail access, implementation of services that allow improved electronic communication between patients and physicians, and increases in the cost to operate a vehicle may reduce the number of parking stalls needed to serve the increased demand resulting from Master Plan projects. Provision of new parking stalls associated with the development of any proposed or potential projects will be assessed during the project planning, programming and design phases.

City code requirements for future parking supplies for Alternative 6b are summarized in Table 17.

Table 17 Future Parking Requirements – Alternative 6b

Zoning Code Category Unit	Unit	Unit Factor	Stall Requirement
Long-term Parking			
Peak hospital based doctors	400	.8	320
Peak staff doctors	75	.25	19
Peak # of other employees	5,400	.3	1,620
Short-term Parking			
# of hospital beds	336	.17	57
Average daily outpatients	4,750	.2	950
Fixed seats in auditorium	268	.1	27
Minimum Required Parking Spaces			**2,993**
Maximum Allowed Parking Spaces (1.35 x Minimum)			**4,041**
Recommended Parking Supply			**4,000**

The recommended parking supply fits within the minimum and maximum code requirements.

Bicycle

Virginia Mason provides bicycle racks for visitors and secure bicycle storage for employees in multiple locations throughout campus, as well as showering and locker facilities for staff. Virginia Mason promotes bicycling through their Bicycle Club, participating in regional activities like Cascade Bicycle Club's ride to work days, and through subsidized locks. Virginia Mason also offers incentives to employees to engage in healthy behaviors like bicycling to work through its Personal Health Assessment rewards program, which pays rewards to employees for healthy behaviors. Additional bicycle features are described in Section C.13 on page 59.

Pedestrian

The pedestrian features of the Master Plan are described in Section C.13 on page 59.

Local Circulation

Virginia Mason's First Hill location to the east of downtown is highly accessible from the surrounding street network. Interstate 5 provides nearby access from the west at interchange ramps at James Street, Madison Street, Seneca Street and Olive Way, which in turn feed Spring Street, Seneca Street and Boren Avenue. Boren Avenue and Madison Street are principal arterials and Seneca Street and Ninth Avenue are minor arterials (Comprehensive Plan – Seattle Arterial Classification). Other local streets complete the circulation network.

Site Access

Local access to Virginia Mason is from arterials and local streets. Boren Avenue and Madison Street have some restricted left turns and limitations on driveways. Virginia Mason existing and proposed parking access/egress, patient drop-off/pick-up, and emergency access/egress locations are shown on Figure 30 on page 100. Entries to parking facilities are distributed around the campus to disperse traffic and avoid conflicts with major traffic flows. The most likely vehicle access/egress locations are identified on the diagram, but other locations may be developed without Master Plan amendment. Additional environmental impact review may be necessary with specific project permitting.

Please see Section C.10 for a description of service access and loading.

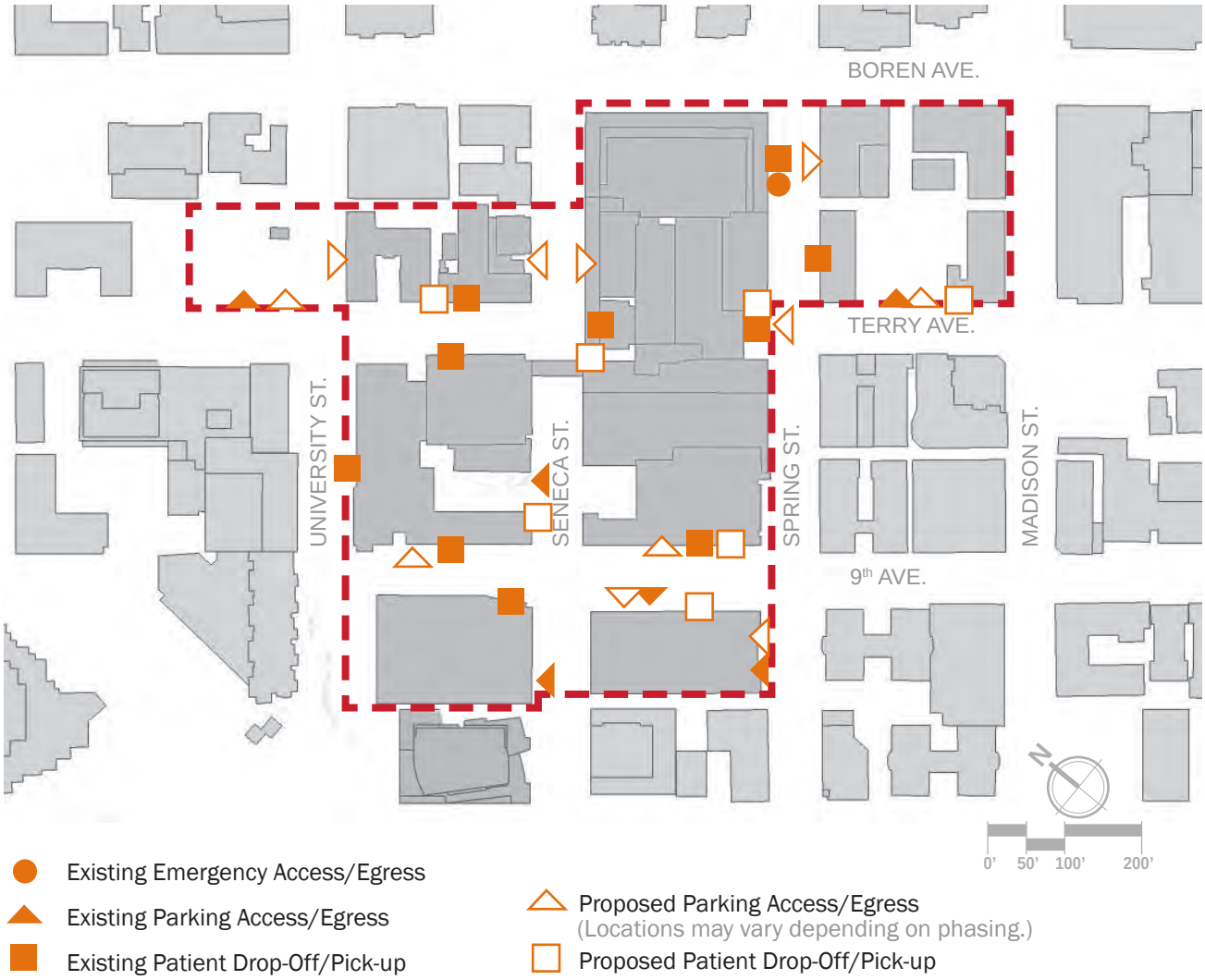

Figure 30 Existing and Proposed Access and Circulation

Impacts on Traffic and Parking in the Surrounding Area

See Section 3.9 of the Final EIS for a discussion of impacts on traffic and parking in the surrounding area for Alternative 6b.

As traffic congestion increases on First Hill, the time it takes for First Responders to bring ill or injured patients in ambulances to the Emergency Department continues to deteriorate. It will be important for Virginia Mason and the other Emergency Medical Providers on First Hill that any traffic plans for First Hill consider improvements that can speed the flow of traffic for First Responders, including Signal Priority systems or other means.

2. Existing Transportation Management Plan (TMP)

The stated goal of the Virginia Mason TMP as adopted from Seattle's Major Institutional Code is to "reduce the percentage of employees of the Major Institution who commute to work by SOV to 50 percent, excluding employees whose work requires the use of the private automobile during working hours." Virginia Mason's program has consistently surpassed that goal as demonstrated by past biennial Commute Trip Reduction (CTR) survey reports, summarized in Table 18 below. Currently 27% of those surveyed commute by SOV and 46% use transit or rail.

Table 18 Virginia Mason Commute Mode Performance by Percentage (2001-2011)

Commute Mode	Year					
	2001	2003	2005	2007	2009	2011
Drove alone	28%	29%	28%	25%	23%	27%
Carpool (2-6)	17%	13%	15%	15%	12%	10%
Vanpool (4-6)	0%	2%	1%	1%	2%	2%
Vanpool 7+	1%	1%	1%	1%	-	-
Bus	42%	43%	41%	43%	46%	43%
Rail	1%	1%	1%	2%	3%	3%
Bicycled	1%	1%	2%	3%	2%	4%
Walked	5%	5%	5%	4%	6%	6%
Teleworked	0%	0%	0%	0%	1%	<1%
Compressed work week	0%	0%	0%	0%	0%	<1%
Did not work	3%	3%	3%	4%	-	-
Other	2%	3%	2%	3%	1%	2%
Motorcycle	0%	0%	0%	0%	1%	1%
Ferry (car/van/bus)	0%	0%	0%	0%	1%	<1%
Ferry (walk-on)	0%	0%	0%	0%	2%	2%

As part of its TMP for the 1992 Master Plan, Virginia Mason committed to a wide range of incentives to encourage commuters to use travel modes other than the SOV. The program elements identified in the 1992 Master Plan included the following:

- A Building Transportation Coordinator to implement and administer the TMP
- Commuter Information Centers in building lobbies and other public areas
- A travel subsidy equal to 75% of the face value of Metro Transit passes to all Virginia Mason Medical Center campus employees commuting to work by transit or vanpool
- Carpool certification
- Carpool parking spaces
- Carpool parking discount of at least 40% of the prevailing SOV monthly parking rate

- Weather protected and secure bicycle parking spaces and access to showers
- Free parking for vanpools consisting of at least seven employees
- Free covered and secure parking for motorcyclists
- TMP monitoring using a biennial survey

Since 1992, the Virginia Mason Medical Center TMP has expanded significantly with increased subsidies for transit users and the addition of new program elements.

Proposed TMP

The proposed TMP incorporates most of the current program elements and includes an aggressive goal of maintaining the SOV rate below 30%. Table 19 summarizes the current program and the enhancements that are proposed as part of this Master Plan.

Virginia Mason has recently increased its services to include surgeries and expanded clinic hours on the weekends, when the availability of transit is more limited and there are fewer commute choices. Virginia Mason has also added more staff, which has increased the total number of staff using SOVs. In addition, the recent regional increase in use of transit, and reduction in some routes, has had the negative effect of crowding some staff off some transit routes and back into SOVs.

Virginia Mason is assessing its recent staff survey results to determine what new efforts can be done to encourage staff using SOVs to choose other, preferred transportation options. Virginia Mason is also encouraging the shift from carpools to vanpools, to encourage higher ridership in fewer vehicles.

Table 19 Proposed/Current TMP Comparison

Element	Current TMP	Proposed TMP
Transit *Goal: Increase transit ridership through subsidies, improved access and the marketing of program benefits.*	1. Lower the cost of transit commutes: a. Virginia Mason offers 75% transit subsidy for bus, ferry and trains b. Guaranteed ride home program c. Zipcar is available for employees for personal and business use (5 hours each per month) d. Company fleet vehicles available through the parking office for business use 2. Improve transit access and utilization: a. Financial support for Metro Bus route 211 b. Participation in Transit Now agreement along with Swedish and Harborview Medical Centers to increase service to the King Street Station and the ferry terminal c. Attend First Hill transportation meetings to work with Swedish, Harborview and Seattle University on common projects such as transit routes d. Work with First Hill institutions to extend bus routes to King Street Station and ferry access e. One after-hour taxi leaves the hospital turnaround at 7:40 pm nightly to cover gaps in transit service due to limited hours of operation 3. Moved to ORCA pass system in 2010 4. Link Light Rail honors Virginia Mason Puget Passes (not vanpool passes)	1. Lower the cost of transit commutes: a. Provide 75% transit subsidy for bus, ferry and trains through the ORCA program b. Provide a guaranteed ride home in case of family emergency c. Provide Zipcar access to employees for personal and business use (5 hours each per month) d. Provide fleet vehicles for business use 2. Improve transit access and utilization: a. Continue financial support for Metro Bus routes where they benefit Virginia Mason employees b. Continue participation in Transit Now agreement along with Swedish and Harborview Medical Centers to increase service to the King Street Station and the ferry terminal c. Participate in First Hill transportation meetings to work with Swedish, Harborview and Seattle University on common projects such as transit routes d. Continue offering ORCA passes to employees through Wageworks, which automatically deducts costs from staff paychecks and applies the appropriate fare reductions stated above to staff purchases for multiple transportation choices

Element	Current TMP	Proposed TMP
High Occupancy Vehicle (HOV) *Goal: Increase HOV program participation by maintaining subsidies and marketing program benefits and opportunities.*	1. Cost of HOV commutes is maintained below the cost of SOV commutes: a. Monthly carpool parking is priced at $102.50 for a three-person carpool and $128 for a two-person carpool b. Free vanpool parking c. Vanpool passes are 75% subsidized 2. Vanshare: One vehicle that operates between King Street station, ferry terminal, etc. 3. Increase ridership: a. Virginia Mason provides own program for carpool/vanpool matching service ("Going My Way" carpool registration service) b. Promotes Regional Ride Match System and Rideshare	1. Maintain the cost of HOV commutes below the cost of SOV commutes: a. Maintain carpool parking rates at no more than 75% of equivalent SOV rates b. Provide free parking for vanpools c. Provide vanpool riders with at least a 75% subsidy of the full cost of ridership 2. Increase ridership by: a. Continuing an internal program for carpool/vanpool matching service ("Going My Way" carpool registration service) b. Promoting the Regional Ride Match System and Rideshare
Bicycle *Goal: Increase bicycle ridership by providing support services and establishing marketing and incentive program.*	1. Support services include: a. Three locked bike cages located at the Ninth Avenue Garage, Benaroya Garage, and the Lindeman Garage (total capacity of 75) b. Shower facilities available in HRB, Buck Pavilion and the Inn at Virginia Mason, with towels provided c. Virginia Mason Bicycle Club started in March 2010 to improve bike storage, security, shower facilities, subsidies for frequent riders, etc.	1. Continue providing support services that include: a. Locked bike cages with weather protection and a minimum capacity of 75 parking spaces b. Shower facilities and lockers in multiple locations c. Support for the Virginia Mason Bicycle Club to improve bike storage, security, shower facilities, and benefits for frequent riders and to encourage ridership
Pedestrian *Goal: Increase pedestrian commutes by providing support services and establishing an incentive program.*	Pedestrian elements are not included in current TMP.	1. Develop new programs and incentives to encourage employees to walk to work or to walk during their breaks 2. Offer incentives for these activities through the Personal Health Assessment rewards program 3. Program benefits will equal those provided to bicycle commuters..

Element	Current TMP	Proposed TMP
Marketing *Goal: Increase the campus population's awareness of program opportunities and benefits.*	1. "V-Net" Parking and Commuter Services website provides information for publicizing events, issuing street closure notices, and providing training and reminders on the CTR program 2. Two commuter boards located in the lobby of Buck Pavilion and in the lobby of the hospital hallway by Tully's are updated with transit information 3. Commute-trip regulations provided twice per year in brochure and emailed to all employees 4. Parking department prepares emails to all employees advertising program elements and providing link to website. 5. Conduct a transportation fair in January and August of each year. 6. Hold transportation contest twice a year with information and registration provided by King County Metro	1. Maintain "V-Net" Parking and Commuter Services website to provide information for publicizing events, issuing street closure notices, and providing training and reminders on the CTR program 2. Either maintain the two commuter boards located in the lobby of Buck Pavilion and in the lobby of the hospital, or replace with computer terminals that access Metro trip planning and current traffic conditions as well as marketing features to reduce SOV trips 3. Provide commuter program policy information, program news and updates at least two times per year in emails to all employees and links to the Virginia Mason website describing the policies 4. Conduct a campus-wide transportation fair twice each year
Institutional Policies *Goal: Establish policies that address trip reduction in the context of Virginia Mason sustainability initiatives.*	1. Attend First Hill transportation meetings once a quarter to work with Swedish, Harborview and Seattle University on common projects 2. Other Virginia Mason locations each have their own Employee Transportation Coordinator (ETC), though Virginia Mason's First Hill campus ETC is relied upon for guidance	1. Continue participation in First Hill transportation meetings to work with Swedish, Harborview and Seattle University on common projects 2. Participate in city or community-led transportation initiatives or planning that affects Virginia Mason 3. Investigate and, when appropriate, implement health care delivery tools to reduce patient trips (potential tools include increased use of electronic communications between patients and physicians and the use of shuttle services or other subsidized transportation for specific patient groups)

Element	Current TMP	Proposed TMP
Parking *Goal: Manage parking supplies to minimize the need for additional parking.*	1. Minimize employee on-site parking: a. Only limited monthly parking is available at costs comparable to downtown Seattle parking rates. Costs range from $179.00 to $230.00/month for parking, depending on garage. b. Staff must park in designated levels at Benaroya garage c. No employee parking on campus Monday through Friday, between 9 am and 3:45 pm d. Early staff entries must be out of garage by 9 am e. On-call and day parking is located off-campus in the Tate Mason Garage at 1100 Minor Avenue for $12/day f. Staff parking in Benaroya, Ninth Avenue and Lindeman Garages allowed only after 3:45 pm and on weekends by a red decal and keycard access g. Saturday staff are directed to use the Benaroya garage as a first option and are only allowed to park in Lindeman garage after 1 pm h. Staff working overtime are directed to park in Benaroya, with parking allowed in Lindeman and Ninth Avenue Garages only if Benaroya is full i. Main campus-Metropolitan Park shuttle offers free rides between Virginia Mason and Metropolitan Park	1. Restrict employee SOV parking on-site during periods of peak demand to encourage use of non-SOV travel modes 2. Provide shuttle service between Virginia Mason and Metropolitan Park facilities 3. Unbundle parking from tenant lease agreements 4. Maintain the minimum parking supply necessary to support operations while minimizing impacts to the surrounding community

Element	Current TMP	Proposed TMP
Parking continued	2. Offer incentives for alternative methods: a. Provide parking stalls for carpool and vanpool parking b. Provide free motorcycle parking c. Provide bicycle parking 3. Minimize patient on-site parking: a. No free parking for patients b. Parking discount of 10% to 25% off the regular parking rate depending on the time in the garage c. Discount is not valid for valet parking at the Buck Pavilion 4. Minimize vendor or business parking: a. Vendor parking is limited in amount and available only at the Benaroya Garage or Terry/University lot, and registration must be made in advance with the parking office b. Business parking is limited to the Benaroya Garage and limited to use twice per month c. Satellite staff on business at main campus are directed to use the Benaroya Garage, and use is limited to twice per week	

Element	Current TMP	Proposed TMP
TMP Regulation and Monitoring *Goal: Establish an SOV goal and monitoring program that meets City requirements.*	1. The goal for the TMP is adopted from Seattle's Major Institution code: "Reduce the percentage of employees of the Major Institution who commute by single occupant vehicle (SOV) to 50%, excluding employees whose work requires the use of the private automobile during working hours." 2. Survey campus employees every two years to determine commute patterns. 3. Submit quarterly reports to the City summarizing parking fees, permits, transit passes sold and actions to promote TMP.	1. The goal for the TMP shall be to maintain an SOV commute rate of less than 30% as calculated using the CTR survey methodology for affected employees 2. Conduct a biennial survey of employee travel mode choices in partnership with King County Metro 3. Provide annual program reports to the City of Seattle Department of Transportation, Department of Planning and Development, and the Standing Advisory Committee.

Appendix A LEGAL DESCRIPTION OF MIO DISTRICT PROPERTIES

Table A.1 Virginia Mason First Hill Campus Properties

Reference	Legal	Address(es)	Land Area (SF)	Land Area (Acres)	King County Tax ID
1 Terry Lot	Block 112, Lots 8,9,12	1300 Terry	16,800	0.39	1978200351
2 Cassel Crag	Block 111, Lots 1,4	1218 Terry	15,360	0.35	1978200285
3 MRI, Blackford	Block 111, Lots 5,8	1200 Terry 1000 Seneca 1204 Terry	15,360	0.35	1978200305
4 North Pavilion	Block 110, Lots 1-8	901 University	61,440	1.41	1978200280
5 BRI	Block 105, Lots 2,3,6,7	1201 Ninth	35,470	0.81	1978200010
6 Ninth Garage	Block 74, Lots 2,3,6,7	1101 Ninth	28,800	0.66	1979200170
7 Buck	Block 75, Lot 1	901 Seneca	3,600	0.08	1979200206
8 Buck	Block 75, Lot 1	911 Seneca	4,080	0.09	1979200205
9 Buck	Block 75, Lots 5,8	1100 Ninth	15,360	0.35	1979200225
10 Buck	Block 75, Lot 4	1120 Seneca	7,680	0.18	1979200220
11 Hospital core	Block 75, Lots 2,3,6,7	925 Seneca	38,640	0.89	1979200210
12 Hospital core	Block 104, Lots 1,4,5	1111 Terry	27,540	0.63	8590901070
13 Inn at VM	Block 104, Lot 8	1006 Spring	9,180	0.21	8590901105
14 East Hospital	Block 104, Lots 2,3	1117 Boren 1119 Boren	14,400	0.33	8590901075
15 East Hospital	Block 104, Lots 6,7	1111 Boren	14,400	0.33	8590901095
Total Ownership Within Existing MIO District			**308,110**	**7.07**	

*Legal plat names are:

-Dennys AA Broadway Addition for Blocks 112, 111, 110, 105; and

-Dennys AA Extension, Terrys 1st for Blocks 74, 75.

Table A.2 Virginia Mason First Hill Campus Properties 1000 - Madison Block

Reference	Legal	Address(es)	Land Area (SF)	Land Area (Acres)	King County Tax ID
16 Chasselton	Block 103, Lots 2,3	1017 Boren 1019 Boren	14,400	0.33	8590901035 8590901040
17 Baroness	Block 103, Lot 1	1005 Spring 1001 Spring 1007 Spring	7,200	0.17	8590901030
18 Madison block	Block 103, Lot 4	None assigned (associated with Baroness)	7,200	0.17	8590901045
19 Madison block	Block 103, Lots 5,6,7,8	1000 Madison	28,800	0.66	8590901050
20 Madison block alley	Block 103 (north-south alley)	N/A	3,840	0.088	N/A
Total Ownership Within 1000 Madison Block			**57,600**	**1.41**	
Total Ownership Within Expanded MIO District			**365,710**	**8.48**	

*Legal plat names are:

-Terrys 2nd Addition for Blocks 104, 103.

Figure A.1 on the following page includes the requested administrative correction to the existing MIO district boundary map to include a 20-foot portion of Lot 8 of Block 112. This correction was approved in the previous MIMP but is not correctly shown within MIO boundaries on the current city maps. The area is shown with cross marks at the north end of the Terry Lot parcel numbered “1” on Figure A.1.

Figure A.1 Parcel Key

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Appendix B CONSISTENCY WITH CITY'S COMPREHENSIVE PLAN GOALS AND POLICIES

SMC 23.69.030 Contents of a Master Plan, Section E, components of the development program, in subsection 13.a, requests a description of the ways in which the institution will address goals and applicable policies under Education and Employability and Health in the Human Development Element of the Comprehensive Plan. The description is to be provided for informational purposes only. The Citizens Advisory Committee, pursuant to SMC 23.69.032.D.1, may comment on the information but may not subject these elements to negotiation nor shall such review delay consideration of the Master Plan or the final recommendation to Council.

The Human Development Element of the Comprehensive Plan has six sections. The two that are applicable to this analysis include goals and policies contained in the following two sections.

C Education and Job Skills to Lead an Independent Life

D Effective Disease Prevention, Access to Health Care, Physical and Mental Fitness for Everyone

Only goals that are directly applicable to major institutions are included. A number of the goals in C are specific to Seattle Public Schools and are not included.

Certain policies pertaining to employment and training are also found in Section A. Labor Force Education, Development and Training in the Economic Development Element of the Comprehensive Plan. A description of the ways Virginia Mason will address the applicable goals and policies of this portion of the Comprehensive Plan is included below following the discussion of applicable goals and policies of the Human Development Element.

Table B.1 Consistency of Virginia Mason's MIMP

Major Institution Goals and Policies	Consistency of Virginia Mason's Master Plan
Human Development Goals and Policies	
Vision Statement The City of Seattle invests in people so that all families and individuals can meet their basic needs, share in our economic prosperity, and participate in building a safe, healthy, educated, just and caring community.	Virginia Mason is unswerving in its focus to improve the health and well-being of the patients it serves. This focus on improving the health of the community is directly aligned with the City of Seattle's goal of investing in the community. Virginia Mason's employment of Seattle's residents, its revenue contribution to the community, its role as an educator and its provision of benefits to the community through numerous activities and reduced or uncompensated care directly support the City of Seattle's Human Development goals.

Major Institution Goals and Policies	Consistency of Virginia Mason's Master Plan
C Education and Job Skills to Lead an Independent Life	
Goal	
HDG4 Promote an excellent education system and opportunities for life-long learning for all Seattle residents.	The First Hill Major Institutions, including Virginia Mason, train a significant percentage of the health care and research practitioners in the Puget Sound and WAMI (Washington, Alaska, Montana, Idaho) region. In their partnerships with the University of Washington, Seattle Pacific University, Seattle University and Seattle Community College, they provide a substantial role in the development and retention of the intellectual capital of the region. This focus on education has generated a workforce that is very highly educated, with nearly 30% of downtown residents having attained a bachelor's degree or higher.[1] The Major Institution's ability to attract national and international talent, grants, research funding and venture capital places Seattle at the top of regional centers of innovation in the nation. Seattle was named Fast Company Magazine's "City of the Year" based on its high rate of creativity and innovation.[3]
Policy	
HD15 Strive to support families so their children can be ready to learn as they enter school. Help coordinate service delivery to families and their children through school-linked programs and support services.	Tender Loving Care, or TLC, is located on Virginia Mason's First Hill campus. TLC provides child care for children ranging in age from 1 year to 12 years old, offering parents the reassurance that their sick child will be well cared for while they work if the child is too ill to attend school. Virginia Mason provides child care for its employees at off-site locations operated by Bright Horizons.

[1] Downtown Seattle Association 2012 State of Downtown Economic Report
[2] Downtown Seattle Association 2012 State of Downtown Economic Report
[3] Fast Company, 2009

Major Institution Goals and Policies	Consistency of Virginia Mason's Master Plan
HD20 Work with schools and other educational institutions, community-based organizations, businesses and other governments to develop strong linkages between education and training programs and employability development resources.	Virginia Mason strongly supports medical education to ensure its patients and the community benefit from advances in medical care and in the development of future providers: • Virginia Mason is a premier teaching hospital that offers postgraduate education programs through its Graduate Medical Education (GME) Department. All GME postgraduate training programs are fully approved by the Accreditation Council on Graduate Medical Education (ACGME). Virginia Mason trains more than 100 residents and fellows annually. • Numerous Virginia Mason Medical Center physicians have faculty appointments at the University of Washington, publish original research and speak at conferences nationally and internationally on their areas of expertise. • Virginia Mason serves as an internship site for students in a variety of other health programs, such as nursing, pharmacy, respiratory therapy and laboratory technology. • Virginia Mason's GME program is partnered with Public Health – Seattle & King County Health Services Division, providing 12 residents for the Eastgate Public Health Center, as well as providing residents at the Carolyn Downs Family Medical Center, Pike Market Medical Clinic and North Public Health Center. • Virginia Mason provides a 0.5 FTE faculty member every fall, winter and spring quarter for undergraduate clinical nursing instruction for the University of Washington School of Nursing. • Virginia Mason Institute, or VMI, provides education and training in the Virginia Mason management method – known as the Virginia Mason Production System (VMPS) – to other health care providers and organizations. VMI's aim is to advance quality, safety and value by sharing VM's knowledge and experience in VMPS. VMI's education and training services cover a wide range of needs, from a basic understanding of the principles and practices that underlie VMPS, to in-depth education and hands-on work in applying VMPS methods that can transform an organization. VMI services include site visits to Virginia Mason, training in tools and methods, on-site assessments and education, and short-term and in-depth engagements.

Major Institution Goals and Policies	Consistency of Virginia Mason's Master Plan
D Effective Disease Prevention, Access to Health Care, Physical and Mental Fitness for Everyone	
Goal	
HDG6 Create a healthy environment where community members are able to practice healthy living, are well nourished, and have good access to affordable health care.	Virginia Mason's First Hill campus contributes to the health of the community by providing a vital pedestrian-accessible health care resource in the heart of First Hill's residential core, and within easy walking or transit distance of the downtown employment core. It also provides a rare, ADA-accessible pedestrian link up First Hill from downtown through the Pigott Corridor and the Terry Avenue breezeway. The Virginia Mason campus is frequented by community neighbors, visitors and workers who enjoy the variety of retail and public amenities on the campus and in the Pigott Corridor. Virginia Mason's restaurant, the Rhododendron, and its cafeteria are frequented by people looking for quality, well-prepared, healthy low-cost food. Virginia Mason's recent opening of the Friday Farmers Market brings fresh, healthy food into the heart of the First Hill community. Virginia Mason's focus on community health extends past the campus to providing classes and services through numerous outreach activities, and through providing students and staff to numerous community health care organizations.
Policies	
HD21 Encourage Seattle residents to adopt healthy and active lifestyles to improve their general health and well-being. Provide opportunities for people to participate in fitness and recreational activities and to enjoy available open space.	Virginia Mason sponsors numerous community activities that support healthy lifestyles and that generate donations for their research efforts including sponsoring the Seafair Benaroya Triathlon, the Seattle Marathon, the Boeing Classic Golf Tournament and other community activities through the Development Office. Virginia Mason's open spaces, including the Pigott Corridor and the Lindeman patio which hosts the Friday Farmers Market, are enjoyed by thousands of people each year. Virginia Mason's Transportation Demand Management program encourages staff to commute by bicycle or to walk by providing secure storage and showing facilities.

Major Institution Goals and Policies	Consistency of Virginia Mason's Master Plan
HD22 Work toward the reduction of health risks and behaviors leading to chronic and infectious diseases and infant mortality, with particular emphasis on populations disproportionately affected by these conditions.	Virginia Mason conducts medical research through its affiliate, Benaroya Research Institute at Virginia Mason (BRI), that is directly targeted at bringing innovations in medicine to the Seattle community and the world. BRI is focused on identifying causes and cures for devastating diseases affecting the immune system including diabetes, arthritis, heart disease and cancer, and through its translational research activities at the Virginia Mason hospital and clinics is bringing these research activities into clinical use. This ability to go from bench to bed is a crucial aspect of BRI's presence on Virginia Mason's First Hill campus and ties the hospital, clinics and laboratories together into a continuum of innovation. Virginia Mason also is a pioneer in the development of treatment options for persons living with HIV and AIDS, and other complex life-threatening illnesses like ALS and Huntington's disease. Its Bailey-Boushay House is a facility centered on providing exceptional care for the needs of this complex and challenging population. Its services range from supportive day health programs through chronic care management, hospitalizations, skilled nursing and hospice care. One-half of all of the people who die of AIDS in King County do so at Bailey-Boushay House. Bailey-Boushay also spearheads a host of programs targeted at reducing the transmission of HIV and increasing community awareness of this devastating illness.

Major Institution Goals and Policies	Consistency of Virginia Mason's Master Plan
HD23 Work to reduce environmental threats and hazards to health. Make use of the City's building and fire codes, food licensing and permit processes, and hazardous materials and smoking regulations for fire and life safety protection. Collaborate through joint efforts among City agencies, such as fire, police, and construction and land use to address health and safety issues in a more efficient manner.	Virginia Mason is an integral part of the regional disaster-response team. VM practices a variety of disaster drills, participates in larger community drills and stands ready to respond to regional needs, in collaboration with regional first responders. Virginia Mason has been undergoing a multiyear cleanup of contaminated soils on the 1000 Madison site. These efforts have stabilized the contaminants to the degree possible without removing the existing structures and soil. The redevelopment of this site will offer the opportunity to complete the remediation. The majority of Virginia Mason's existing buildings proposed to be redeveloped within this Master Plan no longer meet evolving seismic and other building codes. The cost to upgrade exceeds the cost to replace. This aging infrastructure will soon be unable to meet the significant technical requirements for the provision of health care services, or more efficient care delivery models, and will need to be replaced. Virginia Mason is a smoke-free campus and offers smoking cessation programs to all employees.

Major Institution Goals and Policies	Consistency of Virginia Mason's Master Plan
HD24 Seek to improve the quality of, and access to, health care, including physical and mental health, emergency medical and addiction services. Collaborate with community organizations and health providers to advocate for quality health care and broader accessibility to services. Pursue co-location of programs and services, particularly in under-served areas and in urban village areas.	Virginia Mason contributes to the quality of health care in Puget Sound through a wide range of services at its First Hill and regional satellite facilities. Virginia Mason has one of Seattle's largest full-service emergency rooms. Virginia Mason provides a range of mental health and addiction treatment programs at its facilities and at the Bailey-Boushay House. Virginia Mason's main campus is in the urban village of First Hill. It also improves community access to services by reaching out into vulnerable communities through its Graduate Medical Education program, which provides services in collaboration with Public Health – Seattle & King County Health Services Division in under-served areas, such as Carolyn Downs Family Medical Center, the Pike Market Medical Clinic and North Public Health Center. Virginia Mason is actively involved in health care reform activities and has recently been in the national spotlight for innovations in care that improve quality and lower cost. Virginia Mason is now teaching these innovative techniques through its Virginia Mason Institute (VMI) to other health care systems and community groups. Improving health and quality of life extends beyond diagnosis and treatment. It also requires community health education and outreach services. Health improvement and outreach services provided by Virginia Mason include the following: • Community health education, such as classes in the Buse Diabetes Teaching Center • Free health screenings in the community • Free flu shots and health screenings for the homeless in conjunction with United Way of King County's Community Resource Exchange • Sponsorship of many professionally facilitated support groups, including brain tumor, Parkinson's disease, breast cancer, gastric bypass surgery and prostate cancer groups • Bereavement support through its Separation and Loss Services • Leadership roles in several community organizations that focus on health care

Major Institution Goals and Policies	Consistency of Virginia Mason's Master Plan
HD24 continued	Virginia Mason strongly supports medical education to ensure its patients and the community benefit from advances in medical care and in the development of future providers: • Virginia Mason is a premier teaching hospital that offers postgraduate education programs through its Graduate Medical Education Department (GME). All GME postgraduate training programs are fully approved by the Accreditation Council on Graduate Medical Education (ACGME). Virginia Mason trains more than 100 residents and fellows annually. • Numerous Virginia Mason Medical Center physicians have faculty appointments at the University of Washington, publish original research and speak at conferences nationally and internationally on their areas of expertise. • Virginia Mason serves as an internship site for students in a variety of other health programs, such as nursing, pharmacy, respiratory therapy and laboratory technology. • Virginia Mason provides a 0.5 FTE faculty member every fall, winter and spring quarter for undergraduate clinical nursing instruction for the University of Washington School of Nursing.
HD25 Work with other jurisdictions, institutions and community organizations to develop a strong continuum of community-based long-term care services.	Virginia Mason shares its services on the First Hill campus with Group Health Cooperative of Puget Sound, Evergreen Medical Center, and Pacific Medical Center, who refer patients to the First Hill campus from their locations throughout the region for specialty or inpatient care. Group Health, Evergreen, and Pacific Medical Center staff work at the First Hill campus and are integrated into Virginia Mason's program of services. Virginia Mason's recent strategic partnership with Evergreen Medical Center – which serves County Public Hospital District number 2 – joins the largest providers of home care and hospice services in the Puget Sound region, seamlessly extending the continuum of community-based long-term care services to all of Virginia Mason's patients.

Major Institution Goals and Policies	Consistency of Virginia Mason's Master Plan
Economic Development Goals and Policies	
Goals	
EDG1 Add approximately 84,000 jobs in the city over the 20-year period covered by this Plan, in order to ensure long-term economic security and social equity to all Seattle residents.	Virginia Mason employs more than 5,500 people at eight regional medical sites and at three sites in Bothell, Georgetown and Metropolitan Park in Seattle, where administrative support services are decentralized. More than 460 physicians are employed by Virginia Mason, and many provide services at more than one location. Applying normal metrics of 3x the benefit, Virginia Mason Medical Center is indirectly responsible for the creation of over 15,000 jobs in the Puget Sound region. Benaroya Research Institute at Virginia Mason (BRI) houses an additional 200 researchers and staff, who indirectly generate another 600 jobs in the Puget Sound region. The Major Institutions continue to grow at an average rate of 5% a year and include within their employees staff at all income levels, cultures, languages and educational status.
EDG2 Recognize that Seattle's high quality of life is one of its competitive advantages and promote economic growth that maintains and enhances this quality of life.	Virginia Mason pays a living wage to its employees and offers generous benefits, including health coverage, retirement options and significant transit subsidy. Virginia Mason is a community asset that supports economic growth and enhances the quality of life in Seattle and the Puget Sound area. Employers want to locate in communities with first-class health care. Seattle's reputation as a leading force in biotechnology attracts the world's best physicians and scientists and enhances our international reputation as innovators in health care research, treatment and delivery. Seattle is one of the best cities for young professionals (Forbes.com, May 2010), young adults (The Business Journals, 2011) and families (Parenting magazine, 2011). Seattle is "the No. 1 post-recession mecca for young skilled workers" (The Wall Street Journal, October 2009).[4] This focus on knowledge-based employment has created a "wealth island" for Seattle, attracting businesses, talent and wealthier residents, largely attributed to "its diversified new-age corporate base" and "the strength of the high-tech sector."[5]

[4] Downtown Seattle Association 2012 State of Downtown Economic Report

[5] Seattle Times, October 25, 2011

Major Institution Goals and Policies	Consistency of Virginia Mason's Master Plan
EDG3 Support the Urban Village Strategy by encouraging the growth of jobs in Urban Centers and Hub Urban Villages and by promoting the health of neighborhood commercial districts.	Virginia Mason is located adjacent to downtown Seattle and is within the First Hill/Capitol Hill urban center, one of the densest residential and employment areas in the state. Virginia Mason's Master Plan will maintain and encourage the growth of jobs in this urban center. Virginia Mason has proposed to expand its MIO to include the 1000 Madison block. The block currently contains small one-story retail and restaurant uses along Madison Street, the landmarked Baroness Hotel and the 62-unit Chasselton Court Apartments. All properties within the block are owned by Virginia Mason. Virginia Mason is proposing to redevelop the block with major medical institution uses and to comply with the requirements of the NC-3 zoning along Madison Street, Boren Avenue and portions of Terry Avenue, which require street-level uses. If the proposed expansion to include the 1000 Madison block is approved, Virginia Mason intends to consider any of the following uses for potential location at street level along Madison and the portions of Boren and Terry within the NC3 zoning: medical services such as optical, eating and drinking establishments, retail sales and services, indoor sports and recreation, or perhaps lodging uses or additional open space. This change will offer both new retail jobs in the street-level retail development proposed along Madison Street and a significant growth short-term in construction jobs and longer term in health care employment. The neighborhood commercial area would be disrupted during the construction period. Some or all of those businesses may choose to move elsewhere on a temporary (during construction) or permanent basis and may be replaced with other similar uses in the long-term from uses listed above. Redevelopment of the block will increase the population in the immediate area and bring new patients and hospital staff to the street frontage of Madison Street between Boren and Terry Avenues. It will offer opportunities to remediate the contaminated soils in the 1000 Madison site and upgrade the buildings to be fully compliant with ADA and current code standards.

Major Institution Goals and Policies	Consistency of Virginia Mason's Master Plan
EDG4 Accommodate a broad mix of jobs, while actively seeking a greater proportion of living wage jobs that will have greater benefits to a broad cross-section of the people of the City and region.	See response to EDG1. Virginia Mason is a microcosm of a city and employs a broad mix of jobs ranging from medical professionals to food service, technology and education and pays a competitive compensation package to employees in all jobs.
EDG5 Encourage the growth of key economic sectors that build on Seattle's competitive advantages to provide sustained growth in the future.	Health care and education are key economic sectors in Seattle, providing one out of every six jobs.[6] Virginia Mason's continued growth in Seattle and the region will not only make the education and health care sectors more robust, but also will benefit manufacturing, real estate, government, professional, scientific, technical services and other sectors of the regional economy by providing their employees the quality affordable health care they need. Also, see response to EDG2 above.
EDG6 Develop a highly trained local workforce that effectively competes for meaningful and productive employment, earns a living wage and meets the needs of business.	See response to EDG1 and EDG4 above.
Policies	
ED2 Pursue opportunities for growth and strategic development, where appropriate, in urban centers and hub urban villages, which are planned for the greatest concentrations of jobs and job growth outside of downtown.	Virginia Mason is proposing to redevelop its campus to a higher density that reflects the underlying urban center zoning in order to be responsible stewards of its scarce land resources, contain sprawl and concentrate health care services where needed. Also see response to EDG3 above.

[6] Downtown Seattle Association 2012 State of Downtown Economic Report

Major Institution Goals and Policies	Consistency of Virginia Mason's Master Plan
ED10 Encourage key sectors of Seattle's economy that provide opportunities for long-term growth. Criteria for identifying sectors to support include the following: • Pay higher-than-average wage levels; • Bring new capital into the economy, reflecting multiplier effects other than high wage; • Have reasonably good future growth prospects; • Involve a cluster of businesses engaging in similar activities; • Use quality environmental practices; or • Diversify the regional economic base.	Through the hospital, research facilities and outpatient clinics, Virginia Mason provides opportunities for long-term growth in the health care and other sectors of the economy. Virginia Mason employs many staff in high-wage-earning jobs. The demand for health care services is expected to steadily grow both to serve an expanding regional population and to serve the needs of an aging population. Virginia Mason's location on First Hill with Swedish Medical Center, Harborview Medical Center and other health care providers creates a cluster of businesses engaging in similar activities. Virginia Mason's EnviroMason program is a regional model for environmental stewardship, and its transportation demand management program is one of the most successful programs in the region at encouraging employees to use non-SOV travel in their commutes. Also see EDG5 above.

Major Institution Goals and Policies	Consistency of Virginia Mason's Master Plan
ED12 Seek ways to create a local business environment that promotes the establishment, retention and expansion of high-technology industries in the city. Where possible, look for opportunities to link these businesses to existing research institutions, hospitals, educational institutions and other technology business.	First Hill has the unique benefit of hosting four of the region's 10 Major Institutions, which includes Virginia Mason, inferring upon the hill a center of emphasis on the health care, life sciences and education that is unique in the Pacific Northwest. These institutions are bolstered by and have been foundational incubators to other internationally acclaimed organizations like the Fred Hutchinson Cancer Research Center and the University of Washington Global Health program, and are a training and proving ground for developing regional and global expertise fueling the economic engines of research and development in organizations like Amgen, Zymogenetics, the Bill & Melinda Gates Foundation, the Seattle Biomedical Research Institute, Cell Therapeutics, Seattle Science Foundation, Dendreon, Seattle Genetics and many others. The First Hill institutions train a significant percentage of the health care and research practitioners in the Puget Sound region. In their partnerships with the University of Washington, Seattle Pacific University, Seattle University and Seattle Community College, they provide a substantial role in the development and retention of the intellectual capital of the region. Their ability to attract national and international talent, grants, research funding and venture capital places Seattle within the top five regional centers of innovation in the nation.

Virginia Mason's Bicycle Club members man the Bike Station in front of Benaroya Research Institute at 9th Avenue and Seneca Street on May 20, 2012, Bike to Work day.

Appendix C CONSISTENCY WITH CITY'S TRANSPORTATION STRATEGIC PLAN, TRANSIT PLAN, PEDESTRIAN PLAN AND BICYCLE PLAN

The City of Seattle has four transportation-related plans that are intended to form the long-range planning and short-range work programs of the City's Department of Transportation:

- Transportation Strategic Plan (adopted 2005)
- Transit Master Plan (adopted 2012)
- Seattle Pedestrian Master Plan. The Seattle Pedestrian Master Plan is a long-term action plan to make Seattle the most walkable city in the nation. The plan establishes the policies, programs, design criteria and projects that will further enhance pedestrian safety, comfort and access in all of Seattle's neighborhoods. Through the Pedestrian Master Plan, Seattle will make its transportation system more environmentally, economically and socially sustainable (adopted 2009).
- Seattle Bicycle Master Plan (adopted 2007). The Seattle Bicycle Master Plan defines a set of actions, to be completed within 10 years, to make Seattle the best community for bicycling in the United States. By increasing support for bicycling, the city will make its transportation system more environmentally, economically and socially sustainable.

Only plan elements that are directly applicable to Major Institutions or to Virginia Mason's location on First Hill are included in the consistency analysis below.

C.1 Transportation Strategic Plan

The Transportation Strategic Plan (TSP) is the 20-year functional work plan for the Seattle Department of Transportation (SDOT). The TSP describes the actions SDOT will take to accomplish the goals and policies in the Comprehensive Plan over the next twenty years.

Chapter 3 of the Transportation Strategic Plan includes seven plan elements: 3.1 Building Urban Villages; 3.2 Make the Best Use of the Streets We Have to Move People, Goods and Services: 3.3 Increase Transportation Choices; 3.4 Promoting the Economy: Moving Goods and Services; 3.5 Improving the Environment; 3.6 Connecting to the Region; and 3.7 Protect Our Infrastructure – Operations and Maintenance. Plan elements that are applicable to the Virginia Mason Master Plan are found in elements 3.2 and 3.3.

Table C.1 Consistency of Virginia Mason's MIMP With Transportation Strategic Plan

Transportation Strategic Plan Goals and Policies	Consistency of Virginia Mason's Master Plan
3.2 Make the Best Use of the Streets We Have to Move People, Goods and Services	
Applicable Goals	
TG3 Promote safe and convenient bicycle and pedestrian access throughout the transportation system.	Virginia Mason is proposing two pedestrian corridors through the campus to connect the east end of the Pigott Corridor (at the corner of University Street and Ninth Avenue) to Ninth Avenue/Madison Street and Madison Street/Boren Avenue. The corridors would be lighted and signed to promote safe and convenient access for both bicyclists and pedestrians between First Hill and downtown Seattle.
Applicable Policies	
T16 Recognize the important function of alleys in the transportation network. Consider alleys, especially continuous alleys, a valuable resource for access to abutting properties to load/unload, locate utilities and dispose of waste.	Virginia Mason is proposing to vacate the alley on the 1000 Madison block to allow for redevelopment of the block for major medical services. The alley is not continuous, as the alleys on the blocks north and south of this site were previously vacated and are now built over. Madison Street borders the alley on the south, and the four lanes of traffic present a barrier to continuous travel by alley to the south. Virginia Mason owns all of the property on the 1000 Madison block, so no impacts will occur to other property owners. As part of redevelopment of the block, Virginia Mason will provide areas for loading and unloading, the collection of waste and location of utilities.

Transportation Strategic Plan Goals and Policies	Consistency of Virginia Mason's Master Plan
3.3 Increase Transportation Choices	
Applicable Goals	
TG9 Provide programs and services to promote transit, bicycling, walking and carpooling to help reduce car use and SOV trips.	Virginia Mason has an aggressive Transportation Management Plan (TMP) and has proposed enhancements. See Section 5, Table 19 on page 103 of the Master Plan.
TG11 Strive to achieve the following mode choice goals for use of travel modes through the City's land use strategies and transportation programs: Proportion of work trips made using non-SOV modes First Hill/Capitol Hill 2020 Goal: 50% SOV	The stated goal of the Virginia Mason TMP as adopted from Seattle's Major Institutional code is to "reduce the percentage of employees of the Major Institution who commute to work by SOV to 50%, excluding employees whose work requires the use of the private automobile during working hours." The Land Use Code requires a reduction of SOV use to 50%. Virginia Mason's program has consistently surpassed that goal as demonstrated by past biennial Commute Trip Reduction (CTR) survey reports, summarized in Table 18 in Section E of the Master Plan. Currently 27% of those surveyed commute by SOV and 46% use transit or rail.
TG14 Increase transit ridership and thereby reduce use of single-occupant vehicles to reduce environmental degradation and the societal costs associated with their use.	See response to TG11.

Transportation Strategic Plan Goals and Policies	Consistency of Virginia Mason's Master Plan
TG16 Create and enhance safe, accessible, attractive and convenient street and trail networks that are desirable for walking and bicycling.	To improve connections for pedestrians, Virginia Mason is proposing to strengthen existing pedestrian connections at street level through the campus with focus on two pedestrian corridors One pedestrian corridor would extend from the east end of the Pigott Corridor north-south along University, east-west along Terry to Madison (through an interior connection in the redeveloped central block, similar to the current breezeway, and then along the north side of Madison to Boren. A second pedestrian corridor would extend north-south along Ninth Avenue between the east end of the Pigott Corridor and Madison Street. This is shown graphically in Figure 21 on page 51 in Section C of the Master Plan. The intent of the pedestrian corridors are to provide pedestrian-oriented street-level connections from the First Hill neighborhood through the Virginia Mason campus to downtown Seattle. Within these designated pedestrian corridors, Virginia Mason is proposing street trees and other landscaping, pedestrian-oriented lighting, street furniture, special paving, art and wayfinding (signage). Where appropriate, some of these measures will be included in the package of public benefits developed in support of the proposed alley vacation of the 1000 Madison block.

Transportation Strategic Plan Goals and Policies	Consistency of Virginia Mason's Master Plan
TG17 Manage the parking supply to achieve vitality of urban centers and villages, auto trip reduction and improved air quality.	Analysis of existing parking utilization and proposed Master Plan Alternative 6b indicates that the proposed parking supply of approximately 4,000 stalls would be sufficient to meet Virginia Mason's operational requirements to ensure patient access to facilities and still minimize the amount of parking provided for employees. Changes in transportation travel modes due to light rail access, implementation of services that allow improved electronic communication between patients and physicians, and increases in the cost to operate a vehicle may reduce the number of parking stalls needed to serve the increased demand resulting from Master Plan projects. Provision of new parking stalls associated with the development of any proposed or potential projects will be assessed during the project planning, programming and design phases.
Applicable Policies	
T17 Provide, support and promote programs and strategies aimed at reducing the number of car trips and miles driven (for work and nonwork purposes) to increase the efficiency of the transportation system.	See response to TG11.
T20 Work with transit providers to provide transit service that is accessible to most of the city's residences and businesses. Pursue strategies that make transit safe, secure, comfortable and affordable.	See response to TG11. Virginia Mason provides financial support for Metro Bus route 211 and participates in the Transit Now agreement along with Swedish and Harborview Medical Centers to increase service to the King Street Station and the ferry terminal.

Transportation Strategic Plan Goals and Policies	Consistency of Virginia Mason's Master Plan
T24 Work with transit providers to design and operate transit facilities and services to make connections within the transit system and other modes safe and convenient. Integrate transit stops, stations and hubs into existing communities and business districts to make it easy for people to ride transit and reach local businesses. Minimize negative environmental and economic impacts of transit service and facilities on surrounding areas.	Virginia Mason is served by a variety of transit options. Buses traveling along Madison Street, Seneca Street, Ninth Avenue and Boren Avenue provide links to downtown, Seattle neighborhoods and suburban cities. The transit stops within or adjacent to Virginia Mason's property are shown on Figure 22 in Section C of the Master Plan. Virginia Mason intends to work with Metro Transit to identify ways in which Virginia Mason could improve landscaping, lighting, wayfinding or other pedestrian-scale amenities around the bus stops within the boundaries of Virginia Mason property to enhance the transit rider's experience. These improvements would be implemented as street frontages are redeveloped, or as routine landscaping or sidewalk maintenance is performed. A streetcar line is under construction along Broadway connecting the light-rail station on Capitol Hill near Seattle Central Community College on the north end to the Yesler Terrace/International District on the south end with downtown Seattle. The nearest stop to Virginia Mason would be at Broadway Avenue and Marion Street, approximately four blocks southeast of Virginia Mason. Bus Rapid Transit and significant transit improvements are planned along Madison Street per the City of Seattle Department of Transportation's recently adopted 2012 Transit Master Plan. Virginia Mason will work closely with the City to implement the recommendations within the plan as the 1000 Madison block is redeveloped. This planned redevelopment offers the opportunity to realize the vision of this plan.
T25 Work with transit providers to ensure that the design of stations and alignments will improve how people move through and perceive the city, contribute positively to Seattle's civic identity and reflect the cultural identity of the communities in which they are located.	See response to T24.

Transportation Strategic Plan Goals and Policies	Consistency of Virginia Mason's Master Plan
T30 Improve mobility and safe access for walking and bicycling, and create incentives to promote non-motorized travel to employment centers, commercial districts, transit stations, schools and major institutions, and recreational destinations.	As described in Table 19 of Section E of the Master Plan (TMP), Virginia Mason provides 75% transit subsidy for bus, ferry and trains through the ORCA program; provides a guaranteed ride home in case of family emergency; provides Zipcar access to employees for personal and business use (five hours each per month); and provides fleet vehicles for business use. All are intended as incentives to promote nonmotorized travel to work.
T33 Accelerate the maintenance, development and improvement of existing pedestrian facilities, including public stairways. Give special consideration to access to recommended school walking routes; access to transit, public facilities, social services and community centers; and access within and between urban villages for people with disabilities and special needs.	See response to TG16 and T24.

Transportation Strategic Plan Goals and Policies	Consistency of Virginia Mason's Master Plan
S7. Encourage the retention of alleys for service and access to property. Improved alleys are an important part of Seattle's street network. The primary purpose of alleys is to provide for access to adjacent properties, utilities and service functions. Wherever possible, it is important that service and utility functions be located in alleys to protect the character of the adjacent streets that serve a broader purpose, such as access to property by pedestrians, bicyclists, transit patrons as well as for street trees and landscaping and other amenities. In neighborhood business districts, SDOT may allow adjacent property owners to provide pedestrian-oriented design features in the alley. SDOT makes these decisions on a case by case basis and requires that the alley's primary purpose is met, public safety issues are addressed and the property owner agrees to maintain the improvements. SDOT will continue to work with City Council, the Seattle Design Commission, property owners and community groups to retain alleys for their primary purpose through project review for alley vacations and improvements.	See response to T16.

C.2 Transit Master Plan

The City of Seattle Transit Master Plan is a 20-year plan that identifies the types of transit facilities, services, programs and system features that will be required to meet Seattle's transit needs through 2030. The Transit Master Plan identifies capital investment priorities needed to establish a network of top quality, frequent transit services that meets the travel needs of most Seattle residents and workers. The TMP evaluates and recommends preferred transit modes for high priority corridors and sets a framework for implementing corridor-based transit improvements in close coordination with other modal needs.

Consistent with broader transportation system goals, the Transit Master Plan will guide the City of Seattle in developing a complete transit system that:

- Makes riding transit easier and more desirable, bringing more people to transit for more types of trips
- Uses transit to create a transportation system responsive to the needs of people for whom transit is a necessity (e.g., youth, seniors, people with disabilities, low-income populations, people without autos)
- Uses transit as a tool to meet Seattle's sustainability, growth management and economic development goals
- Creates great places at locations in neighborhoods where modes connect to facilitate seamless integration of the pedestrian, bicycle and transit networks
- Balances system implementation with fiscal, operational and policy constraints
- The TMP directs the SDOT to make capital and service investments to help achieve this vision and goals. A strong set of policies will ensure that capital investments are optimized to create a more sustainable, economically resilient and equitable city.

The Virginia Mason Master Plan is supportive of a number of strategies found in Chapter 2 of the Transit Master Plan as described in Table C.2. Only those strategies that are applicable to Virginia Mason or its location on First Hill are included in Table C.2 on page 136.

Table C.2 Consistency of Virginia Mason's MIMP With Transit Master Plan Strategies

Transit Master Plan Strategies	Consistency of Virginia Mason's Master Plan
Strategy: Invest in Programs That Build Transit Ridership	
Develop a Safe Routes to Transit (SR2T) Program: The goal of an SR2T program is to reduce physical barriers to transit use, making access to public transit easier and more convenient. The program should be designed to improve pedestrian, bicycle and motor vehicle movement around high-volume transit stops and stations. SR2T could also provide an opportunity for neighborhoods to submit projects for funding consideration each year. Funding for an SR2T program could leverage local match funds from neighborhood groups or private developers interested in improving transit access around station areas or in priority bus corridors. An SR2T program could be structured to complement development incentives in transit station areas or priority corridors. Activities could include the following: • Secure bicycle storage at transit stations and stops • Safety enhancements for pedestrian and bicycle access to transit hubs, stations and stops	Virginia Mason's existing and proposed Transportation Management Plans include the following measures to support bicycle use: • Locked bike cages with weather protection and a minimum capacity of 75 parking spaces • Shower facilities and lockers in multiple locations • Support for the Virginia Mason Bicycle Club to encourage ridership and improve bike storage, security, shower facilities and benefits for frequent riders.

Transit Master Plan Strategies	Consistency of Virginia Mason's Master Plan
Develop Transit Information and Wayfinding Standards: Challenging topography, multiple transit providers and recently introduced rail transit modes have created significant variability in public information for accessing transit and navigating a complex network of services in Seattle. The TMP (see Chapter 5) identifies guidelines and design standards for enhancing public information and wayfinding. SDOT should build on the work of the TMP and develop a detailed set of standards to govern transit wayfinding in Seattle and to coordinate with other modal and neighborhood-specific wayfinding programs. This effort would: • Develop design standards and specifications for wayfinding improvements, including simplified maps and signs to help orient transit users and others toward facilities in specific areas (e.g., Center City, near a rail station, in an urban village commercial district) • Facilitate coordination between Sound Transit, Metro and other transit operators regarding public information provided at intermodal hubs such as King Street Station, downtown Seattle transit tunnel stations and transfer points • Develop standards for coordination of pedestrian and bicycle wayfinding • Develop standards to ensure transit information is included in neighborhood wayfinding programs	To improve connections for pedestrians and bicyclists, Virginia Mason is proposing to strengthen existing pedestrian connections at street level through the campus with focus on two pedestrian corridors: between the corner of the Pigott Corridor at the corner of University/Ninth Avenue and Madison/Boren, and between the Pigott Corridor along Ninth Avenue to Madison Street as shown in Figure 21 on page 51 in Section C of the Master Plan. One pedestrian corridor would extend from the east end of the Pigott Corridor north-south along University, east-west along Terry to Madison (through an interior connection in the redeveloped central block, similar to the current breezeway, and then along the north side of Madison to Boren. A second pedestrian corridor would extend north-south along Ninth Avenue between the east end of the Pigott Corridor and Madison Street. The intent of the pedestrian corridors is to provide pedestrian-oriented street-level connections from the First Hill neighborhood through the Virginia Mason campus to downtown Seattle. Within these designated pedestrian corridors, Virginia Mason is proposing street trees and other landscaping, pedestrian-oriented lighting, street furniture, special paving, art and wayfinding (signage). Where appropriate, some of these measures will be included in the package of public benefits developed in support of the proposed alley vacation of the 1000 Madison block.

Transit Master Plan Strategies	Consistency of Virginia Mason's Master Plan
Invest in Transportation Demand Management Programs That Increase Transit Use: The City of Seattle, King County, and Seattle businesses and institutions already support a strong suite of transportation demand management (TDM) programs. Still, further investment in TDM remains among the most cost-effective ways to support growth in transit ridership and encourage Seattle residents and workers to get out of their cars and try walking, biking and transit. TDM programs that could be particularly effective in Seattle and would add to the suite of programs already in place include the following: Develop programs that help employees realize the true cost of parking by making transit more price-competitive with driving: Parking cash out is an effective employer-based strategy that allows an employer to charge employees for parking while giving employees a bonus or pay increase to offset the cost of parking. Employees may use this increase to pay for parking or may choose an alternative mode and "pocket" the difference. Other similar employer-based financial incentive programs include: allowing employees to purchase individual days of parking on a prorated basis comparable to monthly rates; providing a few free days of parking each month for employees who usually commute using a non-SOV mode; offering lower parking rates to carpools and vanpools; and offering cash in lieu of free parking to provide a choice for employees.	Virginia Mason is within the center city area and the MIMP provides for growth in facilities and patients, while encouraging transit use and discouraging vehicle use through the elements of the proposed Transportation Management Program. See Table 19 in Section E of the Master Plan, which describes the existing and proposed enhancements to Virginia Mason's TMP. As a major employer in Seattle, Virginia Mason contributes to the funding of transit improvements through taxes, subsidy of transit routes and subsidy of employee transit passes. Virginia Mason also participates in a group that coordinates with Metro and SDOT to support First Hill transit planning.

Transit Master Plan Strategies	Consistency of Virginia Mason's Master Plan
Develop Transit Corridor Zoning Overlays: Transit-supportive overlay zoning should be expanded beyond light-rail station areas to transit-supported urban villages, urban centers and commercial corridors. This expansion could be coordinated with regional efforts being led by Puget Sound Regional Council (PSRC) to develop model transit overlay ordinance language. Recommended elements of an effective overlay zone ordinance could include expansion of policies that require or incentivize: • Increased development capacity • Zoning setbacks in redevelopment corridors where additional right of way may be needed to support transit, bicycle or pedestrian facilities (e.g., Fifth Avenue near Seattle Center) • Improved building frontages at transit stations or stops on High Capacity Transit or Priority Bus Corridors, including promoting the active use of building frontages for passenger shelter and providing ground floor windows • Allowing outdoor seating for restaurants and pedestrian-oriented accessory uses, such as flower, food or drink stands • Requirements that paved areas contain pedestrian amenities such as benches, drinking fountains, and other design elements (e.g., public art, planters, kiosks, overhead weather protection) and provide physical separation from driving lanes with landscaping or planters • Limitations on driveways that cross sidewalks where pedestrians access transit • Review and enhance existing requirements for bicycle parking • Requirements for bicycle parking	The TMP identifies Madison Street as a future transit corridor. The MIMP provides additional setback and wider-than-required sidewalks on Madison Street to support pedestrian circulation, transit stops and small businesses, and to enhance the streetscape. The proposed MIMP provides for enhancements to streetscapes within the Master Plan boundary to encourage pedestrian travel, provide bicycle facilities and create stronger links to transit stops.

C.3 Seattle Pedestrian Master Plan

The Seattle Pedestrian Master Plan is a long-term action plan to make Seattle the most walkable city in the nation. The plan establishes the policies, programs, design criteria and projects that will further enhance pedestrian safety, comfort and access in all of Seattle's neighborhoods. Through the Pedestrian Master Plan, Seattle will make its transportation system more environmentally, economically and socially sustainable.

In order to do this, the plan identifies actions, projects and programs to achieve the goals of safety, equity, vibrancy and health. These four goals and their relationship to the MIMP are described below.

Table C.3 Consistency of Virginia Mason's MIMP With Seattle Pedestrian Master Plan Strategies

Pedestrian Master Plan Strategies	Consistency of Virginia Mason's Master Plan
Safety: Reduce the number and severity of crashes involving pedestrians	To improve connections for pedestrians, Virginia Mason is proposing to strengthen existing pedestrian connections at street level through the campus with focus on two pedestrian corridors: between the corner of the Pigott Corridor at the corner of University/ Ninth Avenue and Madison/Boren, and between the Pigott Corridor along Ninth Avenue to Madison Street as shown in Figure 21 on page 51 in Section C of the Master Plan. One pedestrian corridor would extend from the east end of the Pigott Corridor north-south along University, east-west along Terry to Madison (through an interior connection in the redeveloped central block, similar to the current breezeway, and then along the face of Madison to Boren. A second pedestrian corridor would extend north-south along Ninth Avenue between the east end of the Pigott Corridor and Madison Street. The intent of the pedestrian corridors are to provide pedestrian-oriented street--level connections from the First Hill neighborhood through the Virginia Mason campus to downtown Seattle. Within these designated pedestrian corridors, Virginia Mason is proposing street trees and other landscaping, pedestrian-oriented lighting, street furniture, special paving, art and wayfinding (signage). Where appropriate, some of these measures will be included in the package of public benefits developed in support of the proposed alley vacation of the 1000 Madison block.

Pedestrian Master Plan Strategies	Consistency of Virginia Mason's Master Plan
Safety (continued)	See Section 3.9 of the MIMP EIS for a discussion of pedestrian-related collisions in the vicinity of Virginia Mason. It is anticipated that Master Plan projects would include improvements to adjacent sidewalks and street crossings within the Master Plan boundary to enhance pedestrian circulation and safety.
Equity: Make Seattle a more walkable city for all through equity in public engagement, service delivery, accessibility and capital investments	Section D.13 of the MIMP describes how Virginia Mason, through its community outreach and education programs, serves the community in this area.
Vibrancy: Develop a pedestrian environment that sustains healthy communities and supports a vibrant economy	It is anticipated that Master Plan projects would include improvements to adjacent sidewalks and street crossings within the Master Plan boundary to enhance pedestrian circulation and safety. The portion of the Master Plan area along Madison Street will be redeveloped and include a wider sidewalk and provisions for pedestrian amenities that will support pedestrian circulation and local businesses.
Health: Raise awareness of the important role of walking in promoting health and preventing disease	Virginia Mason, through its community outreach and education programs, provides services to the community that encourage healthy living and general wellness in the First Hill neighborhood. These programs include the Personal Health assessment program for employees, which rewards employees for healthy behaviors including walking with financial and other incentives; the Farmers Market in the warmer months on the Lindeman Pavilion patio, which encourages neighbors, patients, visitors and staff to come out for healthy foods; the multitude of classes and therapies stressing walking as a critical component of a patient's lifestyle; and the focus on walking for patients as a critical step in transitioning from hospital to home.

C.4 Seattle Bicycle Master Plan

Adopted in 2007, the Seattle Bicycle Master Plan defines a set of actions, to be completed within 10 years, to make Seattle the best community for bicycling in the United States. By increasing support for bicycling, the city will make its transportation system more environmentally, economically and socially sustainable. Those actions that are applicable to Virginia Mason are included in C.4.

Table C.4 Consistency of Virginia Mason's MIMP With Seattle Bicycle Master Plan Strategies

Bicycle Master Plan Strategies	Consistency of Virginia Mason's Master Plan
Goal 1: Increase use of bicycling in Seattle for all trip purposes.	The Transportation Management Program as described in Section E of the MIMP contains elements to subsidize and encourage bicycle use by Virginia Mason employees. Virginia Mason also supports the Virginia Mason Bicycle Club, which provides support to bicyclists and evaluates program components.
Goal 2: Improve safety of bicyclists throughout Seattle. Reduce the rate of bicycle crashes by one-third between 2007 and 2017.	Virginia Mason provides support for bicycle use as a commuting mode, and this support includes information on bicycle safety.
Goal 2: Objective 2: Provide supporting facilities to make bicycle transportation more convenient. In order for bicycling to be a fully viable form of transportation in Seattle, other programs and facilities are needed to complement the Bicycle Facility Network. This includes integrated bicycle and transit services, adequate bicycle parking at all destinations, showers at employment centers, convenient repair services, and coordination with a variety of other essential components of a multimodal transportation system.	Virginia Mason's existing and proposed Transportation Management Plans include the following measures to support bicycle use: • Locked bike cages with weather protection and a minimum capacity of 75 parking spaces • Shower facilities and lockers in multiple locations • Support for the Virginia Mason Bicycle Club to encourage ridership and to improve bike storage, security, shower facilities, and benefits for frequent riders.

Appendix D PUBLIC MEETINGS ON THE VIRGINIA MASON MEDICAL CENTER MAJOR INSTITUTION MASTER PLAN

D.1 List of Public Meetings Held on the Virginia Mason Medical Center

8/23/2010	Virginia Mason Filed Notice of Intent with the City of Seattle
11/1/2010	Citizens Advisory Committee selected
12/2/2010	Citizens Advisory Committee forming meeting
12/8/2010	Virginia Mason filed the Concept Plan with the City of Seattle
12/8/2010	Meeting with DPD
12/16/2010	Citizens Advisory Committee meeting #1
1/3/2011	City initiates the SEPA process, signs go up notifying the neighborhood
1/26/2011	Citizens Advisory Committee Meeting - SEPA scoping meeting #2
2/8/2011	Meeting with City of Seattle Office of Housing
2/17/2011	Meeting with City of Seattle DPD on SEPA scoping
3/1/2011	Start tours of existing Virginia Mason campus for CAC members - occur over next 3 months
4/7/2011	Meeting with SDOT to discuss street impacts of concept plan
4/27/2011	Citizens Advisory Committee meeting on Preliminary Draft Master Plan #3
5/25/2011	Citizens Advisory Committee meeting on Preliminary Draft Master Plan #4
6/22/11	Citizens Advisory Committee meeting on Preliminary Draft - working session #5
7/12/2011	Presentation to the First Hill Improvement Association on Preliminary Draft Master Plan
7/27/2011	Citizens Advisory Committee meeting on Preliminary Draft Master Plan #6
8/6/2011	Presentation to the Parkview condominium Homeowners Association
8/24/2011	Citizens Advisory Committee meeting #7 on PDMIMP and PDEIS CAC letter
9/27/2011	Meeting with DPD and EIS consulting team to discuss schedule changes
10/26/2011	Citizens Advisory Committee meeting #8 to review path forward
11/19/201	Community Workshop held on Vision for VM campus - meeting #9
12/7/2011	Citizens Advisory Committee meeting #10 to review workshop findings
1/11/2012	Citizens Advisory Committee meeting #11 reviews draft Goals and Objectives
1/25/2012	Citizens Advisory Committee meeting #12 cancelled due to snowstorm impacts
2/22/2012	Citizens Advisory Committee meeting #12 held on massing options
3/14/2012	Citizens Advisory Committee meeting #13 held on height, bulk and scale - concept 6b approved by the members present

5/23/2012	Citizens Advisory Committee meeting #14 held on Design Guidelines
6/27/2012	Citizens Advisory Committee meeting #15 held on Draft EIS contents
7/19/2012	DPD published Notice of Availability of Draft EIS, Draft MIMP & Draft Design Guidelines
7/25/2012	Citizens Advisory Committee meeting #16 held to begin developing comments on Draft MIMP and Design Guidelines
8/8/2012	Citizens Advisory Committee meeting #17 held to continue developing comments on Draft MIMP and Design Guidelines
8/22/2012	Public Meeting to receive comments on Draft EIS, Draft MIMP and Design Guidelines
8/22/2012	Citizens Advisory Committee meeting #18 held to develop comments on Draft EIS
9/20/2012	Meeting with SDOT on Design Guidelines
9/24/2012	Meeting with Office of Housing on housing replacement
9/26/2012	Citizens Advisory Committee meeting #19 held to discuss VM and DPD responses to CAC comments on DEIS and Draft MIMP

Appendix E DESIGN GUIDELINES

(Under Separate Cover)

Appendix F SEATTLE CITY COUNCIL FINDINGS, CONCLUSIONS AND DECISION

(Attached)

SEATTLE CITY COUNCIL

FINDINGS, CONCLUSION AND DECISION

VIRGINIA MASON MEDICAL CENTER MAJOR INSTITUTION MASTER PLAN

CLERK FILE 311081

December 6, 2013

Introduction

This matter involves the petition of Virginia Mason Medical Center (VM) to establish a new Major Institution Master Plan ("MIMP") and rezones to expand the boundary of the major institution overlay (MIO) and correct a mapping error in the First Hill neighborhood (Clerk File 311081).

The proposed MIMP includes the approval of a physical development plan, a new Transportation Management Plan regulating commuting and parking, development standards governing new construction, and a rezone to expand the existing boundaries of the (MIO) District. The rezone would extend the MIO boundary into two areas and increase the MIO from7.7 acres to 8.1 acres.

One part of the proposed expansion is simply the correction of a mapping error to correctly show the existing MIO boundary as approved in 1994. The other expansion of the boundary encompasses the block bordered by Madison Street, Terry Avenue, Spring Street and Boren Avenue. Attachment A shows the proposed MIO expansion and the existing MIO boundary and zoning.

In late 2010, VM began the process of establishing a new MIMP. In December 2010, a Citizens Advisory Committee (CAC) began its review of the proposed MIMP. The CAC held a total of 23 meetings over two years to review various plans, reports, studies and technical information concerning VM's planned growth. A significant element of these meetings included the consideration of public comment on a variety of issues, both for and against the various alternative development proposals detailed in the MIMP.

On March 7, 2013, the Department of Planning and Development (DPD) issued the Analysis, Recommendation and Determination of the DPD Director, recommending that the MIMP be approved subject to conditions. On March 26, 2013, the CAC issued its Final Report and Recommendation, recommending that the MIMP be approved subject to conditions.

One CAC member, Dr. Sharon Sutton, abstained from voting on the approval of the MIMP and authored a minority report. In her report, she stated that she abstained because the she disagreed with the Seattle Municipal Code provision that prevents the CAC from negotiating an institution's determination of its need for growth. The minority report also argues that the housing VM must construct or fund to replace housing units lost in the 1000 Madison block

should be "equal in all respects" to the units demolished, and thus, affordable to those making 50% or less of the median income.

On April 22, 2013, the Hearing Examiner held a public hearing on MIMP and rezone. On May 20, 2013, the Hearing Examiner issued a recommendation that the Council approve the MIMP, with 63 conditions in support of this recommendation.

Council review

The City Council's Planning Land Use and Sustainability Committee (PLUS) began consideration of the proposed MIMP at its September 25, 2013 meeting. PLUS continued its discussion of the proposed MIMP at subsequent meetings.

At the October 30, 2013 meeting, PLUS invited the parties of record to respond to options for housing replacement conditions for the proposed MIMP. Council staff described these options, different in certain respects from those recommended by the Hearing Examiner, in the memorandum to PLUS dated October 25, 2013. At the November 22, 2013 PLUS meeting, parties of record responded to the options.

On November 25, 2013, Council introduced a bill for the MIMP and MIO rezone, subject to Council's Findings, Conclusions and Decision, and referred the bill to the PLUS Committee for consideration and potential approval.

On December 11, 2013, PLUS voted to recommend adoption of the bill as referred, subject to the conditions of the FCD. The conditions in the FCD are the same as those recommended by the Hearing Examiner, except for the following adjustments:

- formatting and re-organization for ease of reading and clarity;
- defining the area of "greater First Hill neighborhood" consistently throughout the conditions;
- making DPD responsible for submitting proposals for replacement housing to the Standing Advisory Committee for review and comment; and
- requiring the same specifications for replacement housing for both the build and pay options.

The Council hereby adopts the following Findings, Conclusions and Decision.

Findings of Fact

Background

1. Virginia Mason is a nonprofit regional health care system that includes 460 primary and specialty care physicians and a 336-bed acute-care teaching hospital. It employs approximately 5,500 people.

2. Virginia Mason is located just east of downtown, on the west slope of First Hill and within the First Hill Urban Center Village. It has been in this location since 1920. The campus slopes down from southeast to northwest and is bounded generally by University Street on the north, Spring Street on the south, Boren Avenue on the east, and the alley west of 9th Avenue on the west.

3. The surrounding neighborhood is a mix of medium- to high-density residential uses, medical and educational institutions, a few single-family residences, and commercial uses centered on Madison Street. To the north, across University Street, are Horizon House, a continuing care retirement community, and Kindred Hospital. To the east are several multifamily residential buildings and a private fraternal club. To the west, across the alley from the 9th Avenue Parking Garage, are several multifamily residential buildings. North of the Garage and adjacent to the Virginia Mason's Benaroya Research Institute, is a new multifamily residential building under construction. To the south is the "1000 Madison Block," which Virginia Mason owns and proposes to incorporate into its major institution overlay (MIO).

4. The 1000 Madison Block is comprised of a multifamily residential complex (the Chasselton Court Apartments), a designated landmark (the Baroness Hotel), a small accessory structure, and approximately 25,000 square feet of small scale retail uses fronting Boren Avenue and Madison Street. Further south, across Madison Street, is the Cabrini First Hill Senior Apartment structure. Diagonally across Madison is the Swedish First Hill Medical Center MIO. West of the 1000 Madison Block and south of the main Virginia Mason hospital are the Sorrento Hotel, also a historic landmark, and several multifamily residential buildings.

5. The neighborhood is home to four of the City's major institutions: Swedish Medical Center; Harborview Medical Center; Seattle University; and Virginia Mason. See Exhibit 8[1], FEIS, Figure 3.4-3 at 3.4-9; Exhibit 9, Final Major Institution Master Plan (MIMP), Figure 9 at 31.

6. In addition to its main campus and the 1000 Madison block on First Hill, Virginia Mason owns a network of seven satellite medical facilities; support facilities located in Georgetown, Bothell, and the Metropolitan Park West building in downtown Seattle; and the Bailey-Boushay House, a skilled-nursing facility and chronic care management program for people with HIV/AIDS and others suffering from life-threatening illnesses, which is located approximately 2 miles outside the Virginia Mason MIO. Virginia Mason leases space at 1111 Harvard Avenue for its employee day care program and space on Spring Street, between Boylston and Harvard Avenues, for a playground.

Prior Major Institution Master Plan

7. Virginia Mason's last major institution master plan was adopted in 1994 and expired in 2004. It includes a single height district, MIO 240, which is higher than the 160-foot base height of the underlying Highrise Residential zoning but lower than that zone's maximum height of 300-feet. Pursuant to an agreement with Horizon House, also expired, several locations within the MIO were conditioned to heights between 95 feet and 190 feet. See MIMP Figure 19 at 46.

[1] Exhibits as numbered in the Hearing Examiner's record.

8. The existing major institution master plan allowed construction of 1.66 million gross square feet. The existing MIO includes 12 buildings with a total of approximately 1.23 million gross square feet spread over approximately 7.1 acres. See MIMP Table 2 at 24.

9. Virginia Mason owns all of the land within the MIO except the public rights of way. The MIO includes portions of Terry and 9th Avenues, and Seneca, Spring, and University Streets.

10. The Land Use Code prescribes a minimum of 1,667 parking stalls to serve the existing development, but Virginia Mason provides 1,426 parking stalls, including 884 stalls on campus and 542 stalls leased at several nearby properties within 2,500 feet of the MIO boundary. MIMP Figure 27 at page 72 shows the location of all Virginia Mason leased parking.

Procedural Background and Environmental Review

11. Virginia Mason submitted a Notice of Intent to Prepare a New Master Plan on August 23, 2010 and began work with the Department of Neighborhoods toward formation of a Citizens Advisory Committee (CAC). The CAC held a total of 23 meetings over a period of two-plus years. Public correspondence and comments received by the CAC are included with its Final Report, Exhibit 13.

12. Virginia Mason submitted a Concept Plan to the Director on December 8, 2010. Exhibit 2. The Concept Plan included several alternatives for discussion, and the first CAC meeting occurred on December 16, 2010.

13. The Director began the environmental review process with publication of a SEPA determination of significance on January 6, 2011. Public scoping of the requisite environmental impact statement occurred from January 6, through February 3, 2011. From public comments and CAC input, the Director determined the issues and alternatives to be analyzed in the draft environmental impact statement (DEIS) and final environmental impact statement (FEIS). The comments are summarized in the Director's Report, Exhibit 11, at 6-8.

14. Virginia Mason submitted a Preliminary Draft Master Plan to the Director on August 11, 2011. On November 19, 2011, Virginia Mason, the CAC and neighboring residents met in an all-day design charrette and workshop to begin development of a set shared goals and objectives for development of Virginia Mason within the neighborhood. These goals and objectives formed the basis for development of design guidelines that would implement them. The Final Design Guidelines include a table that ties each guideline to the corresponding goal and objective. MIMP Appendix E at 49-65. The Standing Advisory Committee (SAC) will use the Design Guidelines to review projects implementing the MIMP and to monitor construction and construction impacts.

15. Virginia Mason submitted a second Preliminary Draft Master Plan on May 11, 2012. On July 19, 2012, the Director published a notice of the availability of the Draft MIMP and DEIS. Exhibits 4, 5 and 6. The Director held a public hearing on the draft documents on August 22, 2012, and the written comment period ended on September 3, 2012. A total of 12 comment

letters were received, and four people testified at the hearing. The FEIS includes a transcript of the hearing, all written comments on the DEIS and the Director's responses to the public testimony and written comments. Exhibit 8 at 4-1 through 4-71 and 5-1 through 5-25.

16. A Final Master Plan was submitted to the Director and the CAC in December of 2012, and the Director published a notice of availability of the FEIS and Final Master Plan on December 13, 2012. Exhibits 7, 8 and 9.

17. The FEIS examines two alternatives in addition to the no action alternative: The preferred action (also referred to as Alternative 6b), which would involve adding approximately 1.7 million square feet of gross floor area to an expanded MIO that encompasses the 1000 Madison block; and a "no boundary expansion alternative" that would add the same amount of gross floor area but locate it within the existing MIO boundary through increased heights and bulk.

18. The FEIS reviews the impacts to the affected environment in Section III. The land use impacts of the preferred action and alternatives are reviewed at pages 3.4-12 through 3.4-22. Height, bulk and scale impacts are analyzed at pages 3.6.2-1 through 3.6.2-16, and impacts to viewsheds are considered at pages 3.6.1-1 through 3.6.1-19. The FEIS concludes that the preferred action would have no significant unavoidable adverse land use or height, bulk and scale impacts. Exhibit 8 at 3.4-22 and 3.6.2-16. As to views, the FEIS concludes that potential skybridges included in both action alternatives would alter identified view corridors. Exhibit 8 at 3.6.1-19.

19. The FEIS also evaluates the preferred action's impact on housing, including loss of the 62 units in the Chassleton Court Apartments. Exhibit 8 at 3.5-1 to 3.5-14. The 55 studio units are affordable to those with incomes at 50% to 55% of the median area income, and the seven one-bedroom units are affordable to those earning 65% to 76% of the median area income. Both groups would be considered "low-income" under HUD Guidelines for the metro area. Exhibit 8 at 3.5-3 to 3.5-4. The FEIS includes a discussion of the factors that could be considered in determining what would be "comparable" housing for replacement of the Chassleton Court units. Exhibit 8 at 3.5-12.

20. Transportation impacts are analyzed at pages 3.9-1 through 3.9-75 of the FEIS and include an analysis of peak hour levels of service at 33 intersections in the vicinity and at nine parking garage access points within the MIO boundary. In 2042, five signalized intersections are forecast to operate at LOS E with the MIMP whereas three would operate at that level with the no action alternative. Further, three intersections would operate at LOS F with the MIMP compared to one intersection in the no action alternative. Congestion on 9th Avenue, and the potential for vehicle/pedestrian/bicycle conflicts at road crossings and mid-block locations, are also noted. The FEIS observes that the key factor that will drive increases in campus- generated trips (and parking demand) is anticipated increases in out-patient services to an aging population that will frequently need to travel by car. Mitigation strategies are suggested, but long-term solutions are left to citywide planning efforts that would address congestion through trip reduction and corridor improvement strategies. Exhibit 8 at 3.9-75.

21. The FEIS includes an evaluation of the alternatives' relationship to the City's plans, policies and regulations, including major institution policies, the First Hill Neighborhood Plan, and the Swedish Medical Center and Seattle University MIMPs. Exhibit 8 at 3.4-23 to 3.4-44.

22. The CAC received the draft Director's Report on January 23, 2013 and discussed the report at its final two meetings. The final CAC report was issued on March 26, 2013 and recommended adoption of the MIMP with conditions. Exhibit 13 at 3. A minority report was prepared by one CAC member, who also testified at the Examiner's hearing. The minority report disagrees with the Code provision that prevents the CAC from negotiating an institution's determination of its need for growth. The report also argues that the housing Virginia Mason must construct or fund to replace housing units lost in the 1000 Madison block should be "equal in all respects" to the units demolished, and thus, affordable to those making 50% or less of the median income. See Exhibit 13 at 123-125.

23. Most of the CAC's recommendations were incorporated into the recommendations included in the final Director's Report. In its prehearing brief and at hearing, Virginia Mason expressed agreement with the recommendations included in the final Director's Report and with all but one of the recommendations included in the CAC report. Virginia Mason opposes the CAC's recommendation that Virginia Mason increase to 25% its voluntary goal of making 10% of replacement housing units affordable to persons making less than 80% of the median area income (low income under HUD Guidelines).

24. The Examiner received no written comments on the MIMP. Five members of the public testified at the Examiner's public hearing: two former Virginia Mason patients, a housing advocate from Bellwether Housing, a businessman who is a member of the Virginia Mason Board of Directors, and a member of the CAC who signed the majority report. All testimony was supportive of the proposed MIMP. However, the CAC member, who lives in the neighborhood, made three related points in his testimony: 1) the First Hill Neighborhood Plan is greatly outdated and needs to be updated soon to address the issue of the combined neighborhood impacts of all four major institutions and the Yesler Terrence redevelopment; 2) successful retail in the NC3 zone along Madison Street has always been dependent upon on-street parking, which is to be eliminated; and 3) pedestrian safety at the intersection of Terry Avenue and Spring Street is an urgent problem that should be addressed before redevelopment of the 1000 Madison block is complete.

Proposed MIMP

25. Under the Code, a master plan is a conceptual plan for a major institution that consists of a development program component; a development standards component; and a transportation management program. SMC 23.69.030.A. The MIMP includes all three components.

Goals and Objectives

26. Virginia Mason states the core goals of the MIMP process as, "to fully understand the capacities and constraints inherent in the redevelopment of the existing properties, to collaborate

with the surrounding neighborhood on how to best accommodate this growth and to smooth the development process." MIMP at 6.

27. The detailed goals and objectives of the MIMP, as developed with the CAC and neighbors, are set forth in Table 1 and address campus buildings; landscaping and open space; campus mobility; neighborhood vitality and character; environmental stewardship; transit, traffic and parking; and construction impacts. MIMP at 8-12.

28. Virginia Mason has determined that its core hospital functions require approximately 422,000 square feet of contiguous area that must be located as close as possible to the Jones Pavilion, which houses the Emergency Department. Additional space is required for associated expanded clinical care, specialty care, and research facilities. Virginia Mason projects an annual growth rate of 2.8% for clinic and specialty care demand. It estimates that the total area needed by 2040 will be 3,029,567 gross square feet. See MIMP Table 4 at 29.

29. Virginia Mason bases its estimated growth needs on regional population growth, an aging population that requires increasing levels of care, its own aging infrastructure, and changes in modern health care requirements. It cites code changes, such as seismic, fire and life safety, and updated health standards, such as the need for larger single-patient rooms for privacy and disease control and to accommodate complex equipment at the bedside, as well as the fact that the cost of upgrading existing facilities to meet current standards often exceeds the cost of replacing them. See MIMP at 17-19, 25-29.

Development Program

30. Planned and Future Development. Details of the proposed development program are found at pages 63 through 94 of the MIMP.

31. No changes are proposed to Virginia Mason's existing MIO height limits. Properties conditioned to heights lower than 240 feet, in accordance with the expired agreement between Virginia Mason and Horizon House, retain those heights in the MIMP. See MIMP Figures 19 and 20 at 46 and 47, respectively. MIMP Figure 23 at page 64 is a three-dimensional representation of proposed building heights.

32. Virginia Mason proposes expansion of the MIO boundary by 1.41 acres, for a total of 8.48, acres, through the addition of the 1000 Madison block. The northern half of this block is currently zoned HR, and the southern half is zoned Neighborhood Commercial-3 with a 160-foot base height limit and a pedestrian overlay. The MIMP proposes MIO-240 for the entire block, with the height of the existing Baroness Hotel conditioned to 80 feet. Virginia Mason seeks a rezone for this expansion and height increase.

33. Virginia Mason also seeks a rezone to correct the existing MIO district boundary map to accurately reflect Virginia Mason's ownership of property currently developed as a parking lot at the intersection of University Street and Terry Avenue. The legal description for the parcel under Virginia Mason ownership includes lots 9 and 12 plus the south 20 feet of Lot 8 of block 112. However, when the original MIO boundary was mapped, the line was drawn at the boundary line

between lots 8 and 9. The mapping error was not corrected when the 1992 MIMP was adopted. Virginia Mason is also requesting that the existing MIO 240 overlay on lots 9 and 12 be extended to encompass the south 20 feet of Lot 8.

34. The MIMP includes no expiration date. The projects are conceptual, and the MIMP would remain in place until the allowed square footage was constructed. Planned uses include hospital replacement, clinic replacement, research, infrastructure, parking, and other uses related to Virginia Mason's functions.

35. There are four planned projects, which could be completed by 2025: 1) demolition of all structures on the 1000 Madison block except the Baroness Hotel and construction of a replacement hospital facility; 2) demolition of the Cassel Crag/Blackford buildings1 and construction of medical office and clinic facilities on the site; 3) demolition of the buildings on the Lindeman 2 site and construction of medical office and clinic facilities; and 4) demolition of the Ninth Avenue Parking Garage and construction of medical research facilities and underground parking.

36. There are two potential projects, which could be completed by 2035: 1) demolition of the core hospital building and construction of office and/or medical facilities on the site; and 2) replacement of the parking lot on the northeast corner of the intersection of Terry Avenue and University Street with new office and/or medical facilities.

37. The MIMP shows two major development sequences and some minor projects, with one sequence focused first on replacing hospital space, and the other sequence focused first on replacing clinic space. MIMP Figure 28 at page 74 illustrates the sequences, and they are described on pages 74-76. The details of development under the MIMP are listed on page 66.

38. The hospital replacement sequence would begin with demolition of the Chassleton Court Apartments and the retail structures on the 1000 Madison block. Phase 1 of the hospital replacement would require construction of a new hospital on the 1000 Madison block with a connection to emergency services in the recently constructed Jones Pavilion (on Boren Avenue) via a tunnel or skybridge. Phase 2 would replace the portion of the hospital located between Spring and Seneca Streets and east of Terry Avenue. The central portion of the existing hospital located west of Terry would either be replaced as a third phase of hospital development, or as a fourth phase of clinic development, depending upon future need.

39. Phase 1 of the clinic replacement sequence would begin with development of the half block between University and Seneca Streets, east of Terry Avenue. Cassel Crag and Blackford Hall would be demolished to allow construction of new clinical facilities. Phase 2 would involve demolition and new construction on property located east of the Lindeman Pavilion, at the northeast corner of the intersection of Seneca and 9th Avenue. Demolition and construction at the southeast corner of the intersection of Seneca and 9th Avenue and just to the east on Seneca Street would follow.

40. Once sufficient parking was created under either sequence, the Ninth Avenue Parking Garage would be demolished and replaced with underground parking topped with medical

research and medical/office spaces. The parking lot located on the northeast corner of the intersection of University Street and Terry Avenue could also be developed once sufficient replacement parking was available.

41. Density. Under SMC 23.69.030.E.2, density for a major institution is calculated across the entire campus using floor area ratio (FAR). Virginia Mason's current FAR is 3.99, lower than the 4.3 FAR allowed by the expired MIMP. At full buildout of all planned and potential projects under the MIMP, the campus FAR would be 8.1, which is consistent with the maximum FAR allowed in the underlying HR zone. The following spaces are excluded from FAR calculation: above and below-grade parking; below-grade space; rooftop mechanical space/penthouses; in buildings over 85 feet in height, an equipment allowance of 3.5% of non-exempt gross floor area; ground floor commercial uses meeting the requirements of SMC 23.45.532, if the street level of the structure containing the commercial uses has a minimum floor to floor height of 13 feet and a minimum depth of 15 feet; skybridge and tunnel circulation space within the public right-of-way; interstitial space that cannot be occupied (mechanical floors/levels); and other similar spaces that cannot be occupied, as approved by the Director.

42. Alley Vacation, Skybridges and Tunnels. The MIMP proposes a future application to vacate the alley in the 1000 Madison block to allow hospital and commercial development on the block. The MIMP also anticipates a future need for skybridges and/or tunnels for circulation above or below Terry and 9th Avenues and Spring, Seneca, and University Streets. See MIMP Figure 29 at 77. The MIMP includes a list of initial screening questions for use in determining whether a future sky bridge or tunnel would be needed. MIMP at 79.

43. Housing. The MIMP calls for demolition of the Chasselton Court Apartments and a small garage structure on the 1000 Madison block to allow construction of a replacement hospital. The Chasselton is an 85-year-old, unreinforced masonry structure which has an assessed valuation of $2.6 million and has not been upgraded to meet current seismic or construction code standards. A 2009 seismic evaluation of the building concluded that it has substantial deficiencies and that structurally upgrading it would cost between $7.5 and $12.5 million. Exhibit 17. The 55 studio and seven one- bedroom apartments are rented at market rates. However, as noted in the FEIS, they are considered affordable for those earning between 50 and 76 percent of the median income, and would be considered affordable to "low income" households under established HUD guidelines for the area. Virginia Mason proposes to provide comparable replacement housing, and has agreed to a replacement housing condition recommended by the Director. See Exhibit 11 at 70-73.

44. Maximum Number of Parking Spaces. As noted, Virginia Mason presently provides 1,426 parking stalls, which is fewer than the Code- prescribed minimum of 1,667 stalls. The maximum number of parking stalls allowed by Code for the proposed action is 4,041. The MIMP proposes a parking supply of approximately 4,000 stalls but recognizes that changes in transportation travel modes and medical service delivery modes, as well as increases in vehicle operation costs, may reduce the number of stalls needed. A recommended condition requires that SEPA analysis of each proposed development under the MIMP include a traffic study and review of then-current parking demand.

45. Consistency with Purpose and Intent of Chapter 23.69 SMC. The MIMP's analysis of this factor is contained in the discussions under the following sections: MIMP goals, objectives and intent; Virginia Mason's mission; regional growth and health care needs; the existing campus, including programmatic needs and community-campus integration; applicable goals, policies and public benefits of the development program; and portions of the text in each MIMP element.

Development Standards

46. The development standards component of the MIMP is found at pages 31 through 61. The MIMP's consistency with applicable sections of the City's Land Use Code is analyzed in MIMP Table 15 at pages 80-88.

47. Height. As noted, no change is proposed to the height districts within Virginia Mason's existing MIO. MIO-240 is proposed for the entire 1000 Madison block expansion area, with the Baroness Hotel conditioned to MIO-80.

48. Setbacks. The MIMP proposes to meet or exceed setbacks for the underlying zone with one exception. SMC 23.47A.014.B requires a setback for development on an NC-zoned lot that abuts a residential zone. The north half of the 1000 Madison block is zoned HR, and the south half is zoned NC. Virginia Mason is seeking a waiver of the setback requirement in this location to allow development of a hospital structure across the block. See MIMP Figure 20 at 47.

49. MIMP Tables 5 through 12 at pages 36-45 summarize the setbacks for each block within the proposed MIO, and Figures 10 through 18 at pages 34-44 depict them. Along most street frontages, the MIMP proposes ground level setbacks of seven to 10 feet, with an additional 10-foot upper-level setback for heights above 45 feet. Along Madison Street, the upper-level setback would be 40 feet. The MIMP proposes setbacks from the Baroness Hotel of 20 feet on the east side and 40 feet on the south side. In accordance with the Code, the MIMP shows no ground level structure setback from the alley west of 9th Avenue, and shows an upper-level setback of 10 feet above 45 feet in height. However, Virginia Mason has agreed to a CAC recommendation that would increase those setbacks to seven and 12 feet, respectively.

50. Facade Width, Floor Size and Building Separation. Because hospital functions normally require larger floor plates than those typically found in high rise residential structures, the MIMP proposes elimination of Code-imposed limits on building facade width, floor size, and building separation in the HR zones. Virginia Mason intends to rely on setbacks, modulation requirements, and the Design Guidelines to mitigate height, bulk and scale impacts.

51. Street-Level Uses and Facades in the NC Zone. Within the underlying NC3/P zone along Madison Street and Boren and Terry Avenues, the MIMP proposes to meet Code-required standards for street level uses and facades.

52. Lot Coverage. The underlying HR and NC3 zones do not regulate lot coverage. The MIMP defines the maximum available building envelope on any single site through identified setbacks and open space. The existing campus-wide lot coverage is approximately 98%, with 1.9

percent of the campus in open space. The MIMP proposes that a minimum of 4% of the campus be dedicated open space, which would result in a campus-wide lot coverage of 96%.

53. Landscaping and Open Space. The MIMP proposes to add 6,600 square feet of open space to the existing 9,400 square feet of campus open space. The existing 3,400 square feet of public open space just west of the Lindeman Pavilion will be expanded to a public open space plaza of approximately 10,000 square feet. See MIMP Figure 21 at 51. Virginia Mason will work with both Horizon House and the SAC to identify the location, design, and accessibility of the space. Landscaping standards for the underlying HR zone require a Green Factor score of .5 or greater for residential development of more than one dwelling unit. The MIMP proposes that Virginia Mason not be required to comply with this Green Factor unless it develops housing. However, Virginia Mason would comply with Green Factor requirements for new commercial uses in the NC3/P zone along the southern half of the 1000 Madison block.

54. Landscaping within the existing MIO is located in planting areas adjacent to buildings, courtyard entrances, and within the landscaped open space area adjacent to the Pigott Corridor, which connects Freeway Park to University Street and 9th Avenue. Virginia Mason and Horizon House will continue to maintain this landscaped area under an agreement with the City's Park and Recreation Department. Virginia Mason has also embarked on a multiyear project to upgrade its landscaping and will involve the SAC in this effort. Virginia Mason proposes to incorporate landscaping within building setback areas and will consider green roofs and building terraces where feasible. MIMP Figure 21 at page 51 shows Virginia Mason's existing and future landscape and open space plans and also includes key pedestrian corridors.

55. Pedestrian and Bicycle Circulation. Pedestrian and bicycle circulation are addressed at page 59 of the MIMP. Some "Key Pedestrian Streets" identified in the First Hill Neighborhood Plan are included within the existing and proposed MIO boundaries. The MIMP notes the few connections across Interstate 5 between First Hill and downtown, the steep slopes that that limit the usefulness of some streets for bicyclists, and the need for pedestrian and bicycle improvements on others. The MIMP proposes to strengthen pedestrian connections at street level with a focus on the connection between the Pigott Corridor and the intersection of Madison Street and Boren Avenue to the southeast, and the intersection of Madison Street and 9th Avenue to the south. A recommended condition requires that pedestrian facilities be upgraded to existing City standards as individual blocks or frontages are developed along any street within the MIO. Accessibility will also be evaluated and ADA accessibility measures included where feasible. The existing "Breezeway," which connects Spring and Seneca Streets at Terry Avenue, will remain open to pedestrians at all times.

56. Virginia Mason's Transportation Management Program supports bicycle use by employees, and a large percentage of them commute by bike. Virginia Mason also offers bicycle parking at each major building entrance. The need for additional bicycle amenities and bicycle access will be considered in the programming for each new building under the MIMP.

57. View Corridors. Boren Avenue and Interstate 5 are both SEPA- designated scenic routes in the vicinity of the MIO. Development under the MIMP would not impact westerly views from Interstate 5 because of its elevation relative to Virginia Mason. Setbacks provided in the MIMP

would protect westerly views from Boren Avenue along University, Seneca, Spring, and Madison Streets. There is an existing skybridge across Seneca Street. As noted above, the MIMP anticipates other potential skybridges, and the FEIS includes visual simulations of them. A more detailed analysis of their visual impact would be part of each project level review.

58. Development under the MIMP would not affect street-level views of any of the four historic landmarks in the vicinity, but views of the upper floors of both the Baroness and Sorrento Hotels would be affected. The FEIS includes an analysis of these impacts, but a more detailed review would be done at the project level. The FEIS notes that westerly views from First Hill Park toward downtown and Elliott Bay along University Street would be affected by development under the MIMP. FEIS at 3.6.1-4.

59. Preservation of Historic Structures. Of all the buildings on the Virginia Mason Campus that are over 25 years old, only the Baroness Hotel has been designated a historic landmark. The Cassel Crag Apartments and the Inn at Virginia Mason/Rhododendron Restaurant have been nominated, but were not designated. Existing controls and incentives address alterations or significant changes to the exterior of the Baroness Hotel, and adjacent development will be reviewed by the Landmarks Preservation Board. The landmark status of other buildings would be reviewed as each site within the MIO is proposed for redevelopment.

60. Loading and Service Facilities. Under Table A for SMC 23.54.035, the 3 million gross square feet proposed by the MIMP at buildout would require 22 offstreet loading berths. Because Virginia Mason has worked to maximize delivery flows, and multiple campus buildings share four common central loading areas, Virginia Mason has asked the Director to waive loading berth formulas and require only capacity sufficient to meet actual need as established during project review.

61. Transit Access. Virginia Mason is served by multiple buses on Madison and Seneca Streets and 9th and Boren Avenues, and a stop for the First Hill streetcar line will be located nearby, at Broadway Avenue and Marion Street. Existing Metro transit stops adjacent to Virginia Mason property are shown on MIMP Figure 22 at page 61. The MIMP states that Virginia Mason will work with Metro Transit concerning potential improvements that could be implemented as street frontages are developed. Madison Street is designated as a Major Transit Street for which a bus rapid transit line is proposed. To provide for high pedestrian volume, the MIMP proposes 10-foot setbacks along Madison, which will yield an 18.5-foot space between the building façade and curb. The MIMP also proposes public amenities within the space, such as street trees, landscaping, pedestrian-scale lighting, street furniture, weather protection, special paving, art, and wayfinding.

Transportation Management Program

62. The Transportation Management Program (TMP) is found at MIMP pages 101 through 108. Virginia Mason's 1994 TMP achieved a single occupancy vehicle rate of 27%, with 46% of employees using the bus or rail to get to work, and 10% bicycling or walking. The proposed TMP is a continuation of the 1994 TMP with enhancements. A comparison of the TMP elements is found at MIMP pages 103 through 108.

Conclusions

1. The Hearing Examiner has jurisdiction over this matter pursuant to Chapters 23.69 and 23.76 SMC.

2. The Director's report, Exhibit 11, includes a detailed analysis of the proposed MIMP in accordance with the criteria included in SMC 23.69.032.E, and of the proposed rezones pursuant to SMC 23.34.008 and .124. Except as otherwise indicated, the Director's analyses are adopted.

3. The intent of the Comprehensive Plan's Major Institution Goals and Policies, and the Major Institution Code, Chapter 23.69 SMC, is to balance public benefits of a major institution's growth and change with the need to protect the livability and vitality of adjacent neighborhoods.

4. Virginia Mason's assessment of its need for growth is reasonable in light of the age of its existing facilities, regional growth, the increasing health care needs of an aging population, and the physical space demands associated with current health care delivery. A peer review of Virginia Mason's expansion program by an architecture and planning firm and a consulting firm specializing in healthcare planning determined that the MIMP was within the range of acceptable planning for similar replacement hospitals, but was planning at the low end of current standards for hospital programming. See Exhibit 14.

5. The public benefits of Virginia Mason's proposed growth and expansion are described in the record and include: increased employment opportunities; continued provision of uncompensated care, community health improvement services, subsidized health care services, a comprehensive environmental stewardship program; expanded facilities for medical research; continued support for medical education; an enhanced TMP; and enhanced open spaces, landscaping, and pedestrian amenities throughout the campus, which will be available to the public.

6. The proposed boundary expansion to the 1000 Madison block has drawbacks. For example, it would increase the MIO by 1.41 acres, result in the demolition of 62 units of housing affordable to low-income individuals, impact views of two landmarks, and bring the Virginia Mason campus to Madison Street, a key commercial corridor for the neighborhood, where it would face the Swedish Medical Center MIO diagonally across the street. However, Virginia Mason's existing campus is relatively small and compact. Further, the evidence supports Virginia Mason's assertion that it needs space outside its existing campus on which to construct a replacement hospital, adjacent to emergency services in the Jones Pavilion, before it can demolish the existing hospital and repurpose that space. The record shows that Virginia Mason could achieve its institutional goals and development needs within its existing boundaries only through additional heights and bulk that were not acceptable to the CAC or the community.

7. The proposed rezones should be approved. One would correct the mapping error in the boundary line of the Terry Avenue/University Street parking lot and expand the MIO 240 height to the 20-foot strip of Lot 8 under Virginia Mason ownership. The other would expand the MIO to incorporate the 1000 Madison block (bounded by Boren and Terry Avenues and Madison and

Spring Streets) and extend the MIO 240 height to that block, with the Baroness Hotel conditioned to 80 feet. The rezone of the 1000 Madison block was shown to be consistent with applicable rezone criteria. It could have bulk and scale impacts, but those will be mitigated by the setbacks proposed for the Baroness Hotel and Madison Street, by the Design Guidelines, by attention to edge conditions as prescribed in the MIMP, and by the conditions recommended below.

8. To maintain the housing stock of the City, the Code prohibits new or expanded MIO boundaries that would result in the demolition of residential structures unless comparable replacement housing is proposed. The Director's Report analyzes the issue of "comparability" and suggests a condition addressing it. The CAC expressed a strong preference that replacement housing be "affordable" and asked for a voluntary goal that 15 units, or 25 percent of all housing constructed as replacement, would be affordable to those making less than 80% of the median area income. As noted, the minority report expressed the opinion that all replacement housing should be as affordable as the existing units in the Chasselton Court Apartments.

9. Maintenance of the City's low-income housing stock is a complex issue. The Chasselton Court units are market-rate apartments that are affordable to low-income individuals only because of their location in a privately owned, substandard building and the availability of similar housing in the neighborhood. Further, existing codes would not allow construction of units that were truly "comparable" to those in the Chasselton Court. Consequently, replacement units will inevitably exceed the existing units in structural integrity, quality of construction, desirability, and construction cost.

10. The recommended housing condition accommodates the CAC's strong preference that all replacement housing be located on First Hill. The language also allows, but does not require, a voluntary goal that 25% of the replacement housing be affordable to those earning less than 80% of the area median income. The recommended condition is similar to those imposed on two recently approved master plans, and it represents an appropriate balance of the factors included in the concept of "comparable" replacement housing.

11. The MIMP is consistent with the Comprehensive Plan, and the proposed development is consistent with the Goals and Policies under the Education and Employability and Health in the Human Development Element. These, as well as economic development goals and policies, are discussed in MIMP Appendix B, and in the Director's Report at pages 37-38.

12. The MIMP components comply with the Code and should be approved subject to the recommended conditions. The development program is consistent with SMC 23.69.030. The development standards further the goals and objectives of the MIMP and the Major Institution Policies. The TMP includes the required elements and satisfies SMC 23.54.016. The Design Guidelines, which were very important to the CAC and the community, will guide SAC review of development under the MIMP.

13. All environmental issues have been adequately addressed in the MIMP and the Director's recommended conditions.

14. With the recommended conditions, the proposed MIMP fulfills the intent and requirements of the Major Institution Code and should be approved.

DECISION

The Council hereby **approves** the proposed MIMP for Virginia Mason Medical Center, Clerk File 311081, subject to the following conditions:

Master Plan

1. The Standing Advisory Committee (SAC) will review and comment during the schematic and design stage of all proposed and potential projects intended for submission of applications to the City as follows: Any proposal for a new structure greater than 4,000 square feet or building addition greater than 4,000 square feet; proposed alley vacation petitions; and proposed street use term permits for skybridges. Design and schematics shall include future mechanical rooftop screening. The SAC will use the Design Guidelines checklist (Appendix E) for evaluation of all planned and potential projects outlined in the MIMP.

2. The goal for the TMP is to maintain the employee SOV rate below 30 percent.

3. Prior to Master Use Permit submittal of the Madison block redevelopment, submit to SDOT for review and acceptance a concept streetscape design plan for the north side of Madison Street between Boren and Terry Avenues. Virginia Mason shall submit a draft of the Plan to the SAC for its review and comment concurrent with review by SDOT.

The plan shall be consistent with the provisions of the Seattle Right-of-Way Improvements Manual. Elements of the plan must include, but are not limited to: a minimum 18-foot-wide sidewalk; street trees and landscaping; continuous facade-mounted overhead weather protection; seating and leaning rails; pedestrian scaled lighting; transit patron amenities, such as real-time bus arrival displays; and wayfinding that directs pedestrians to campus uses and the Bus Rapid Transit on Madison, as well as other transit options, such as the First Hill Street Car and transit connections to Sound Transit light rail.

4. Prior to approval of the first Master Use Permit for development under the final MIMP, submit to DPD for review and approval a comprehensive wayfinding plan incorporating entry points to and through the campus for pedestrians, bicyclists and motorists. DPD shall consult with SDOT in its review. Virginia Mason shall submit a draft of the Plan to the SAC for its review and comment concurrent with review by SDOT.

5. Virginia Mason shall coordinate with King County Metro to ensure existing transit stops are not impacted by development.

6. Current transit stops shall be incorporated into street improvement plans that are submitted with development. Amenities, such as benches and landscaping, should be provided and maintained by Virginia Mason.

7. Virginia Mason shall provide and maintain recycling and trash receptacles at any bus stop directly abutting Virginia Mason development.

8. Prior to issuance of a Master Use Permit for redevelopment of the Lindeman block, Virginia Mason shall present the open space plan to the SAC and Horizon House for review and comment and obtain DPD approval of the plan. Provision of a total of 10,000 square feet of open space on this block is a requirement of development approval of the plan.

9. In the event a development footprint on the Lindeman block would preclude 10,000 square feet of public open space on that block, Virginia Mason shall submit a plan for review and comment by the SAC that shows Virginia Mason's actual open space plan for this site and where the remaining open space requirement would be provided. Prior to issuance of a Master Use Permit for the Lindeman block site, or for any development or addition exceeding 4,000 square feet on the site, Virginia Mason shall present the open space plan to the SAC for review and comment and obtain DPD approval of the plan. Provision of this open space shall be a requirement of development approval of the plan. Relocation of open space from the Lindeman Pavilion block to another location within the campus shall include an open space concept plan, including a Shadow Study, for the new location and will be reviewed as a minor amendment to the Master Plan.

10. No un-modulated facade shall exceed 110 feet in length. Modulation shall be achieved by stepping back or projecting forward sections of building facades. Modulation shall be perceivable at the building block scale, which is identified in the Design Guidelines as 200-400 feet.

11. With each Master Use Permit application, and each skybridge term permit application, Virginia Mason shall provide an updated view corridor analysis for that specific project.

12. Specific buildings have been conditioned to have lower height limits than MIO 240 (Benaroya Institute, Lindeman, Jones Pavilion and the Baroness Hotel). Conditioned heights are shown on page 47 of the MIMP. Existing buildings, and any future buildings that have not been identified in the MIMP, may not exceed the conditioned height limits on these sites. Any request to change the conditioned heights shall require a major amendment to the MIMP.

13. No new surface parking lots are included in the MIMP. Any change of use within the MIO to surface parking for up to six months shall be considered a minor amendment to the MIMP. Such a change of use for a period greater than six months shall be considered a major amendment.

14. For new construction, the mechanical equipment, screening, and penthouses, with the exception of minor plumbing and ventilation stacks, may not exceed the MIO height limit of 240 feet or the conditioned height, whichever is lower.

15. With each subsequent Master Use Permit application, Virginia Mason shall provide an analysis of the impacts of parking driveways, loading and service area drives, and pick-up/drop-off areas on pedestrian and vehicular flow on the surrounding sidewalks and streets. Appropriate

design measures shall be identified and implemented to avoid adverse impacts to pedestrians, bicyclists and motorists.

16. Five years after the effective date of the MIMP, and every five years thereafter, Virginia Mason shall hold a public meeting to review its annual report and other information intended to illustrate the status of MIMP implementation. The meeting shall be held in conjunction with a meeting of the SAC, and shall be widely advertised to the surrounding community and include the opportunity for public comment.

Revisions to MIMP Text

17. Revise page 32, text under Proposed Structure Setbacks, Figures 10 and 14 and Table 8 of the Final MIMP to state and show graphically that the future building located on the Ninth Avenue Garage redevelopment site will have a maximum depth (east/west) of 93 feet. The east and west lower and upper level building setbacks shall be based on the merits of the building design and by balancing the needs of the residents to the west and the needs of the pedestrian experience on 9th Avenue. A minimum setback of seven feet shall be required for portions of the building 45 feet or less in height and 12 feet for portions of the building above 45 feet in height.

18. Revise Figure 10 (page 34 of MIMP) to remove the area that appears to be an alley but is actually an existing driveway, and correct the setbacks shown on the east side of the Cassel Crag/Blackford Hall site to 7' for portions of building <45' and 20' for portions of building >45'.

19. Revise Figure 12 (page 37 of MIMP) to remove the notation of "alley" on the east side of the Cassel Crag/Blackford Hall site. The area is an existing driveway.

20. Revise Table 6 (page 37 of MIMP) Proposed Building Setbacks - Cassel Crag/Blackford Hall Block, row labeled "Abutting an Alley". Replace this label with "Abutting an Interior Lot Line". The Code language shall read "Land Use Code requires 7' average/5' minimum setback for portions of buildings <45' in height and 20' for portions of buildings >45' in height". The "Street/Avenue" column shall be changed from "Alley" to "Interior Lot Line". In the columns under Virginia Mason's proposal, change "0" to "7" feet for portions of structure <45' and change "10" to "20" feet for portions >45'.

21. On page 50 of the MIMP under Street-Level Uses and Facades in NC zones, the last sentence of the second paragraph shall be amended as follows:

"If the proposed expansion to include the 1000 Madison block is approved, Virginia Mason intends to consider any of the following uses for potential location at street level along Madison Street and the portions of Boren and Terry Avenues within the NC-3 zoning and would be in compliance with the underlying zoning: medical services such as optical, eating and drinking establishments, retail sales and services, indoor sports and recreation, or perhaps lodging uses or additional open space."

22. On page 54, the fourth sentence of the third full paragraph shall be amended as follows:

~~"The average life of a street tree in Seattle is approximately 15 years, demonstrating an ongoing need for~~ Virginia Mason to be is committed to maintaining mature street trees where possible and replacing trees as needed over time.

23. On page 79, the second sentence of the last paragraph in the description of the Chasselton Court Apartments shall be corrected as follows:

"The majority of the apartments are studio apartments (55 units) with ~~six~~ seven one-bedroom apartments."

24. On page 80, the description of Virginia Mason's housing replacement proposal shall be replaced with the following:

Virginia Mason's housing replacement shall:

- Provide a minimum number of units equal to the number of units in the Chasselton Court apartments (62 units);
- Provide no fewer than seven one-bedroom units and no units smaller than the size of the studio units in the Chasselton Court apartments;
- Include a minimum of 31,868 net rentable square feet, equivalent to that in the Chasselton Court apartments;
- Be of a construction quality equal to or greater than that in the Chasselton Court apartment units; and
- Be located within the greater First Hill neighborhood, defined as the area between Interstate Highway 5 on the west, Pike Street on the north, 12th Avenue and Boren Avenue on the east, and the south boundary of Yesler Terrace on the south, as shown outlined in a broken black line on Figure 1 at page four of the MIMP.

Revisions to Design Guidelines (Appendix E)

25. On page 44, the following sentence shall be added at the beginning of the first paragraph on the right side of the graphic: "The views of upper level facades are of great importance to residents in surrounding highrise buildings."

26. On page 45, amend 2.b "Multiple Views," as follows:

Design buildings, including rooftops, street level facades, and upper level facades with consideration of how they will appear to viewers from surrounding residential buildings, non-motorized travelers at street level, and motorized travelers.

27. On page 74, under 5.a, "Consider the building from multiple vantage points," add "Views of Upper Level Facades".

28. The underlying street-level development standards for commercial zones shall apply, per SMC 23.47A.008, to all street-facing facades in the underlying NC3-160 Pedestrian designated zones including Madison Street and portions of Boren and Terry Avenues.

29. In the event that development occurs along Madison Street, all existing businesses facing termination of leases and relocation shall: 1) be provided assistance from both the City of Seattle Office of Economic Development and Virginia Mason to identify available spaces in the surrounding areas for permanent or interim relocation; and 2) receive advance notice of the availability of lease space in the completed development. Virginia Mason is encouraged to continue leasing the existing commercial structures on the 1000 Madison Block until they are demolished for new construction.

30. Before Virginia Mason may receive a permit to demolish the Chasselton or change the use of the Chasselton to a non-residential major institution use, DPD must find that Virginia Mason has performed either of the following two options:

a. Virginia Mason has submitted or caused to be submitted a building permit application or applications for the construction of comparable housing to replace the housing in the Chasselton. The building permit application(s) for the replacement housing project(s) may not include projects that were the subject of a MUP application submitted to DPD prior to Council approval of the MIMP. Minor involvement by Virginia Mason in the housing project, such as merely adding Virginia Mason's name to a permit application for a housing project, does not satisfy Virginia Mason's obligation under this option. If Virginia Mason chooses performance option a, it is encouraged to:

- Contribute to the housing replacement project in a manner that will assure that at least 10% of the units (i.e., a number equal to 10% of the demolished units, or a total of 7 units) will be rented for at least 10 years at rates affordable to persons earning less than 80% of the median area income; and

- Utilize a design that allows the project to compete effectively for public and private affordable housing grants and loans. This design provision is not intended to discourage creative solutions, such as siting affordable units in high-rise buildings otherwise containing market rate housing. Virginia Mason may not receive credit in fulfillment of the housing replacement requirement for any portion of the housing replacement cost that is financed by City funds. However, any City funds spent in excess of construction costs to provide affordability in what would otherwise be market-rate replacement units (i.e., to "buy down" rents in the completed building), shall not disqualify units as replacement housing under this condition.

b. Virginia Mason has paid the City of Seattle to finance the construction of comparable replacement housing. Payment to the City under this option b shall be subject to the

provisions of the City's Consolidated Plan for Housing and Community Development and the City's Housing Levy Administrative and Financial Plan in existence at the time the City assists in financing the replacement housing. The Office of Housing shall devote all funds provided by Virginia Mason under this option b to a project or projects within the greater First Hill Neighborhood. Under this option b, Virginia Mason may elect either:

- Within two years of MIMP approval, to pay the City of Seattle $4,460,000 to help fund the construction of comparable replacement housing; or

- More than two years after final MIMP approval, to pay the City of Seattle 35% of the estimated cost of constructing the comparable replacement housing. The estimated cost shall be determined by DPD and the Office of Housing based on at least two development pro formas prepared by an individual(s) with demonstrated expertise in real estate financing or development. The determination of the estimated cost by DPD and the Office of Housing is final and not subject to appeal.

For purposes of performance option a and of performance option b, the replacement housing must:

a. Provide a minimum number of units equal to the number of units in the Chasselton Court apartments (62 units);
b. Provide no fewer than seven one-bedroom units and no units smaller than the size of the studio units in the Chasselton Court apartments;
c. Include a minimum of 31,868 net rentable square feet, equivalent to that in the Chasselton Court apartments;
d. Be of a construction quality equal to or greater than that in the Chasselton Court apartment units; and
e. Be located within the greater First Hill neighborhood, defined as the area between Interstate Highway 5 on the west, Pike Street on the north, 12th Avenue and Boren Avenue on the east, and the south boundary of Yesler Terrace on the south, as shown outlined in a broken black line on Figure 1 at page four of the MIMP.

DPD shall submit all proposals for replacement housing to the Standing Advisory Committee for review and comment. At the discretion of the City, the submittal may exclude financing details and related information.

<u>During Construction for Future Development - Air Quality</u>

31. Site development would adhere to Puget Sound Clean Air Agency's regulations and the City's construction best practices regarding demolition activity and fugitive dust emissions, including the following:

a. As necessary during demolition, excavation, and construction, sprinkle debris and exposed areas to control dust;

b. As necessary, cover or wet transported earth material;

c. Provide quarry spall areas on-site prior to construction vehicles exiting the site;

d. Wash truck tires and undercarriages prior to trucks traveling on City streets;

e. Promptly sweep earth tracked or spilled onto City streets;

f. monitor truck loads and routes to minimize dust-related impacts;

g. Use well-maintained construction equipment and vehicles to reduce emissions from such equipment and construction-related trucks;

h. Avoid prolonged periods of vehicle idling; and,

i. Schedule the delivery and removal of construction materials and heavy equipment to minimize congestion during peak travel time associated with adjacent streets.

During Construction for Future Development - Noise

32. A Construction Management Plan (CMP) shall be provided with each development proposal. The CMP would be coordinated with the DPD Noise Abatement Office (DPD), SDOT and VMMC. The Construction Management Plan shall be included in any information provided to the SAC for any new structure greater than 4,000 square feet or building addition greater than 4,000 square feet. The following elements shall be included in the CMP if applicable. The plan would include the following elements:

a. Construction Communication Plan - Prior to the initiation of the first major project under the Plan, Virginia Mason, in close coordination with the Standing Advisory Committee, shall develop an overall construction communication plan. This plan shall include a Contact person and Community Liaison. The Chair of the Standing Advisory Committee will also be included in the Construction Communication Plan associated with site-specific development along with the Contact person and Community Liaison.

b. Construction Hours and Sensitive Receivers - identify demolition and construction activities within permissible construction hours.

c. Construction Noise Requirements - all demolition and construction activities shall conform to the Noise Ordinance, except as approved through the variance process.

d. Measures to Minimize Noise Impacts - list of measures to be implemented to reduce or prevent noise impacts during demolition and construction activities during standard and non-standard working hours.

e. Construction Milestones - a description of the various phases of demolition and construction, including a description of noise and traffic generators, and anticipated construction hours for each phase.

f. Construction Noise Management - identify techniques to minimize demolition and construction noise including: timing restrictions, noise reduction construction technologies, process modifications. These techniques may go beyond code requirements and could include the following:

- Using properly sized and maintained mufflers, engine intake silencers, engine enclosures, and turning off idle equipment. Construction contracts can specify that mufflers be in good working order and that engine enclosures be used on equipment when the engine is the dominant source of noise.

- Stationary equipment could be placed as far away from sensitive receiving locations as possible. Where this is infeasible, or where noise impacts are still significant, portable noise barriers could be placed around the equipment with the opening directed away from the sensitive receiving property. These measures are especially effective for engines used in pumps, compressors, welding machines, and similar equipment that operate continuously and contribute to high, steady background noise levels. In addition to providing about a 10-dBA reduction in equivalent sound levels, the portable barriers demonstrate to the public the contractor's commitment to minimizing noise impacts during construction.

- Substituting hydraulic or electric models for welding and impact tools such as jack hammers, rock drills and pavement breakers where feasible could reduce construction and demolition noise. Electric pumps could be specified if pumps are required.

- Although, as safety warning devices back-up alarms are exempt from noise ordinances, these devices emit some of the most annoying sounds from a construction site. One potential mitigation measure would be to ensure that all equipment required to use backup alarms utilize ambient-sensing alarms that broadcast a warning sound loud enough to be heard over background noise -- but without having to use a preset, maximum volume. An even better alternative would be to use fixed volume or ambient-sensing broadband backup alarms instead of typical pure tone alarms. Broadband alarms have been found to be very effective in reducing annoying noise from construction sites. Requiring operators to lift rather than drag materials wherever feasible can also minimize noise from material handling.

- Construction staging areas expected to be in use for more than a few weeks should be placed as far as possible from sensitive receivers, particularly residences. Likewise, in areas where construction would occur within about 200 ft. of existing uses (such as residences, schools/classrooms, and noise-

sensitive businesses), effective noise control measures (possibly outlined in a construction noise management plan) should be employed to minimize the potential for noise impacts. In addition to placing noise-producing equipment as far as possible from homes and businesses, such control could include using quiet equipment and temporary noise barriers to shield sensitive uses, and orienting the work areas to minimize noise transmission to sensitive off-site locations. Although the overall construction sound levels will vary with the type of equipment used, common sense distance attenuation should be applied. Additionally, effort could be made by VMMC to plan the construction schedule to the extent feasible with nearby sensitive receivers to avoid the loudest activities (e.g., demolition or jack- hammering) during the most sensitive time periods (10 PM to 7 AM weekdays, 10 PM to 9 AM weekends). A construction noise management plan would again be an appropriate location to identify these types of conflicts and establish less-intrusive construction schedules.

During Construction for Future Development - Historic Resource

33. Care should be taken in order to avoid structural damage to nearby buildings that could occur due to construction-related vibrations and/or earthwork. Excavation, earthwork, pile driving etc. should be designed and/or monitored to minimize and/or immediately address any such impacts to historic properties. Monitoring could include crack monitors, periodic observation, and photography to document the structural integrity of historic buildings and determine whether there was resulting damage of interior or exterior finishes, or exterior masonry and/or framing. If such damage occurred, repairs should be made to the affected buildings.

34. Care should be taken in order to avoid or limit the introduction of atmospheric elements that could alter and/or potentially damage historic building fabric or architectural features of historic resources. Construction activity could be monitored in order to prevent and address any such impacts to historic properties. Dust control measures would be implemented.

During Construction for Future Development - Traffic and Parking

35. Development and Implementation of a Construction Management Plan (CMP) for proposals that require demolition and/or construction that affects on or off site parking, existing pedestrian, bicycle, and vehicular circulation patterns or transit routes or stops. The CMP would be coordinated with DPD, SDOT and VMMC. The following elements shall be included in the CMP, if applicable:

a. Construction Parking Management - Implementation of a construction parking management program to identify off-site parking supplies for construction workers and minimize impacts to VMMC parking supplies and surrounding public parking supplies.

b. Construction Traffic/Street and Sidewalk Closures - demolition, earthwork excavating, concrete and other truck routing plans will be developed and submitted for approval through SDOT for site-specific development. Truck routing plans may include limitations on hauling of debris, earth and construction materials during peak hours. Traffic and pedestrian control signage and flaggers will be used as necessary to facilitate traffic and pedestrian flow per the requirements of any street use permit issued by SDOT. Sidewalk closures maybe required to protect the public or provide site access during construction. If such closures are necessary, a plan specifying phasing and timing will be submitted to SDOT for approval. Other mitigation measures could include:

- Coordinate with Metro transit relative to construction activity that could affect transit service proximate to the project site.
- Where existing sidewalks or walkways are temporarily closed during construction, develop alternative routes to maintain pedestrian circulation patterns.
- Enclose construction sites with a cyclone fence and cover walkways with staging for pedestrian safety.
- Include a parking provision in construction contracts between VMMC and the general contractor and between the general contractor and subcontractors, such as specifying where construction workers should park, shuttles, etc.
- Minimize any lane closures on Madison, Boren, and Seneca.
- To the extent possible, schedule deliveries at off peak times to avoid congestion.
- Develop a parking phasing plan to minimize disruptions to the parking supply serving VMMC patients and visitors.
- Restrict peak period truck traffic.

<u>During Construction for Future Development - Public Services</u>

36. The portions of the site that are under construction during phased redevelopment could be fenced and lit, as well as monitored by surveillance cameras to help prevent construction site theft and vandalism.

37. During demolition and construction, recycle construction and debris waste to the extent feasible, based on the existence of hazardous materials.

During Operation

Noise

38. Potential noise impacts from emergency vehicle sirens are exempt from the City noise limits. However, VMMC, commercial ambulance companies, Medic One and the City should work jointly to address ambulance-related noise impacts between midnight and 6 AM.

39. Potential noise impacts could also result from new HVAC equipment and other mechanical equipment associated with new or renovated facilities and from loading docks and any refuse-hauling sites near off-site receivers. The following processes could be implemented to reduce the potential for noise impacts from these sources and activities.

a. Select and position HVAC and air handling equipment to minimize noise impacts and maximize noise reduction to the extent possible. When conducting analyses to ensure compliance with the Seattle noise limits, assess sound levels as they relate to the nearest residential uses and any adjacent commercial locations.

b. Locate and control exhaust vents for all underground parking facilities to reduce noise at both on- and off-site residential uses and to ensure compliance with the City noise limits.

c. Design and site loading docks with consideration of nearby sensitive receivers and to ensure that noise from truck traffic to and from the docks and from loading activities would comply with the City noise limits. In locations where loading docks are located near on- and off-site sensitive receivers, evaluate the feasibility of mitigation measures such as implementing restrictions to limit noisy activities associated with deliveries to daytime hours.

d. To the extent feasible, design garbage and recycling collection to minimize or eliminate line-of-sight to nearby sensitive receivers. In addition, work with the collection vendors to schedule collections at appropriate (i.e., least intrusive) times. For example, garbage and recycle hauling contracts could specifically limit pickups to daytime hours so as to avoid potential noise impacts from such activities at night.

40. Minimize the potential for noise impacts resulting from regular testing of emergency generators by locating the equipment away from sensitive receptors, and equipping the generators with noise controls, including installation of a silencer on the power source and mounting the generator on an isolation system to control ground borne vibration.

41. Minimize the potential for noise impacts related to outdoor maintenance activities by ensuring outdoor maintenance is restricted to daytime hours, whenever possible. In addition, minimize the impacts of any noisy outdoor work, such as lawn mowing and leaf blowing, by using the quietest available power equipment and limiting its duration when working near (e.g., within 200 feet) sensitive receivers. Finally, as redevelopment occurs, install exterior electrical outlets at appropriate locations on campus to enable the use of electric power maintenance tools when possible.

Aesthetics

42. Potential skybridges will be designed and constructed with materials that would contribute to transparency of the skybridge to the extent possible in order to minimize potential impacts to view corridors on campus. Height and width of skybridges will be limited to accommodate the passage of people and supplies between buildings. Approval of the location and final design of any skybridges will occur through the City's Term Permit process.

Light and Glare

43. Control light spillage and light trespass, including direct glare, through lighting design measures, such as luminaire locations, light distributions, aiming angles, mounting heights, and shielding. Direct the light from exterior lighting fixtures downward and/or upward and away from off-site residential land uses.

44. Design new buildings with low reflective glass, window recesses and overhangs, and facade modulation to limit light and glare impacts to pedestrians, motorists and nearby residents.

45. Use street trees, landscaping and screening at ground level to obstruct reflected glare from impacting off-site receptors.

46. Include landscaping or screens at the edges of parking lots and parking structures to obstruct light and glare caused by vehicle headlights.

47. Design street-level retail activities to shield light to minimize spilling over onto adjacent residential areas.

48. Equip interior lighting with automatic shut-off devices consistent with code, function and safety requirements.

49. Provide pedestrian-scale lighting consistent with code, function and safety requirements.

50. Where feasible, limit the amount of reflective surfaces.

Shadows

51. To the extent feasible, orient the massing of the new buildings on adjacent campus open spaces and offsite residential uses to minimize the potential shadow impacts to these campus resources and offsite uses.

Historic Resources

52. Prior to the approval of a demolition permit for a building that was constructed 50 years ago or earlier, an historical analysis will be required to be submitted to the City. An analysis of potential impacts caused by new buildings constructed adjacent or across the street from a designated historic Landmark is also required at the time of Master Use Permit submittal, and will be referred to DON for review and approval.

Transportation

53. As part of each project, ensure that pedestrian and vehicular circulation needs are addressed in a manner consistent with the campus wayfinding plan.

54. As part of each project, provide frontage improvements to ensure that pedestrian facilities meet established city standards at the time of redevelopment. The extent of such improvements should take into account 'priority design features' as described in the SDOT Right of Way Manual and the intent of the VMMC Master Plan Design Guidelines.

55. The redevelopment of the 1000 Madison Block under the Proposed Action is of particular significance to the Madison Street corridor and should take into account the need for frontage improvements that would support the planned 'High Capacity Transit Corridor' as well as providing amenities that exceed code requirements that would enhance the pedestrian experience along this segment of Madison Street. Such amenities could include seating areas, more extensive landscaping than required by code, a transit stop shelter that is integrated with the building design, retail uses that help activate the frontage, and weather protection.

56. As part of the review process for master plan projects:

a. Apply updated TMP elements and assess TMP performance

b. Update MIMP parking requirements and reassess long-term campus parking supply recommendations

c. Assess operational and safety conditions for proposed garage accesses and loading areas

d. Assess pedestrian, truck, and vehicular circulation conditions, and identify safety deficiencies that could be remedied as part of the project under review.

e. Assess loading berth requirements and where possible consolidate facilities so that the number of berths campus wide is less than the code requirement.

f. Assess truck delivery routes between VMMC and I-5 and along Boren Street and other arterials to identify potential impacts to roadways along those routes.

g. Reduce the impact of truck movements on local streets and potential conflicts with pedestrians by consolidating loading facilities and managing delivery schedules.

h. Evaluate proposed bicycle parking facilities through the following design elements :

- Bicycle parking access should be ramped and well lit.

- Bicycle parking should be located close to building entrances or elevators if in a parking structure.

- Short-term general bicycle parking areas should be sheltered and secure
- Long-term staff bicycle parking should be located in enclosures with secure access.
- Staff lockers for bicycle equipment should be provided in long-term bicycle parking areas.
- Bicycle racks should be designed to allow a U-lock to secure the frame and wheels to the rack.
- Bicycle parking should be separated from motor vehicle parking.
- Shower facilities and locker rooms should be close to the bicycle parking area.

57. As part of the project level environmental review, evaluate the potential for increased vehicular traffic and, if warranted by anticipated project impacts, implement the following roadway improvements to mitigate impacts.

a. On 9th Ave from Madison to University Streets:

- Add northbound and southbound left turn pockets at Madison Street/9th Ave within the existing road width.
- Signalize the intersection of Spring Street/9th Avenue and add a southbound left turn pocket and northbound right turn pocket on 9th Avenue. As part of the redesign of the intersection to add the turn pockets, work with King County Metro to evaluate the relocation of the existing transit stop to optimize commuter use and connections and avoid conflicts with access to Virginia Mason facilities. Maintain pedestrian safety by including pedestrian crossing beacons and controls and curb bulbs on Spring Street and on 9th Avenue if there is adequate road width. Add northbound and southbound left turn pockets at Seneca Street/ 9th Ave within the existing road width.
- Improve sidewalks and roadway crossings to enhance pedestrian safety as part of frontage improvements when the 9th Avenue Garage and Buck Pavilion sites are redeveloped.

b. On Seneca Street:

- Signalize the intersection of Seneca Street/ Terry Ave when the hospital core is redeveloped and the south leg of the intersection is constructed as a garage access.
- Remove the Lindeman Garage access on Seneca Street and provide a new access on 9th Avenue when the Lindeman Pavilion is expanded.

c. At Spring Street/ 8th Ave, provide a northbound right turn lane within the existing road width or shift the stop control to the northbound/southbound movements.

Public Services - Police

58. Include permanent site design features to help reduce criminal activity and calls for service, including: orienting buildings towards sidewalks, streets and/or public open spaces; providing convenient public connections between buildings onsite and to the surrounding area; and, providing adequate lighting and visibility onsite, including pedestrian lighting.

59. Apply Crime Prevention Through Environmental Design (CPTED) principles to the development of its open space and public amenities to enhance the safety and security of the areas.

Public Services - Water/Sewer/Stormwater

60. Evaluate the impact of development on the sewer infrastructure from the development site to where SPU's collection system connects to King County interceptors (approximately 4,500 LF downstream).

61. Consider the installation of low impact development measures such as bioretention cells or bioretention planters to reduce the demand on stormwater infrastructure.

62. Continue implementation of EnviroMason measures and other measures to reduce the demand on water and sewer.

63. Implement the VMMC's Goal and Objective - To build facilities that are resource-efficient - Participate in the Seattle 2030 District challenge. Public Services - Solid Waste Continue implementation of EnviroMason measures, VMMC's environmental stewardship initiative, to include waste reduction programs, such as recycling operating room plastics, food waste composting, hazardous waste recycling, and general office recycling.

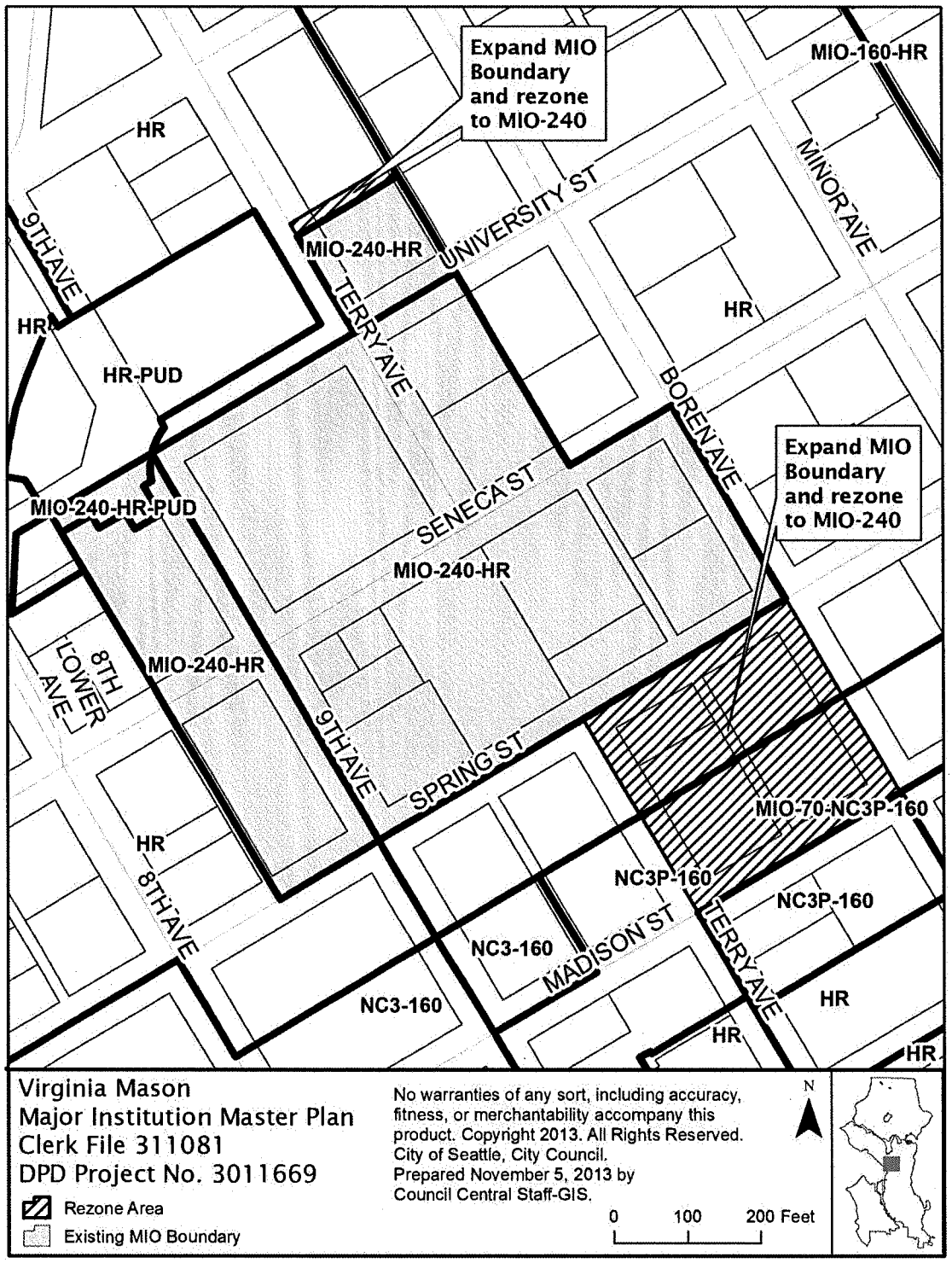
Public Services -- Solid Waste

64. Continue implementation of EnviroMason measures, VMMC's environmental stewardship initiative, to include waste reduction programs, such as recycling operating room plastics, food waste composting, hazardous waste recycling, and general office recycling.

Entered this 16 th day of December, 2013.

President, Seattle City Council

ATTACHMENT A: REZONE MAP



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APPENDIX G

Swedish Medical Center First Hill Campus
Final Major Institution Master Plan document – 14 March 2005

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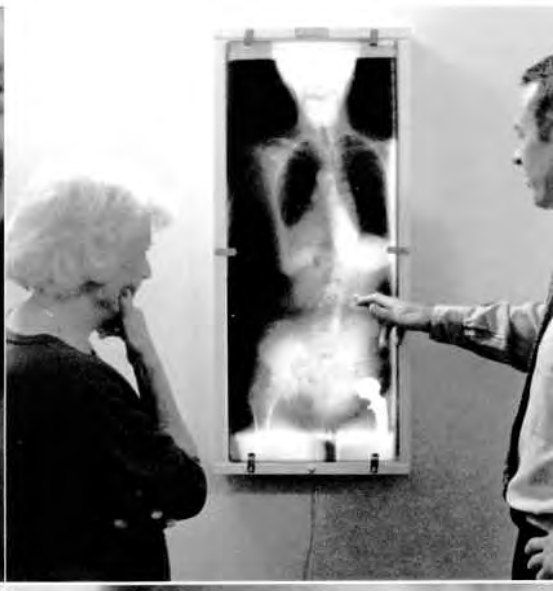


FINAL

MAJOR INSTITUTION MASTER PLAN

14 MARCH 2005

SWEDISH MEDICAL CENTER

FIRST HILL CAMPUS

City of Seattle
Department of Planning
and Development



SWEDISH MEDICAL CENTER

FIRST HILL CAMPUS

FINAL

MAJOR INSTITUTION MASTER PLAN

(FINAL MIMP)

14 MARCH 2005

Prepared consistent with City of Seattle SMC Chapter 23.69, and 23.12.120, 23.54.016 and 23.05

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1. Introduction

A. Background/Purpose/Process

The current Swedish master plan was adopted by Ordinance 111993 in November 1984, with subsequent amendments. Most contemplated development has been completed. All hospital and clinical/medical office space of the development program has been developed which prevents Swedish from replacing aging facilities, and meeting building and programatic needs. Research space remains, but that was originally intended for the Fred Hutchinson Cancer Research Center (FHCRC) who relocated from the First Hill campus to South Lake Union. The renewed MIMP is intended to replace the current master plan. The focus is to update the development program component to further the Swedish mission and the First Hill campus vision. The development standards and transportation management program will be reviewed as well during the process.

Swedish Medical Center is proceeding with a new major institution master plan (MIMP) for the First Hill campus, consistent with all applicable City of Seattle requirements. The purpose of the master planning entitlement work is to fulfill all City of Seattle requirements in an efficient, collaborative process with stakeholder input that shapes the most appropriate Swedish First Hill campus development and mitigates identified impacts. This Final MIMP is issued with an accompanying Final Environmental Impact Statement (Final EIS).

Key milestones in the process to date include:

- A 'Notice of Intent' to prepare a new master plan was submitted by Swedish to the City of Seattle Department of Planning and Development (DPD) on December 10, 2003.
- The MIMP Application concept plan was submitted to DPD on March 26, 2004. Swedish also worked with the Department of Neighborhoods (DON) to assist with the formation of a new Citizen Advisory Committee (CAC).
- DON advised CAC candidates of the recommended appointments on May 13, 2004. The recommended membership of the CAC was forwarded to the City Council by DON.
- The environmental review process was initiated with DPD publishing the Determination of Significance (DS) Threshold Determination on May 6, 2004.
- The first CAC meeting was held on May 24, 2004 for orientation, to review the MIMP Application concept plan and to provide input to the environmental analysis scoping.
- Public Scoping of the environmental impact statement (EIS) occurred during May and June including a public scoping meeting held on May 26, 2004.
- Additional CAC meetings on June 16, 2004 and July 14, 2004 were held to further discuss the Swedish proposal and neighborhood implications.

- A preliminary version of the Draft MIMP and Draft EIS were reviewed by the CAC in August and September 2004 and resulted in changes to the Master Plan proposal and the documents.

- A "proof copy" of the Revised Draft MIMP and Revised Draft EIS was reviewed and discussed by the CAC in October 2004 and resulted in further changes.

- The Draft MIMP and Draft EIS were issued to the public on November 15, 2004.

- A public hearing was held on December 15, 2004.

- The CAC held additional meetings on November 10, 2004 and December 8, 2004 to review and comment on the Draft MIMP and Draft EIS.

- DPD reviewed comments received and determined the appropriate format and content of the Final MIMP and Final EIS in January 2005.

- A preliminary copy of the Final MIMP and Final EIS was prepared and submitted to DPD and the CAC on January 31, 2005.

- Additional CAC meetings were held on January 12, 2005, February 9, 2005, and March 9, 2005. (March meeting may be postponed).

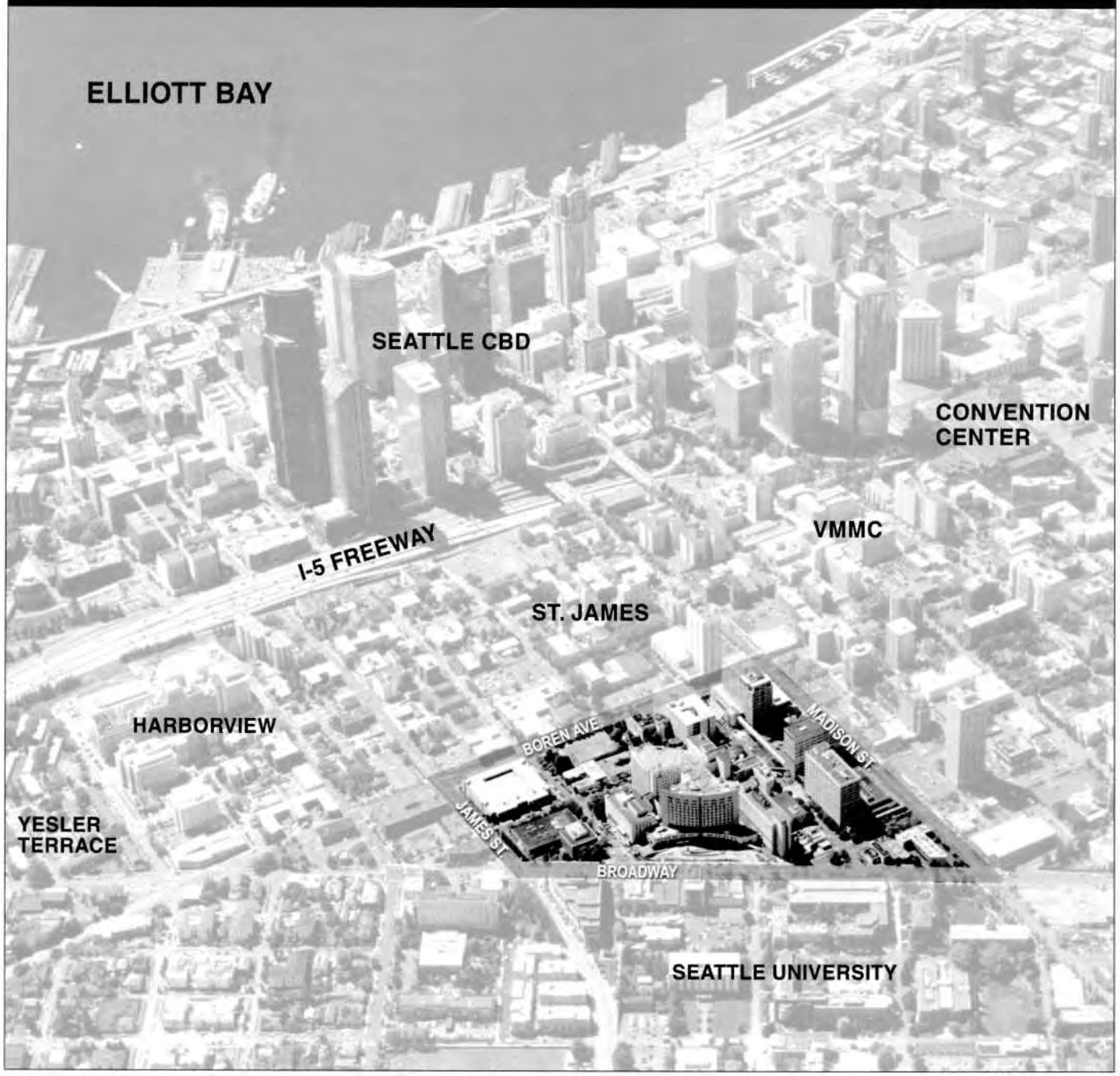
- Review comments resulted in modifications to the documents and preparation of a revised set for DPD approval.

- The current milestone of the process is the public issuance of the Final MIMP and Final EIS on March 14, 2005.

Also see Appendix B: Process Milestones for a complete listing of events and dates associated with the MIMP and EIS process.

Figure 1.1 is an aerial photo of the Swedish Medical Center First Hill campus and its First Hill and downtown context. The master plan concerns the Swedish Campus area bounded by Boren-Madison-Broadway-James which corresponds with the Major Institution Overlay (MIO) District.

FIGURE 1.1
Aerial Photo



B. Swedish Mission

The mission of Swedish Medical Center is to improve the health and well-being of each person served. The nearly century old Swedish tradition of medical excellence spans the entire continuum of healthcare and extends far beyond hospital services. Swedish provides state-of-the-art care to patients of every age and stage of life for virtually every healthcare need. Swedish is recognized not only for the scope of its services, but for the caliber of its physicians and its highly skilled nurses, professional, and other staff. Year after year, Swedish has been recognized as the most trusted name in healthcare. In independent surveys conducted by the National Research Corporation, King County residents consistently rank Swedish Medical Center as the area's most preferred hospital, with the best overall quality, most personalized care, the best doctors and nurses, and the best care in a variety of specialty areas.

As a private, nonprofit organization, Swedish has the opportunity and responsibility to make significant contributions to the health of its community. Swedish upholds this responsibility by reinvesting profits back into the community and ensuring that healthcare needs are met through means such as charity care, education, and community health programs. Swedish is committed to making quality healthcare available to all members in our communities, regardless of their ability to pay. In 2003, Swedish donated over $33 million in charity care and community benefits.

In order to continue to provide the highest quality and most comprehensive care to the community, Swedish must replace facilities included in the proposed new MIMP.

C. Healthcare Needs & Master Plan Goals/Objectives

Building Needs

An assessment of the existing medical center at the First Hill Campus reveals a number of buildings that are nearing the end of their useful life with structural, mechanical and functional limitations. Necessary improvements include floor-plates sized and structured to create unobstructed areas necessary for long term functionality; adequate floor-to-floor heights; replacement of aging mechanical and electrical systems; and improved infection control capabilities to reflect escalating isolation and emergency preparedness needs.

Programmatic Needs

Healthcare, including state-of-the-art healthcare technology, is rapidly advancing from year to year. Significant new discoveries in biomedical science and healthcare services are occurring faster now than at any time in our history. The projects included in this master plan are vitally necessary for Swedish to stay at the leading edge of these advances and continue to provide the highest level of healthcare services to the community. The need to respond to evolving community healthcare needs, new medical technologies, changes in clinical practice, and demographic and population swings drive optimum flexibility in the facility construction. Current facilities need to be replaced by new buildings capable of accommodating contemporary and future medical services. The proposed MIMP includes the replacement and accommodation of several existing buildings that have been identified as limited in their usability, as well as considers possible future programmatic uses for these areas.

Patient-Centered Campus Organization

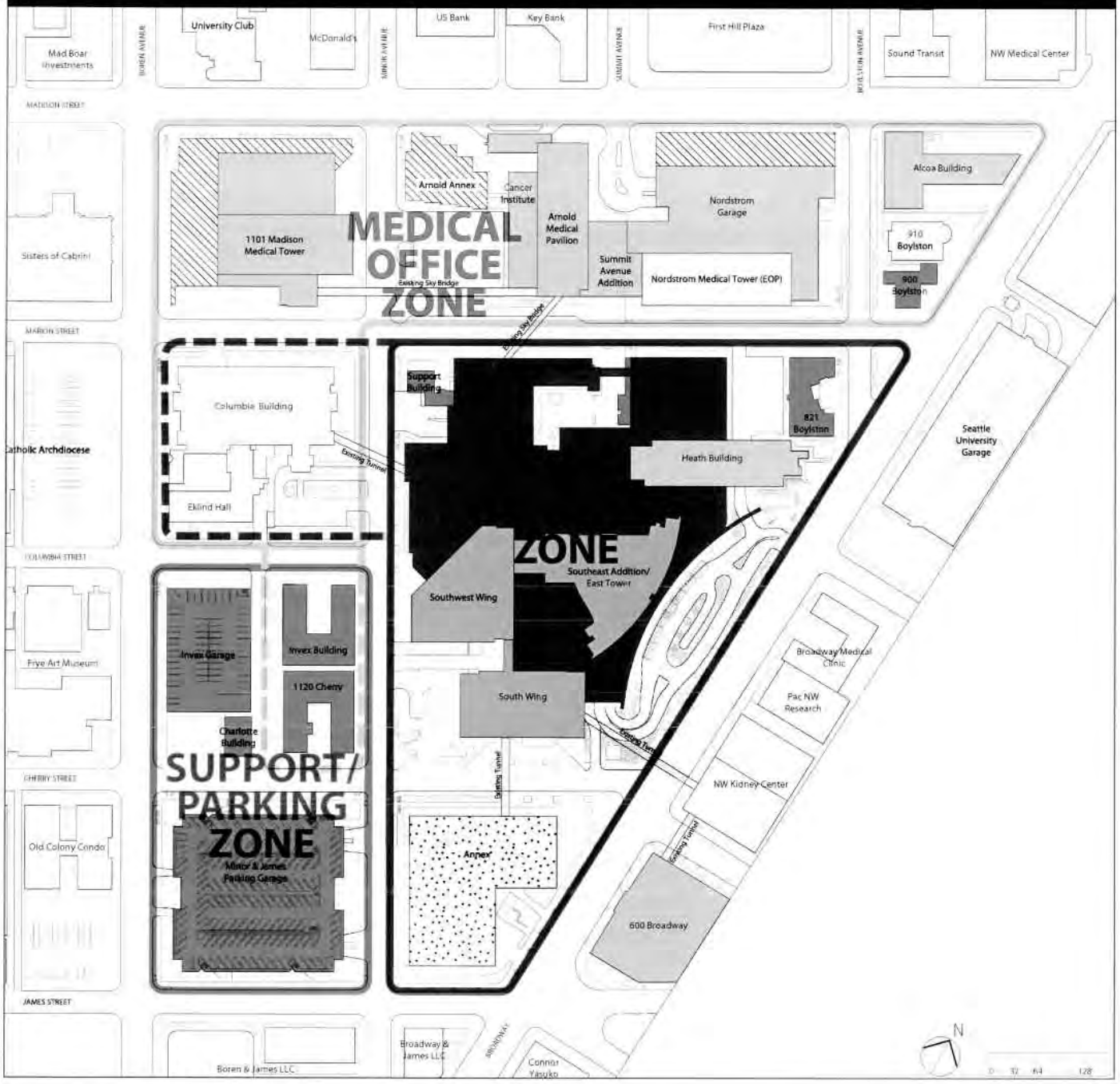
Swedish Medical Center, First Hill Campus, is generally organized into zones in which one type of function (such as medical office buildings, acute-care hospital facilities, service or support, and parking) predominates. The benefits of further consolidating like or related functions in close proximity to one another would improve quality of care and patient safety. Zoning would also enhance clarity and ease of patient flow, ability to share supporting functions, and efficiency for staff providing materials, support or services to functional areas. The MIMP is meant as a tool for envisioning improved functional zoning and circulation and defining a coherent organizational structure to improve healthcare delivery. Figure 1.2 depicts the functional zones of the First Hill Campus.

Community-Campus Linkages

Beyond providing state-of-the-art facilities and technologies to ensure high-quality care, Swedish strives to create a physical environment that connects with the community. Through the proposed new MIMP, Swedish will provide a place that is welcoming and appealing to patients, employees, and other community partners. The vision of the campus proposes the concept of many "faces" to the community. This design would promote openness to the community; create entrances from all sides; and create a sense of campus coherency. The proposed MIMP also includes new campus open spaces: places intended to collect people and sunlight; connect spaces to edges; and symbolically represent a place for healing.

FIGURE 1.2

Functional Zones



KEY TO FIGURE 1.2

Medical Office Zone

Primary Services:

- Physician office suites
- Ambulatory care services
- Outpatient parking
- Outpatient and neighborhood retail amenities
- Research

Core Hospital Zone

Primary Services:

- Inpatient care nursing units
- Hospital-based diagnostic and treatment services
- Hospital-based / patient care - related support functions

Support / Parking Zone

Primary Services:

- Central plant services
- Central materials management services
- Parking

Note: 1101 Madison, 600 Broadway, Arnold - 9th floor and above, and retail recently sold to Health Care Property Investors, Inc. (HCPI).

D. First Hill Campus Vision

Swedish is renewing the First Hill campus development vision to reflect what Swedish seeks to accomplish over the next 15 years and beyond. Swedish assessed existing facilities and functions, quantified space needs, tested growth scenarios, and has defined planned and potential projects.

The development objectives for the Swedish First Hill campus are:

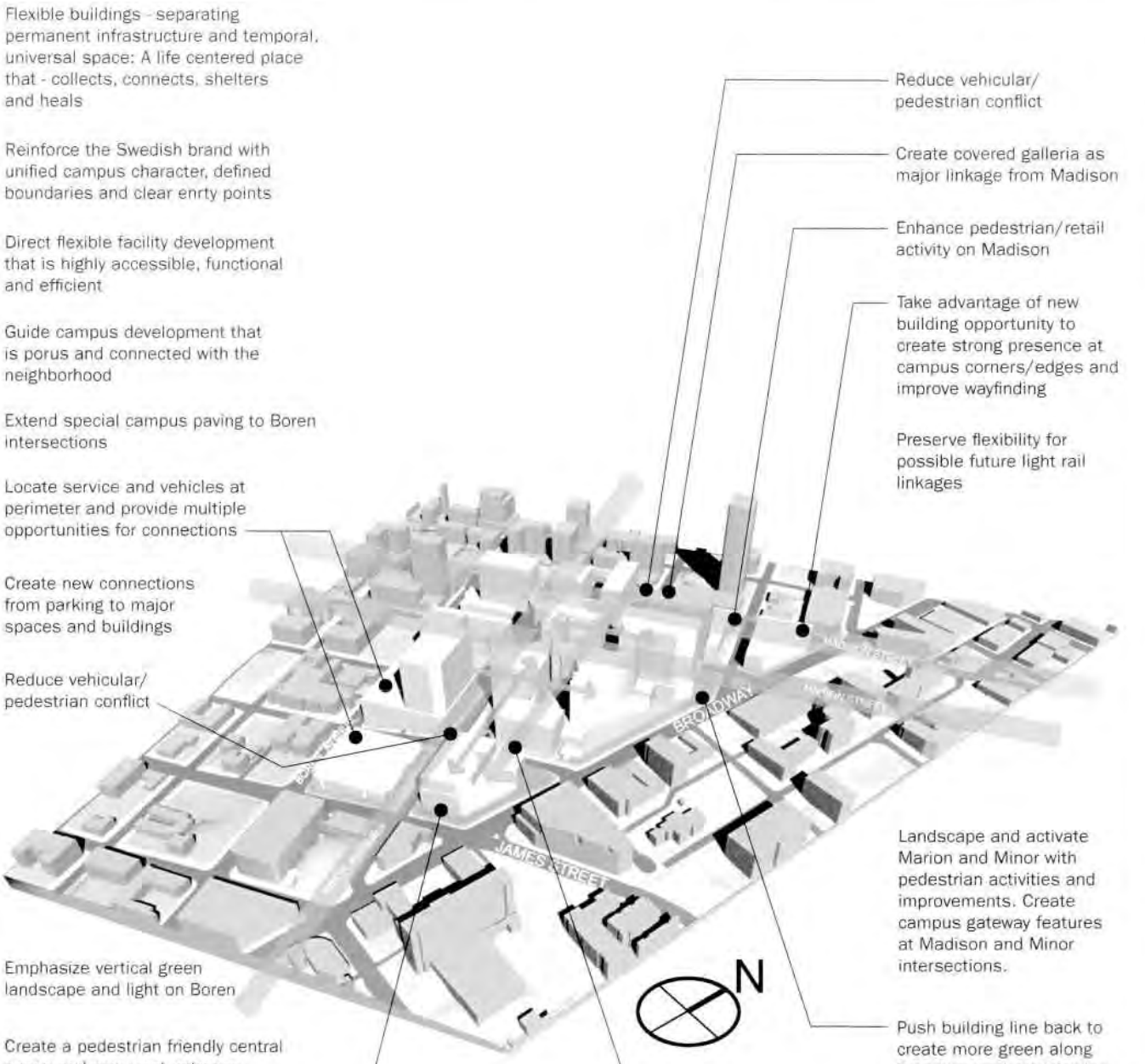
- Replace aging facilities that are increasing in obsolescence.
- Direct facility development that is highly accessible, with optimum function, efficient and extremely flexible to meet changing community healthcare needs.
- Reinforce the Swedish brand in an improved patient-centered campus that functions appropriately, relates to its location, and creates a physical environment that connects with the community.
- Mitigate growth impacts and achieve compatibility with the First Hill neighborhood and downtown urban center.
- Secure City of Seattle MIMP regulatory entitlements and community support to permit the phased improvements.

In addition to the aggressive waste stream management and reduce/reuse/recycle programs at Swedish, sustainability initiatives are desired for creating high performance healing environments. The Swedish First Hill campus vision includes a commitment to the intent of evolving LEED and similar guidelines for sustainable healthcare facilities. Specifically, master plan projects will consider the "Green Guidelines for Healthcare Construction," December 2003 Version 1.0 PC, published by the American Society for Healthcare Engineering (ASHE). Note that Version 2.0 Pilot was released in November 2004.

Figure 1.3 depicts the Swedish campus vision and lists a number of design principles or 'precepts.' The overall vision is an urban medical campus connected with the community it serves. Most development intensity is concentrated at the core, with transitions toward the campus edges. The campus is intended to be highly accessible and 'permeable' with improved pedestrian connections along Marion and Minor. The Madison Street commercial pedestrian corridor is to be reinforced. Landscaped open spaces will improve the Broadway, James and Boren frontages. Integral campus way-finding will be simplified and strengthened. The design precepts are the key ingredients of a proposed campus wayfinding plan, intended to improve both internal and external movement and orientation. Swedish proposes that the design precepts be implemented and applied to each building project as it is implemented through the Master Use Permit process. Specifically, each project would implement its block frontages portion of the campus improvement. A Wayfinding Plan with Design Guidelines will also be prepared by Swedish that would improve campus functions.

FIGURE 1.3

Design Precepts



2. Development Program

A. First Hill Campus

Neighborhood Context/Other Major Institutions

Swedish is located within the urban, medium density First Hill Neighborhood of Seattle's city center with a mixture of residential, retail/commercial, and institutional activities. The location is adjacent to the downtown Seattle core and is an employment and residential center (designated as the First Hill/Capitol Hill Urban Center in the Seattle Comprehensive Plan). The neighborhood is the home of four of Seattle's major institutions; Virginia Mason Medical Center, Seattle University, and Harborview Medical Center, are all located within a 2-block radius from Swedish Medical Center. Figure 2.1 shows the vicinity and nearby major institutions.

The wide diversity of existing land uses includes: retail and commercial particularly along the Madison Street corridor, multi-family residential (senior/nursing/low-income/high-income/subsidized/market-rate housing), an art museum, a high school and religious facilities. The character of development is also varied ranging from old apartments, historic landmarks, high-rise residential towers, low-rise apartments, and major institutions. Parking lots are near the freeway and serve commuters to downtown and First Hill.

Swedish is located at the crest of First Hill which slopes down to the west to downtown, down to the east to the Madison valley, down to the south toward the Yesler Terrace, and down to the north to the Broadway/Capitol Hill district. The interstate freeway (I-5) provides direct access via James Street and Madison Street to Swedish and also separates First Hill from downtown. Boren Avenue and Broadway are arterials bordering Swedish that provide north-south access.

Swedish Property Ownership

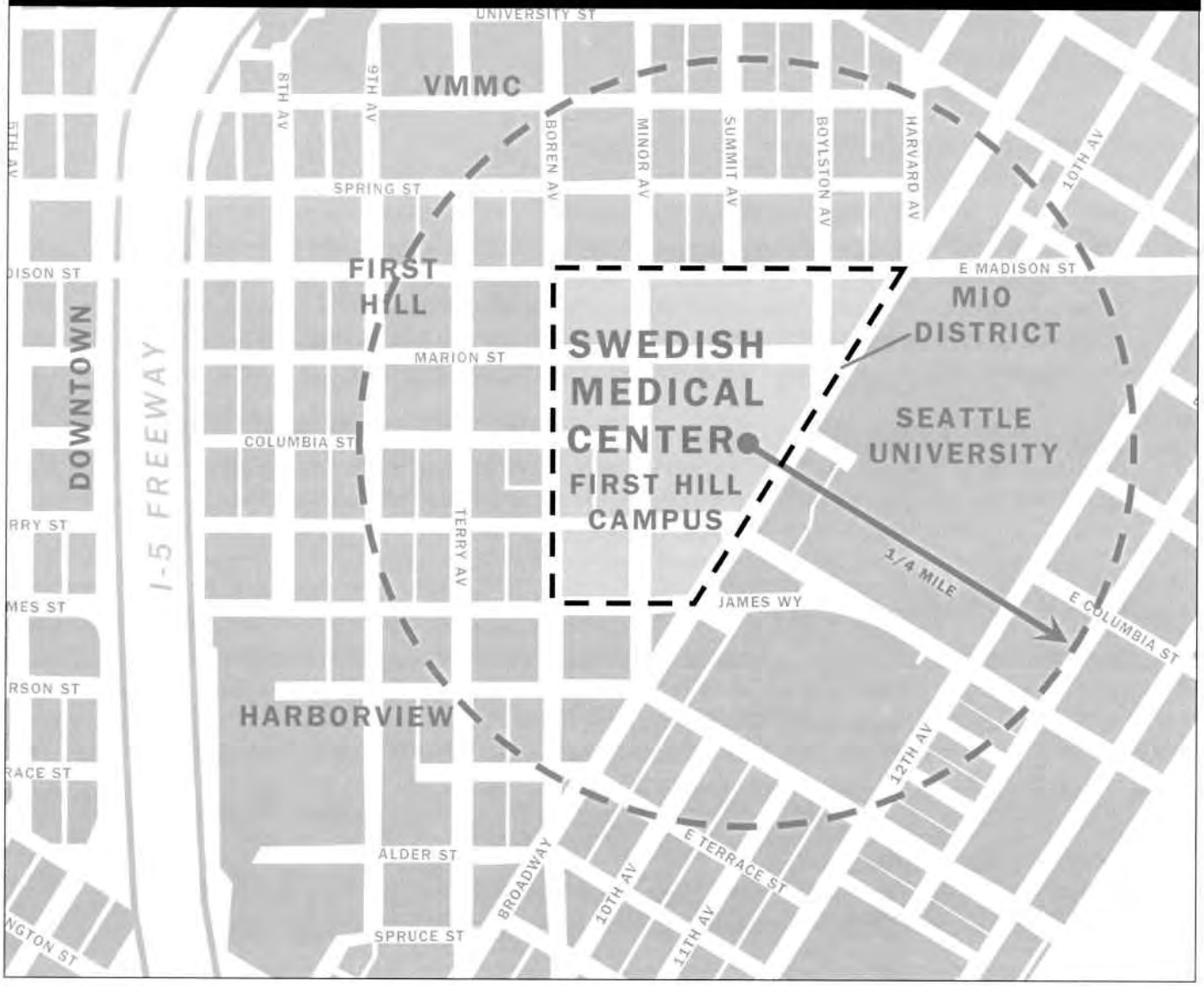
Swedish owns some eleven city blocks of property that comprise its First Hill campus within the trapezoidal area bounded by Boren-Madison-Broadway-James. Swedish owns all the property except for:

- The block bounded by Marion-Minor-Columbia-Boren (Seattle Life Sciences Center),
- 910 Boylston (small medical office),
- The Nordstrom Medical Office Tower (building is condominium ownership), and
- Public right-of-ways.

Swedish owns a parcel east of Broadway outside the MIO District (600 Broadway) that is medical office. Swedish owns the property at 600 Broadway but sold the building and garage. Swedish owns property at the Providence Campus (500 17th Ave). Swedish recently leased about 60,000 SF of space at the Metropolitan Park office in downtown for administrative functions (human resources and finance divisions). Swedish leases a clinic space downtown (1001 4th Ave) with about 12,600 SF for the Swedish Physician division. Swedish owns or leases no other property or facilities within 2,500 feet of its First Hill campus. (Also see property map in Appendix). Swedish recently sold and may continue to sell buildings, including support buildings/parking,

FIGURE 2.1

Vicinity Map



research buildings, clinical and medical office buildings, so that Swedish can concentrate on its core competency of hospital services. The recent sale included 1101 Madison, retail space and the parking garage along Madison, the Arnold Pavilion (9th floor and above), and the 600 Broadway medical office building and garage. The uses in these buildings will continue to be functionally integrated with or substantively related to the major institution and/or they will primarily serve the users of the major institution. Swedish will continue to own the land of the First Hill campus and will ground lease land to the building owners. Ground leases and sales agreements will include restrictions imposed upon the non-Swedish owners to comply with certain major institution provisions, such as transportation management.

The property legal description and parcel data are given in the Appendix A.

The MIO District bounded by James-Boren-Madison-Broadway includes a land area of about 648,876 SF (14.92 acres) excluding public right-of-ways (see Appendix A for details).

Existing/Approved Development

Existing development is depicted in Figure 2.2. The age and building areas are noted. The master plan seeks to replace the aging facilities.

The development program of the existing approved major institution master plan includes building space for hospital, research use, outpatient and patient family housing, medical office space, subsequent office development and commercial space. Two phases of development were included; an initial phase from 1983 to 1988 and a 2003 conceptual phase.

The total hospital expansion above the level existing in 1983 was limited to 256,000 sf. This development has been completed.

The approved research space was limited to a maximum of 494,000 sf plus parking for 610 spaces. This development did not occur, primarily because it was intended for expansion of FHCRC who moved off the Swedish campus.

The approved outpatient and patient family housing amounted to a maximum of 150 units outside the MIO campus boundary but within one mile, and no limit to such housing beyond the one mile. This development did not occur.

Approved medical office space totaled 450,000 sf plus sufficient parking per code requirements. The development was proposed in two phases and has all been completed.

Commercial development was required at street level along parking garages that fronted Madison, Boren and Broadway. This commercial development has been mostly completed except at the Broadway/Madison and Broadway/James corners of the campus where garage development has not occurred.

Swedish is licensed for 697 beds for the First Hill campus and this bed number will not be affected by the master plan. Currently there are 566 set-up beds.

The following Tables 2.1 and 2.2 summarize the existing Swedish First Hill campus building development and parking (garages and surface lots). It provides a new baseline for the master plan.

FIGURE 2.2

Existing Building Ages and Area

KEY TO FIGURE 2.2

Existing
Non-Swedish Building

Note: 9th floor and above of Arnold Building not owned by Swedish

Hospital

East Tower
Age: 1999
Area: 441,067 sf

Main Surgery
Age: 1963
Area: 62,302 sf

North/Northwest Wing
Age: 1926, 1933, 1945
Area: 61,703 sf

Old East Wing
Age: 1936, 1941, 1947
Area: 118,448 sf

Old Tumor Institute
Age: 1930's - 1953
Area: 12,541 sf

South Wing
Age: 1979
Area: 157,967 sf

Southwest Wing
Age: 1972
Area: 285,070 sf

West Wing
Age: 1955, 1963, 1967
Area: 140,255 sf

Medical Office Buildings

1101 Madison*
Age: 1994
Area: 306,266 sf

600 Broadway*
Age: 1990
Area: 166,211 sf

Arnold*
Age: 1987
Area: 197,201 sf

Arnold Annex
Age: 1974
Area: 9,794 sf

Heath
Age: 1969
Area: 118,297 sf

Other Buildings

1120 Cherry
Age: 1950's
Area: 25,205 sf

819 Boylston
Age: 1947
Area: 11,094 sf

900 Boylston
Age: 1946
Area: 8,124 sf

Alcoa Building
Age: 1963
Area: 39,634 sf

Annex
Age: 1959
Area: 75,165 sf

Charlotte Building
Age: 1970's
Area: 7,826 sf

Invex Building
Age: 1950's
Area: 21,284 sf

Retail*
Age: 1987
Area: 8,608 sf

* Recently sold to Health Care Property Investors, Inc (HCPI).
(Portion of Arnold Building sold to HCPI: 9th floor and above.

TABLE 2.1

Existing Swedish First Hill Campus Building Area

	Building Area (GSF)
Hospital	
East Tower	441,067
Main Surgery	62,302
North/Northeast Wing	61,703
Old East Wing	118,448
Old Tumor Institute	12,541
South Building	157,967
Southwest Wing	285,070
West Wing	140,255
Total Hospital Area	1,279,353
Medical Office Buildings*	
1101 Madison**	306,266
600 Broadway***	166,211
Arnold**	197,201
Arnold Annex	9,794
Heath	118,297
Nordstrom Garage Retail**	8,608
Total MOB Area	806,377
Other Buildings	
1120 Cherry	25,205
819 Boylston	11,094
900 Boylston	8,124
910 Boylston	9,332
Alcoa	39,634
Annex	75,165
Charlotte Building	7,826
Invex	21,284
Old Incinerator Building	NA
Total Other Building Area	197,664
Total First Hill Campus	2,283,394

* Nordstrom MOB space of 186,700 GSF not included because not owned by Swedish
** Included but recently sold to HCIP
*** Located outside MIO boundary

TABLE 2.2

Existing Swedish First Hill Campus Off-Street Parking Supply

	Facility	Building Area (GSF)	Spaces
	Parking Garages*		
1	Marion & Minor Garage	376,164	1,025
2	Madison/Nordstrom Garage**	153,078	597
4	Doctor's Garage	70,162	115
6	Invex Garage	56,912	190
8	Broadway Garage	261,095	540
9	Minor & James Garage	307,207	1,043
	Total Parking Garages	1,224,618	3,510
	Surface Parking Lots		
3	Alcoa Building		50
5	Heath Lot		12
7	Invex Alley		20
10	Annex Lot		53
11	Arnold Valet Parking		14
12	Main Lobby Valet Parking		19
13	Arnold Retail Lot***		37
14	910 Boylston		16
15	East Entrance Lot N/NE		5
16	Columbia Lot****		7
	Total Surface Parking Lots		233
	Total First Hill Campus Parking		3743

Note: The reference numbers in the left column are keyed to the Parking Analysis in the Final EIS document.

* The 600 Broadway Garage (123,205 GSF, 355 spaces) is located outside the MIO boundary so it is not included.
** Included but recently sold to HCPI and subject to Swedish TMP.
*** 37 spaces controlled by lease to bank.
**** Not owned or controlled by Swedish, but located within the MIO boundary.

Local Circulation/Access

Local First Hill campus circulation and access of different Swedish functions is depicted in the following series of graphics (Figures 2.3 - 2.10 for existing and future conditions respectively. The concept is to limit vehicular access along block frontages along Boren-Madison-James-Broadway and park cars at dispersed campus edge locations near functions served. Inpatient, outpatient, emergency, and service circulation corresponds with the campus functional zones. Parking will continue to be dispersed in the future. Some changes are proposed to emergency and service traffic flows.

FIGURE 2.3

Existing Local Circulation/Access to Inpatient Buildings

FIGURE 2.4

Future Local Circulation/Access to Inpatient Buildings

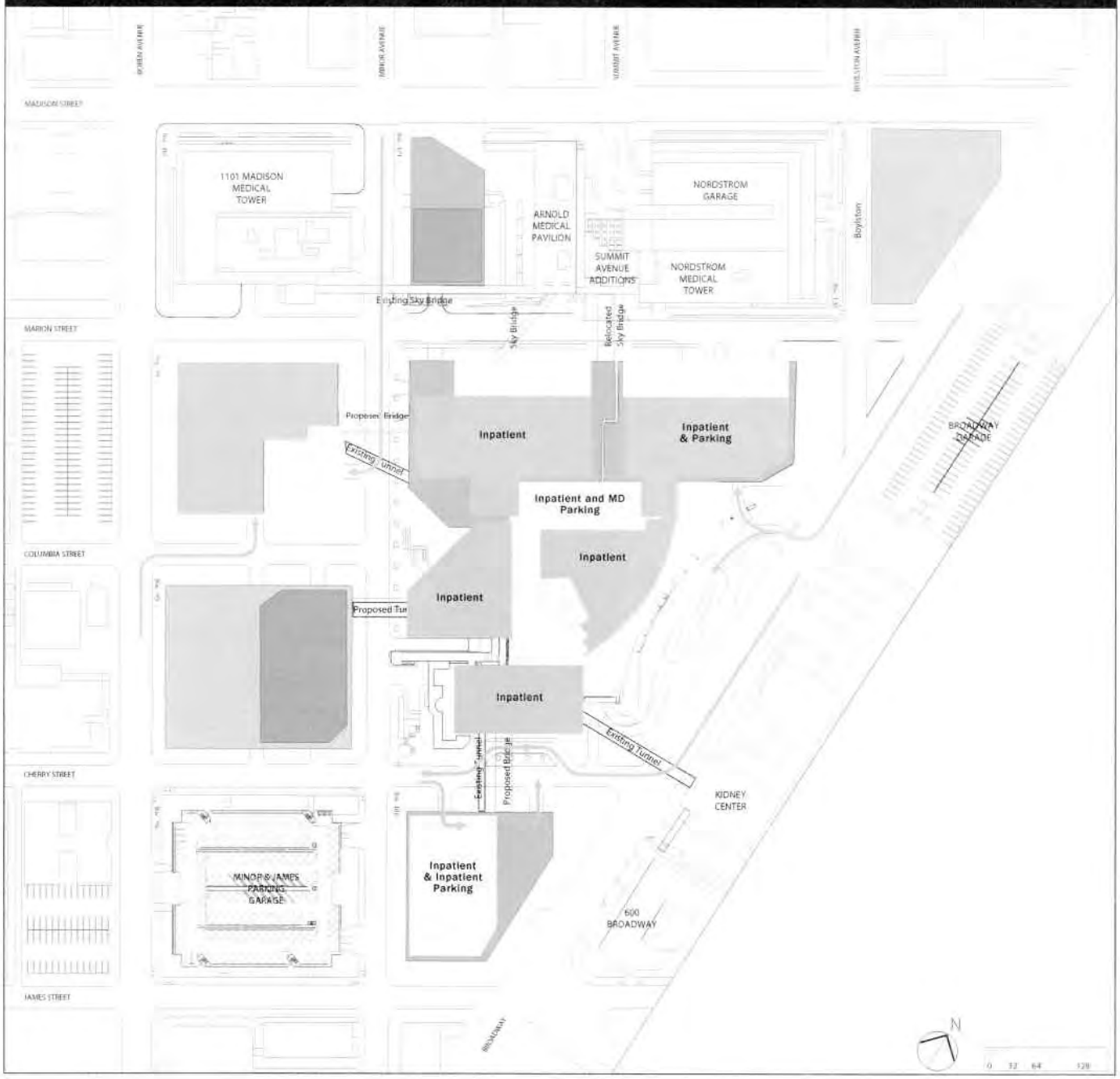


FIGURE 2.5

Existing Local Circulation/Access to Outpatient Buildings

FIGURE 2.6

Future Local Circulation/Access to Outpatient Buildings

FIGURE 2.7

Existing Local Circulation/Access to Emergency Department

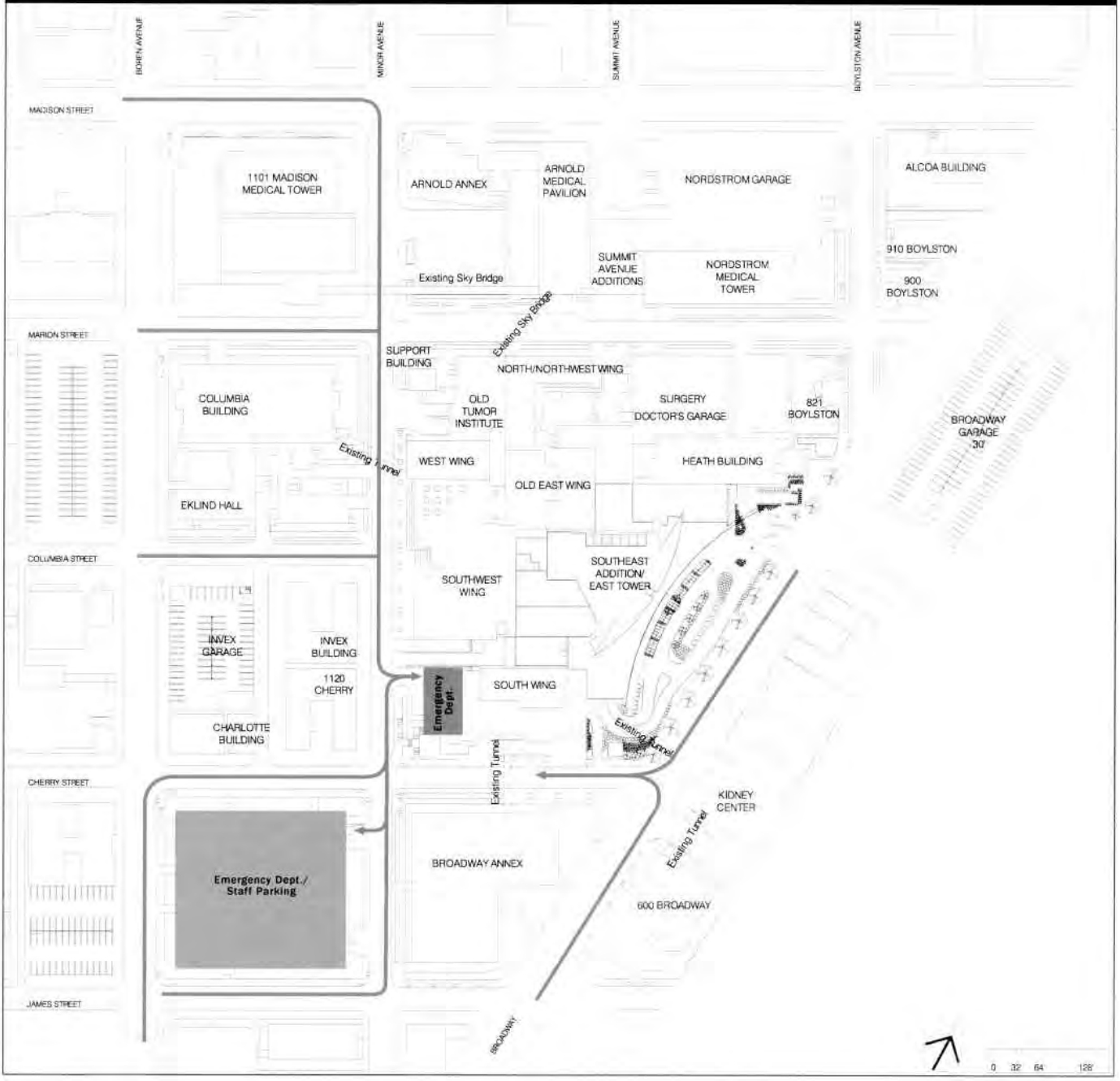


FIGURE 2.8

Future Local Circulation/Access to Emergency Department

FIGURE 2.9

Existing Local Circulation/Access to Service/Loading Docks

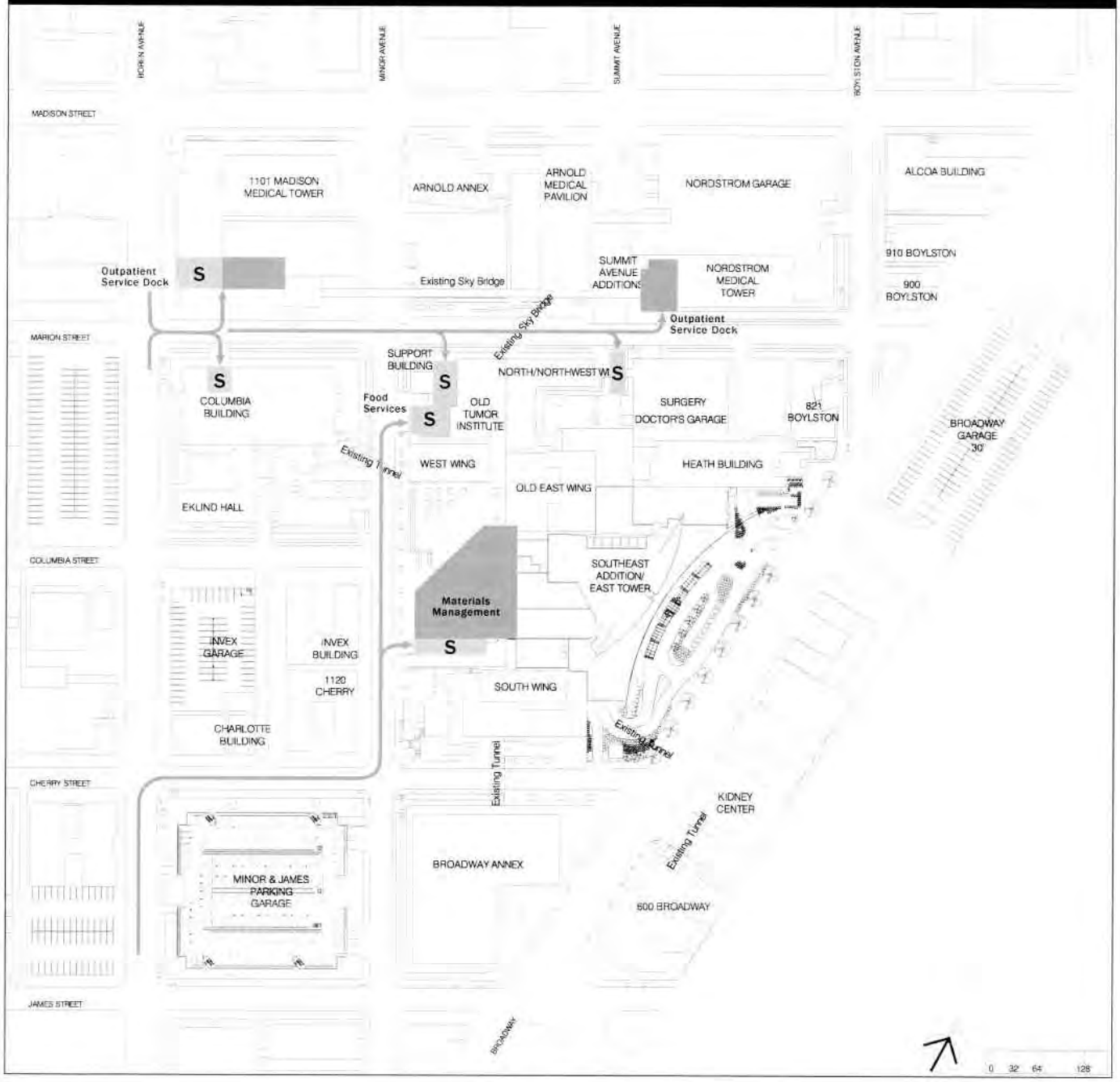
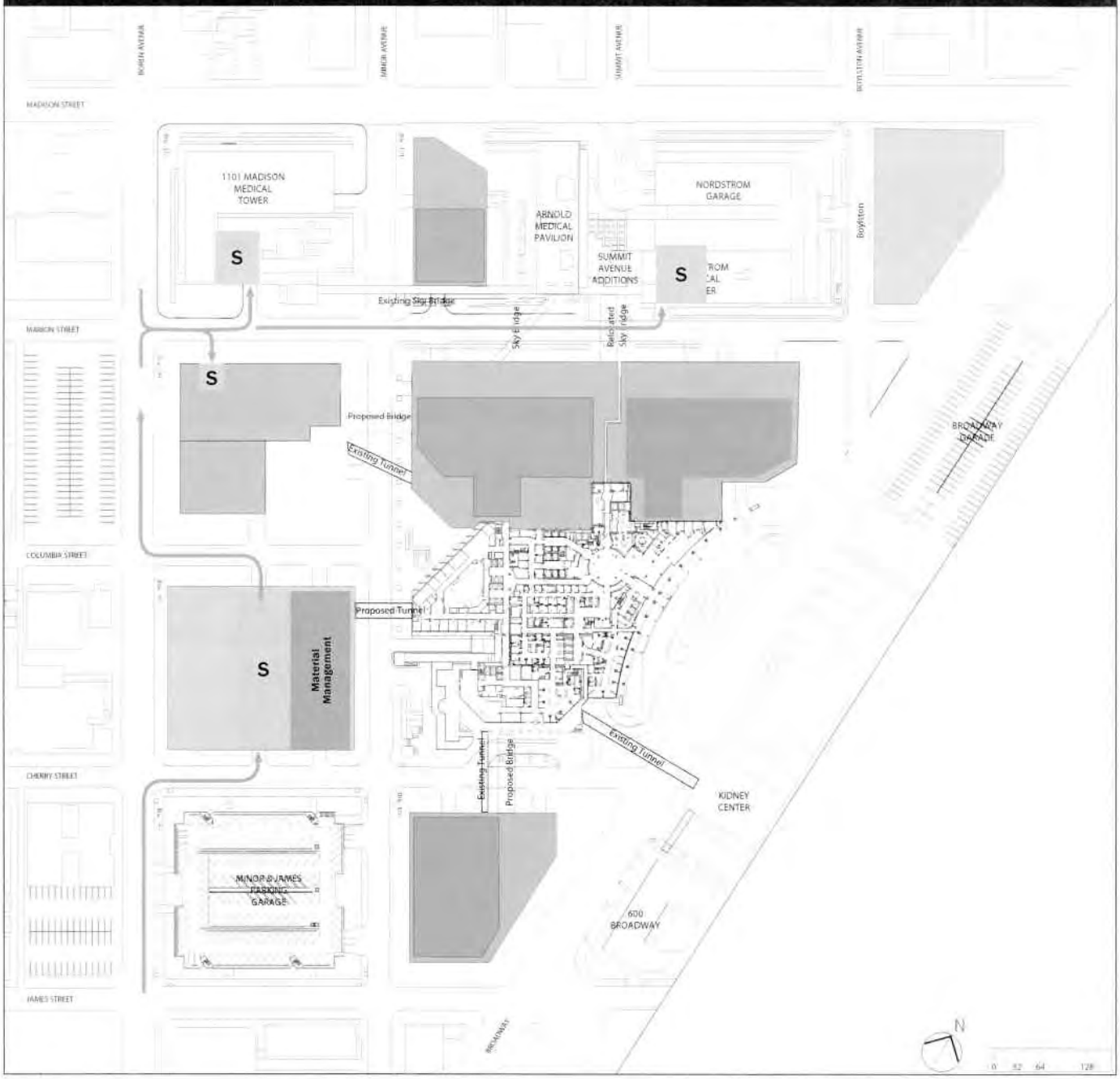


FIGURE 2.10

Future Local Circulation/Access to Service/Loading Docks



Pedestrian Circulation

Figure 2.11 depicts a plan for both internal and external pedestrian circulation at the Swedish First Hill campus. The pedestrian system for the urban campus consists of the street grid sidewalk network with an emphasis on Marion and Minor streetscapes as cross-campus routes with pedestrian amenities and the Madison retail/commercial corridor. Distinguishable campus edges would be defined but the intent is to not separate the campus from the neighborhood. Rather, the pedestrian circulation connects the context and passes through the porous campus.

Simple internal building wayfinding is established by clearly distinguishable and direct routes. Linkages between hospital buildings are provided by skybridges. A service tunnel under Minor connects the centralized physical plant/materials management facility with the main hospital.

The pedestrian improvements for wayfinding would be implemented in phases with each building development project. Streetscapes along the project blocks would be implemented with the master plan project.

Wayfinding

Based on a review of campus wayfinding features and conditions, and comments from the Swedish Citizens Advisory Committee, DPD, and DON, Swedish has elected to incorporate plans to develop a Wayfinding Program in this MIMP. A Wayfinding Plan containing Design Guidelines will be developed to address campus orientation, distinguishing places, ease of pedestrian movement and traffic management. The intent is to improve the pedestrian and vehicular wayfinding environment, safety and amenities. There is the opportunity for a broad range of place-making and streetscape improvements including, but not limited to signage.

Phased implementation of campus wayfinding elements would occur with each Planned and Potential development project and specifically along the project's block street frontages. There should be particular emphasis to the continuity of streetscape amenities along Minor Avenue and Marion Street and to the reinforcement of the retail/commercial Madison Street corridor as noted in the pedestrian circulation graphic (Figure 2.11).

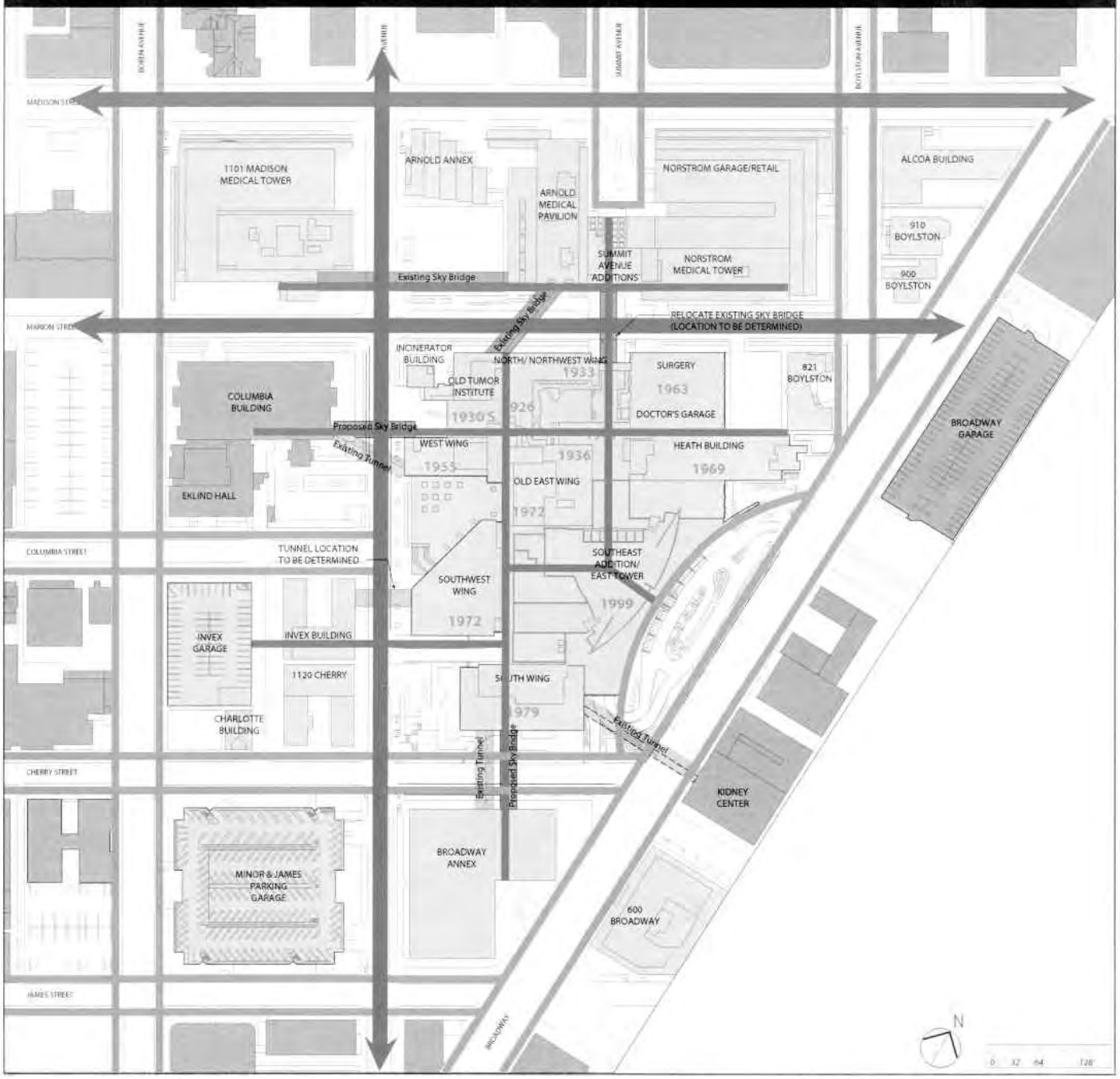
A Wayfinding Plan with detailed designs or prescriptive standards cannot be defined at this conceptual master planning stage. Swedish will develop the Wayfinding Plan and Design Guidelines with CAC and public input. A standing CAC and DPD would review future building designs to assure that the Wayfinding Plan and Design Guidelines are appropriately considered and reinforce wayfinding in the First Hill context.

Development Purpose and Public Benefits

The purpose of the proposed development is to allow Swedish to continue to provide the highest quality and most comprehensive healthcare to the community by replacing facilities of increasing obsolescence on the First Hill campus. The hospital development program of the current master plan has been fully built out so a renewed master plan is required for needed improvements.

FIGURE 2.11

Pedestrian Circulation



KEY

- Active Pedestrian Shopping Corridor
- Primary Cross-Campus Pedestrian Route
- Pedestrian Routes
- Internal Pedestrian Routes

Swedish has provided medical excellence in the community for nearly a century. In 2003, Swedish donated over $33 million in charity care and community benefits. As a charitable nonprofit organization, Swedish invests its resources in programs and services that improve the health of the community and region. Examples of continuing programs provided in coordination with other organizations are: Youth at Risk, Healthcare Services for Youth, Support for Patients and Families, Family Violence Program, Clinical Services for Low-Income Seniors, Swedish Mobile Mammography Van, Developmentally Disabled Students, Health Adventures for Middle School Students and Bereavement Support Groups. Swedish partners and provides an array of community health programs targeting the underserved and those affected by violence and substance abuse. For example, Swedish joins with Seattle & King County Public Health and Seattle Public Schools to provide comprehensive medical, counseling and preventative health services at the Ballard Teen Health Center.

Swedish provides extensive health information resources and classes to improve well-being. Programs include an online health library, 'ask Dr Auer', health classes, education centers, a Health Watch newsletter, and even heart-healthy recipes. Swedish outreach serves those who may not otherwise receive needed services, such as programs for newly arrived immigrants, homeless teenagers, low-income seniors, pregnant women with addictions, and charity care.

Consistency with Comprehensive Plan and Policies

Major Institution Policies

The relationship of the Comprehensive Plan goals and policies related to major institutions is described in the following Table, 2.3.

TABLE 2.3

Relationship of the Seattle Comprehensive Plan Major Institution Goals and Policies with the Swedish Master Plan

Major Institution Goals and Policies	Consistency with Swedish Master Plan
Purpose and Intent (23.69.002)	
A. Permit appropriate institutional growth within boundaries while minimizing the adverse impacts associated with development and geographic expansion;	Consistent with Swedish Master Plan. Proposed growth is all within existing campus boundaries. No geographic expansion is proposed.
B. Balance a Major Institution's ability to change and the public benefit derived from change with the need to protect the livability and vitality of adjacent neighborhoods; and	The purpose of the proposed Swedish development is to allow continued provision of the highest quality and most comprehensive healthcare to the community by replacing facilities of increasing obsolescence. The local land use patterns and separations by the major arterials at campus boundaries protect neighborhood livability.
C. Encourage the concentration of Major Institution development on existing campuses, or alternatively, the decentralization of such uses to locations more than 2,500 feet from campus boundaries.	The master plan proposes increased development concentration at the First Hill campus and decentralization at other locations (Providence, Ballard, Issaquah, etc.), consistent with the purpose/intent.
Application of Regulations (23.69.006)	
A. All land located within the Major Institution Overlay District shall be subject to the regulations and requirements of the underlying zone unless specifically modified by this chapter or an adopted master plan. In the event of irreconcilable differences between the provisions of this chapter and the underlying zoning regulations, the provisions of this chapter shall apply.	The master plan proposes to replace underlying zoning regulations with the MIMP development standards. A detailed comparison of the zoning standards is included in Appendix D.

Major Institution Goals and Policies	Consistency with Swedish Master Plan
Goals	
LG79 Maximize the public benefits of major institutions, including healthcare and educational services, while minimizing the adverse impacts associated with development and geographic expansion.	The goal is shared with the Swedish master plan. No geographic expansion of the MIO boundary is proposed.
LG80 Recognize the significant economic benefits of major institutions in the city and the region and their contributions to employment growth.	The Swedish 2003 Annual Report notes over $462 million in employee salaries and benefits, $33 million in community benefit contributions, and almost $43 million taxes paid.
LG81 Balance each major institution's ability to change and the public benefit derived from change with the need to protect the livability and vitality of adjacent neighborhoods.	Common goal.
LG82 Promote the integration of institutional development in the overall planning for urban centers.	The MIMP process publicly discloses Swedish future plans that can be integrated with overall planning.
Policies	
L262 Provide for the coordinated growth of major institutions through major institutional master plans and the establishment of major institutions overlay zones.	Consistent with Swedish master plan.
L263 Allow modifications to the underlying zone provisions in order to allow major institutions to thrive while ensuring that impacts of development on the surrounding neighborhood are satisfactorily mitigated.	No boundary changes are proposed but changed height limits at two locations are proposed. One makes the MIO and underlying zoning height limits the same.
L264 Discourage the expansion of established major institution boundaries.	Consistent; no boundary expansion is proposed.

Major Institution Goals and Policies	Consistency with Swedish Master Plan
L265 Encourage significant community involvement in the development, monitoring, implementation and amendment of major institution master plans, including the establishment of citizen's advisory committees containing community and major institution representatives.	A new CAC has been formed with coordination of DON, DPD and Swedish, and will fulfill these responsibilities.
L266 Encourage Advisory Committee participation throughout the process of revision, amendment and refinement of the master plan proposal.	Consistent with Swedish master plan.
L267 Require preparation of either a master plan or a revision to the appropriate existing master plan when a major development is proposed that is part of a major institution, and does not conform with the underlying zoning and is not included in an existing master plan.	A new master plan is being prepared.
L268 Provide procedures for considering the establishment of new major institutions.	Not applicable.
L269 New institutions shall be located in areas where such activities are compatible with the surrounding land uses and where the impacts associated with existing and future development can be appropriately mitigated.	Not applicable.

Major Institution Goals and Policies	Consistency with Swedish Master Plan

Overlay District

L270

Establish a Major Institution Overlay (MIO) to permit appropriate institutional development within boundaries while minimizing the adverse impacts associated with development and geographic expansion. A further purpose is to balance the public benefits of growth and change for major institutions with the need to maintain the livability and vitality of adjacent neighborhoods. When appropriate, the establishment of MIO boundaries may contribute to the transition of physical development to ensure compatibility between major institution areas and less intensive zone.

A MIO is already established for the Swedish First Hill campus.

L271

Allow all functionally integrated major institution uses within each overlay district, provided the development standards of the underlying zone are met. Permit development standards specifically tailored for the major institution and its surrounding area within the overlay district through a master plan process.

Consistent with Swedish master plan. Swedish and non-Swedish owned uses include medical offices, clinics, research, support retail/ commercial, and other uses that are functionally integrated with the major institution. Development standards are tailored to Swedish.

L272

Allow modification of use restrictions and parking requirements of the underlying zoning by the overlay to accommodate the changing needs of major institutions, provide flexibility for development and encourage a high quality environment. Allow modification of the development standards and other requirements of the underlying zoning by an adopted master plan.

Consistent with Swedish master plan.

Major Institution Goals and Policies	Consistency with Swedish Master Plan
Uses	
L273 Define all uses that are functionally integrated with, or substantially related to, the central mission of the major institution or that primarily and directly serve the users of the institution. The major institution uses and permit these uses in the Major Institution Overlay district, subject to the provisions of this policy, and in accordance with the development standards of the underlying zoning classifications or adopted master plan.	Consistent with Swedish master plan.
Development Standards	
L274 Apply the development standards of the underlying zoning classifications for height, density, bulk, setbacks, coverage, and landscaping for institutions to all major institution development, except for specific standards altered by a master plan.	Swedish development standards replace the underlying zoning standards.
L275 The need or appropriate transition shall be a primary consideration in determining setbacks.	Consistent with Swedish master plan.
Parking Standards	
L276 Establish minimum parking requirements in MIO Districts to meet the needs of the major institution and minimize parking demand in the adjacent areas. Include maximum parking limits to avoid unnecessary traffic in the surrounding areas to limit the use of single occupancy vehicles (SOV).	Consistent with Swedish master plan.
L277 Allow short-term or long-term parking space provisions to be modified as part of a Transportation Management Program (TMP).	Consistent with Swedish master plan.

Major Institution Goals and Policies	Consistency with Swedish Master Plan
L278 Allow an increase to the number of permitted spaces only when it 1) is necessary to reduce parking demand on streets in surrounding areas and 2) is compatible with the goals to minimize traffic congestion in the area.	Parking demand and traffic impact analysis are conducted as part of the environmental review.
L279 Use the TMP to reduce the number of vehicle trips to the major institution, minimize the adverse impacts of traffic on the streets surrounding the institution, minimize demand for parking on nearby streets, especially residential streets, and minimize the adverse impacts of institution-related parking on nearby streets. To meet theses objectives seek to reduce the number of SOV's used by employees and students at peak time and destined for the campus.	Consistent with Swedish master plan.

Residential Structures

L280 Encourage the preservation of housing within major institution overlay districts and the surrounding areas. Discourage conversion or demolition of housing within a major institution campus, and allow such action only when necessary for expansion of the institution.	No housing exists on the Swedish First Hill campus or would be directly impacted by proposed expansion.
L281 Prohibit demolition of structures with non-institutional residential uses for the development of any parking lot or parking structure which could provide non-required parking or be used to reduce a deficit of required parking spaces.	Consistent with Swedish master plan.
L282 Prohibit development by a major institution within 2,500 feet of the MIO District boundaries when it would result in the demolition of structures with residential uses or change of these structures to non-residential uses.	Consistent with Swedish master plan.

Major Institution Goals and Policies	Consistency with Swedish Master Plan
Master Plan	
L283 Require a master plan for each Major Institution proposing development which could affect the livability of the adjacent neighborhoods or has the potential for significant adverse impacts on the surrounding areas. Use the master plan to facilitate a comprehensive review of benefits and impacts of the Major Institution development.	Consistent with Swedish master plan.
L284 Use the master plan to: 1. Give clear guidelines and development standards on which the major institutions can rely for long-term planning and development; 2. Provide the neighborhood the advance notice of the development plans of the major institution; 3. Allow the City to anticipate and plan for the public capital or programmatic actions that will be needed to accommodate development; and 4. Provide the basis for determining appropriate mitigating actions to avoid or reduce adverse impacts from major institution growth.	Consistent with Swedish master plan.
L285 The master plan should establish or modify boundaries; provide physical development standards for the overlay district; define the development program for the specified time period; and describe a transportation management program.	Consistent with Swedish master plan. No boundary modification is proposed.
L286 Require City Council review and adoption of the master plan following a cooperative planning process to develop the master plan by the major Institution, the surrounding community and the city.	Consistent with Swedish master plan. This process is anticipated and Swedish intends to fulfill requirements.

Major Institution Goals and Policies	Consistency with Swedish Master Plan
L287 Encourage the preservation, restoration and reuse of designated historic buildings.	No designated historic buildings.
L288 In considering rezones, the objective shall be to achieve a better relationship between residential or commercial uses and the Major Institution uses, and to reduce or eliminate major land use conflicts in the area.	The proposed MIO height limit changes require a rezone. Land use compatibility is an objective of Swedish.

Comprehensive Plan Land Use

The Seattle Comprehensive Plan Future Land Use Map designates the Swedish First Hill campus as "Major Institutions" (bounded by Boren/Madison/Broadway/James). The proposed uses and development of the Swedish master plan are consistent with this designation.

The Seattle University area east of Broadway is similarly designated "Major Institutions." The remainder of the Broadway frontage, the James frontage, and the Madison frontage are designated "Commercial/Mixed Use Areas Inside Urban Centers/Villages." The area west of Boren is designated "Multi-Family Residential Areas."

The entire area is located within the First Hill/Capitol Hill Urban Center, one of five such centers of the Comprehensive Plan. The goal of the Urban Centers (G20) is to "Identify and reinforce concentrations of employment and housing in locations that would support and have direct access to the regional high capacity transit system." The further intensification of the Swedish Master plan is consistent with the goal. Note that one alignment of the proposed light-rail transit system passes under First Hill/Capitol Hill with a potential station at Madison between Summit and Boylston.

Comprehensive Plan Health/Human Development Policies

The Seattle Comprehensive Plan Human Development Element includes goals and policies related to health that apply to the Swedish MIMP. The relationship of the relevant Comprehensive Plan aspects is described in the following table.

TABLE 2.4

Relationship of Seattle Comprehensive Plan Health Goals/Policies with the Swedish Master Plan

Human Development Element	Consistency with Swedish Master Plan
Vision Statement The City of Seattle invests in people so that all families and individuals can meet their basic needs, share in economic prosperity, and participate in building a safe, healthy, educated, just, and caring community.	The mission of Swedish is to improve the health and well-being of each person served. The master plan is consistent with the Plan Element vision statement.
Healthcare to be as Physically and Mentally Fit as Possible	
Goal HDG6 Create a healthy environment where community members are able to practice healthy living, are well nourished, and have good access to affordable healthcare.	Swedish has provided medical excellence in the community for nearly a century. In 2003, Swedish donated over $33 million in charity care and community benefits.
Policy HD21 Encourage Seattle residents to adopt healthy and active lifestyles to improve their general health and well-being. Provide opportunities for people to participate in fitness and recreational activities and to enjoy available open space.	Swedish provides extensive health information resources and classes to improve well-being. Programs include an online health library, 'ask Dr Auer,' health classes, education centers, a HealthWatch newsletter, and even heart-healthy recipes. The master plan proposes enhancement of the Broadway open space and the Marion and Minor streetscapes.
Policy HD 22 Work toward the reduction of health risks and behaviors leading to chronic and infectious diseases and infant mortality, with particular emphasis on populations disproportionately affected by these conditions.	Swedish outreach serves those who may not otherwise receive needed services, such as programs for newly arrived immigrants, homeless teenagers, low-income seniors, pregnant women with addictions, and charity care.

Human Development Element	Consistency with Swedish Master Plan
Policy HD 23 Work to reduce environmental threats and hazards to health. a. Make use of the City's building and fire codes, food licensing, and permit processes, and hazardous materials and smoking regulations for fire and life safety protection. b. Collaborate through joint efforts among City agencies, such as fire, police, and construction and land use to address the health and safety issues in a more efficient manner.	Swedish complies with all applicable federal, state and local requirements related to environmental and health hazards. Swedish was selected by the nonprofit Patient Safety Institute to serve as one of two national demonstration sites for innovative communications programs intended to reduce costs and improve patient safety. Swedish works regularly with City agencies and collaborates to assure efficient heath and safety compliance, including the major institutions process for this master plan.
Policy HD 24 Swedish seeks to improve the quality of, and access to healthcare, including: physical and mental health, emergency medical and additional services. a. Collaborate with community organizations and health providers to advocate for quality healthcare and broader accessibility to services. b. Pursue co-location of programs and services, particularly in under-served areas and in urban village areas.	As a charitable nonprofit organization, Swedish invests its resources in programs and services that improve the health of the community and region. Examples of continuing programs provided in coordination with other organizations are: Youth at Risk, Healthcare Services for Youth, Support for Patients and Families, Family Violence Program, Clinical Services for Low-Income Seniors, Swedish Mobile Mammography Van, Developmentally Disabled Students, Health Adventures for Middle School Students and Bereavement Support Groups.
Policy HD 25 Work with other jurisdictions, institutions and community organizations to develop a strong continuum of community-based long-term care services.	Swedish Medical Center has a Home Healthcare Division that provides services in the home setting. This fully licensed Medicare/Medicaid-certified program works closely with physicians and other departments at Swedish to ensure continuity of care and ease a patient's transition from hospital to home. In 2002, over 6,200 patients were served in over 118,000 visits. Swedish's goal is to promote the highest level of independence for the patient. Patients and their family members are very involved in the plan of care. In addition to the broad range of services

Human Development Element	Consistency with Swedish Master Plan
	available to patients, support services are also available for families and caregivers. Swedish Home Care Services offers the following services: home healthcare, home infusion treatments, hospice care, home helpers, bereavement support, nurse telephone access, and Swedish LifeNet (emergency response system and medication management).
Coordination and Joint Planning of Services	
Goal HDG11 Develop a more flexible, comprehensive, coordinated and efficient system of services that addresses whole needs of people, families, and communities.	Swedish provides state-of-the-art care to patients of every age and stage of life for virtually every healthcare need (see programs above).
Policy HD 44 Encourage cooperative planning, decision-making, and funding for health and a human service delivery throughout the region. Join with other public and private institutions in the region to strive for a stable and adequate funding base for services that supports safe and healthy communities.	Swedish partners and provides an array of community health programs targeting the underserved and those affected by violence and substance abuse. For example, Swedish joins with Seattle & King County Public Health and Seattle Public Schools to provide comprehensive medical, counseling and preventative health services at the Ballard Teen Health Center.
Policy HD45 Promote effective, efficient community-based and community-delivered services using a combination of public, private, community and personal resources.	(See preceding response to HD 44). In 2003, friends of Swedish donated almost $2.6 million to support the steadfast commitment to highest quality healthcare.
Policy HD 46 Strive to provide better and more coordinated information to people about the availability of services in the community and make use of available and new technologies to improve access to services and information.	Swedish is a leader in technology based access to services and information (see response to HD 21). The noted programs are all available on-line.

Human Development Element	Consistency with Swedish Master Plan
Policy HD 47 Encourage customer-focused services with feedback from those who use them and involvement of consumers in identifying needs and planning for service delivery.	King County residents consistently rank Swedish as the area's best hospital, with the best quality, personalized care and providers (from independent survey by National Research Corporation).
Policy HD 48 Encourage connections between services that coordinate, link and integrate public, private and community-based services. Facilitate collaboration of programs through the use of City funding.	Long-term affiliations have been established with area hospitals to provide outpatient and radiation oncology services closer to home. Neonatal intensive care services are linked with the Swedish Pediatric Intensive Care Transport Coach.
Policy HD 49 Encourage consideration of issues like transportation and the need for dependent care in planning for health, human services, employment and recreation programs.	Multiple Swedish programs, such as the Support for Patients and Families, offer special assistance beyond primary healthcare.

Decentralization Plans

Swedish Medical Center is a system of three campuses, affiliations with suburban community hospitals and physicians groups, and a home-care services program. Swedish also has 11 primary-care clinics throughout the greater Seattle area and multiple specialty clinics.

The Swedish Heart and Cancer Institutes have longstanding alliances with community hospitals. Strong partnerships exist with Stevens Hospital, Valley Medical Center, Northwest Hospital, and Highline Hospital. Swedish also formed a joint regional pediatric heart-surgery program with Mary Bridge Children's Hospital in Tacoma in early 2004.

Swedish provides acute care services at all of its campuses, but has concentrated some services to only one campus. Addiction recovery is located only at the Ballard campus, while inpatient rehabilitation, sleep medicine, and behavioral services are all localized at the Providence Campus. Swedish is also making great strides toward the vision of a world-class Heart and Vascular Institute on its Providence Campus.

Swedish leases space outside of its institutional boundaries and has moved many of its services off of its First Hill Campus. For example, Home Health Services is located in leased space in the Design Center in South Seattle, and the administrative services for its Physician Division are in Downtown Seattle. There will also be much interim and permanent relocation of services expected during construction of replacement facilities on the First Hill Campus.

Swedish is also pursuing many initiatives off of the First Hill Campus, in order to meet healthcare need and bring services out to the community. The hospital system is currently planning for a phased expansion into Issaquah. A freestanding emergency-room (ER) complex opened in early 2005, with intentions to build a state-of-the-art nonprofit community hospital in the next several years.

Master Plan Timeframe

The master plan's development program will remain in effect until all proposed development is constructed or until the time that a new master plan is adopted by the City Council. The master plan development standards and Transportation Management Program will remain in effect until amended. No master plan term is established. For purposes of environmental impact analysis, time estimates are made but actual master plan implementation may differ.

Alternatives

Three master plan alternatives, in addition to the Proposal Action, are described that seek to approximate development objectives and satisfy environmental requirements. The alternatives are:

- Changes to Planned and Potential Projects
- No Alley Vacation
- No Action

1) Changes to Planned and Potential Projects

The proposed master plan projects seek to maximize allowable development envelopes but there is the possibility the changes would be made to specific project uses involving: location, building form, heights, development sequencing/timing and site specific density. Changes may include re-development of other portions of the hospital. Additional or different street or alley vacations and skybridges/tunnels may be proposed. Such change is expected in a master plan and flexibility to allow such change must be included in the MIMP. Any change to the Planned and Potential Projects is included in this alternative as long as the change is consistent with the development standards, within the total maximum building area of the development program and the project is located within the MIO boundary. The alternative shifts/re-configures proposed development within the MIO District.

The eventual replacement of somewhat newer core hospital facilities located in the South and Southwest Wings is included in this alternative. In addition, the two blocks west of Minor, between Marion and Cherry, and the one block south of Cherry, between Broadway and Minor, would be developed with mixed uses including offices, research, clinics, support, parking and other related Swedish uses. The segment of Columbia Street Between Boren and Minor may be vacated as envisioned in the existing master plan.

2) No Alley Vacation

The City requires this alternative for comparison with the proposed street and alley vacations. The one proposed vacation would be eliminated in this alternative.

The alley on the block bounded by Boren-Minor-Columbia-Cherry would remain and the proposed central support building, parking and upper level medical office and research would have to be re-designed to function on two city half-blocks. Proposed off-street service functions (inside buildings) for loading docks, service, and materials transfer and storage may be relocated along streets and the alley in order to function. Below grade development would be separated on the two half-blocks. Upper level development would be oriented to fit on the two half blocks.

3) No Action

This alternative is required as a baseline for comparing impacts (WAC197-11-440 5.b.ii and SMC 25.05.440.D.2.b). No new development would occur. The distribution and location of existing uses may change and involve renovations but no net increase in space would be developed. User populations may increase demand for services but facilities would not expand to accommodate the change. There would be no expanded physical development.

B. Planned Projects

The Proposed Action includes Planned Projects and Potential Projects. The master plan projects are depicted in Figure 2.12.

Uses and Areas

The total existing Swedish First Hill campus chargeable development totals to about 2.3 million square feet. Parking is additional and amounts to about 1.3 million square feet or about 3800 spaces.

The proposed Planned Projects amount to about 950,000 square feet net new of chargeable space (about 1.47 million square feet of new construction less demolition of about 520,000 square feet). Proposed parking adds from 1400 to 1500 net new spaces.

Proposed uses that comprise the space include replacement of hospital and hospital related functions including clinics, medical offices, research, support facilities (physical plant, materials management, etc.).

The required master plan building areas for Swedish respond to the healthcare needs for increased functional space. The change to single patient rooms (from double bedrooms), accommodations for family members, higher patient acuity, additional space for diagnostic and treatment equipment, increased technology use, and overall 'up-sizing' to meet current and future hospital space standards require more building area. However, Swedish does not anticipate significant service and population increases. Space needs for all bed types, from medical surgical units to intensive care units, continue to grow dramatically.

Swedish has 697 licensed beds for the First Hill campus. The proposed master plan projects will not change this number. The current number of 566 set-up beds may be increased to the licensed bed limit.

Note: See the following Development Standards section for the proposed maximum campus development density (floor area ratio-FAR) of the MIO District.

Height/Bulk/Scale

Each project is intended to maximize the allowable building volume including maximum height allowed by the MIO District. The buildings are proposed to the height limits as well as all other maximum building volume defining parameters, such as lot coverage, setbacks and open space. The overall campus massing concept is to locate the most intense activities and concentrated building massing in the center of the campus. There is a height/bulk/scale transition with lower heights toward the campus edges along the four campus-defining arterials. The organization is intended to minimize any compatibility impacts with the immediate neighborhood.

FIGURE 2.12

Planned and Potential Projects

KEY TO FIGURE 2.12

Planned Projects

A. Medical Office Building

B. Hospital Replacement: Building B

C. Hospital Replacement: Building C

D. Hospital Replacement: Building D

E. Central Support Facility w/ Medical Office Tower

G. Hospital Replacement: Building G

Potential Projects

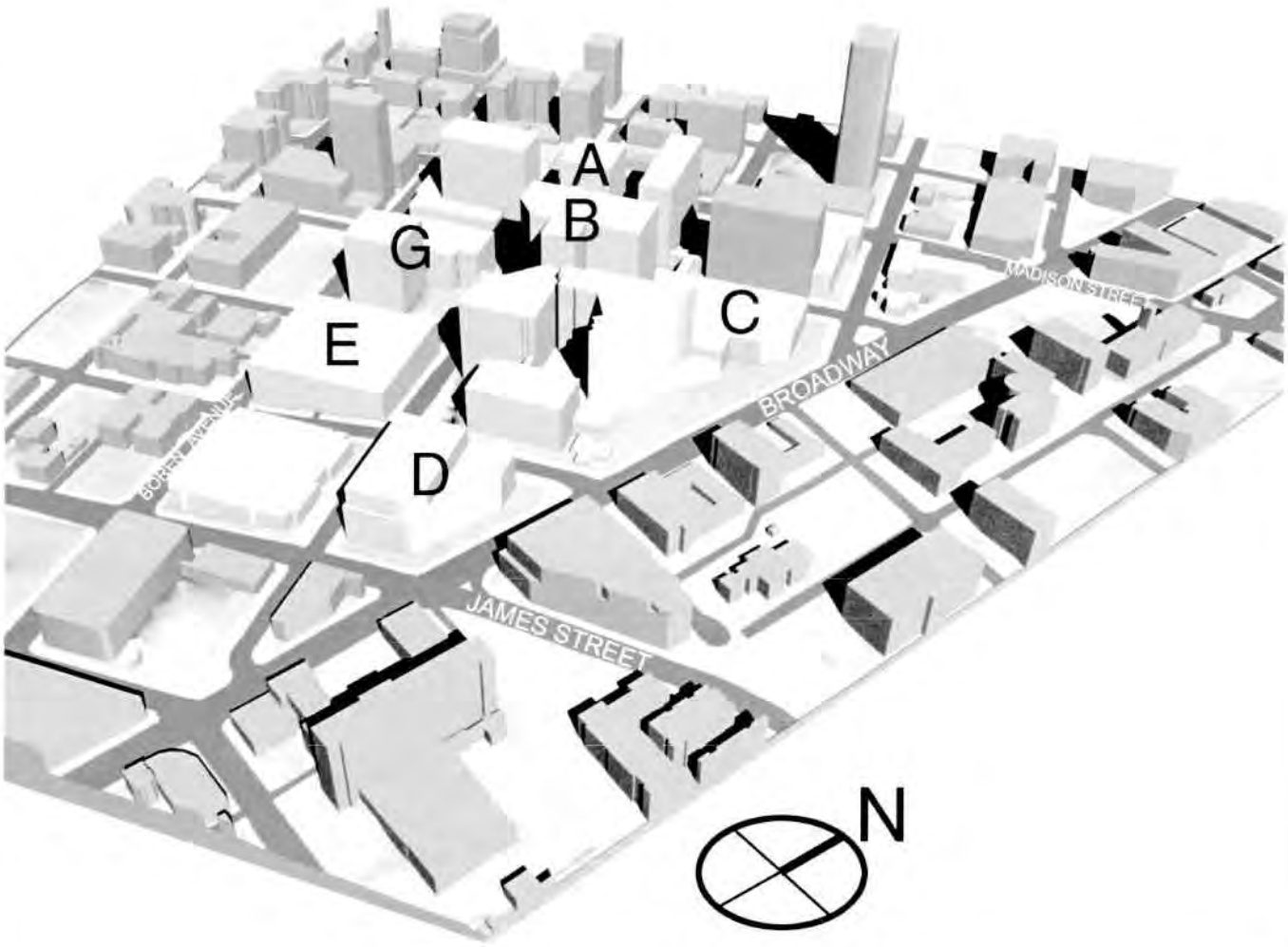
F. Medical Office Building

C-1. Hospital Replacement: Building C - Future Tower Addition

E-1. Central Support Facility w/Medical Office Tower and Research

FIGURE 2.13

Planned Projects 3-Dimensional View



KEY

Planned Projects

A. Medical Office Building

B. Hospital Replacement: Building B

C. Hospital Replacement: Building C

D. Hospital Replacement: Building D

E. Central Support Facility w/Medical Office Tower

G. Hospital Replacement: Building G

The maximum height/bulk/scale impacts are assessed for the 'worst case' impact. Future actual project building designs may be less than allowed. Flexibility in the future building massing design is required given uncontrollable and unpredictable changes to healthcare conditions. A 3-dimensional view of the Planned Projects is shown in Figure 2.13.

Street and Alley Vacations

No street vacations are proposed. One alley vacation is proposed. The alley on the block bounded by Boren-Columbia-Minor-Cherry (Block 95) would be vacated to allow development of Project E, Central Support Facility. This project includes materials management and central plant. All truck access/loading/maneuvering would be located off-street/off-alley and within the proposed building. Wider curb cuts (60 to 90 feet) along Columbia and Cherry may be required. Long-term public benefits are proposed and would include landscaped open space, pedestrian improvements and other amenities.

This vacation was also included in the currently approved Swedish master plan but was never implemented.

The proposed vacation and skybridges and tunnels are depicted on Figure 2.14. The skybridges are required linkages to allow movement of non-ambulatory patients. The projects with skybridges are all inpatient hospital uses. The tunnel is required to link the consolidated materials management/physical plant with the hospital.

Skybridge and tunnel connections across public right-of-ways are proposed but permits will be sought rather than aerial and/or below-grade vacations. All existing skybridges and tunnels on the Swedish campus are allowed by permit.

Circulation & Parking

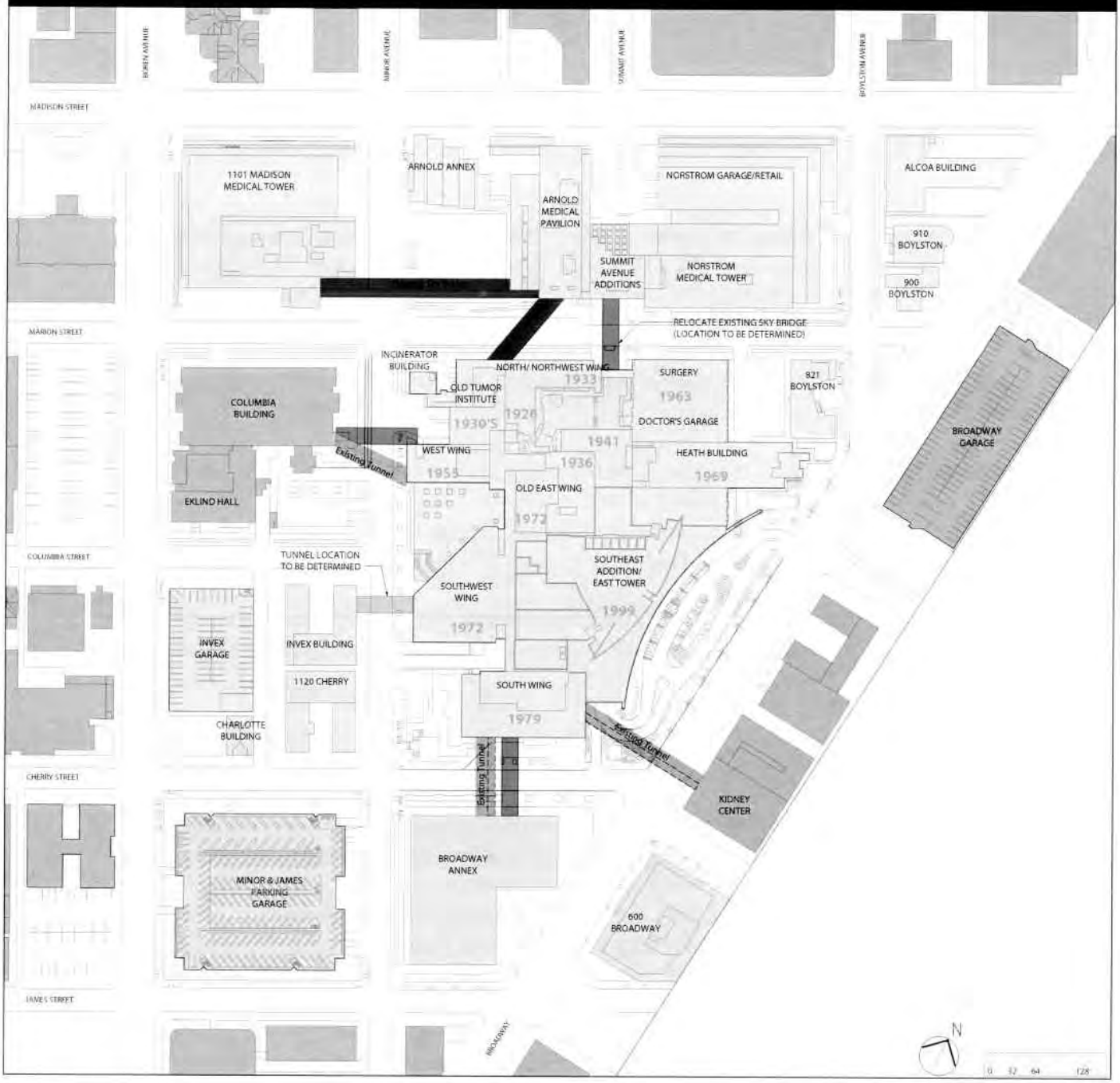
Generally the existing land platting and street layout on the campus will be maintained. One proposed alley vacation would alter the local block service pattern. No change is proposed to the existing street layout system unless warranted to improve traffic operations and safety. Traffic flows are proposed to be improved within the campus area by eliminating some on-street parking to achieve adequate lane widths. No right-of-way dedications are required or expected in the future except along Boren, between Cherry and Columbia Streets. Some exceptions to city requirements related to curb cut widths, number of driveways and other design details may be required.

Parking and vehicular access is proposed to be improved within the campus area. Parking locations and site access points are shown in Figure 2.15. New drop-off/pick-up areas will be designed to minimize traffic impacts and operate efficiently.

The maximum number of off-street parking spaces for the MIO District is 6000 spaces (See Development Standards section for calculation). This number does not include temporary loading/drop-off spaces, service parking, or on-street parking. Parking is distributed throughout the campus and located to conveniently serve the nearest uses. Access avoids conflicts with major arterials and pedestrian activity to the extent possible.

FIGURE 2.14

Proposed Alley Vacation and Skybridges/Tunnels

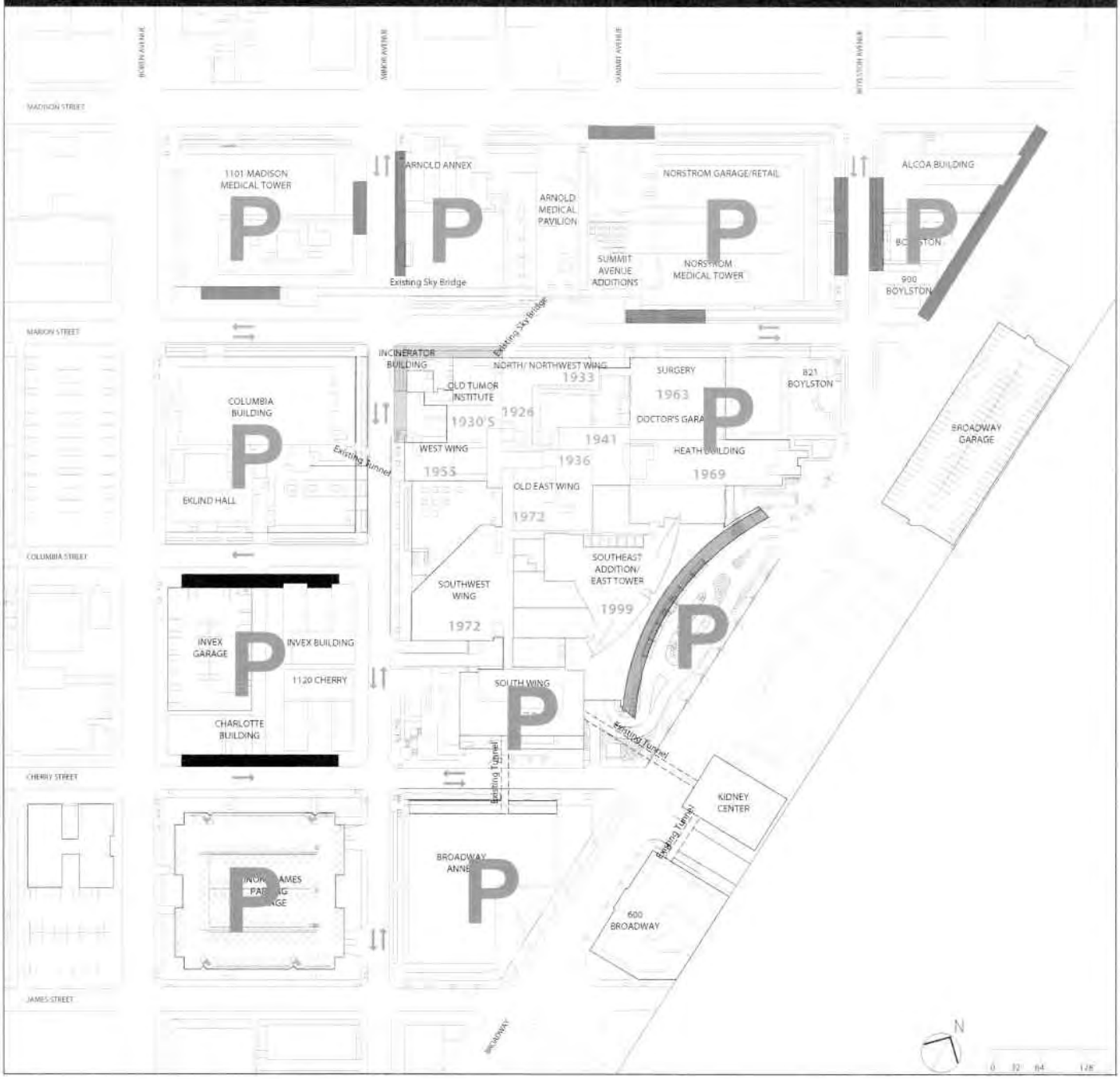


KEY

- Existing Skybridge
- Proposed Skybridge
- Existing Tunnels
- Proposed Tunnel
- Proposed Alley Vacation

FIGURE 2.15

Parking and Vehicular Access



KEY

- P — Parking
- Outpatient Access
- Main Hospital Entrance
- Emergency Department Access
- Hospital Access
- Service/Physical Plant Access

Note: Also see previous Local Circulation/Access graphics for comparison of existing and future conditions in First Hill campus section.

Open Space

Open space includes landscaped open areas and paved plazas and streetscapes. The Broadway campus frontage is proposed to be enhanced by more landscaped open space. (Also see following development standards for open space and landscaping.)

Open spaces on the First Hill campus are shown in Figure 2.16. The existing open space entry drive along Broadway at the main hospital entrance is proposed to be designated as permanent open space. Portions may be landscaped or paved. The minimum designated open space at the Broadway main hospital entrance location is 0.5 acres.

The urban plazas, landscaped areas and improved streetscapes are intended to contribute to the limited open space amenities of First Hill. The improvements will reinforce the local campus cohesiveness and also assure a "porous" campus that encourages cross-pedestrian movement.

The Seattle Parks and Recreation Department is in the process of identifying a site on First Hill for a new park funded by the voter passed Pro Parks levy. Swedish will coordinate its planning of open space with this on-going effort.

Utility Infrastructure

See EIS Energy and Utilities sections. Utility systems are sufficient to service Swedish. A physical plant (Project E) is proposed as part of the master plan.

Phasing

The phasing of specific projects is uncertain. The primary need is hospital replacement so the sequencing of projects would occur to this end and must enable current hospital operations and minimize disruption. Certain existing functions must be replaced before they are displaced. One phasing example is replacement of support functions at the Project B location so existing buildings could be demolished. Replacement may be developed at Project E. Once Project E is completed, then the hospital proposal Project B could be developed. Project D may be an early project because the hospital development would be less disruptive to other existing hospital functions. However, existing offices would have to be relocated. Project A may also be an early project. Project phasing is to be determined.

FIGURE 2.16

Open Spaces

KEY

Existing Open Space
(Landscaped Areas and Plazas)

Designated Open Space

Street Trees

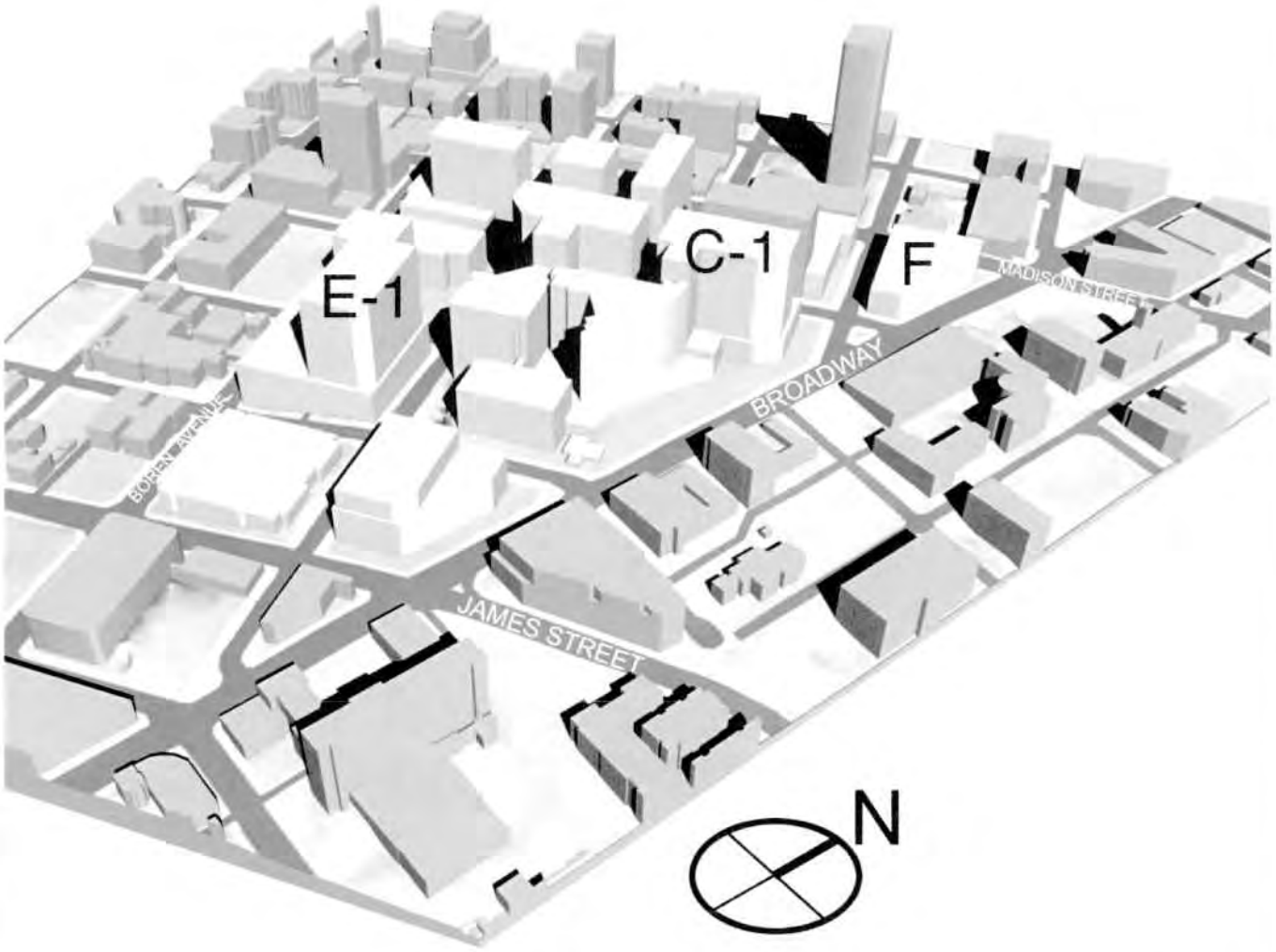
C. Potential Projects

Potential Projects add approximately 270,000 square feet net new of chargeable space (about 305,000 square feet new construction less demolition of about 35,000 square feet). Proposed parking adds about 50 to 100 net new spaces.

The total of 697 licensed beds for the First Hill campus is not changed by the Potential Projects. The number of set-up beds may increase to the licensed bed limit. A 3-dimensional view of the Potential Projects is shown in Figure 2.17. (Also see prior graphic Planned and Potential Projects for plan view).

FIGURE 2.17

Potential Projects 3-Dimensional View



KEY

Potential Projects

F. Medical Office Building

C-1. Hospital Replacement: Building C - Future Tower Addition

E-1. Central Support Facility w/Medical Office Tower and Research

3. Development Standards

The master plan replaces all underlying zoning standards with the following development standards that are tailored to Swedish Medical Center First Hill campus. Proposed master plan projects are described to fully fill maximum allowable building envelopes defined by the development standards. Actual projects may be reduced in volume when designed in the future but in no case would exceed the maximum limits. No development conditions are proposed, but impact mitigation is identified in the EIS. Conditions will likely be developed during the review/approval process following issuance of the Final MIMP and Final EIS.

A. Zoning District

Major Institution Overlay (MIO) District and Underlying Zoning

The existing and proposed major institution overlay (MIO) district boundary and height districts are shown in Figure 3.1, along with the underlying zoning districts. The zoning of the immediate context is also shown. No changes are proposed to the MIO District boundary. It defines the Swedish First Hill campus, bounded by Boren-Madison-Broadway-James. Two changes (rezones) are proposed to the MIO height districts within this area:

1. The block bound by James-Cherry-Minor-Broadway would be changed from MIO-70' to MIO-105'. The underlying zoning would remain unchanged as NC3-85'.

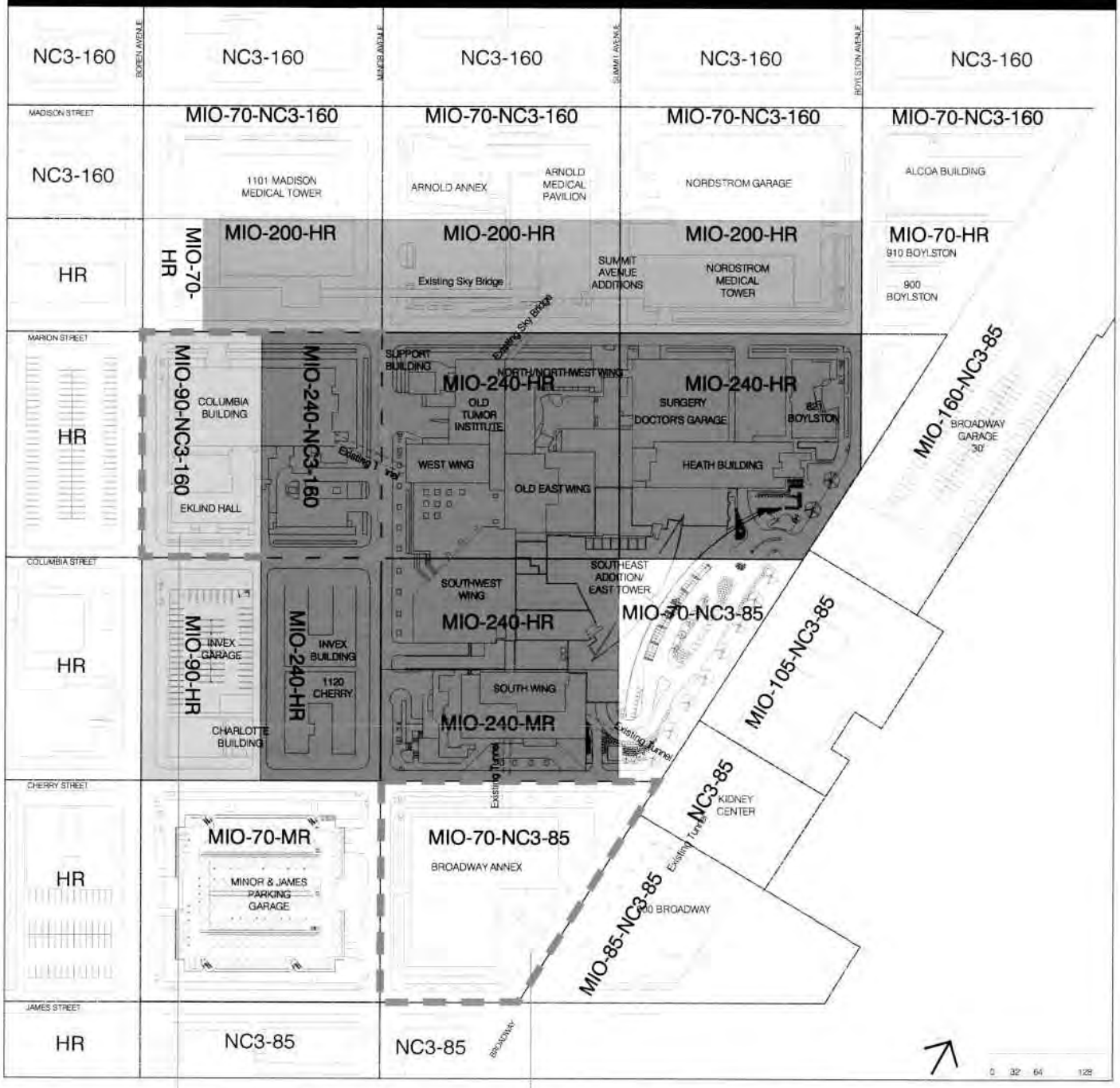
2. The block bound by Marion-Minor-Columbia-Boren would be changed from MIO-90 and MIO-240' to MIO-160' to be consistent with the recent re-zone of the underlying zoning. The underlying zoning was changed from Highrise (HR) multi-family residential to Neighborhood Commercial (NC3-160'). Swedish does not own the block and the zoning was changed by the current property owner. However, Swedish proposes that the same MIO height district apply to the entire block and that the height be the same as the current underlying zoning.

The Swedish First Hill campus now includes four different MIO height districts: MIO-70', -90', -200' and -240'. A fifth district, MIO-105' is proposed. The greatest heights are centered at the core of the campus and reduced heights transition to the campus edges. A re-zone is requested as part of the master plan for the MIO District changes. Underlying zoning would not be changed. The underlying zoning includes both residential and commercial districts. It is largely Highrise (HR) multi-family residential, except for the one block noted that was re-zoned and the half-block deep frontage along Madison that is zoned NC3-160'. Underlying zoning along Broadway is NC3-85'. The parking garage block at Boren and James has underlying zoning of MR, Mid-rise multi-family residential. There is a P1 Pedestrian Overlay district along Madison Street. Swedish is located within the First Hill Urban Village as defined by the Seattle Comprehensive Plan.

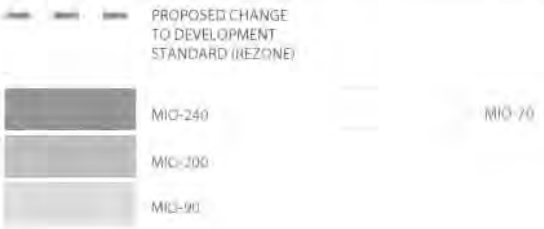
The MIO District east of Broadway (MIO-85, 105', 160') is associated with Seattle University. The MIO District south of James (MIO-240') is associated with Harborview Medical Center.

FIGURE 3.1

MIO Districts and Underlying Zoning



KEY TO FIGURE 3.1



HR	Highrise Multi-Family Residential
MR	Midrise Multi-Family Residential
NC3	Neighborhood Commercial 3
MIO	Major Institution Overlay District

*Building heights are approximate and vary by measurement location due to grade differences

MIO-240

East Tower
Height: 182'
Area: 441,067 sf

Main Surgery
Height: 31'
Area: 62,302 sf

821 Boylston
Height: 21'
Area: 61,703 sf

Heath Building
Height: 121'
Area: 118,297 sf

North/Northwest Wing
Height: 77'
Area: 61,703 sf

Old Tumor Institute
Height: 26'
Area: 12,541 sf

West Wing
Height: 125'
Area: 140,255 sf

Old East Wing
Height: 160'/168'-6"
Area: 118,448 sf

Southwest Wing
Height: 164'
Area: 285,070 sf

South Wing
Height: 87'
Area: 157,967 sf

Columbia Building
Height: 103'
Area: 285,070 sf

MIO-200

Nordstrom Medical Tower
Height: 174'
Area: 201,764 sf

1101 Madison Medical Tower
Height: Base 60'
Tower 120'
Area: 306,266 sf

Arnold
Height: 179'
Area: 197,201 sf

MIO-90

Columbia Building
Height: 103'
Area: 285,070 sf

Eklind Hall
Height: 63'
Area: 18,000 sf

Invex Garage
Height: 14'
Area: 21,284 sf

Charlotte Building
Height: 47'
Area: 7,826 sf

MIO-70

Alcoa Building
Height: 30'
Area: 39,634 sf

900 Boylston
Height: 16'
Area: 8,124 sf

910 Boylston
Height: 21'
Area: 9,332 sf

Nordstrom Garage
Height: 59'
Area: 153,078 sf

Arnold Medical Pavillion
Height: 179'
Area: 197,201 sq

Arnold Annex
Height: 26'
Area: 21,284 sf

1101 Madison Medical Tower
Height: 60'
Area: 306,266 sf

Minor & James Parking Garage
Height: 40'
Area: 307,207 sf

Broadway Annex
Height: 51'
Area: 75,165 sf

B. Basic Standards

MIO District Density

Density of development is proposed to include the entire First Hill MIO District and the net chargeable floor area that is less than the total gross building area. The customary exclusions for calculating floor area ratio (FAR) apply to the Swedish development standards. The floor area and parking calculations are detailed in Table 3.1

The density standard (FAR) applies to the entire MIO District and not to specific sites. There are no applicable sub-areas within the MIO District (23.69.030E2). Proposed master plan projects fill the maximum allowable building envelope per other development standards but are not quantified (or limited) in terms of individual project density. Massing diagrams and the impact analysis do consider this maximum development condition.

New construction is chargeable building area/functional space. Total gross building area will increase this net space numbers.

The maximum chargeable building area standard for MIO District density is proposed to be 3,500,000 chargeable square feet. The standard is higher than estimated numbers (3,471,083) due to uncertainty and the conceptual level of design definition of projects. The number does not include mechanical floors, interstitial space, below grade space, parking or circulation areas.

The density limit may be expressed in terms of a FAR linking chargeable building area to existing land area (land from the proposed alley vacation is not included). Assuming a Swedish First Hill campus MIO District land area of 649,876 SF (based on Assessor's records and not including public right-of-ways) and a chargeable building area of 3,500,000 SF (not including mechanical, below grade, parking and circulation spaces), then the calculated FAR is 5.386.

The Swedish First Hill campus density standard is a maximum FAR 5.5. The higher number expresses the uncertainty/accuracy of the numbers and the need for master plan project flexibility. The density limit would be applied to the total campus and total development and not to individual sites and projects. The maximum off-street parking supply standard is 6,000 spaces within the MIO District.

Note: Appendix D is a comparison of zoning development standards. The standards of underlying and adjacent zones are included.

TABLE 3.1

Floor Area and Parking Calculation

	Existing MIO District Swedish Building Area	Planned Additional Development	Potential Additional Development	Future MIO District Swedish Building Area
Hospital	1,279,353 SF	1,024,000 SF	135,000 SF	2,438,353 SF
MOB	806,377 SF	156,000 SF	70,000 SF	1,032,377 SF
Other	197,664 SF	254,000 SF	100,000 SF	551,664 SF
New Construction Building Total	–	1,434,000 SF	305,000 SF	4,022,394 SF
Demolition	–	(515,833 SF)	(35,478 SF)	(551,311 SF)
Net New Building*	–	918,167 SF	269,522 SF	1,187,689 SF
Total First Hill Campus Building	2,283,394 SF	–	–	3,471,083 SF
Parking Garages**	1,224,618 SF 3,510 spaces	676,000 SF 1,835	40,000SF 100	1,940,618 SF
Displaced Parking	–	(432)	(66)	
Surface Parking	233 spaces	–	–	
Net New Parking	–	1,403	34	1437
Total First Hill Campus Parking	3,743 spaces	–	–	5,180 spaces

* New construction is chargeable building area/functional space and does not include interstitial areas, mechanical floors, and below-grade space. Total gross building area will increase the space numbers. The maximum chargeable building area standard is proposed to be 3,500,000 chargeable square feet. The standard is higher than estimated numbers due to uncertainty and the conceptual level of design definition of projects.

** Proposed parking areas and number of spaces are order of magnitude approximation and actual number is dependent upon project design. Surface parking may be developed as interim use but quantity is not included. Maximum off-street parking supply standard is proposed to be 6,000 spaces and includes a 15% factor for design uncertainty.

Total Swedish First Hill campus land area is assumed to be 649,876 SF and corresponds with the MIO District (not including right-of-ways). See property ownership details in Appendix A.

Height Limits

Five height districts apply to the Swedish First Hill campus as previously described under the Zoning District section. The maximum height limits are: 240 FT, 200 FT, 105 FT, 90 FT and 70 FT.

The greatest heights are located toward the center of the First Hill campus. The heights are reduced toward the campus edges and approximate the allowable heights of adjacent zoning. This step-back occurs midblock from the Madison frontage (70 feet along Madison and 200 feet along Marion). The transition supports the pedestrian activities along the Madison corridor.

Because of the high-rise urban scale of the Swedish First Hill development and the topographic characteristics at the hill crest, the downtown zoning measurement technique applies (23.86.006E). Customary exceptions for rooftop height exceptions apply unique to medical facilities. Rooftop mechanical space may extend up to 25 FT above the height limit and cover up to 90% of the roof top.

Structure Setbacks

Setbacks are most important for the Swedish campus edges that border major arterials: Boren, Madison, Broadway and James. The setback standards are as follows (also see Figure 3.2):

- A minimum, heavily landscaped setback of 10 feet is established along the Boren and James frontages. The intent is to create a 'softened' landscape screen between the buildings and the high traffic volume arterials. The existing landscaping along Minor Avenue between James and Cherry is an example of the character of the landscaped setback desired. Note that right-of-way dedications at the time of future development may be required by the city along the Boren frontage. Setbacks are proposed from existing property lines.
- A minimum structure setback of 10 feet is established along the Madison Street frontage to enable widened sidewalks with street trees or other pedestrian amenities. The current sidewalk widths and improvements along the Madison frontage of the 1101 Madison Medical Tower is an example of the streetscape improvements desired.
- Structures along the Broadway frontage will have a minimum setback of 5 feet in combination with pocket park clusters of landscaping. The larger landscaped areas are to be located along Broadway at Madison, at Marion, and at Cherry. The distributed pattern will set a rhythm of landscaped spaces in conjunction with the main Swedish entrance drive.

Generally, no structure setbacks are required along interior campus property lines along streets or adjacent to other lots. New structure setbacks are to be no greater that existing structure setbacks. Setbacks may be provided with project designs to provide façade relief or open space/ plazas but are not required. The intent is to blend new development with the existing to complete the urban campus composition. Continuity of the building street edge should be reinforced, particularly along the pedestrian oriented Madison Street corridor.

The Swedish setback development standards supersede the underlying zoning (23.45.096) and the major institution provisions of 23.69.030C3a. An Administrative Conditional Use Permit (ACUP) or other relief may be required and is included with the MIMP proposal. Structures or other improvements that are 100% below-grade are permitted within the setback areas. Incidental

FIGURE 3.2

Setbacks

KEY

- 10 Foot Landscape Setback
- 10 Foot Setback
- 5 Foot Setback
- No Setback

structures (such as fences, screen walls, architectural features, vents, gratings, etc.) customarily allowed in setback areas are permitted. The setback area may be covered by decorative pavings and/or landscaping.

Lot Coverage

The maximum structure lot coverage standard of the entire MIO District (not individual project sites) is 80%.

The existing campus-wide amount of lot coverage by existing structures is approximately 66%. The Planned and Potential Projects would result in approximately 73% coverage. The calculations are estimated based upon plan drawings and aerial photos. The standard is proposed to be somewhat greater than estimated for the proposed development because project details are unknown at this time.

Open Space & Landscaping

Multiple landscaped open spaces and paved plazas are currently located throughout the Swedish First Hill campus and amount to about 6% of the total campus land area. This does not include entry driveways, drop-off areas and paved parking. In addition, there are numerous street trees located within the public right-of ways within the campus area.

The urban nature of the Swedish campus with small, dispersed open spaces is proposed to be maintained in the master plan. The development standard for open space and landscaping is a minimum 5% of the total campus land area. The areas may be landscaped planted areas, or paved plazas or building setbacks. The areas may be at grade or above grade as long as they are accessible to the public. The standard applies to the entire MIO District and not to individual projects.

Small pockets of landscaping would be developed with projects along Broadway frontage. The angled street grid creates triangular pockets that are suitable for improved landscaping.

The existing open space at the hospital main entrance along Broadway is identified as "designated open space" and amounts to a minimum area of 0.5 acres (also see open space discussion with Planned Projects). Additional landscaping would be provided along Broadway at the northern end of the main entrance with re-development (Project C).

The dispersed pattern of open space on the Swedish campus is similar to the multiple small parks of First Hill. Swedish is coordinating its planning with the Seattle Parks and Recreation Department.

Height and Scale Transitions

No standards are provided for this element because compatibility of height and scale is effectively addressed by the location of the MIO Districts, with the greatest development intensity located in the central campus and reduced heights at the campus edges. The four major arterials around the campus also establish an adequate land use and development transition.

A design guideline is provided to reduce height/bulk/scale impacts at campus edges, particularly for proposed projects at James/Broadway, Madison/Broadway, Madison/Marion and Boren/Columbia: Scale reducing architectural measures, such as facade detailing, materials, transparency and modulation should reduce apparent building massing along campus edges. Appropriate project review by DPD and the standing CAC will occur during the project permitting process.

Width and Depth Limits

No width and depth limit standards are proposed in the master plan. The combination of other standards is sufficient to regulate building volumes. Height/bulk/scale impact mitigation is proposed for Project D at Broadway and James. Impacts from heights and facade locations would be mitigated by consideration of:

- Modified ground-level building configuration
- Facade alignments
- Massing
- Architectural detailing
- Landscape pockets

Historic Preservation

There are no documented historically significant buildings or any designated landmarks on the Swedish First Hill campus. As part of the campus signage and wayfinding, Swedish may include plaques or signs with historical information about former buildings, sites or events.

Historical assessment research was completed by BOLA Architecture + Planning and is described in Section 3 of the EIS and in Appendix 7 of the EIS.

View Corridors

There are no designated view corridors in the area. The location and setting on First Hill establishes no significant view corridors. No view corridor standards are proposed.

Pedestrian Circulation

The provisions of the P1 Pedestrian Overlay District along the Madison Street frontage apply (affects Projects A and F). The overlay extends around the corner to mid block on Broadway. Swedish would comply with the use and development standards required in the overlay zone.

Streetscape and pedestrian amenity improvements are proposed along both Marion Street and Minor Avenue but no specific standards are provided.

Pedestrian circulation improvements will be consistent with the conceptual Pedestrian Circulation Plan. (see page 27, Figure 2.11).

C. Other Standards

Loading Berths

Relief from loading berth requirements and space standards (23.54.035) is included in the master plan. Specifically, the number of loading berths for the 'high demand' hospital use may be waived by DPD during project review. The proposed materials management and central plant project would allow internal 24-hour operation so the number of berths may not apply. Other exceptions for width, length and clearance of loading berths may be required because of the unique medical facility operations and the types of vehicles providing service.

Signs

In order to achieve the campus cohesive, design vision, exceptions may be required from strict application of signage standards (23.55). Strict adherence to sign standards is not required by this development standard. Specifically, the number, size, location of signs may be varied as long as DPD determines that public safety is protected. The off-premise sign provisions (23.55.014) do not apply to campus identity signage. Discretionary review by DPD will occur during project permit reviews. The more detailed signage design would support the campus wayfinding plan concept of the Design Precepts.

Lighting

A variation to standard SDOT street lighting and other City standards is allowed as long as public safety is not compromised, as determined by DPD during project reviews. For example, pedestrian scale lighting for safety, campus signage lighting for identity and art lighting may vary from strict code requirements by this development standard.

Landscaping/Open Space

Strict compliance with underling zoning landscaping and open space requirements is superseded by the master plan open space and landscape development standards. Exceptions to standards contained within the Seattle Street Improvement Manual may also be sought. DPD may allow the exceptions during project reviews.

Curb Cuts/Driveways

Relief from city requirements, and specifically the Seattle Street Improvement Manual Standards related to the size, location, number and clearances is included in the master plan. The proposed physical plant may require wide and/or multiple curb cuts to allow vehicular and service access/egress. The need for this and other facilities (parking, emergency department, etc.) requires flexibility to the strict application of city standards, particularly along streets internal to the First Hill campus. DPD, in consultation with SDOT, may allow project exceptions, through the MUP process.

Emergency Department Access

The proposed relocation of the Swedish emergency department includes access from local streets (Minor and Marion). This supersedes the requirements in the underlying zone which requires emergency department access to be located on an arterial.

4. Transportation Management Program

A. Intent

The intent of the Transportation Management Program (TMP) is to reduce impacts to the environment, such as air quality degradation and traffic congestion associated with traffic demands and parking generated by Swedish Medical Center (SMC). The TMP is the programmatic arm of the Transportation and Parking Element of the Master Plan. The TMP identifies strategies and actions that are intended to reduce parking and traffic demands associated with projected growth at the Swedish Medical Center campus.* The TMP elements provide SMC staff and employees with incentives and disincentives to reduce or eliminate commuter trips in Single Occupant Vehicles (SOV).

B. Project Location

The Swedish Campus is located in the First Hill area of Seattle. The campus consists of several buildings in an area roughly bounded by Boren Avenue to the West, Madison Street to the North, Broadway to the East and James Street to the South.

C. Authority

This program is established as a requirement of the Major Institution Master Plan, Seattle Municipal Code 23.69.0030, and the State Environmental Policy Act (SEPA). The TMP shall be consistent with DCLU Director's Rule 14-2002, which establishes procedures for Transportation Management Programs. Director's Rule 14-2002 supersedes DCLU Director's Rule 2-94 and SED Director's Rule 94-3. This program requirement shall be a covenant running with the land as well as a condition of occupancy.

Swedish Hospital is also defined as a Major Employer by the requirements of Washington State's Commute Trip Reduction (CTR) Law which defines goals, reporting requirements and mandatory and optional program elements. The State required CTR program is different from the City of Seattle requirements for a TMP though the goal to reduce impacts of site generated vehicle trips is similar. Swedish will be subject to on-going review of it's CTR program in order to meet State mandated CTR requirements however the TMP does not specifically address CTR program requirements.

* Description of the major institution's impact on traffic and parking is provided in the EIS

This document responds to the TMP requirements from DPD and SDOT. No additional TMP will be required for any use or development which has been approved in the Master Plan. If the Master Plan is amended to add new uses or development that would independently require the development of a TMP, those uses or development may be subject to the requirement for preparation of a new or supplemental TMP for the use or development.

D. Existing Transportation Management Program

SMC has an existing TMP Memorandum of Agreement, which was entered into with SED and DCLU in 1993. Although this TMP, along with CTR program requirements and review, has been very effective in reducing SOV travel demand, enhancements and additions to the TMP are proposed as part of this Master Plan to address the potential transportation impacts that could result from the proposed development included in this Master Plan. These are intended to achieve additional reductions in SOV travel and to reduce impacts associated with parking and traffic demands that would be associated with new development under the Master Plan.

The existing TMP is documented in a Memorandum of Agreement between SMC, the Seattle Engineering Department (SED), the Department of Construction and Land Use (DCLU), and the Municipality of Metropolitan Seattle (METRO). The Memorandum of Agreement identified program goals and elements as described below.

Program Goal

The goal of the TMP program on file with the City is to reduce the number of commuter trips in employee SOV to Swedish Medical Center to fifty percent (50%) or less of the total number of weekday, day shift commuter trips excluding employees whose work requires the use of a private automobile during working hours.

Program Elements

The elements of the Swedish Medical Center Transportation Management Program are described below:

Standard Required Elements for all TMPs include:

1. Provision of a Transportation Coordinator
2. Periodic Promotional Events
3. Provision of a Commuter Information Center
4. Tenant Participation in the program
5. Ridematch Opportunities
6. Annual Program Performance Reports
7. Site and Access Improvements as required by Land Use Code or environmental impact mitigation

In addition to the Standard Required Elements for all TMPs additional elements may be required of specific projects. For Swedish Medical Center, the following additional elements are currently required:

1. Provide and make available priority parking for carpools and vanpools to all campus employees.
2. Sell transit passes to employees at a reduced rate.
3. Require tenants in the tower and Nordstrom Medical Office Building, such as the Medical Office Buildings on campus, to provide transit pass subsidies.
4. Establish reciprocal agreement with other major institutions on First Hill for carpool and vanpool programs.
5. Offer a 25% discounted parking rate to carpools and eliminate parking charge for vanpools.
6. File quarterly reports with Seattle Commuter Services.
7. Establish a part-time carpool program aimed at regularly scheduled part-time employees.

E. Proposed Transportation Management Program

The TMP shall be consistent with the City's Director's Rules regarding TMP's (DCLU Director's Rule 14-2002). As specified in the Director's Rule, the TMP will consist of the following:

- TMP Goal
- Required Elements

Program Goal

The goal of the new TMP will be to continue the existing program goal to reduce the number of SMC commuter trips in employee SOV to fifty percent (50%) of the total number of weekday, day shift commuter trips excluding employees whose work requires the use of a private automobile during working hours. Program participants will include all SMC employees meeting the following criteria:

- arrive on weekdays between 6:00 am and 8:00 am
- leave on weekdays between 4:00 p.m. and 6:00 p.m.
- do not require private vehicle to conduct their work assignments

Required Elements

Director's Rule 14-2002 includes a list of 29 required elements to be included in the TMP unless specifically waived by the Director in the approved TMP document. These required elements are listed below along with a brief description of how each will be incorporated in the proposed TMP. Those elements that are not applicable or are not included in the proposed TMP and are proposed to be waived are identified as such.

1. Transportation Coordinator. A transportation coordinator (TC) will be appointed to implement the TMP. The TC will be available to employees and tenants during regular business hours to promote the TMP and stock the Commuter Information Center(s). The TC will receive training from the City.

2. Biannual Promotional Events. At least twice per year, the TC will organize and staff events to promote the TMP elements. The TC will be supported by King County Metro and the City. Information on the TMP will be provided to new employees.

3. Commuter Information Centers. Commuter information centers (CIC), including ridesharing and transit information, will be located in convenient locations for employees. Bicycle and pedestrian information also will be included in the CICs.

4. Tenant Participation in TMP. Tenant participation in the transit pass subsidy program shall be required.

5. Ridematch Programs. The TC will promote and administer a ridematching service for employees.

6. Site and Access Improvements. The site and access improvements identified in Items 7, 8, 9, and 10 below will be implemented to assist in achieving the TMP goals.

7. Height Clearance and Turning Radii for Vanpools. Design criteria for accommodating vanpool vehicles will be incorporated in the design for new garages in which vanpool parking will be provided.

8. Secure Preferential Parking for Carpools and Vanpools. Preferential Parking will be designated for carpools and vanpools in secure locations.

9. Secure Bicycle Parking. Covered bicycle racks will be provided in weather protected areas convenient to potential users including employees and visitors.

10. Shower / Locker Rooms. Showers and lockers will be made available for employees.

11. Pedestrian and Bicycle Links. Not applicable. The area's street grid system runs through the SMC campus. As a result, there is direct access from the campus facilities to any pedestrian and bicycle facilities on the public street grid system without the need for additional links.

12. Transportation Management Associations. SMC will continue to participate in the First Hill Transportation Network Group.

13. Parking Fees. Fees at SMC parking garages and lots will be reviewed annually in order to establish peak and off-peak rates to encourage non-SOV use.

14. Non-SOV Incentives/Subsidies. A discounted parking fee of at least 80% will be offered by SMC to each participating carpool member and vanpool parking will be free. SMC will

provide a fully subsidized transit pass for any SMC employee commuting to work at SMC by transit. SMC will also provide a fully subsidized ferry pass for employees as walk on passenger.

15. Unbundling of Parking Charges from Tenant Leases. The price of parking spaces in SMC garages will not be included in tenant leases, but shall be priced separately from the cost of building space.

16. Alternative/Flexible Schedules. SMC will permit flexible hours or vary shift times to the extent possible to accommodate use of high occupancy vehicles to and from work.

17. Subscription Bus Services. SMC will continue to provide access to the First Hill Express service for its employees assuming that other participants in the service continue their participation.

18. Shuttle Services. No shuttle service is proposed to meet TMP goals.

19. Telecommuting. Some departments will allow telecommuting if possible to reduce commute trips.

20. Reduced SOV Parking Supply. The total proposed parking supply of 5,180 stalls is 600 stalls less than the maximum allowed by code. HOV parking that will be provided for carpools and vanpools will to meet demand will replace SOV parking stalls.

21. Fleetpools. None is proposed to meet TMP goals. It is anticipated that the readily accessible regional and local transit service, in combination with carpools and vanpools, will be the primary means used to meet TMP goals.

22. Car-Sharing Programs. None is proposed to meet TMP goals.

23. Guaranteed Ride Home. SMC will offer a guaranteed ride home for registered program participants.

24. Multifamily Building Requirements. Not applicable.

25. Additional Site and Access Improvements. See Items 7, 8, 9, and 10.

26. Off-Site Mitigation. None are proposed to meet TMP goals.

27. Residential Parking Zones. None are proposed to meet TMP goals.

28. Annual Program Reports. The TC will prepare and submit annual reports documenting the TMP programs and compliance with goals.

29. Biennial Surveys. Employee surveys will be conducted every two years to be used in measuring compliance with the SOV goals.

Table 4.1 summarizes the proposed changes to the TMP:

TABLE 4.1

Swedish Medical Center Transportation Management Program

Program Element	Current TMP Requirement	Proposed TMP
Transportation Coordinator	Required	Same
Promotions	One annually plus new employee orientation	Increase to two events annually plus new employee orientation
Commuter Information Center	Required	Same
Tenant Participation	Required	Same
Ridematch program	Required	Same
Site and Access Improvements	Required	Same
Height and Turning Clearances for Vanpools	Not Included	New garages to accommodate vanpool access to designated vanpool parking
Carpool/Vanpool Parking	Required but no specific number	To meet demand for registered carpools and vanpools
Bicycle Parking	Required	Same
Shower/Lockers	Not Included	Provides showers and lockers for bike riders
Pedestrian/Bicycle Links	Not Applicable	Same - Not Applicable
Transportation Management Associations	Not Included	Participate in First Hill Transportation Network
Parking Fees	Not specific	Review annually to establish rate that encourages non SOV modes
Non-SOV Subsidy	Requires unspecified subsidy of transit pass and 25% of vanpool and carpool parking	Fully subsidized transit passes, walk-on ferry passes, and vanpool parking, as well as discount of at least 80% per person for monthly pass for participating carpools
Unbundling of Parking Charges	Not Included	Parking costs in SMC garages to be identified separately from cost of building in leases
Flexible Work Schedule	Not Included	Accommodates where applicable
Subscription Bus Service	Not Included	Participate in First Hill Express service
Shuttle Service	Not Included	Same - Not Included

Program Element	Current TMP Requirement	Proposed TMP
Telecommuting	Not Included	Accommodates where applicable
Reduced SOV Parking	Not Included	Parking supply will be less than code allowable. HOV stalls provided to meet HOV demand will replace SOV stalls
Fleetpools	Not Included	Same - Not Included
Car-Sharing Programs	Not Included	Same - Not Included
Guaranteed Ride Home (GRH)	Not required	Provides GRH benefit
Multi-Family Requirements	Not Applicable	Same - Not Applicable
Additional Improvements	Not Included	Same - Not Included
Off-Site Mitigation	Not Included	Same - Not Included
Residential Parking Zones	Not Included	Same - Not Included
Annual Program Reports	Required	Same
Biennual Surveys	Not Included	Survey to be conducted every two years

5. Appendix

A. Property Legal Description

Legal Description Of Swedish Health Services - Seattle First Hill Campus
(Includes all property within City's Major Institution boundaries as of 1/22/2004)

Parcel 1 (East Wing/North And Northeast Wings/Old Tumor Institute/West Wing/ southwest Wing):

Lots 1 through 8, inclusive, Block 120, A. A. Denny's Broadway Addition to the City of Seattle, according to the plat thereof recorded in Volume 6 of Plats, page 40, in King County, Washington;

TOGETHER WITH vacated alley in said Block 120, as described and vacated under Ordinance Number 53208 of the City of Seattle;

AND TOGETHER WITH the southwesterly half of vacated Summit Avenue adjacent to said block, lying southeasterly of the southeast line of Marion Street and northwesterly of the northwest line of Columbia Street, as described and vacated under Ordinance Number 89570 of the City of Seattle;

AND

That portion of Columbia Street and of Summit Avenue as vacated under Ordinance Number 101585 of the City of Seattle, and described as follows:

Beginning at the most southerly corner of Lot 8, Block 131, A. A. Denny's Broadway Addition, according to the plat thereof recorded in Volume 6 of Plats, page 40, in King County, Washington; thence south 59°22'43" west along the northwesterly line of Columbia Street to the most southerly corner of Lot 8, Block 120, said addition; thence south 30°35'29" east along the production of the southwesterly line of said lot, 66 feet to the most westerly corner of Block 101, Terry's Second Addition, according to the plat thereof recorded in Volume 1 of Plats, page 87, in King County, Washington; thence north 59°22'43" east along the northwesterly line of said block to the most northerly corner thereof; thence north 30°37'02" west along the production of the northeasterly line of said block, 0.012 feet to a point of curvature; thence northwesterly, northerly, and northeasterly along a curve to the right, having a radius of 66 feet, a distance of 103.66 feet to a point of tangency on the northwesterly line of Columbia Street, said point being the beginning;

AND

Lots 1, 2, 3 and 4, Block 101, Terry's Second Addition to the Town of Seattle, according to the plat thereof recorded in Volume 1 of Plats, page 87, in King County, Washington;

TOGETHER WITH vacated alley lying between said lots in Block 101, as described and vacated under Ordinance Number 5956 of the City of Seattle;

EXCEPT that portion of said Lots 3 and 4 and vacated alley conveyed to the City of Seattle by deed recorded under Recording Number 7211170618;

TOGETHER WITH the northwesterly half of vacated public walkway in said Block 101, as described and vacated under Ordinance Number 110712 of the City of Seattle.

Parcel 2 (Surgery/heath Building/821 Boylsen/1317 Marion):

Lots 1 through 8, inclusive, Block 131, A. A. Denny's Broadway Addition to the City of Seattle, according to the plat thereof recorded in Volume 6 of Plats, page 40, in King County, Washington;

TOGETHER WITH vacated alley in said Block 131, as described and vacated under Ordinance Number 1941 of the City of Seattle;

AND TOGETHER WITH the northeasterly half of vacated Summit Avenue adjacent to said block, lying southeasterly of the southeast line of Marion Street and northwesterly of the northwest line of Columbia Street, as described and vacated under Ordinance Number 89570 of the City of Seattle.

Parcel 3 (Arnold Building):

Lots 2, 3, 6 and 7, Block 121, A. A. Denny's Broadway Addition to the City of Seattle, according to the plat thereof recorded in Volume 6 of Plats, page 40, in King County, Washington;

Parcel 4 (Bank And Shops):

Lots 1, 4, 5 and 8, Block 121, A. A. Denny's Broadway Addition to the City of Seattle, according to the plat thereof recorded in Volume 6 of Plats, page 40, in King County, Washington;

TOGETHER WITH all of the vacated alley in said Block 121, as described and vacated under Ordinance Number 103180 of the City of Seattle.

Parcel 5 (South Wing):

Lots 5, 6, 7 and 8, Block 101, Terry's Second Addition to the Town of Seattle, according to the plat thereof recorded in Volume 1 of Plats, page 87, in King County, Washington;

TOGETHER WITH vacated alley lying between said lots in Block 101, as described and vacated under Ordinance Number 5956 of the City of Seattle;

AND TOGETHER WITH the southeasterly half of public walkway in said Block 101, as described and vacated under Ordinance Number 110712 of the City of Seattle.

Parcel 6 (Cherry Street Garage):

Lots 1 through 8, inclusive, Block 96, Terry's Second Addition to the Town of Seattle, according to the plat thereof recorded in Volume 1 of Plats, page 87, in King County, Washington;

TOGETHER WITH vacated alley in Block 96, as described and vacated under Ordinance Number 106393 of the City of Seattle;

EXCEPT that portion of said Lots 7 and 8 and vacated alley conveyed to the City of Seattle for street purposes by deed recorded under Recording Number 9203131065.

Parcel 7 (Main Entrance):

Lots 1 through 4, inclusive, Block 132, A. A. Denny's Broadway Addition to the City of Seattle, according to the plat thereof recorded in Volume 6 of Plats, page 40, in King County, Washington.

Parcel 8 (Madison Street Garage/Madison Medical Office Building/ Summit Avenue Additions):

Lots 1 through 8, inclusive, Block 130, A. A. Denny's Broadway Addition to the City of Seattle, according to the plat thereof recorded in Volume 6 of Plats, page 40, in King County, Washington;

TOGETHER WITH vacated alley in said Block 130, as described and vacated under Ordinance Number 2776 of the City of Seattle;

AND TOGETHER WITH all of vacated Summit Avenue, as described and vacated under Ordinance Number 112631 of the City of Seattle;

EXCEPT the airspace lying above a horizontal plane at an elevation of 383.0 feet, City of Seattle Datum, over said lots and vacated alley;

AND EXCEPT the airspace lying above a horizontal plane at an elevation of 383.0 feet, City of Seattle Datum, over that portion of said vacated Summit Avenue described as follows:
Beginning at the intersection of the northerly margin of Marion Street and the easterly margin of said Summit Avenue; thence northerly along the easterly line of said Summit Avenue 77.00 feet; thence westerly, at right angles to Summit Avenue, 2.00 feet; thence southerly, parallel with the easterly margin of Summit Avenue 77.00 feet to the northerly margin of Marion Street; thence easterly along said margin 2.00 feet to the point of beginning.

Parcel 9 (601 Broadway):

Lots 1 through 8, inclusive, Block 100, Terry's Second Addition to the Town of Seattle, according to the plat thereof recorded in Volume 1 of Plats, page 87, in King County, Washington;

TOGETHER WITH vacated alley in said Block 100, as described and vacated under Ordinance Number 5956 of the City of Seattle.

Parcel 10 (Shmc Eye Institute):

Lots 1, 2, 3 and 5 in Block 134 of A. A. Denny's Broadway Addition to the City of Seattle, according to the plat recorded in Volume 6 of Plats, page 40, in King County, Washington.

Parcel 11 (Northwest Garage And Mob):
Lots 1 through 8, inclusive, Block 119, together with vacated alley adjoining said lots, A. A. Denny's Broadway Addition to the City of Seattle, according to the plat thereof recorded in Volume 6 of Plats, page 40, records of King County, Washington.

Parcel 12 (Invex Building/invex Garage):
Lots 1 through 5, inclusive, Block 95, Terry's Second Addition to the Town of Seattle, according to the plat thereof recorded in Volume 1 of Plats, page 87, records of King County, Washington.

Parcel 13 (Cherry Building):
Lots 6 and 7, Block 95, Terry's Second Addition to the Town of Seattle, according to the plat thereof recorded in Volume 1 of Plats, page 87, in King County, Washington.

Parcel 14:
Lot 8, Block 95, Terry's Second Addition to the Town of Seattle, according to the plat thereof recorded in Volume 1 of Plats, page 87, in King County, Washington.

The following parcels, which are owned by entities other than Swedish Medical Center, are located within Swedish's major institution boundaries as established by the City of Seattle pursuant to the Major Institution Land Use Code (Ch. 23.69 SMC):

Parcel 15 (Eklind Hall):
Lots 1 through 8, inclusive, Block 94, Terry's Second Addition to the Town of Seattle, according to the plat thereof recorded in Volume 1 of Plats, page 87, in King County, Washington;

TOGETHER WITH vacated alley in Block 94, as described and vacated under Ordinance Number 73797 of the City of Seattle.

Parcel 16:
Lot 4, Block 134, A. A. Denny's Broadway Addition to the City of Seattle, according to the plat recorded in Volume 6 of Plats, page 40, in King County, Washington.

Situate in the County of King, State of Washington.

TABLE 5.1

Swedish First Hill Campus Property Ownership

Map Ref.	Assessor Parcel Number	Description	Address	Owner	Land Area	Existing Use/ Year Built/ Construction Type
A*	197820 -0625	Denny's AA Broadway Addition Block 119 Lots 1-8	1101 Madison St.	Swedish Health Services	61,440 SF 1.41 acres	Medical Office and Parking 1992 Reinforced Concrete
B	197820 -0670	Denny's AA Broadway Addition Block 121 Lots 1 & 4 & vacated alley portion	1223 Madison St.	Swedish Health Services	14,400 0.33 acres	Bank and Retail 1976 Concrete Reinforced
C	197820 -0691	Denny's AA Broadway Addition Block 121 Lots 5 & 8 & vacated alley portion	900 Minor Ave.	Swedish Health Services	11,520 SF 0.26 acres	Surface Parking
D*	197820 -0675	Denny's AA Broadway Addition Block 121 Lots 2.3.6.7 & vacated Summit portion	1221 Madison St.	Swedish Health Services	28,800 SF 0.66 acres	Arnold Medical Pavilion 1976 Structural Steel
E*	197820 -1015	Denny's AA Broadway Addition Block 130 Lots 1-8 & vacated Summit portion	1229 Madison St.	Swedish Health Services (garage) Office is condo ownership	37,951 SF 0.87 acres	Nordstrom Medical Tower and Garage 1985 Reinforced Concrete

* Building sold to Health Care Property Investors, Inc. (Arnold 9th floor and above). Swedish owns the property.

Map Ref.	Assessor Parcel Number	Description	Address	Owner	Land Area	Existing Use/ Year Built/ Construction Type
F	197820 -1116	Denny's AA Broadway Addition Block 134 Lots 1,2,3	1401 Madison St.	Swedish Health Services	20,040 SF 0.46 acres	Alcoa Office Building 1962 Reinforced Concrete
G**	197820 -1130	Denny's AA Broadway Addition Block 134 Lot 4	906-910 Boylston Ave.	Fredrick & Rochelle Casserd	6,720 SF 0.15 acres	Clinic 1966 Wood Frame
H	197820 -1135	Denny's AA Broadway Addition Block 134 Lot 5	900 Boylston Ave.	Swedish Health Services	4,500 SF 0.10 acres	Offices 1946 Masonry
I**	859090 -0646	Terry's 2nd Addition Block 94 Lots 1-8	1100 Columbia St.	Alexandria Real Estate	61,440 SF 1.41 acres	Lab - 1945 Structural Steel Research Bldg. 1975 Structural Steel Lab - 1982 Reinforced Concrete
J	197820 -0665	Denny's AA Broadway Addition Block 120 Lots 1-8 & vacated alley portion	805 Summit Ave.	Swedish Health Services	78,897 SF 1.81 acres	Hospital 1912 Reinforced Concrete
K	197820 -1055	Denny's AA Broadway Addition Block 131 Lots 1,4-8 & vacated street & alley portion	801 Broadway	Swedish Health Services	50,482 SF 1.16 acres	Surgery Garage Heath Medical Office 1970 Reinforced Concrete

** Not owned by Swedish

Map Ref.	Assessor Parcel Number	Description	Address	Owner	Land Area	Existing Use/ Year Built/ Construction Type
L	197820 -1060	Denny's AA Broadway Addition Block 131 Lots 2 & 3 & vacated alley portion	819 Boylston Ave.	Swedish Health Services	15,360 SF 0.35 acres	Offices 1946 Masonry
M	859090 -0685	Terry's 2nd Addition Block 95 Lots 1,4,5	722 Boren Ave.	Swedish Health Services	21,600 SF 0.50 acres	Invex Garage 1974 Reinforced Concret
N	859090 -0690	Terry's 2nd Addition Block 95 Lot 2 & 3	1115 Columbia St.	Swedish Health Services	14,400 SF 0.33 acres	Invex Office 1956 Masonry
O	859090 -0721	Terry's 2nd Addition Block 95 Lot 8	702 Boren Ave.	Swedish Health Services	4,500 SF 0.10 acres	Vacant Building Open Space
P	859090 -0710	Terry's 2nd Addition Block 95 Lots 6 & 7	1120 Cherry St.	Swedish Health Services	14,400 SF 0.33 acres	Medical Offices 1959 Masonry
Q	859090 -0951	Terry's 2nd Addition Block 101 Lots 1 &4 & vacated street portion	747 Broadway	Swedish Health Services	14,157 SF 0.33 acres	Hospital SW Wing 1975 Reinforced Concrete
R	859090 -0950	Terry's 2nd Addition Block 101 Lots 1,2,3,4 & vacated alley portion	747 Broadway	Swedish Health Services	13,781 SF 0.32 acres	Hospital SW Wing 1975 Reinforced Concrete

Map Ref.	Assessor Parcel Number	Description	Address	Owner	Land Area	Existing Use/ Year Built/ Construction Type
S	197820 -1096	Denny's AA Broadway Addition Block 132 Lots 1,2,3,4 & vacated street portion	747 Broadway	Swedish Health Services	28,573 SF 0.66 acres	SE Addition Hospital Garage - 1994 Reinforced Concrete
T	859090 -0970	Terry's 2nd Addition Block 101 Lots 5,6,7,8 & vacated alley portion	747 Broadway	Swedish Health Services	36,125 SF 0.83 acres	Hospital Tower 1999 Structural Steel
U	859090 -0725	Terry's 2nd Addition Block 96 Lots 1-8 & vacated alley portion	612 Boren Ave.	Swedish Health Services	60,885 SF 1.4 acres	Minor & James Garage 1979 Reinforced Concrete
V	859090 -0860	Terry's 2nd Addition Block 100 Lots 1-8 & vacated alley portion	601 Broadway	Swedish Health Services	49,740 SF 1.14 acres	Annex Offices 1959 Reinforced Concrete
W	197820 -1115	Denny's AA Broadway Addition Block 133	702 Broadway	City of Seattle Parks Dept.	165 SF	Median Open Space

Total Swedish First Hill Campus Land Area
(Total MIO District that includes non-Swedish owned property and excludes public ROW's)
649,876 SF
14.92 acres

FIGURE 5.1

Swedish Property Ownership

NOTE: Parcels with map reference 'G' and 'I' are not owned by Swedish.
Other owned/leased space within 2,500 feet of the First Hill campus is limited to 1) 600 Broadway property - building and garage sold, 2) the Providence campus (500 17th Ave), 3) a leased clinic downtown (1001 4th Ave, Suite 420), and 4) leased administrative office space at the Metropolitan Park building downtown.

B. Process Milestones

1. Application/Scoping

December 10, 2003	File Notice of Intent to prepare master plan (Swedish)
January 2003	Initiate establishment of Citizen Advisory Committee (DON/DPD/Swedish)
February 9, 2004	Conduct Pre-Application Conference with DPD leadership
March 22, 2004	Conduct Pre-Application Conference with DPD staff
March 26, 2004	Submit Concept Plan Application for master plan (Swedish)
May 2003	Define DPD/DON/Swedish acceptable schedule
May 13, 2004	Recommend CAC membership to City Council (DON)
May 24, 2004	Conduct CAC Meeting #1 (Orientation, Concept Plan review, EIS scoping)
May 6, 2004	Issue SEPA Threshold Determination of Significance (DS) and Initiate EIS Scoping
May 26, 2004	Conduct Public Scoping meeting
June 4, 2004	Complete public EIS scoping comment period
June 10, 2004	Determine EIS scope (DPD)
June, 16 2004	Conduct CAC Meeting #2
July, 2004	Confirm CAC membership (City Council)
July 14, 2004	Conduct CAC Meeting #3

2. Draft MIMP/Draft EIS

August 12, 2004	Prepare & submit preliminary Draft Master Plan (within 70 days of finalization of EIS scope)
August 12, 2004	Prepare & submit preliminary Draft EIS (within 70 days of finalization of EIS scope or EIS consultant contract)
August 18, 2004	Conduct CAC Meeting #4
September 8, 2004	Conduct CAC Meeting #5
September 13, 2004	Review/Comment on Draft Master Plan and Draft EIS (CAC, SDOT, DPD due within 3 weeks of document receipt)
September 16, 2004	Submit compiled list of all comments (DPD to Swedish, within 10 days of receipt of all comments)
September-October, 2004	Review comments & revise Draft EIS (within 3 weeks of receipt of compiled comments)
October 11, 2004	Submit revised Draft Master Plan and revised Draft EIS (Proof copies)
October 13, 2004	Conduct CAC Meeting #6
October 2004	Review/Comment on revised Draft Master Plan and revised Draft EIS (within 3 weeks of receipt of revised drafts)
November 2004	Complete final revisions of Draft Master Plan and Draft EIS & prepare for publication (3 additional weeks to revise/publish)
November 10, 2004	Conduct CAC Meeting #7
November 15, 2004	Issue Draft Master Plan and Draft EIS to public, with notices
December 8, 2004	Conduct CAC Meeting #8
December 15, 2004	Conduct public review and hearing (required 30 days and may be extended to 45 days)
December 20, 2004	Review and comment due on Draft Master Plan and Draft EIS (CAC, SDOT, DPD, comments within 6 weeks of documents issuance)

3. Final MIMP/Final EIS

January 12, 2005	Conduct CAC Meeting #9
January 31, 2005	Prepare & submit preliminary Final Master Plan (within 13 weeks of receipt of comments)
January 31, 2005	Prepare & submit preliminary Final EIS (within 6 weeks of receipt of comments)
February 9, 2005	Conduct CAC Meeting #10
February 28, 2005	Complete review/comment on preliminary documents (CAC, SDOT, DPD)
March 9, 2005	Conduct CAC Meeting #11 (May be postponed until after Final MIMP/EIS issuance).
March 14, 2005	Revise and issue Final Master Plan (within 7 weeks after preparation of the preliminary Final Master Plan)
March 14, 2005	Revise and issue Final EIS (within 7 weeks after preparation of the preliminary Final EIS)

4. Decisions and Actions

NOTE: FOLLOWING DATES ARE SCHEDULED, NOT YET COMPLETED, AND SUBJECT TO CHANGE.
NOTE: CAC MEETINGS TO BE DETERMINED.

April 18, 2005	Prepare/Issue Draft DPD Director's Report (within 5 weeks of publication of Final Master Plan and Final EIS)
April 18, 2005	Prepare/Issue Draft CAC Report (at same time as Draft Director's Report)
May 2, 2005	Review and comment by CAC of Draft Director' Report (within 3 weeks of receipt of draft)
May 16, 2005	Prepare/Issue Final DPD Director's Report/recommendations and submit to CAC (within 2 weeks of receipt of CAC comments)
May 30, 2005	Prepare/Issue Final CAC Report/recommendations (within 2 weeks of receipt of Final Director's Report)

June 6, 2005	Submit DPD Director's recommendations and CAC report to Hearing Examiner/Notice of Hearing
June-July 2005	Review by Hearing Examiner of record and conduct public hearing
July-August 2005	Prepare/Issue Hearing Examiner's Report/Recommendations and submit to Council (within 30 days of hearing)
July-August 2005	Possible request for further consideration to Council
August-November 2005	Review and action (ordinance) by City Council (goal of 3 months after receiving Hearing Examiner's Report/recommendations)
November 2005	Possible appeal/challenge to King County Superior Court
November-Dec 2005	Prepare and submit draft Compiled Plan (within 30 days of master plan adoption)
December 2005	Review and comment by DPD Director (within 30 days of receipt of draft)
January 2006	Complete and Issue approved final Compiled Plan
	Process completed (total elapsed time approximately two years)

C. Swedish Citizen Advisory Committee (CAC)

(Confirmed by Seattle City Council in July 2004)

Beverly Baker	Nurse/Swedish Medical Center
James Rothwell	Resident/Architect—CAC Chairperson
Greg Harris	Resident/Attorney/SU CAC
Jeff Myrter	Manager Nordstrom Medical Tower
Jerry O'Leary	Resident/Attorney
Eric Bultemeier	Resident/Civil Engineer
Robert W. Fenn	Seattle University Facilities Director
Deborah M. Gibby	Resident, Chair First Hill Community Council—CAC Vice Chairperson
Kristi Drebick Brown	Alexandria Real Estate/Seattle Life Sciences Center
Dr. Stephen Jones	Pastor Seattle First Baptist Church
Betsy Mickel	Northwest Kidney Center
Bill Clancy	Resident/Banker

Alternates:

Anne Parry	Resident
Hal Steiner	Resident /Baroness Hotel Manager
Donald A. Moody	Resident

D. Comparison of Zoning Development Standards

	Highrise (HR)	Midrise (MR)	NC-3 85	NC-3 160	P-1 Ped. Overlay	Current Swedish Master Plan Standards (Ordinance #111993)	Proposed Swedish Master Plan Standards
Maximum Height	160 feet; 240 feet w/ public benefits	60 feet	85 feet	160 feet	NA	70 feet; 90 feet; 200 feet; 240 feet	70 feet; 90 feet; 105 feet; 200 feet; 240 feet
Setbacks	Front: Average of structs. on adjoining lots; but not to exceed 20 feet Rear: 20 feet Side: 5 feet, except 10 feet min. side street or abut res. zone; 14 feet setback for struct. 91-120' height; 16 feet setback for struct. >120' height; additional side setbacks on sliding scale if >65' depth	Front: Average of structs. on adjoining lots; but not to exceed 20 feet Rear: 10 feet Side: 5 feet except 10 feet min. side street or abut res. zone; additional side setbacks on sliding scale if >65'depth	15 feet triangular setback where NC lot abuts side/front lot line of res. zone; Rear & Side: req. if NC zone lot abuts res. zone; 0 feet setback where <13' ht, 10 feet setback 10'-65' ht, 1 foot setback for every 10'> 65' ht;	15 feet triangular setback where NC lot abuts side/front lot line of of res. zone; Rear & Side: req. if NC zone lot abuts res. zone; 0 feet setback where <13' ht, 10 feet setback 10'-65' ht, 1 foot setback for every 10'> 65' ht;	NA	Based on façade height and zone across street, lot or alley; None on Madison, James and Broadway; 0-20 feet along Boren; 0-20 feet along internal streets Exceptions: Block 95: 12 feet for garage; No setbacks for Blocks 119, 121, 130, or 134 for Marion Garage step-backs 10 feet/story along Madison, James, Broadway, and Boren	10 feet along Boren, Madison, James; 5 feet along Broadway; none along internal campus streets
Maximum density (FAR)	None	None	FAR 6 mixed use; FAR 4.5 single use	FAR 7 mixed use; FAR 5 single use	NA	None	FAR 5.5 for total campus
Maximum Lot Coverage	None but open space controls; effective 50-75%	None but open space controls; effective 60-90%	None;	None;	NA	None	80% for total campus

	Highrise (HR)	Midrise (MR)	NC-3 85	NC-3 160	P-1 Ped. Overlay	Current Swedish Master Plan Standards (Ordinance #111993)	Proposed Swedish Master Plan Standards
Open Space	50% lot area; may be reduced to 25% at grade	25% to 40% of lot area; minimum 10% at grade	None	None	NA	Street trees along Madison and Boren and other perimeter streets; per landscape plan (Exhibit G)	Minimum 5% of total campus 0.5 acre designated open space along Broadway
Modulations & Width/ Depth Limits	Max. 90 feet width for facades < 37' height w/o modulation; Max. 100' width for facades >37' w/o modulation No max. width and mod. only for first 60' of facade for facades > 37' height w/ modulation Maximum depth = 65% lot depth	Max. 60 feet width w/o modulation; Max. 150 feet width w/ modulation Maximum depth = 65% lot depth	None	None	Maximum 30 foot blank façade length	None	None
Street Level Uses	NA	NA	NA	NA	Retail/ commercial along Madison and corner at Broadway Restricts parking and curbcuts	Retail/commercial along Madison	Retail/commercial along Madison
Other							
Location of ED Access	Only on an arterial	Only on an arterial	-	-	-	Any new ER entrance need not be on arterial	Any new ER entrance need not be on arterial
Light/ Glare	Standards apply	Standards apply	Standards apply	Standards apply	NA	Per code: No glare analysis required if materials used <20% reflectance	As proposed in MIMP

Parking Access and Location	Standards apply	Standards apply	Standards apply	Standards apply	Standards apply	No entrances or exits for new parking garages on James, Boren Broadway & Madison	As proposed in MIMP
Odor	Standards apply	Standards apply	Standards apply	Standards apply	NA	NA	Code provisions apply
Noise	Standards apply	Standards apply	Standards apply	Standards apply	NA	Per code	Code provisions apply
Loading	Standards apply	Standards apply	Standards apply	Standards apply	Standards apply	Based on actual utilization as determined by SED	As proposed in MIMP
Signage	Standards apply	Standards apply	Standards apply	Standards apply	NA	NA	As proposed in MIMP
Land-scaping	Standards apply	Standards apply	5% at grade for new construction on vacant lots	5% at grade for new construction on vacant lots	NA	Per MIMP Landscaping Plan (Exhibit G)	As proposed in MIMP

APPENDIX F

presentation to CAC by Terrie Martin Consulting, 16 January 2014

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SWEDISH MEDICAL CENTER CHERRY HILL

MIMP SPACE NEEDS ANALYSIS

JANUARY 16, 2014

Terrie Martin
CONSULTING

1. Purpose of Space Needs Analysis

2. The Context
   - Demographics: Existing and Projected
   - Trends in Health Care Delivery
   - The Region

3. Forecasts
   - Volumes
   - Space

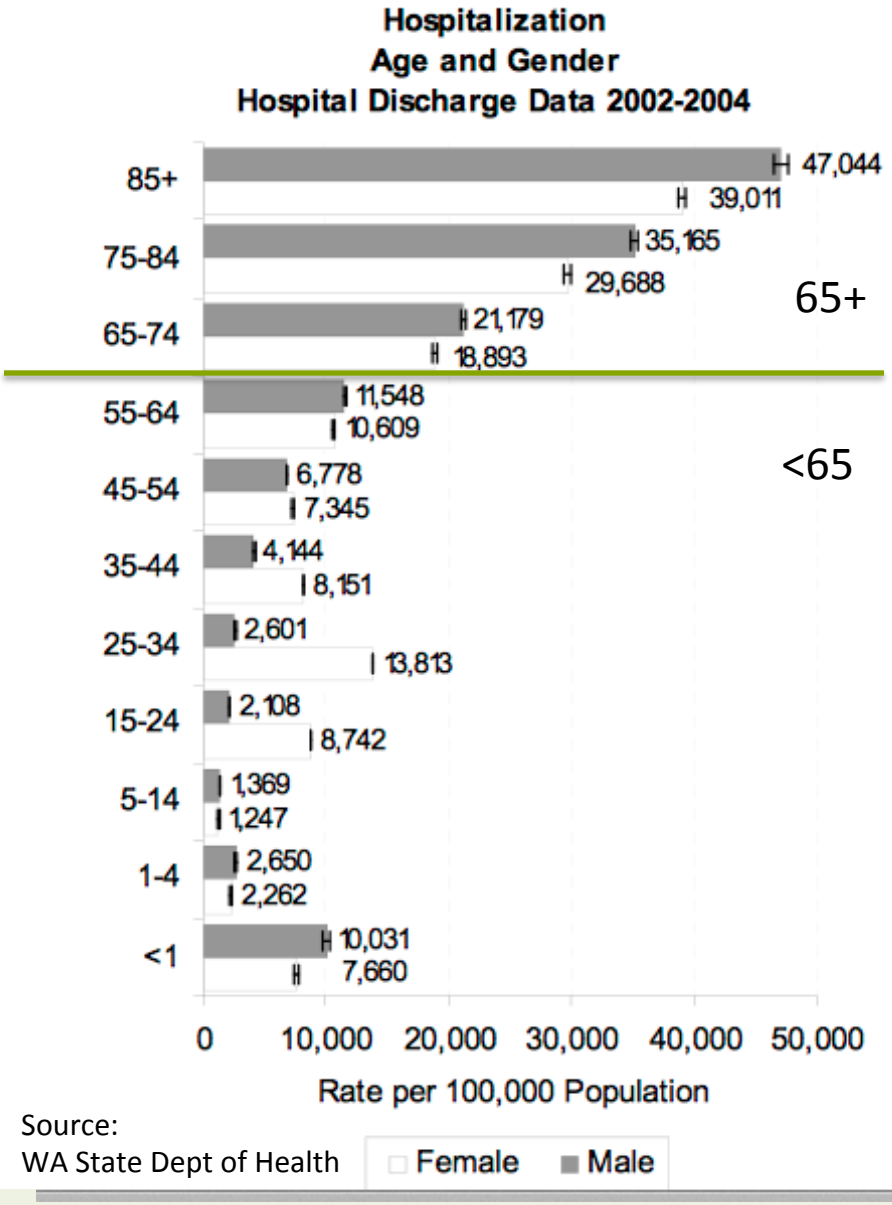
To validate and refine future space needs on the Campus by type of space

1. Hospital
2. Clinical/Research
3. Education
4. Hotel
5. Long Term Care/Assisted Living/ Skilled Nursing
6. Other Campus Support

Aging Population

year	1910	2013
Ave Life Expectancy	51.5	80.3

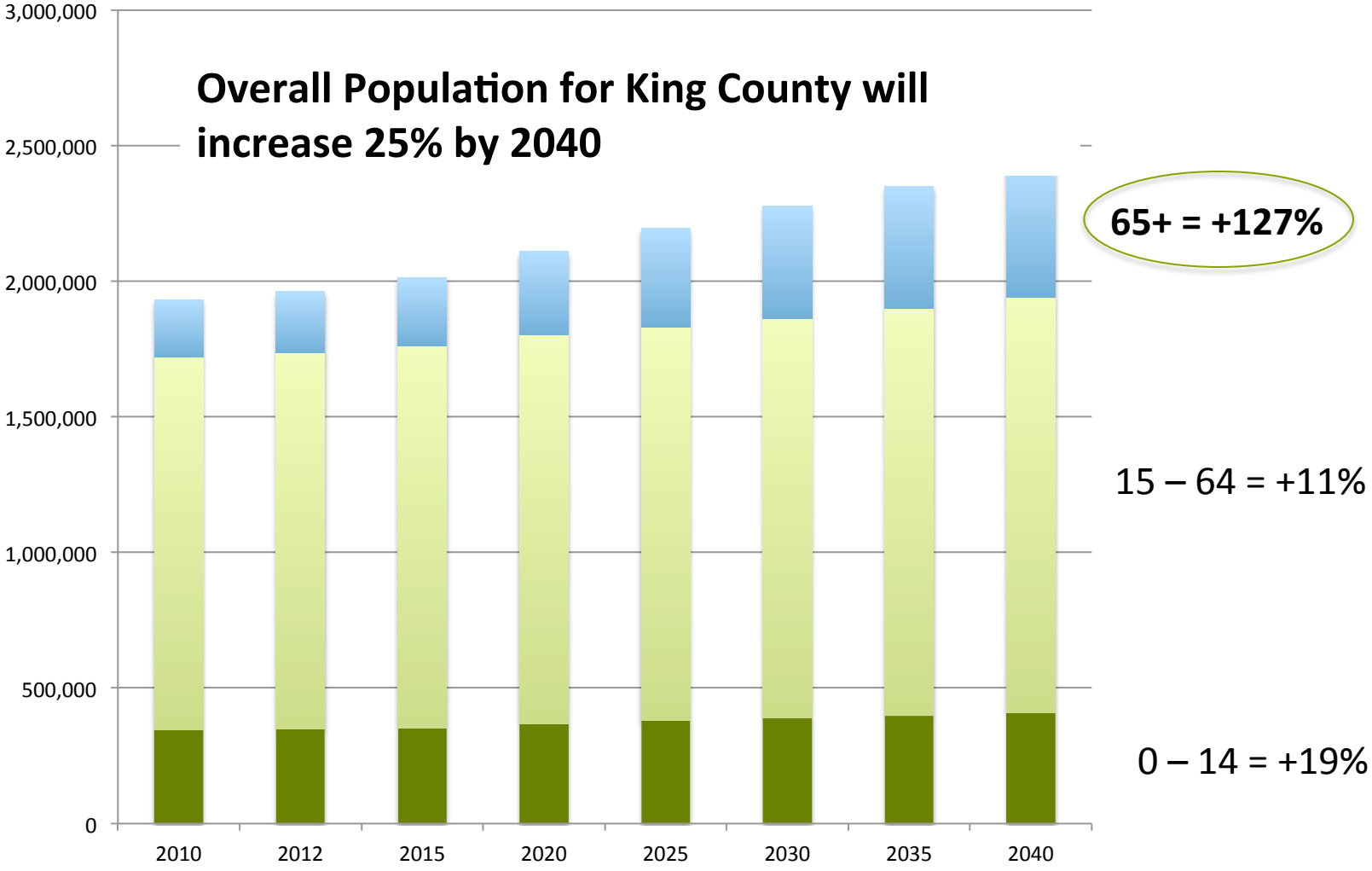
- People living longer means:
  - more elderly alive today because of medical interventions
  - more chronic disease
  - more complex medical conditions prevalent with the elderly
  - more support needed for elderly
  - Sicker inpatients
  - More fragile outpatients



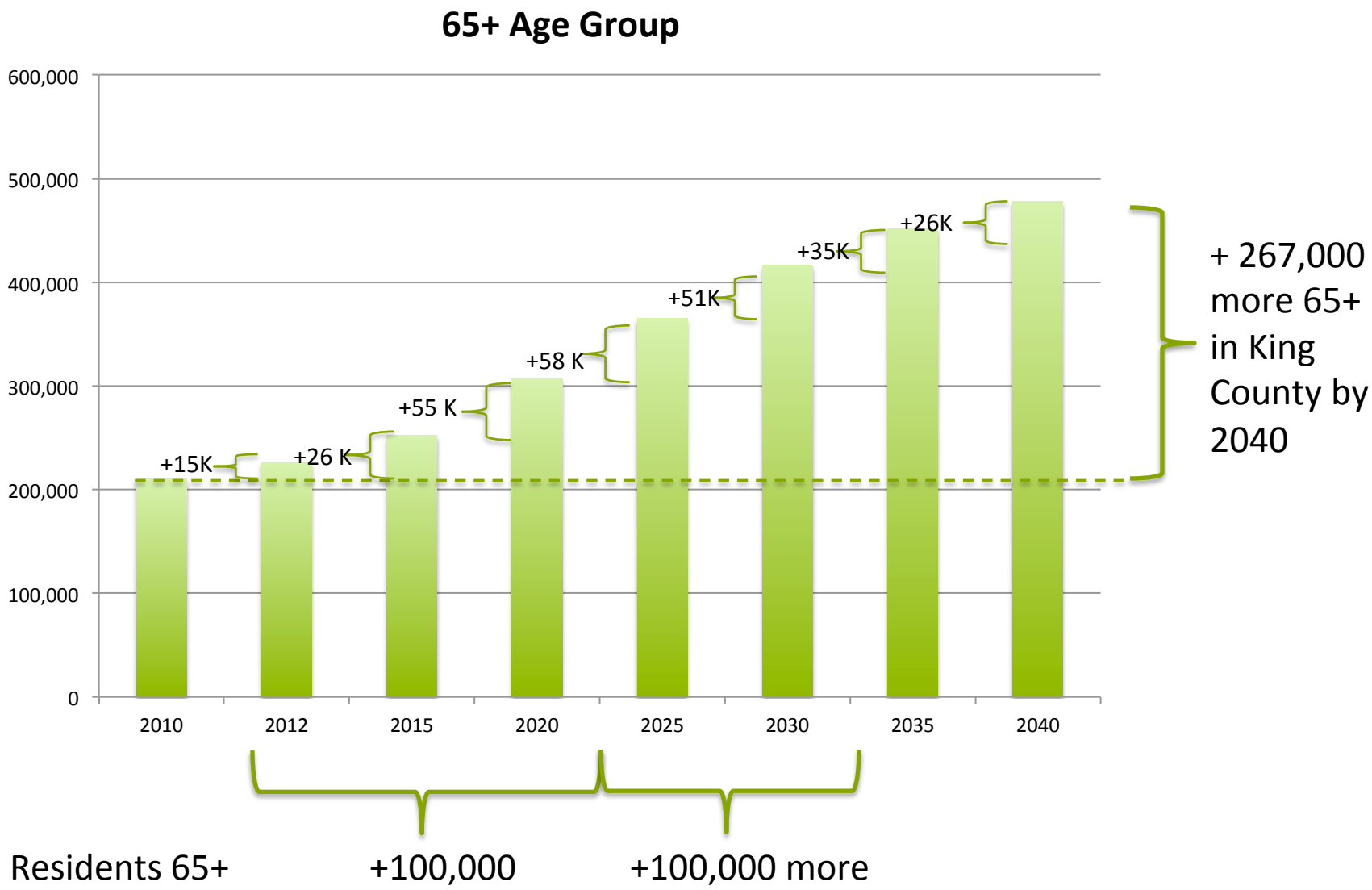
Source:
WA State Dept of Health

Those aged 65+ are admitted to hospitals 3.5 times more often than those under 65.

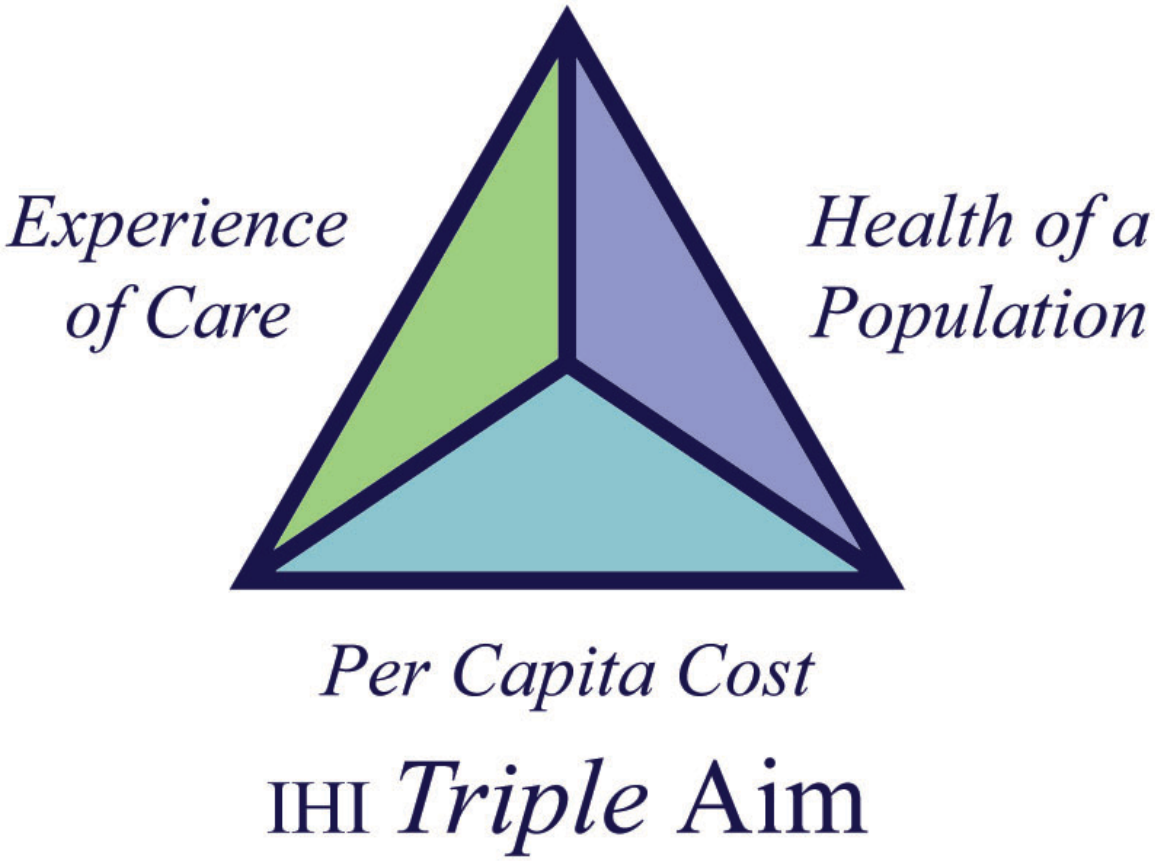
HOSPITAL DISCHARGE RATES BY AGE: WASHINGTON STATE

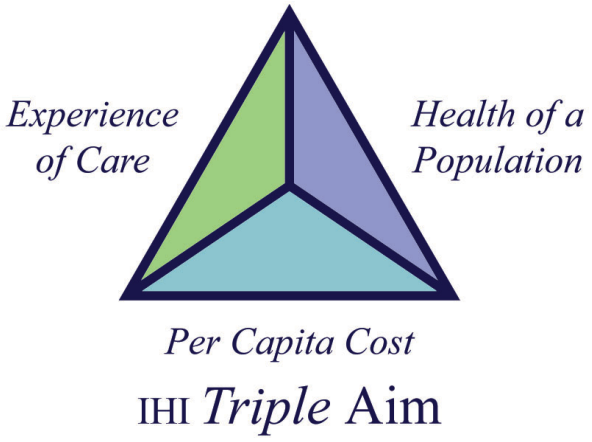


POPULATION GROWTH BY AGE

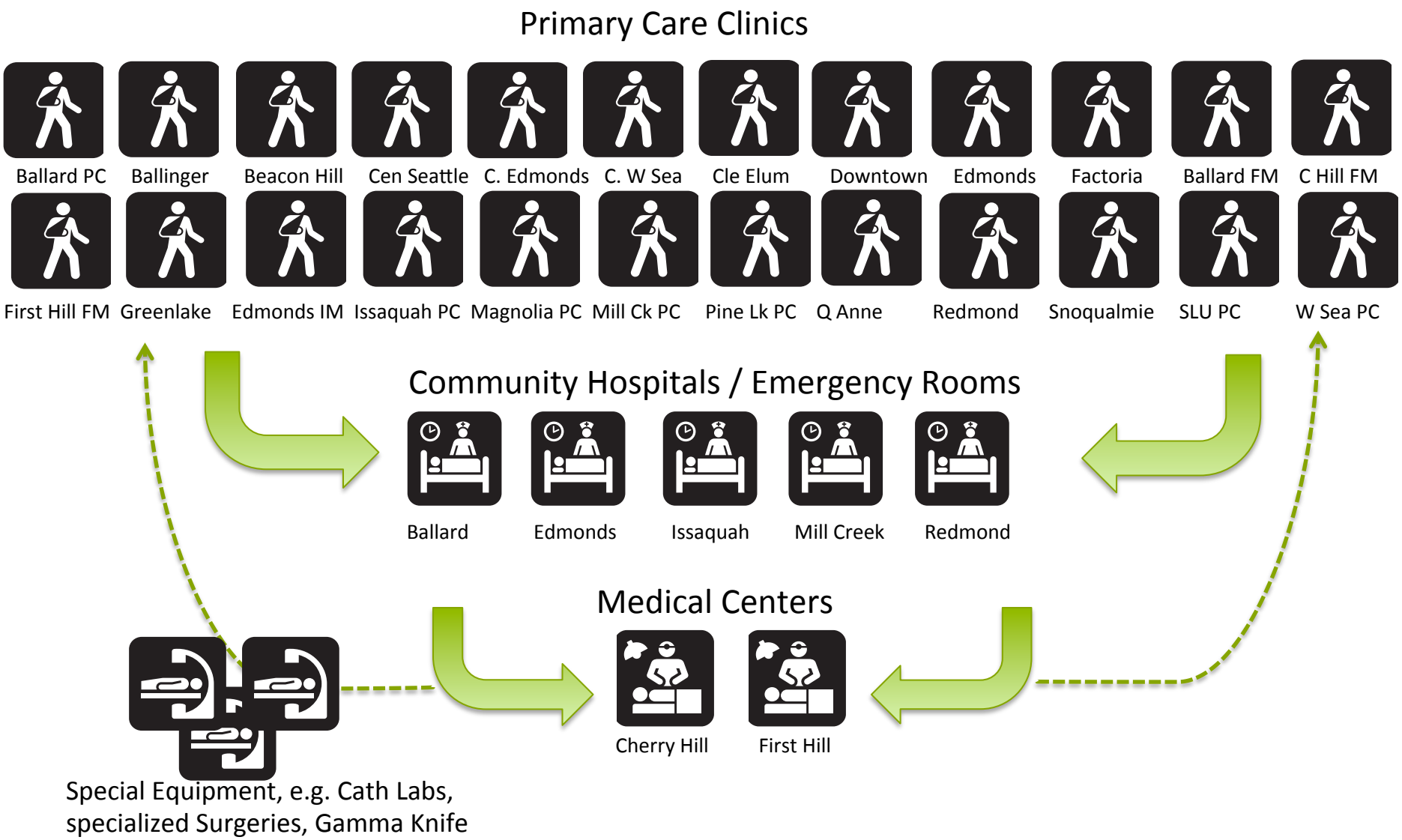

65+ Age Group
600,000
500,000
400,000
300,000
200,000
100,000
0
+15K
+26 K
+55 K
+58 K
+51K
+35K
+26K
2010
2012
2015
2020
2025
2030
2035
2040
+ 267,000 more 65+ in King County by 2040
Residents 65+
+100,000
+100,000 more

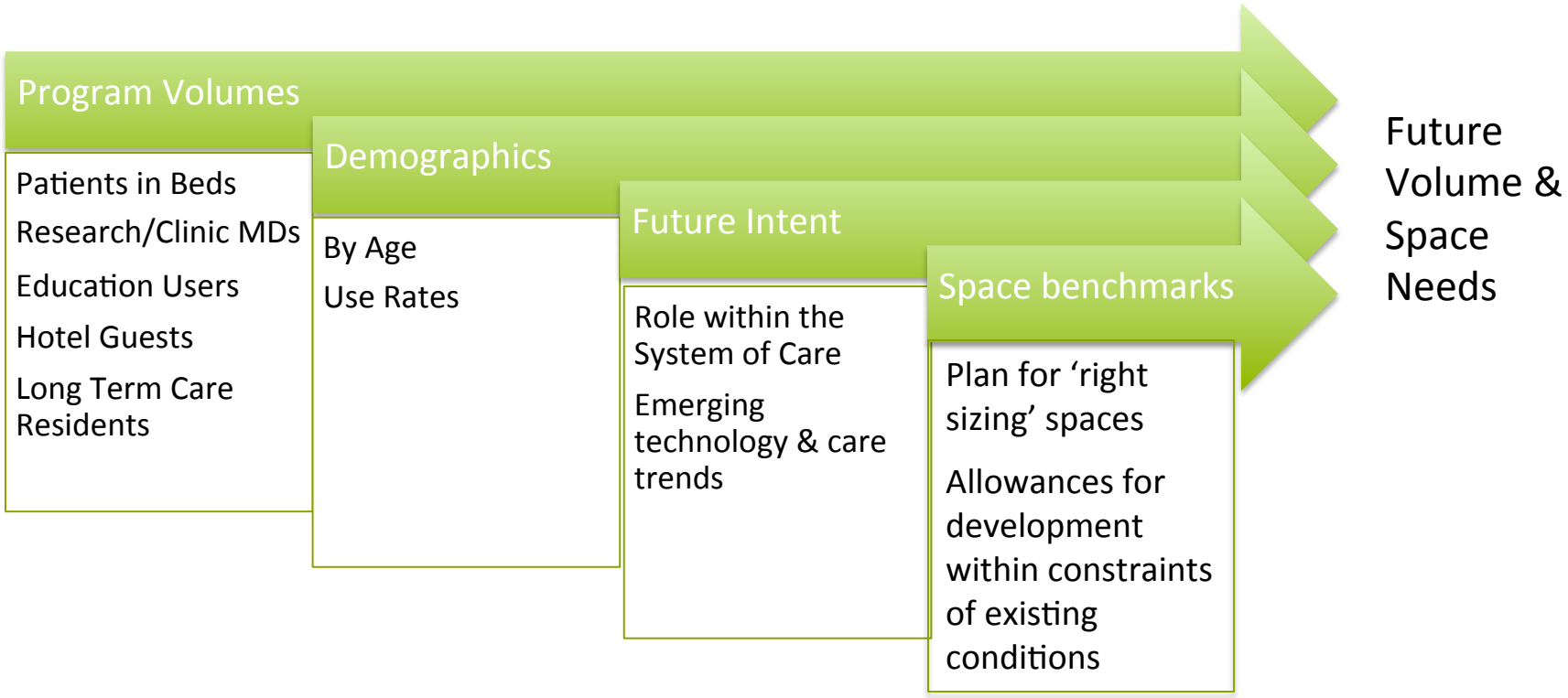
Major Trends in Health Care Delivery



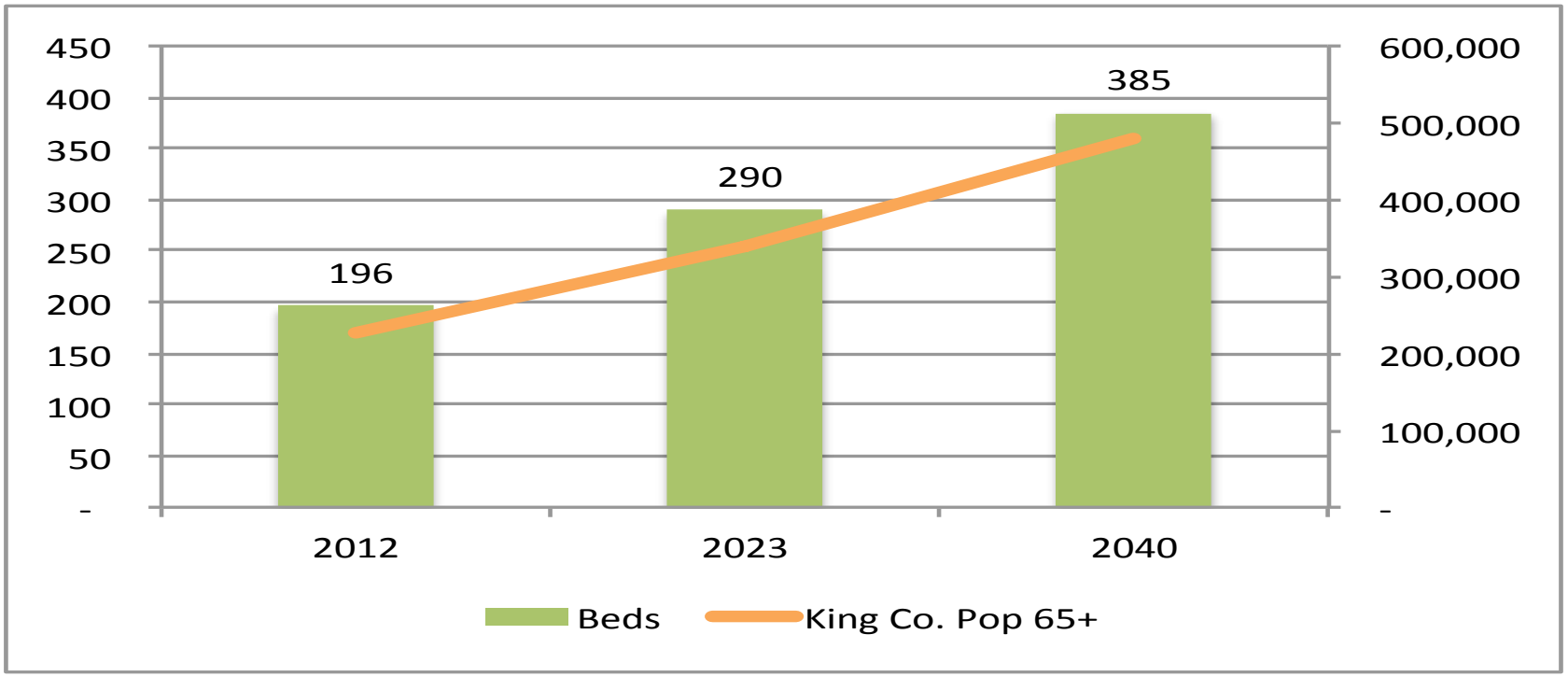


- Improved access to the right care at the right time
- Shift from inpatient to outpatient
- Improved outcomes
- Integrated systems of care
  - Hospital mergers
- **Better care for lower cost**
- Prudent use of technologies
- Changing/evolving reimbursement systems
- **Breakthroughs in research**
  - Integration of clinical care and research
  - Innovative technologies
- **Challenges in medical professional staffing**
  - **Optimize precious resources**
- **Aging physical infrastructure**


Primary Care Clinics
Ballard PC
Ballinger
Beacon Hill
Cen Seattle
C. Edmonds
C. W Sea
Cle Elum
Downtown
Edmonds
Factoria
Ballard FM
C Hill FM
First Hill FM
Greenlake
Edmonds IM
Issaquah PC
Magnolia PC
Mill Ck PC
Pine Lk PC
Q Anne
Redmond
Snoqualmie
SLU PC
W Sea PC
Community Hospitals / Emergency Rooms
Ballard
Edmonds
Issaquah
Mill Creek
Redmond
Medical Centers
Cherry Hill
First Hill
Special Equipment, e.g. Cath Labs,
specialized Surgeries, Gamma Knife

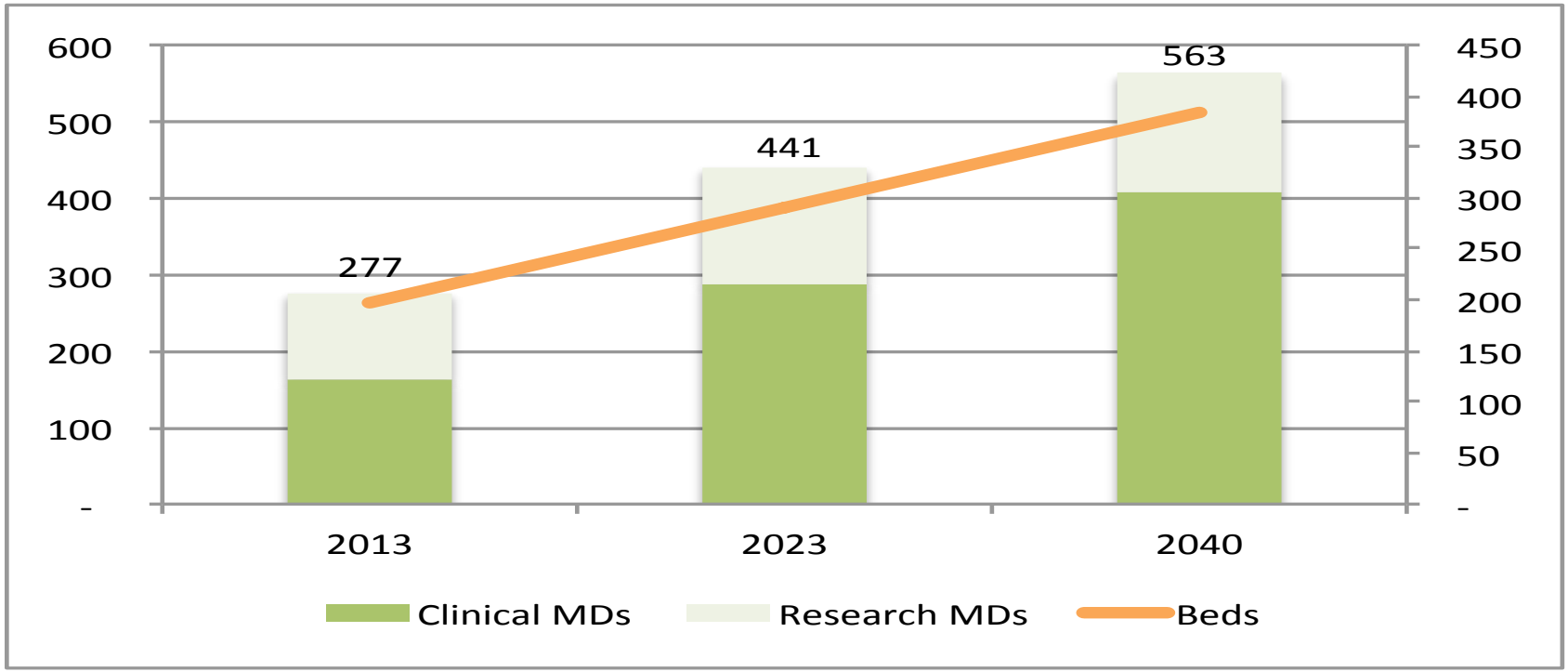

Program Volumes
Patients in Beds
Research/Clinic MDs
Education Users
Hotel Guests
Long Term Care Residents
Demographics
By Age
Use Rates
Future Intent
Role within the System of Care
Emerging technology & care trends
Space benchmarks
Plan for 'right sizing' spaces
Allowances for development within constraints of existing conditions
Future Volume & Space Needs

Hospital Bed Forecast



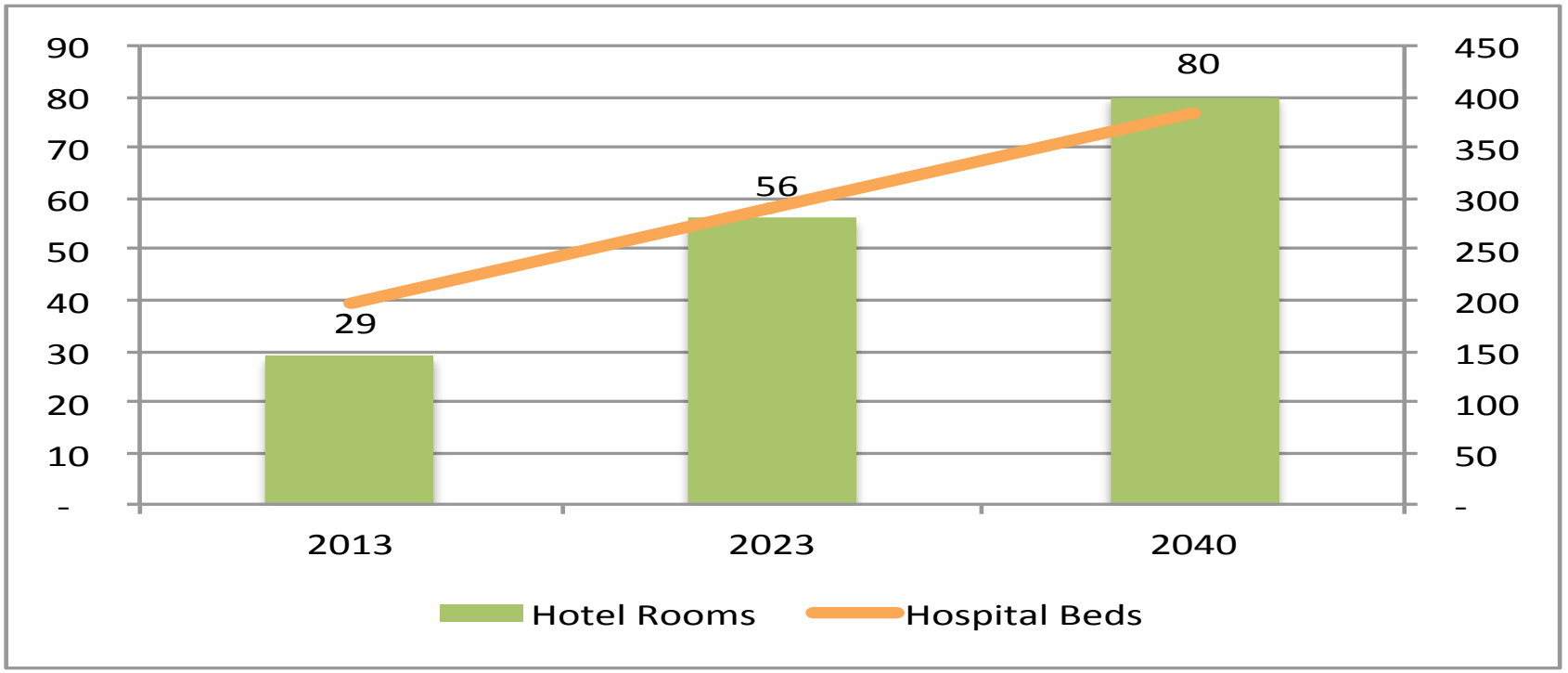
Bed forecasts influenced by population change, service demand, ACA (new patients), and average length of stay.

Clinical and Research MDs



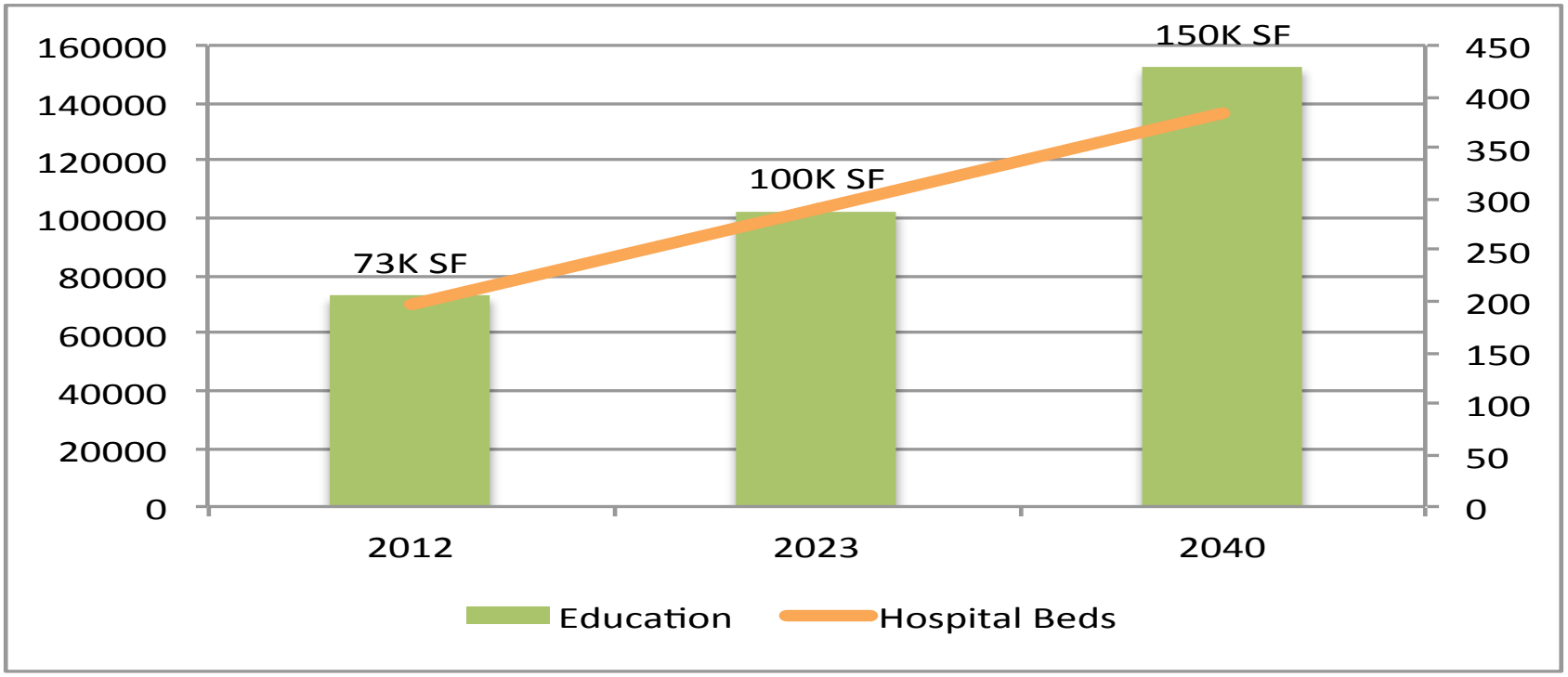
Clinical & Research MD forecasts influenced by inpatient bed growth, enhancing specialty programs, and expanding to meet needs of ACA.

Hotel Rooms



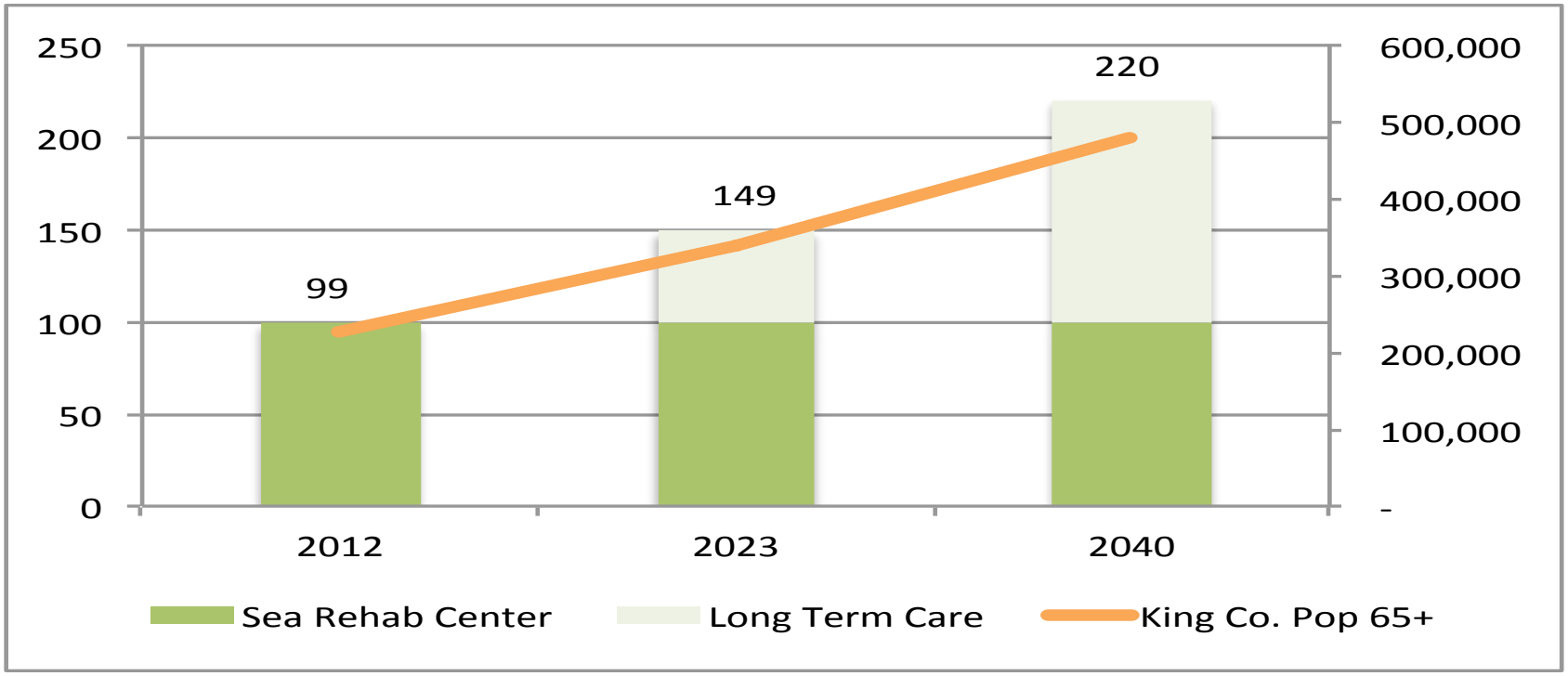
Hotel Room forecast primarily influenced by inpatient bed growth. Some beds set aside for outpatients coming from out-of-town for treatment.

Education



Education forecast influenced by increases in patient volumes driving the need for additional staff, staff training for new technology and data/record systems, residency programs, and other teaching and training.

Long Term Care/Assisted Living/Skilled Nursing Beds



Long Term Care forecast assumes Seattle Rehab Center maintains existing program. Additional development on campus is assumed to be a mix of acute rehab and assisted living. Size is based on operational considerations.

Building Gross Square Feet

Year	Existing	2023	2040
Hospital	541,300	1,014,000	1,350,000
Clinical/Research	427,000	1,014,000	1,250,000
Education	73,000	100,000	150,000
Hotel	12,500	40,000	80,000
Long Term Care	43,000	93,000	220,000
Other Support	50,000	50,000	50,000
TOTAL	**1,146,800**	**2,311,000**	**3,100,000**

APPENDIX E

materials concerning Providence acquisition of Swedish in 2012

- *Seattle Times* article about Providence acquisition of Swedish, 1 February 2012
- initial articles of incorporation for Western HealthConnect, filed 29 December 2011
- amended articles of incorporation for Western HealthConnect, filed 27 January 2012
- amended and restated bylaws of Western HealthConnect, effective 1 February 2012
- restated articles of incorporation for Providence Health & Services – Western Washington, effective 1 February 2012
- restated bylaws for Providence Health & Services – Western Washington, effective 1 February 2012
- restated articles of incorporation for Swedish Health Services, effective 1 February 2012
- restated articles of incorporation for Swedish Edmonds, effective 1 February 2012

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The Seattle Times

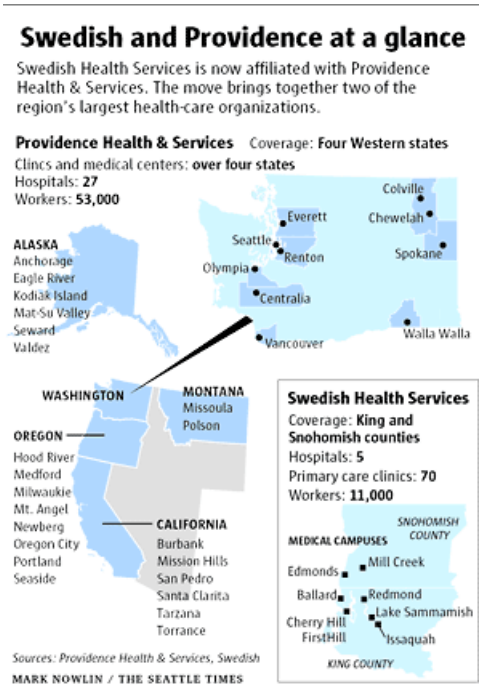
HEALTH | LOCAL NEWS

February 1, 2012

Swedish alliance with Providence is now complete

Formerly independent Swedish Health Services is now part of a division of Providence Health & Services, officials announced Wednesday.

By Carol M. Ostrom



The affiliation between Swedish Health Services and Providence Health & Services is official, chief executives from the two organizations announced Wednesday.

The agreement between Providence, a much larger organization, and Swedish will create a new organization for the greater Puget Sound area, including all of Swedish's operations in King and South Snohomish counties, and Providence's operations in King, Snohomish, Thurston and Lewis counties.

Patients will see no difference in how they access care, officials said, other than having an electronic medical record available through more providers in a larger area.

Swedish's Dr. Rod Hochman, currently president and CEO, will move to an expanded role as one of two group presidents for Providence's five-state system. In that role, he will oversee clinical quality, physician services, human resources and communication for the Providence system; in addition, he will be in charge of the Oregon and Washington operations.

Kevin Brown, previously Swedish's chief strategy officer and administrator for Ballard, Issaquah, Mill Creek and Redmond facilities, will become new CEO for Swedish Health Services.

When the two systems first announced their tentative agreement in October — before receiving approval from state and federal antitrust authorities — they were careful to say it was not a merger or acquisition. However, under the agreement, formerly independent Swedish becomes a part of a division of Providence, which controls an overseeing board.

The two organizations emphasize that each system will keep its name, and Swedish will remain a nonreligious organization, despite its announcement late last year that it would no longer perform elective abortions, but instead would help underwrite a Planned Parenthood center adjacent to its Seattle hospital.

The decision, which Swedish said was made "out of respect for the affiliation," was controversial among women's rights groups and those who fear Catholic control of health-care providers will foreclose reproductive or end-of-life options. Swedish said there would be no change to its current end-of-life care policy.

Both hospital systems announced late last year that they had budget shortfalls, and subsequently each made substantial job cuts.

In an interview Wednesday, Hochman said Swedish was financially healthy and could have stayed independent. But the question, in a time of crisis for health care nationally, was "survive – or thrive," he said. "Consolidation in health care is inevitable in order to achieve some of the goals."

In a joint statement, the two systems said the affiliation would allow both organizations "to collaborate to better deliver health care to the region."

Dr. John Koster, Providence Health & Services president and CEO, said in an interview that the intent of the agreement is to improve the quality of care. "That's how costs come down," he added.

In addition, he said, the partnership creates a large "repository of intellectual capital" and the ability to disseminate bright ideas to improve care throughout a large network of providers.

Eric Earling, spokesman for Premera Blue Cross, one of the state's largest insurers, said that in the past, Premera has observed that, "mergers can create market-dominant positions that sometimes result in increased costs to our members." But in this case, he added, "we are encouraged by the stated desire by Providence and Swedish to enhance quality of care and control costs for their patients and our members."

Regence BlueShield spokeswoman Rachelle Cunningham said because cost is the top issue in health care today, Regence would work very closely with Swedish and Providence to "deliver on their commitments to lower health-care costs to our members and our community."

Swedish Health Services, based in Seattle, operates five hospitals and more than 70 primary care clinics, with about 11,000 workers.

Renton-based Providence Health & Services operates 27 hospitals and various other medical facilities throughout a five-state region from Alaska to California, and employs about 53,000 workers.

Arnie Schaffer, previously overseeing Providence operations in Alaska, Washington, Montana and California, will become chief executive of the new Western Washington Region created by the agreement. He will be responsible for affiliation operations and integration between Swedish and Providence.

Carol M. Ostrom: 206-464-2249 or costrom@seattletimes.com

UNITED STATES OF AMERICA

The State of Washington

Secretary of State

I, SAM REED, Secretary of State of the State of Washington and custodian of its seal, hereby issue this

CERTIFICATE OF INCORPORATION

to

WESTERN HEALTHCONNECT

a/an WA Non-Profit Corporation. Charter documents are effective on the date indicated below.

Date: 12/29/2011

UBI Number: 603-169-266

Given under my hand and the Seal of the State of Washington at Olympia, the State Capital

Sam Reed

Sam Reed, Secretary of State

STATE OF WASHINGTON
SECRETARY OF STATE

12/20/11 2087177-001
$80.00 K #788892
ud: 2228721

FILED
SECRETARY OF STATE
SAM REED

DECEMBER 29, 2011

STATE OF WASHINGTON

12/29/11 2092801-001
$0.00 D
ud: 2228721

Washington Nonprofit Corporation

See attached detailed instructions

☐ **Filing Fee $30.00**

☑ **Filing Fee with Expedited Service $80.00**

UBI Number: **603 169 266**

ARTICLES OF INCORPORATION

Chapter 24.03 RCW

ARTICLE 1

NAME OF CORPORATION:

Western HealthConnect

(***MAY NOT*** *contain any of the following designations or abbreviations of: Corporation, Company, Incorporated, Limited, Limited Partnership, Limited Liability Company, or Limited Liability Partnership. If one of the prohibited designations is used, it will be removed when processed.)*

ARTICLE 2

EFFECTIVE DATE OF INCORPORATION: *(Please check one of the following)*

☑ Upon filing by the Secretary of State

☐ Specific Date: _____ *(Specified effective date must be within 90 days AFTER the Articles of Incorporation have been filed by the Office of the Secretary of State)*

ARTICLE 3

TENURE: *(Please check one of the following and indicate the date if applicable)*

☑ Perpetual existence

☐ Specific term of existence _____ *(Number of years or date of termination)*

ARTICLE 4

PURPOSE FOR WHICH THE NONPROFIT IS ORGANIZED: *(if necessary, attach additional information)*

See Attachment A.

ARTICLE 5

IN THE EVENT OF A VOLUNTARY DISSOLUTION, THE NET ASSETS WILL BE DISTRIBUTED AS FOLLOWS: *(if necessary, attach additional information)* See Attachment A.

ARTICLE 6

NAME AND ADDRESS OF EACH INITIAL DIRECTOR: *(If necessary, attach additional names and addresses)*

Name: See Attachment A.

Address: _____

City _____ State _____ Zip Code _____

ARTICLE 7

NAME AND ADDRESS OF THE WASHINGTON STATE REGISTERED AGENT:

Name: Cindy Fein Strauss

Physical Location Address ***(required)***:

Swedish Health Services, 747 Broadway

City Seattle WA Zip Code 98122

Mailing or Postal Address ***(optional)***:

Same as above.

City _____ WA Zip Code _____

CONSENT TO SERVE AS REGISTERED AGENT:

I consent to serve as Registered Agent in the State of Washington for the above named corporation. I understand it will be my responsibility to accept Service of Process on behalf of the corporation; to forward mail to the corporation; and to immediately notify the Office of the Secretary of State if I resign or change the Registered Office Address.

x Cindy F. Strauss — Cindy Fein Strauss — 12/9/11

Signature of Registered Agent — Printed Name — Date

ARTICLE 8

NAME, ADDRESS AND SIGNATURE OF EACH INCORPORATOR:

*(If necessary, attach additional names, addresses **and signatures**)*

Name: Cindy Fein Strauss

Address: Swedish Health Services, 747 Broadway

City Seattle State WA Zip Code 98122

This document is hereby executed under penalties of perjury, and is, to the best of my knowledge, true and correct.

x Cindy F. Strauss — Cindy F. Strauss, President — 12/9/11 — 206.628.2512

Signature of Incorporator — Printed Name/Title — Date — Phone

Important note: If your nonprofit organization is currently fundraising, or plans to fundraise from the public, it may also be required to register with the Charities Program of the Secretary of State. Registration with the Charities Program is separate from, and in addition to, filings required under corporate law. Please visit the Charities Program website at www.sos.wa.gov/charities/ to review the registration requirements and forms for Charitable Organizations.

ATTACHMENT A

Article 4

This Corporation is organized and shall be operated exclusively for the benefit and support of, to perform the functions of and to carry out the charitable, educational and scientific purposes of Swedish Health Services, a Washington non-stock corporation ("SHS"), so long as SHS is and shall remain a tax-exempt organization described in Sections 501(c)(3) and 509(a)(1) or 509(a)(2) of the Code of 1986, as amended (the "Code"). In furtherance of such charitable purposes, the Corporation may, to the extent consistent with such purposes, take such actions and perform such acts to accomplish such purposes with all powers conferred on nonprofit corporations under the laws of the State of Washington, subject to the limitations imposed on its actions under Section 501(c)(3) and 509(a)(3) of the Code. This Corporation shall be operated exclusively for charitable and scientific purposes within the meaning of Section 501(c)(3) of the Code, in the course of which operation:

(a) No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, any private shareholder or individual, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth herein;

(b) No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of any candidate for public office except as authorized under the Code; and

(c) The Corporation shall not carry on any other activities not permitted to be carried on (i) by a corporation exempt from federal income tax under Section 501(c)(3) of the Code or (ii) by a corporation contributions to which are deductible under Section 170(c)(2) of the Code.

Article 5

Upon the dissolution or liquidation of the Corporation, the assets of the Corporation not disposed of in discharging the Corporation's liabilities or otherwise distributed in accordance with applicable legal requirements, shall be distributed to SHS, or to such organization or organizations as shall be determined by the Board of Trustees of the Corporation and which are organized and operated exclusively for charitable, scientific or educational purposes and that at the time qualify as an exempt organization or organizations under Section 501(c)(3) and Section 509(a)(1) or 509(a)(2) of the Code. Any such assets not so disposed of shall be disposed by a court of competent jurisdiction of the county in which the principal office of the Corporation is then located, exclusively for such purposes or to such organizations, as such court shall determine, that are organized and operated exclusively for such purposes.

Article 6

Cindy Strauss, President, Swedish Health Services, Administration, 747 Broadway, Seattle WA 98122-4307

Dan Dixon, VP and Secretary, Swedish Health Services, Administration, 747 Broadway, Seattle WA 98122-4307

Janice Newell, Treasurer, Swedish Health Services, Administration, 747 Broadway, Seattle WA 98122-4307

STATE OF WASHINGTON
SECRETARY OF STATE

Washington Nonprofit Corporation

See attached detailed instructions

☐ **Standard Filing Fee $20.00**

☑ **Filing Fee with Expedited Service $70.00**

This Box For Office Use Only

FILED
SECRETARY OF STATE
JAN 27 2012
STATE OF WASHINGTON

UBI Number: 603169266

ARTICLES OF AMENDMENT

Chapter 24.03 RCW

SECTION 1

NAME OF CORPORATION: *(as currently recorded with the Office of the Secretary of State)*

Western HealthConnect

SECTION 2

ARTICLES OF AMENDMENT WERE ADOPTED BY: *(please check and complete one of the following)*

☐ The amendment was adopted by a meeting of members held: (Date) _____
A quorum was present at the meeting and the amendment received at least two-thirds of the votes which members present or represented by proxy were entitled to cast.

☑ The amendment was adopted by a consent in writing and signed by all members entitled to vote.

☐ There are no members that have voting rights. The amendment received a majority vote of the directors at a board meeting held: (Date) _____

SECTION 3

AMENDMENTS TO ARTICLES ON FILE: *(if necessary, attach additional information)*

See Attachment A

SECTION 4

EFFECTIVE DATE OF ARTICLES OF AMENDMENT: *(please check one of the following)*

☐ Upon filing by the Secretary of State

☑ Specific Date: February 1, 2012 *(Specified effective date must be within 30 days AFTER the Articles of Amendment have been filed by the Office of the Secretary of State)*

SECTION 5

SIGNATURE: *(see instructions page)*

This document is hereby executed under penalties of perjury, and is, to the best of my knowledge, true and correct.

x Signature	Printed Name and Title	Date	Phone
Cindy Strauss	Cindy F. Strauss, President	1/26/12	206.628.2512

ATTACHMENT A

Article 4

This Corporation is organized and shall be operated exclusively for the benefit and support of, to perform the functions of and to carry out the charitable, educational and scientific purposes of Swedish Health Services, a Washington nonprofit corporation ("SHS"), Swedish Edmonds, a Washington nonprofit corporation ("SE"), and Providence Health & Services-Western Washington, a Washington nonprofit corporation ("PHS-WW") (collectively, the "Health Care Corporations"), so long as each corporation is described in Sections 501(c)(3) and 509(a)(1) or 509(a)(2) of the Code of 1986, as amended (the "Code"). SHS and SE are engaged in the delivery of health care services and at all times retain their secular identity and charitable purposes, consistent with SHS's 100 year history of service to the community. PHS-WW is engaged in the delivery of health care services and shall at all times retain its Catholic identity and adherence to Catholic Church teaching and its existing charitable purpose, consistent with its 150 year history of service in the Western United States. As the sole member of SHS and SE and a co-member of PHS-WW, the Corporation shall create a western Washington regional health care delivery system with a common culture that respects the identity, history, philosophy and values of each of the Health Care Corporations that would support significant improvements in health care delivery and outcomes within the context of nonprofit, charitable ownership. In furtherance of such charitable purposes, the Corporation may, to the extent consistent with such purposes, take such actions and perform such acts to accomplish such purposes with all powers conferred on nonprofit corporations under the laws of the State of Washington, subject to the limitations imposed on its actions under Section 501(c)(3) and 509(a)(3) of the Code. This Corporation shall be operated exclusively for charitable and educational purposes within the meaning of Section 501(c)(3) of the Code, in the course of which operation:

(a) No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, any private shareholder or individual, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth herein;

(b) No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of any candidate for public office except as authorized under the Code; and

(c) The Corporation shall not carry on any other activities not permitted to be carried on (i) by a corporation exempt from federal income tax under Section 501(c)(3) of the Code or (ii) by a corporation contributions to which are deductible under Section 170(c)(2) of the Code.

Article 5

Upon the dissolution or liquidation of the Corporation, the assets of the Corporation not disposed of in discharging the Corporation's liabilities or otherwise distributed in accordance with applicable legal requirements, shall be distributed to such organization or organizations as shall be determined by the Board of Directors of the Corporation and which are organized and operated exclusively for charitable, scientific or educational purposes and that at the time qualify

as an exempt organization or organizations under Section 501(c)(3) and Section 509(a)(1) or 509(a)(2) of the Code. Any such assets not so disposed of shall be disposed by a court of competent jurisdiction of the county in which the principal office of the Corporation is then located, exclusively for such purposes or to such organizations, as such court shall determine, that are organized and operated exclusively for such purposes.

AMENDED AND RESTATED BYLAWS
OF
WESTERN HEALTHCONNECT

ARTICLE I
THE CORPORATION IN GENERAL

1.1 NAME AND DESCRIPTION. The name of the corporation shall be Western HealthConnect ("**Corporation**"). It is a nonprofit corporation organized and existing under the laws of the State of Washington.

1.2 PURPOSES. This Corporation is organized and shall be operated exclusively for the benefit and support of, to perform the functions of and to carry out the charitable, educational and scientific purposes of Swedish Health Services, a Washington nonprofit corporation ("**SHS**"), Swedish Edmonds, a Washington nonprofit corporation ("**SE**"), and Providence Health & Services-Western Washington, a Washington nonprofit corporation ("**PHS-WW**") (collectively, the "**Health Care Corporations**"), so long as each corporation is described in Sections 501(c)(3) and 509(a)(1) or 509(a)(2) of the Code of 1986, as amended (the "Code"). SHS and SE are engaged in the delivery of health care services and at all times retain their secular identity and charitable purposes, consistent with SHS's 100 year history of service to the community. PHS-WW is engaged in the delivery of health care services and shall at all times retain its Catholic identity and adherence to Catholic Church teaching and its existing charitable purpose, consistent with its 150 year history of service in the Western United States. As the sole member of SHS and SE and a co-member of PHS-WW, the Corporation shall create a western Washington regional health care delivery system with a common culture that respects the identity, history, philosophy and values of each of the Health Care Corporations that would support significant improvements in health care delivery and outcomes within the context of nonprofit, charitable ownership. In furtherance of such charitable purposes, the Corporation may, to the extent consistent with such purposes, take such actions and perform such acts to accomplish such purposes with all powers conferred on nonprofit corporations under the laws of the State of Washington, subject to the limitations imposed on its actions under Section 501(c)(3) and 509(a)(3) of the Code. This Corporation shall be operated exclusively for charitable and educational purposes within the meaning of Section 501(c)(3) of the Code, in the course of which operation:

1.2.1 No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, any private shareholder or individual, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth herein;

1.2.2 No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of any candidate for public office except as authorized under the Code; and

1.2.3 The Corporation shall not carry on any other activities not permitted to be carried on (i) by a corporation exempt from federal income tax under Section 501(c)(3) of the Code or (ii) by a corporation contributions to which are deductible under Section 170(c)(2) of the Code.

1.3 LOCATION. The principal office of the Corporation shall be located at c/o Swedish Health Services, Administration, 747 Broadway, Seattle, Washington 98122-4307.

ARTICLE II
MEMBERS

The Corporation shall have no members. Any provision of law requiring notice to, the presence of, or the vote, consent or other action of members of a corporation shall be satisfied by notice to, the presence of, or the vote, consent or other action of the Board of Directors (the "**Board**") of the Corporation.

ARTICLE III
BOARD OF DIRECTORS OF THE CORPORATION

3.1 POWER OF THE BOARD OF DIRECTORS. The Board of the Corporation shall exercise general governance and control of the mission and business affairs of the Corporation and shall have and exercise all of the powers which may be exercised or performed by the Corporation under the laws of the State of Washington and these Bylaws.

3.2 COMPOSITION OF THE BOARD. The Board shall consist of the same individuals as those then currently serving on the Board of Directors of PH&S-WW (each, a "**Director**"). Each officer and member of the Board would serve in his/her individual capacity and not as a representative, or on behalf of, any other organization. In carrying out their respective responsibilities, the officers and members of the Board would act in the best interest of the Corporation, and specifically would not act as representatives of Providence Health & Services or its affiliates. Appointment, term, and removal of a member of the Board of Directors from PH&S-WW shall constitute appointment, term of office, and removal from such individual's service as a member of the Board of this Corporation. In the event a member of the Board of Directors of PH&S-WW shall resign, such resignation shall automatically cause the resignation of such individual as a Director of this Corporation.

3.3 CHAIRPERSON OF THE BOARD. The Chairperson of the Board shall be the same individual then serving as Chairperson of the Board of Directors of PH&S-WW. Such Chairperson of the Board of this Corporation shall serve in such capacity so long as such individual is serving as the Chairperson of the Board of Directors of PH&S-WW.

3.4 ACTING CHAIR. Any individuals serving as the Acting Chair of the Board of Directors of PH&S-WW shall also serve as the Acting Chair of this Corporation.

3.5 MEETINGS AND PROCEDURAL RULES.

3.5.1 Annual Meeting. The annual meeting of the Board shall be held by December 31 of each year. Such meeting shall be held at the principal office of the

Corporation or at such place as may be designated from time to time by the Chairperson. The purposes of the annual meeting shall include, without limitation, electing officers as herein provided and transacting such other business as shall be necessary or desirable.

3.5.2 Regular Meetings of the Board. Regular meetings of the Board shall occur at least four (4) times a year at such time and place as the Directors shall provide by resolution.

3.5.3 Special Meetings of the Board. Special meetings of the Board may be called upon written request by two (2) or more Directors, the Chairperson of the Board or the President/Chief Executive Officer.

3.5.4 Notice of Board Meetings. Written notice of all Board meetings shall be mailed by first class mail, personally delivered, or sent by electronic transmission pursuant to Section 18.5 to each Director at least five (5) days before the date of the meeting, which notice shall in the case of special meetings state the nature of the business to be taken up at the meeting. If mailed, such notice shall be deemed to be delivered when deposited in the U.S. Mail, postage prepaid, addressed to the Director at their address as it appears in the records of the Corporation.

3.5.5 Quorum. For all meetings of the Board (other than for action taken by unanimous written consent), a quorum shall be a simple majority of the Directors then serving unless a greater majority is required by law or by these Bylaws.

3.5.6 Action by Unanimous Written Consent. Waiver of notice of any Board meeting or any action required to be taken at a meeting of the Board, or any other action which may be taken at a meeting of the Board, may be taken without a meeting if a consent in writing, setting forth the actions so taken, is signed by all the Directors entitled to vote with respect to the subject matter thereof. Any consent signed by all the Directors shall have the same effect as a unanimous vote.

3.5.7 Telephonic Meetings. Directors may participate in and act at any meeting of such Board by means of conference telephone, videoconference or similar communication equipment by which all persons participating in the meeting can hear each other at the same time. Participation in such a meeting shall constitute presence in person at the meeting.

3.5.8 Voting. Voting on any question or in any election may be by voice, unless the individual presiding at the meeting shall order, or a Director shall demand, that voting be by ballot.

3.5.9 Manner of Acting. Each Director shall be entitled to one vote on all matters voted on at any meeting. Except as otherwise provided by law, the Articles of Incorporation, or these Bylaws, the act of a majority of the Directors present at the meeting at which a quorum is present shall be the act of the Board.

3.5.10 Compensation/Reimbursement of Directors. Directors may receive reasonable compensation for their services as Directors, as determined from time to time

by the Member. Directors shall be reimbursed for reasonable expenses of attendance at meetings or when on other business of the Corporation.

3.5.11 Board Evaluation. The Board shall annually evaluate their performance.

3.6 PRESUMPTION OF ASSENT. Any Director who is present at a meeting of the Board at which action on any corporate matter is taken shall be conclusively presumed to have assented to the action taken unless (1) he/she abstains and his/her abstention is recorded in the minutes of the Corporation; (2) his/her dissent shall be entered in the minutes of the meeting; (3) he/she shall file his/her written dissent to such action with the person acting as the secretary of the meeting before the adjournment thereof; or (4) he/she shall forward such dissent by registered mail to the Secretary of the Corporation immediately after the adjournment of the meeting. The right to dissent shall not apply to a Director who voted in favor of an action.

ARTICLE IV
OFFICERS OF THE CORPORATION

4.1 OFFICERS. The officers of the Corporation shall be the President/Chief Executive Officer, one or more Vice President(s), a Secretary and a Treasurer and such other officers as may be elected from time to time by the Board. The officers of this Corporation shall be the same individuals serving as the officers of PH&S-WW. The powers and duties of the officers shall be as set forth in these Bylaws and as otherwise designated from time to time by the Board, to the extent consistent with law, the Articles of Incorporation of the Corporation and these Bylaws. Any number of offices may be held by the same person except that the Secretary may not serve concurrently as the President. In the event such officer either resigns or is otherwise removed as an officer of PH&S-WW, such officer's office with this Corporation shall automatically terminate as of the effective date of their removal or resignation as an officer of PH&S-WW.

4.2 PRESIDENT/CHIEF EXECUTIVE OFFICER. The President/Chief Executive Officer shall be the chief executive officer of the Corporation and shall be the direct executive representative of the Board in the management of the Corporation. The President/Chief Executive Officer shall have and exercise general management and supervision of the affairs of the Corporation.

4.3 VICE PRESIDENT(S). The Vice President(s) shall perform such duties as are established from time to time by the Board and shall report to the President/Chief Executive Officer. In all other matters, the Vice President(s) shall function in accordance with the specific powers which have been delegated to them by the Board and/or the President/Chief Executive Officer.

4.4 TREASURER. The Treasurer shall have general charge and responsibility relating to the financial concerns of the Corporation. The Treasurer shall perform such other duties and functions as may from time to time be designated by the Board, subject to the overall control of such Board. The Treasurer shall be responsible for causing an audited financial statement to be provided to the Board at least annually.

4.5 SECRETARY. The Secretary shall be the custodian of and shall maintain the corporate books and records, the minutes of the meetings of the Board and assure that all required notices are duly given in accordance with these Bylaws, the Articles of Incorporation of the Corporation or as otherwise may be required by law. The Secretary shall, in general, perform all duties incident to the office of Secretary, subject to the control of the Board and shall do and perform such other duties as may be assigned from time to time by the Board.

4.6 ASSISTANT TREASURERS AND ASSISTANT SECRETARIES. The assistant treasurers and assistant secretaries shall perform such duties as shall be assigned to them by the Treasurer or Secretary, respectively, or by the President/Chief Executive Officer or the Board.

4.7 ADDITIONAL OFFICERS. The Board by resolution may create such additional and special offices as may be necessary or desirable in addition to those described herein and may by such resolution provide for the election by the Board of any person to perform the duties and exercise the authority of such office.

4.8 DELEGATION. The Board may delegate temporarily the powers and duties of any officer, in case of such officer's absence or for any other reason, to any other officer, and may authorize the delegation by an officer of any such officer's powers and duties to any agent or employee subject to the general supervision of such officer.

ARTICLE V
COMMITTEES OF THE BOARD

The Corporation shall have the same committees, committee members, and concurrent committee meetings with those committees established by PHS-WW. This Corporation's committees shall meet concurrently with the PHS-WW Board committees established pursuant to the PHS-WW Bylaws. The Board committee charters and other rules for functioning of such committees of this Corporation shall be identical to those of PHS-WW.

ARTICLE VI
REGIONAL MISSION

The Corporation shall support the Health Care Corporations in accomplishing specific mission-based goals and objectives arising from its activities in the service area, including the goals outlined in Section 1.2 of the Affiliation Agreement dated January 26, 2012, entered into by and among Corporation, SHS, SE, PHS-WW, Providence Ministries, Providence Health & Services and Providence Health & Services-Washington.

ARTICLE VII
VOTING UPON STOCK OF OTHER CORPORATIONS

Unless otherwise ordered by the Board and subject to the direction, if any, given by the Board, any officer of this Corporation shall have full power and authority on behalf of the Corporation to vote either in person or by proxy at any meeting of stockholders of any corporation in which this Corporation may hold stock or otherwise have an opportunity to vote, and at such meeting may possess and exercise all the rights and powers incident to the ownership of such stock or membership which, as the owner thereof, this Corporation might have possessed and exercised if present.

ARTICLE VIII
CONFLICT AND DUALITY OF INTERESTS

Any Director, officer, employee, Community Board member or committee member having an interest in a transaction, contract or other matter presented to the Board or a committee thereof for authorization, approval or ratification shall provide prompt, full and frank disclosure of his or her interest to the Board or committee prior to its acting on such contract or transaction. The body to which such disclosure is made shall determine, by a majority vote, whether a duality or conflict of interest exists or can reasonably be construed to exist. If a conflict is deemed to exist, such person shall not vote on, nor use his or her personal influence on, nor participate (other than to present factual information or to respond to questions) in the discussions or deliberations with respect to, such contract or transactions. Such person may be counted in determining the existence of a quorum at any meeting where the contract or transaction is under discussion or is being voted upon. The minutes of the meeting shall reflect the disclosure made, the vote thereon and, where applicable, the abstention from voting and participation, and whether a quorum is present. This Corporation may also adopt policies from time to time more clearly setting forth any requirements regarding disclosure and actions relating to duality or conflicts of interest.

ARTICLE IX
INDEMNIFICATION

9.1 DEFINITIONS. For the purposes of this Article IX:

9.1.1 "**Director**" means an individual who is or was a Director of the Corporation or an individual who, while a Director of the Corporation, is or was serving at the Corporation's request as a Director, officer, partner, trustee, employee, or agent of another foreign or domestic corporation, partnership, joint venture, trust, employee benefit plans, or other enterprise. "Director" includes, unless the context requires otherwise, the estate or personal representative of a Director.

9.1.2 "**Liability**" means the obligation to pay a judgment, settlement, penalty or fine, including an excise tax assessment with respect to an employee benefit plan, or reasonable expenses incurred with respect to a proceeding.

9.1.3"**Official Capacity**" means:

(i) when used with respect to a Director, the office of Director in the Corporation; and

(ii) when used with respect to an officer, the elective or appointive office in the Corporation held by that individual.

9.1.4 "**Proceeding**" means any threatened, pending, or completed action, suit, or proceeding, whether civil, criminal, administrative, or investigative and whether formal or informal.

9.2 ACTION NOT BY OR IN THE RIGHT OF THE CORPORATION. The Corporation shall indemnify any Director or officer who was or is a party or is threatened to be made a party to any Proceeding (other than an action by or in the right of the Corporation) by reason of the fact that he/she is or was a Director or officer of the Corporation against judgments, penalties, fines, settlements and reasonable expenses, including attorneys' fees, actually and reasonably incurred by the Director or officer in connection with the Proceeding if he/she conducted himself/herself in good faith and:

9.2.1 in the case of conduct in his/her own Official Capacity with the Corporation, he/she reasonably believed his/her conduct to be in the Corporation's best interests; or

9.2.2 in all other cases, he/she reasonably believed his/her conduct to be at least not opposed to the Corporation's best interests; and

9.2.3 in the case of any criminal proceeding, he/she had no reasonable cause to believe his/her conduct was unlawful.

The termination of any Proceeding by judgment, order, settlement, conviction, or upon a plea of nolo contendere or its equivalent, shall not, of itself, be determinative that the Director or officer did not meet the requisite standard of conduct set forth in this Section 9.2.

9.3 ACTION BY OR IN THE RIGHT OF THE CORPORATION. The Corporation shall indemnify any Director or officer who was or is a party or is threatened to be made a party to any Proceeding by or in the right of the Corporation by reason of the fact that he/she is or was a Director or officer of the Corporation against reasonable expenses, including attorneys' fees, actually and reasonably incurred by him/her in connection with such Proceeding if he/she conducted himself/herself in good faith and:

9.3.1 in the case of conduct in his/her Official Capacity with the Corporation, he/she reasonably believed his/her conduct to be in the Corporation's best interests; or

9.3.2 in all other cases, he/she reasonably believed his/her conduct to be at least not opposed to the Corporation's best interests, provided that no indemnification shall be made pursuant to this Section 9.3 in respect of any Proceeding in which such person shall have been adjudged to be liable to the Corporation.

9.4 LIMITATION ON INDEMNIFICATION. A Director or officer shall not be indemnified under this Article in respect of any Proceeding, whether or not involving action in his/her Official Capacity, in which he/she shall have been adjudged to be liable on the basis that the Director or officer personally received a benefit in money, property, or services to which the Director or officer was not legally entitled.

9.5 EXPENSES IF SUCCESSFUL. To the extent that the Director or officer of the Corporation has been successful on the merits or otherwise in the defense of any Proceeding referred to in this Article, he/she shall be indemnified against reasonable expenses, including attorneys' fees, incurred by him/her in connection with the Proceeding.

9.6 AUTHORIZATION. No indemnification shall be made by the Corporation unless the Corporation is authorized upon the Board's determination that indemnification of the Director or officer is permissible under the facts and circumstances because he/she has met the applicable standard of conduct set forth in this Article. Such determination shall be made: (a) by the Board by a majority vote of a quorum consisting of Directors not at the time parties to the Proceeding; (b) if a quorum is unobtainable, by majority vote of a committee duly designated by the Board, in which designation Directors who are parties may participate, consisting solely of two or more Directors not at the time parties to the Proceeding; or (c) in a written opinion by legal counsel (other than an attorney or a firm having associated with it an attorney, who has been retained by or who has performed services within the past three (3) years for the Corporation or any party to be indemnified) selected by the Board or a committee thereof by vote as set forth in (a) or (b) of this Section.

9.7 ADVANCE PAYMENT. Reasonable expenses incurred in defending a Proceeding may be paid by the Corporation in advance of final disposition of the Proceeding: (a) upon receipt by the Corporation of a written undertaking by or on behalf of the Director or officer to repay such amount if it shall ultimately be determined that the Director or officer has not met the standard of conduct necessary for indemnification by the Corporation as authorized by this Article; and (b) upon receipt by the Corporation of a written affirmation by the Director or officer of his/her good faith belief that he/she has met the standard of conduct necessary for indemnification by the Corporation as authorized in this Article.

9.8 INSURANCE. The Corporation shall have the power to purchase and maintain insurance on behalf of an individual who is or was a Director or officer of the Corporation or who, while a Director or officer of the Corporation, is or was serving at the request of the Corporation as a Director, officer, partner, trustee, employee, or agent of another foreign or domestic corporation, partnership, joint venture, trust, employee benefit plan, or other enterprise, against liabilities asserted against or incurred by the individual in that capacity or arising from the individual's status as a Director, officer, employee, or agent, whether or not the Corporation would have the power to indemnify the individual against the same Liability under these Bylaws or the Washington Nonprofit Corporation Act.

9.9 NONEXCLUSIVITY. The indemnification and advancement of expenses provided by, or granted pursuant to this Article of these Bylaws shall not be deemed exclusive of any other rights to which any present or former Director or officer of the Corporation may be entitled by contract, policy or otherwise under applicable law.

9.10 PERMISSIVE INDEMNIFICATION. The Board may establish policies to indemnify members of the medical staff, community boards, employees and others providing service to the Corporation.

9.11 WASHINGTON LAW. Notwithstanding the indemnification provided under this Article of the Bylaws, indemnification to any person by the Corporation shall only occur in compliance with the Washington Nonprofit Corporation Act.

ARTICLE X
FISCAL YEAR

The fiscal year of this Corporation shall commence on January 1 and end on December 31 of each year.

ARTICLE XI
PROHIBITION AGAINST SHARING IN CORPORATE EARNINGS

No Director, officer, employee, committee member or other person connected or affiliated with this Corporation, and no other private individual, shall receive at any time any of the net earnings or pecuniary profit from the operations of this Corporation, provided that this Corporation shall not prevent the payment to any such person of such reasonable compensation for services rendered to or for this Corporation in effecting any of its purposes as such compensation shall be fixed by the Board; and no such person or persons shall possess any proprietary right in or to the property of this Corporation or be entitled to share in the distribution of any of the corporate assets upon dissolution of this Corporation.

ARTICLE XII
DISSOLUTION OF THE CORPORATION

Upon the dissolution or liquidation of the Corporation, the assets of the Corporation not disposed of in discharging the Corporation's liabilities or otherwise distributed in accordance with applicable legal requirements, shall be distributed to such organization or organizations as shall be determined by the Board of the Corporation and which are organized and operated exclusively for charitable, scientific or educational purposes and that at the time qualify as an exempt organization or organizations under Section 501(c)(3) and Section 509(a)(1) or 509(a)(2) of the Code. Any such assets not so disposed of shall be disposed by a court of competent jurisdiction of the county in which the principal office of the Corporation is then located, exclusively for such purposes or to such organizations, as such court shall determine, that are organized and operated exclusively for such purposes.

ARTICLE XIII
INVESTMENTS

Except as otherwise provided in the Articles of Incorporation of the Corporation, this Corporation shall have the right to retain all or any part of any securities or property acquired by

it in whatever manner, and to invest and reinvest any funds held by it, according to the judgment of the Board.

ARTICLE XIV
EXEMPT ACTIVITIES

Notwithstanding any other provisions of these Bylaws, a Director, officer, employee or agent of this Corporation shall not take any action or carry out any activity by or on behalf of the Corporation that is not permitted to be taken or carried on by an organization exempt from federal taxation under Section 501(c)(3) of the Code, as now exists or as may hereafter be amended.

ARTICLE XV
AMENDMENTS

The Board shall regularly review these Bylaws and adopt any revisions to these Bylaws, including any revisions necessary to conform to applicable requirements of state or federal law and/or accreditation standards.

ARTICLE XVI
MISCELLANEOUS PROVISIONS

16.1 DEPOSITORIES. All funds of the Corporation not otherwise employed shall be deposited from time to time to the credit of the Corporation in such banks, financial institutions, mutual funds or other depositories as the Board may designate.

16.2 CHECKS. All checks, drafts, or other orders for the payment of money issued in the name of the Corporation shall be signed by such officer or officers or person or persons (whether or not officers of Corporation) in such manner as shall from time to time be determined by the Board.

16.3 CONTRACTS AND INSTRUMENTS. Subject to any limitations contained in these Bylaws or by resolution of the Board, all deeds, mortgages, bonds and other contracts or instruments of the Corporation shall be signed on behalf of this Corporation by the President/Chief Executive Officer or any other officer.

16.4 AGENTS AND REPRESENTATIVES. The Board may appoint such agents and representatives of the Corporation with such powers and with the authority to perform such acts or duties on behalf of the Corporation as the Board may deem appropriate, consistent with these Bylaws, the Articles of Incorporation of the Corporation and applicable law.

16.5 ELECTRONIC COMMUNICATIONS. To the fullest extent permitted by law, the Board and Board Committees may utilize electronic communications such as e-mail, faxes and other electronic communications for purposes of distributing notices of meetings, voting by ballot or otherwise, executing unanimous written consents as otherwise authorized by these Bylaws, and for all other legitimate purposes of communicating.

Dated this 26th day of January, 2012 to be effective on February 1, 2012.

Cindy Strauss
President of the Corporation

FILED
SECRETARY OF STATE

JAN 27 2012

STATE OF WASHINGTON

RESTATED ARTICLES OF INCORPORATION
OF
PROVIDENCE HEALTH & SERVICES—WESTERN WASHINGTON

Pursuant to the provisions of RCW 24.03.183 of the Washington Nonprofit Corporation Law, the undersigned corporation adopts the following Restated Articles of Incorporation:

ARTICLE I
NAME

The name of the corporation shall be Providence Health & Services—Western Washington, (the "Corporation").

ARTICLE II
DURATION

The Corporation shall have perpetual existence.

ARTICLE III
PURPOSES

The purposes for which the Corporation has been formed are as follows:

3.1 To establish, operate, manage and maintain for charitable purposes, hospitals, nursing homes, and other health care, educational, and social service facilities and programs designed to meet the health, educational and social needs of all people;

3.2 To provide scientific research and educational, charitable and such other activities, services and programs related to its health care, educational and social service facilities and services;

3.3 To engage in other charitable works which are consistent with the objectives of the Corporation and the mission and values of Providence Health & Services and Western HealthConnect, a Washington nonprofit corporation ("WHC"), and guided by the tradition and charism of the Sisters of Providence, as appropriate; and

3.4 To do any and all other things in furtherance of these purposes which are consistent with the laws of the State of Washington, the Articles and Bylaws of Providence Health & Services and the Roman Catholic moral tradition as articulated in documents such as *The Ethical and Religious Directives for Catholic Health Care Services*.

ARTICLE IV
TAX EXEMPT STATUS

The Corporation is organized and is to be operated exclusively for charitable, religious, educational and scientific purposes. No part of the net earnings of the Corporation shall inure to the benefit of, or be distributed to, the Directors, Officers or other private persons, except that the Corporation is authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of its exempt purposes. No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in (including the publication or distribution of statements) any political campaign on behalf of or in opposition to any candidate for public office. The Corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from Federal income tax under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue Law) (the "Code") or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code (or the corresponding provision of any future United States Internal Revenue Law).

ARTICLE V
MEMBERS

The Members of the Corporation are Providence Ministries ("Providence"), an unincorporated association, and WHC.

ARTICLE VI
AMENDMENTS

The power to alter, amend or repeal the Articles of Incorporation and Bylaws of the Corporation shall be vested exclusively in the Members of the Corporation.

ARTICLE VII
DISSOLUTION

Upon dissolution of the Corporation, the Board of Directors shall, after paying or making provision for the payment of all of the liabilities of the Corporation, dispose of all of the assets of the Corporation to Providence Health & Services-Washington or to its designee, provided that such recipient entity is organized and operated exclusively for charitable, educational, religious or scientific purposes, and qualifies as an exempt organization under 501(c)(3) of the Code (or the corresponding provision of any future United States Internal Revenue Law). If, at the time of dissolution, Providence Health & Services-Washington is in not existence, is not an exempt organization under the Code, or makes no such designation, the Board of Directors shall dispose of all the corporate assets to Providence or its designee, provided that such recipient entity is still in

existence and is organized and operated exclusively for charitable, educational, religious or scientific purposes, and qualifies as an exempt organization under the Code. If, at the time of dissolution, Providence is not in existence, is not an exempt organization under the Code, or makes no such designation, the Board of Directors shall dispose of all the corporate assets to any other organization(s) selected by the Sisters of Providence, General Administration, Montreal, provided that each such recipient entity is organized and operated exclusively for charitable, educational, religious or scientific purposes and qualifies as an exempt organization under the Code.

ARTICLE VIII
RESTATED ARTICLES

These Restated Articles of Incorporation correctly set forth without change the provisions of the Articles of Incorporation of the Corporation as amended and these Restated Articles of Incorporation supersede the original Articles of Incorporation and all amendments thereto.

* * *

The foregoing Restated Articles of Incorporation of Providence Health & Services —Western Washington were adopted by its Member on January 10, 2012, to be effective on February 1, 2012.

IN WITNESS WHEREOF, the undersigned Secretary of the above named corporation has executed these Restated Articles of Incorporation.

Secretary

RESTATED BYLAWS
OF
PROVIDENCE HEALTH & SERVICES—WESTERN WASHINGTON

ARTICLE I
THE CORPORATION IN GENERAL

1.1 NAME AND DESCRIPTION. The name of the corporation shall be Providence Health & Services—Western Washington ("**Corporation**"). It is a nonprofit corporation organized and existing under the laws of the State of Washington. It is a Roman Catholic institution, sponsored by Providence Ministries.

1.2 PURPOSES. The purposes for which the Corporation has been formed are as follows:

1.2.1 To establish, operate, manage and maintain for charitable purposes, hospitals, nursing homes, and other health care, educational, and social service facilities and programs designed to meet the health, educational and social needs of all people;

1.2.2 To provide scientific research, educational, charitable and such other activities, services and programs related to its health care, educational and social service facilities and services;

1.2.3 To engage in other charitable works which are consistent with the objectives of the Corporation and the mission and values of the Providence Health & Services and Western HealthConnect, and guided by the tradition and charism of the Sisters of Providence, as appropriate; and

1.2.4 To do any and all other things in furtherance of these purposes which are consistent with the laws of the State of Washington, the Articles and Bylaws of Providence Health & Services and the Roman Catholic moral tradition as articulated in documents such as The Ethical and Religious Directives for Catholic Health Care Services.

1.3 LOCATION. The principal office of the Corporation shall be located at 1801 Lind Avenue SW #9016, Renton, Washington 98057-9016.

ARTICLE II
MEMBERS

2.1 MEMBERS. The Members of the Corporation are Providence Ministries ("**Providence**") and Western HealthConnect ("**Western HealthConnect**"). Upon

recommendations of the Board of Directors of the Corporation (the "**Board**"), the Members shall collaborate on the exercise of the reserved powers set forth in Sections 2.2 and 2.3.

2.2 POWERS OF WESTERN HEALTHCONNECT. The following powers are reserved to and exercised exclusively by Western HealthConnect, to be exercised consistent with the Affiliation Agreement among Providence Ministries, Providence Health & Services, Providence Health & Services- Washington, Corporation, Swedish Health Services, Swedish Edmonds and Western HealthConnect, dated February 1, 2012:

2.2.1 To amend or repeal the Articles of Incorporation or Bylaws;

2.2.2 To approve the acquisition of assets, the incurrence of indebtedness or the lease, sale, transfer, assignment, or encumbering of the assets;

2.2.3 To approve the dissolution, liquidation, consolidation or merger with another corporation or entity;

2.2.4 To approve the annual operating and capital budgets of the Corporation on a consolidated region-wide basis and recommend approval of the Corporation's budget by Providence; and

2.2.5 To appoint certified public accountants after receiving the recommendation of the Board of Directors, and to receive the annual audit report from such accountants.

2.3 POWERS OF PROVIDENCE. Notwithstanding the foregoing, the following powers are reserved to and exercised exclusively by Providence, to preserve the Catholic identity of the Corporation and ensure adherence to Catholic Church teaching and The Ethical and Religious Directives for Catholic Health Care Services:

2.3.1 To adopt or change the mission, philosophy, or values of the Corporation;

2.3.2 To amend the purposes section of, or language in, the Articles of Incorporation or Bylaws of the Corporation;

2.3.3 To approve the acquisition of assets, the incurrence of indebtedness, and the lease, sale, transfer, assignment or encumbering of the assets, if the amount involved in the transaction is in excess of an amount specified from time to time by resolution of Providence;

2.3.4 To approve the dissolution, liquidation, consolidation or merger with another corporation or entity, if the amount involved in the transaction is in excess of an amount specified from time to time by resolution of Providence;

2.3.5 To approve a consolidated system-wide operating and capital budget which includes the budget of the Corporation; and

2.3.6 To approve the initiation or closure of any major work (e.g., hospital or facility, or other entities delineated in the Hyperion database).

2.4 ACTION BY THE MEMBERS. The Members may exercise their rights by taking either of the following actions:

2.4.1 The governing body of each Member may act on that member's behalf in exercising the Member's rights with respect to the corporation. The manner in which the board of directors of each Member shall meet and conduct its affairs shall be governed by the applicable governing documents of the Member. The action of the governing body of the member may be communicated in writing to the Chairperson of the Board, President/Chief Executive Officer or Secretary of the Corporation by any reasonable means. Unless otherwise indicated by the Member, the action of a Member shall be deemed to have been taken at the time of passage of the resolution of the board of directors of the Member. Nothing in these Bylaws shall prevent the boards of directors of Members from holding a joint meeting.

(b) The governing body of each Member by resolution may appoint, but shall not be required to appoint, any officer of the Member to act on the member's behalf, and such authorization may be general or limited to specific instances. The officers of the member shall execute and deliver to the Chairperson of the Board, President/Chief Executive Officer or Secretary of the Corporation a written instrument or instruments setting forth the action taken and the applicable corporate authorizations or direction from the board of directors of the Member to such officers. The action of the Member shall be deemed to have been taken on the dates the written instruments are so delivered unless the instruments provide otherwise.

ARTICLE III
BOARD OF DIRECTORS OF THE CORPORATION

3.1 POWER OF THE BOARD OF DIRECTORS. The Board shall exercise general governance and control of the mission and business affairs of the Corporation and shall have and exercise all of the powers which may be exercised or performed by the Corporation under the laws of the State of Washington and these Bylaws, with due regard for the powers reserved to the Members of the Corporation as stated in Article II of these Bylaws.

3.2 COMPOSITION OF THE BOARD. The Board shall consist of the same individuals as those then currently serving on the Board of Directors of Providence Health & Services-Washington (each, a "**Director**"). The Board shall have a minimum of eight Directors, and no member of the Board shall be an employee of the Corporation. Appointment, term, and removal of a member of the Board of Directors from Providence Health & Services-Washington shall constitute appointment, term of office, and removal from such individual's service as a member of the Board of this Corporation. In the event a member of the Board of Directors of Providence Health & Services-Washington shall resign, such resignation shall automatically cause the resignation of such individual as a Director of this Corporation.

3.3 CHAIRPERSON OF THE BOARD. The Chairperson of the Board shall be the same individual then serving as Chairperson of the Board of Directors of Providence Health & Services-Washington. Such Chairperson of the Board of this Corporation shall serve in such capacity so long as such individual is serving as the Chairperson of the Board of Directors of Providence Health & Services-Washington.

3.4 ACTING CHAIR. Any individuals serving as the Acting Chair of the Board of Directors of Providence Health & Services-Washington shall also serve as the Acting Chair of this Corporation.

3.5 MEETINGS AND PROCEDURAL RULES.

3.5.1 Annual Meeting. The annual meeting of the Board shall be held by December 31 of each year. Such meeting shall be held at the principal office of the Corporation or at such place as may be designated from time to time by the Chairperson. The purposes of the annual meeting shall include, without limitation, electing officers as herein provided and transacting such other business as shall be necessary or desirable.

3.5.2 Regular Meetings of the Board. Regular meetings of the Board shall occur at least four (4) times a year at such time and place as the Directors shall provide by resolution.

3.5.3 Special Meetings of the Board. Special meetings of the Board may be called upon written request by the Member, two or more Directors, the Chairperson of the Board or the President/Chief Executive Officer.

3.5.4 Notice of Board Meetings. Written notice of all Board meetings shall be mailed by first class mail, personally delivered, or sent by electronic transmission pursuant to Section 18.5 to each Director at least five (5) days before the date of the meeting, which notice shall in the case of special meetings state the nature of the business to be taken up at the meeting. If mailed, such notice shall be deemed to be delivered when deposited in the U.S. Mail, postage prepaid, addressed to the Director at their address as it appears in the records of the Corporation.

3.5.5 Quorum. For all meetings of the Board (other than for action taken by unanimous written consent), a quorum shall be a simple majority of the Directors then serving unless a greater majority is required by law or by these Bylaws.

3.5.6 Action by Unanimous Written Consent. Waiver of notice of any Board meeting or any action required to be taken at a meeting of the Board, or any other action which may be taken at a meeting of the Board, may be taken without a meeting if a consent in writing, setting forth the actions so taken, is signed by all the Directors entitled to vote with respect to the subject matter thereof. Any consent signed by all the Directors shall have the same effect as a unanimous vote.

3.5.7 Telephonic Meetings. Directors may participate in and act at any meeting of such Board by means of conference telephone, videoconference or similar communication equipment by which all persons participating in the meeting can hear each other at the same time. Participation in such a meeting shall constitute presence in person at the meeting.

3.5.8 Voting. Voting on any question or in any election may be by voice, unless the individual presiding at the meeting shall order, or a Director shall demand, that voting be by ballot.

3.5.9 Manner of Acting. Each Director shall be entitled to one vote on all matters voted on at any meeting. Except as otherwise provided by law, the Articles of Incorporation, or these Bylaws, the act of a majority of the Directors present at the meeting at which a quorum is present shall be the act of the Board.

3.5.10 Compensation/Reimbursement of Directors. Directors may receive reasonable compensation for their services as Directors, as determined from time to time by the Member. Directors shall be reimbursed for reasonable expenses of attendance at meetings or when on other business of the Corporation.

3.5.11 Board Evaluation. Under the direction of the Governance Committee, the Board shall annually evaluate their performance.

3.6 PRESUMPTION OF ASSENT. Any Director who is present at a meeting of the Board at which action on any corporate matter is taken shall be conclusively presumed to have assented to the action taken unless (1) he/she abstains and his/her abstention is recorded in the minutes of the Corporation; (2) his/her dissent shall be entered in the minutes of the meeting; (3) he/she shall file his/her written dissent to such action with the person acting as the secretary of the meeting before the adjournment thereof; or (4) he/she shall forward such dissent by registered mail to the Secretary of the Corporation immediately after the adjournment of the meeting. The right to dissent shall not apply to a Director who voted in favor of an action.

ARTICLE IV
OFFICERS OF THE CORPORATION

4.1 OFFICERS. The officers of the Corporation shall be the President/Chief Executive Officer, one or more Vice President(s), a Secretary and a Treasurer and such other officers as may be elected from time to time by the Board. The powers and duties of the officers shall be as set forth in these Bylaws and as otherwise designated from time to time by the Board, to the extent consistent with law, the Articles of Incorporation of the Corporation and these Bylaws. Any number of offices may be held by the same person except that the Secretary may not serve concurrently as the President. The officers of this Corporation shall be the same individuals serving as the officers of Providence Health & Services-Washington. In the event such officer either resigns or is otherwise removed as an officer of Providence Health & Services-Washington, such officer's office with this Corporation shall automatically terminate as

of the effective date of their removal or resignation as an officer of Providence Health & Services-Washington.

4.2 PRESIDENT/CHIEF EXECUTIVE OFFICER. The President/Chief Executive Officer shall be the chief executive officer of the Corporation and shall be the direct executive representative of the Board in the management of the Corporation. The President/Chief Executive Officer shall have and exercise general management and supervision of the affairs of the Corporation, subject to the reserved powers of the Member and the direction of the Board.

4.3 VICE PRESIDENT(S). The Vice President(s) shall perform such duties as are established from time to time by the Board and shall report to the President/Chief Executive Officer. In all other matters, the Vice President(s) shall function in accordance with the specific powers which have been delegated to them by the Board and/or the President/Chief Executive Officer.

4.4 TREASURER. The Treasurer shall have general charge and responsibility relating to the financial concerns of the Corporation. The Treasurer shall perform such other duties and functions as may from time to time be designated by the Board, subject to the overall control of such Board. The Treasurer shall be responsible for causing an audited financial statement to be provided to the Member and to the Board at least annually.

4.5 SECRETARY. The Secretary shall be the custodian of and shall maintain the corporate books and records, the minutes of the meetings of the Board and assure that all required notices are duly given in accordance with these Bylaws, the Articles of Incorporation of the Corporation or as otherwise may be required by law. The Secretary shall, in general, perform all duties incident to the office of Secretary, subject to the control of the Board and shall do and perform such other duties as may be assigned from time to time by the Board.

4.6 ASSISTANT TREASURERS AND ASSISTANT SECRETARIES. The assistant treasurers and assistant secretaries shall perform such duties as shall be assigned to them by the Treasurer or Secretary, respectively, or by the President/Chief Executive Officer or the Board.

4.7 ADDITIONAL OFFICERS. The Board by resolution may create such additional and special offices as may be necessary or desirable in addition to those described herein and may by such resolution provide for the election by the Board of any person to perform the duties and exercise the authority of such office.

4.8 DELEGATION. The Board may delegate temporarily the powers and duties of any officer, in case of such officer's absence or for any other reason, to any other officer, and may authorize the delegation by an officer of any such officer's powers and duties to any agent or employee subject to the general supervision of such officer.

ARTICLE V
COMMITTEES OF THE BOARD

This Corporation shall have the same committees, committee members, and concurrent committee meetings with those committees established by Providence Health & Services-Washington. This Corporation's committees shall meet concurrently with the Providence Health & Services-Washington Board committees established pursuant to the Providence Health & Services-Washington Bylaws. The Board committee charters and other rules for functioning of such committees of this Corporation shall be identical to those of Providence Health & Services-Washington.

ARTICLE VI
MINISTRIES

The Corporation shall be organized into such ministries ("**Ministries**") as the Board may determine from time to time. As designated from time to time by the Board and the President/Chief Executive Officer, appropriate management ("**Designated Manager**") shall be responsible for the various Ministries. In such capacity, the Designated Manager shall have authority for carrying out the general administration and management of such Ministries in accordance with all applicable resolutions of the Board, policies of this Corporation or of Providence ("**System Policies**"), the Western HealthConnect Governance and Executive Management Authority and Shared Governance Accountability Matrix (the "**Matrix**") and the management reporting relationships that are in effect from time to time as determined by the President/Chief Executive Officer and the Board. In addition, the Designated Manager shall have authority to act on all matters relating to the medical staffs of the Ministries, subject to the authority delegated to the Community Ministry Board and further subject to the applicable medical staff bylaws and other System Policies and resolutions relating to medical staff relationships that may be in effect from time to time. Each Designated Manager shall be appointed in accordance with System Policies and the Matrix and shall be designated by such other title or designation as may be determined by the President/Chief Executive Officer.

ARTICLE VII
MEDICAL STAFF

7.1 MEDICAL STAFF. Each hospital owned and/or operated by this Corporation shall have a medical staff consisting of those licensed physicians, dentists and other independent licensed practitioners as the Board may permit in accordance with the provisions of applicable state law, accreditation standards and the provisions of the medical staff bylaws for each such hospital.

Each long term care facility or other health care facility or division of this Corporation shall establish necessary or appropriate policies, guidelines, procedures, or bylaws where applicable, as are appropriate for the institutional management and maintenance of quality patient care to be provided by licensed physicians, dentists or other independent licensed practitioners.

7.2 QUALIFICATIONS. Subject to any delegated authority pursuant to Section 7.5 and Section 8.2 hereof, the Board shall have final authority over appointments and reappointments of medical staff members, over the granting of and delineation of clinical and practice privileges, and over the revocation or other curtailment of medical staff membership and/or clinical or practice privileges. Each medical staff shall evaluate the professional competence and qualifications of applicants for appointment or reappointment and for the granting of clinical privileges, and shall make recommendations concerning the suitability of all such applicants. Each medical staff shall in like manner evaluate all cases where revocation, curtailment, suspension or other limitation of staff membership or privileges is being considered and shall recommend action to the administrator relating to such matter. The Board shall only take action on appointments, reappointments, revocations or curtailment of membership and/or privileges after receiving and considering the recommendation of the medical staff except in those cases where such recommendation is being unreasonably delayed or where quality of patient care concerns warrant summary or other immediate action. Designated management may be assigned authority to act on behalf of the Board consistent with these Bylaws, applicable System Policies and corporate resolutions and medical staff bylaws.

7.3 MEDICAL STAFF BYLAWS. Subject to approval of the Board, each medical staff is responsible for the development, adoption and periodic review and revision of medical staff bylaws, rules and regulations that are consistent with hospital and System Policies, Joint Commission standards, and applicable federal and state laws and regulations. Such bylaws shall define the organization of the medical staff and establish procedures for evaluations and recommendations concerning appointments, reappointments, revocation or curtailment of staff membership or privileges, procedures for formal and effective medical staff participation in formulating hospital policies and standards of patient care and such other matters as the medical staff and the hospital shall deem appropriate for inclusion in such medical staff bylaws, rules and regulations. The medical staff bylaws and any amendment thereto are subject to, and effective upon, approval by the Board.

No person shall be denied medical staff membership or clinical privileges in any institution of this Corporation on the basis of sex, race, creed, color or national origin or on the basis of any other criteria unrelated to professional competence, patient care, the purpose, needs and capabilities of the hospital and/or the community in which it is located or other criteria reasonably related to professional standards, hospital efficiency, or other appropriate criteria as may be established from time to time.

Medical staff bylaws shall include appropriate provisions requiring all members of the medical staff to conform to the Providence mission and core values and the Roman Catholic moral tradition as articulated in documents such as The Ethical and Religious Directives for Catholic Health Care Services as may be amended from time to time while such medical staff member is practicing in any hospital, health care facility, program or service operated by this Corporation.

7.4 RELATIONSHIP OF RESPONSIBILITIES OF BOARD OF DIRECTORS AND MEDICAL STAFF. The Board holds the medical staff accountable for the professional care practiced in each hospital. Each medical staff shall regularly review and analyze its clinical

experience and shall be responsible for participating in quality management activities as mandated from time to time by the Joint Commission or other state licensing bodies of healthcare organizations, by applicable laws and regulations, by the medical staff bylaws, by System Policies and procedures and by this Board. Adequate, accurate and timely medical records shall be prepared and maintained for all patients. A report of the results of the quality review and analysis shall be regularly submitted to the Board in accordance with System policy and in a manner designed to assure maximum protection under applicable provisions of state law regarding the confidentiality of quality assurance and peer review information.

7.5 DELEGATION OF MEDICAL STAFF AUTHORITY. The Board may, from time to time, delegate its authority with respect to medical staff matters as provided for in Section 8.2 of these Bylaws to the Community Ministry Boards. In such event, the Community Ministry Boards shall have all authority of the Board as stated in these Bylaws with respect to medical staff matters and shall function as the governing body of this Corporation for such matters, consistent with applicable requirements of federal and state laws and regulations, meeting Medicare conditions of participation requirements, and fulfilling compliance with the Joint Commission's requirements.

ARTICLE VIII
SHARED GOVERNANCE

8.1 COMMUNITY MINISTRY BOARDS. This Corporation shares governance with its Community Ministry Boards as set forth in the Community Ministry Board Bylaws, as approved by the Board. Each of the Corporation's Ministries, as determined appropriate by the Board shall establish a Community Ministry Board to assist, consult with and advise management and this Corporation. The Community Ministry Board Bylaws shall be uniform for all Providence Ministries.

8.2 DELEGATED AUTHORITY. The Board of Directors may, from time to time, delegate certain Board responsibilities to the Community Ministry Boards as set forth in the Community Ministry Board Bylaws or by policy. In matters that have been delegated by the Board to the Community Ministry Boards, the Community Ministry Boards shall have full authority and be accountable to the Board with respect to the matters delegated and shall serve as the governing body of the Corporation's Ministries for fulfilling such delegated responsibilities consistent with applicable federal and state laws and regulations, meeting Medicare conditions of participation requirements, and fulfilling compliance with the Joint Commission.

8.3 ADVICE AND COUNSEL. The Community Ministry Board is responsible, as set forth in the Community Board Bylaws, for providing advice, counsel and direction to this Corporation for the Ministries for which it is accountable.

ARTICLE IX
VOTING UPON STOCK OF OTHER CORPORATIONS

Subject to the reserved rights set forth in Section 2.2, and unless otherwise ordered by the Board and subject to the direction, if any, given by the Board, any officer of this Corporation

shall have full power and authority on behalf of the Corporation to vote either in person or by proxy at any meeting of stockholders of any corporation in which this Corporation may hold stock or otherwise have an opportunity to vote, and at such meeting may possess and exercise all the rights and powers incident to the ownership of such stock or membership which, as the owner thereof, this Corporation might have possessed and exercised if present.

ARTICLE X
DUALITY OF INTEREST

Any Member, Director, officer, employee, Community Board member or committee member having an interest in a transaction, contract or other matter presented to the Board or a committee thereof for authorization, approval or ratification shall provide prompt, full and frank disclosure of his or her interest to the Board or committee prior to its acting on such contract or transaction. The body to which such disclosure is made shall determine, by a majority vote, whether a duality or conflict of interest exists or can reasonably be construed to exist. If a conflict is deemed to exist, such person shall not vote on, nor use his or her personal influence on, nor participate (other than to present factual information or to respond to questions) in the discussions or deliberations with respect to, such contract or transactions. Such person may be counted in determining the existence of a quorum at any meeting where the contract or transaction is under discussion or is being voted upon. The minutes of the meeting shall reflect the disclosure made, the vote thereon and, where applicable, the abstention from voting and participation, and whether a quorum is present. This Corporation may also adopt policies from time to time more clearly setting forth any requirements regarding disclosure and actions relating to duality or conflicts of interest.

ARTICLE XI
INDEMNIFICATION

11.1 DEFINITIONS. For the purposes of this Article XI:

11.1.1 "**Director**" means an individual who is or was a Director of the Corporation or an individual who, while a Director of the Corporation, is or was serving at the Corporation's request as a Director, officer, partner, trustee, employee, or agent of another foreign or domestic corporation, partnership, joint venture, trust, employee benefit plans, or other enterprise. A Director is considered to be serving an employee benefit plan at the Corporation's request if the Director's duties to the Corporation also impose duties on, or otherwise involve services by, the Director to the plan or to participants in or beneficiaries of the plan. "Director" includes, unless the context requires otherwise, the estate or personal representative of a Director.

11.1.2 "**Liability**" means the obligation to pay a judgment, settlement, penalty or fine, including an excise tax assessment with respect to an employee benefit plan, or reasonable expenses incurred with respect to a proceeding.

11.1.3 "**Official Capacity**" means:

(i) when used with respect to a Director, the office of Director in the Corporation; and

(ii) when used with respect to an officer, the elective or appointive office in the Corporation held by that individual.

11.1.4 "**Proceeding**" means any threatened, pending, or completed action, suit, or proceeding, whether civil, criminal, administrative, or investigative and whether formal or informal.

11.2 ACTION NOT BY OR IN THE RIGHT OF THE CORPORATION. The Corporation shall indemnify any Director or officer who was or is a party or is threatened to be made a party to any proceeding (other than an action by or in the right of the Corporation) by reason of the fact that he/she is or was a Director or officer of the Corporation against judgments, penalties, fines, settlements and reasonable expenses, including attorneys' fees, actually and reasonably incurred by the Director or officer in connection with the proceeding if he/she conducted himself/herself in good faith and:

11.2.1 in the case of conduct in his/her own official capacity with the Corporation, he/she reasonably believed his/her conduct to be in the Corporation's best interests; or

11.2.2 in all other cases, he/she reasonably believed his/her conduct to be at least not opposed to the Corporation's best interests; and

11.2.3 in the case of any criminal proceeding, he/she had no reasonable cause to believe his/her conduct was unlawful.

The termination of any proceeding by judgment, order, settlement, conviction, or upon a plea of nolo contendere or its equivalent, shall not, of itself, be determinative that the Director or officer did not meet the requisite standard of conduct set forth in this Section 11.2.

11.3 ACTION BY OR IN THE RIGHT OF THE CORPORATION. The Corporation shall indemnify any Director or officer who was or is a party or is threatened to be made a party to any proceeding by or in the right of the Corporation by reason of the fact that he/she is or was a Director or officer of the Corporation against reasonable expenses, including attorneys' fees, actually and reasonably incurred by him/her in connection with such proceeding if he/she conducted himself/herself in good faith and:

11.3.1 in the case of conduct in his/her official capacity with the Corporation, he/she reasonably believed his/her conduct to be in the Corporation's best interests; or

11.3.2 in all other cases, he/she reasonably believed his/her conduct to be at least not opposed to the Corporation's best interests, provided that no indemnification shall be made pursuant to this Section 11.3 in respect of any proceeding in which such person shall have been adjudged to be liable to the Corporation.

11.4 LIMITATION ON INDEMNIFICATION. A Director or officer shall not be indemnified under this Article in respect of any proceeding, whether or not involving action in his/her official capacity, in which he/she shall have been adjudged to be liable on the basis that the Director or officer personally received a benefit in money, property, or services to which the Director or officer was not legally entitled.

11.5 EXPENSES IF SUCCESSFUL. To the extent that the Director or officer of the Corporation has been successful on the merits or otherwise in the defense of any proceeding referred to in this Article, he/she shall be indemnified against reasonable expenses, including attorneys' fees, incurred by him/her in connection with the proceeding. The Corporation shall provide notice to the Member prior to such indemnification.

11.6 AUTHORIZATION. No indemnification shall be made by the Corporation unless authorized in the specific case upon a determination that the indemnification of the Director or officer is permissible in the circumstances because he/she has met the applicable standard of conduct set forth in this Article. Such determination shall be made: (a) by the Board by a majority vote of a quorum consisting of Directors not at the time parties to the proceeding; (b) if a quorum is unobtainable, by majority vote of a committee duly designated by the Board, in which designation Directors who are parties may participate, consisting solely of two or more Directors not at the time parties to the proceeding; (c) in a written opinion by legal counsel (other than an attorney or a firm having associated with it an attorney, who has been retained by or who has performed services within the past three (3) years for the Corporation or any party to be indemnified) selected by the Board or a committee thereof by vote as set forth in (a) or (b) of this Section; or (d) by the Member.

11.7 ADVANCE PAYMENT. Reasonable expenses incurred in defending a proceeding may be paid by the Corporation in advance of final disposition of the proceeding: (a) upon receipt by the Corporation of a written undertaking by or on behalf of the Director or officer to repay such amount if it shall ultimately be determined that the Director or officer has not met the standard of conduct necessary for indemnification by the Corporation as authorized by this Article; and (b) upon receipt by the Corporation of a written affirmation by the Director or officer of his/her good faith belief that he/she has met the standard of conduct necessary for indemnification by the Corporation as authorized in this Article.

11.8 INSURANCE. The Corporation shall have the power to purchase and maintain insurance on behalf of an individual who is or was a Director or officer of the Corporation or who, while a Director or officer of the Corporation, is or was serving at the request of the Corporation as a Director, officer, partner, trustee, employee, or agent of another foreign or domestic corporation, partnership, joint venture, trust, employee benefit plan, or other enterprise, against liabilities asserted against or incurred by the individual in that capacity or arising from the individual's status as a Director, officer, employee, or agent, whether or not the Corporation would have the power to indemnify the individual against the same liability under these Bylaws or the Washington Nonprofit Corporation Act.

11.9 NONEXCLUSIVITY. The indemnification and advancement of expenses provided by, or granted pursuant to this Article of these Bylaws shall not be deemed exclusive of any other rights to which any present or former Director or officer of the Corporation may be entitled by contract, policy or otherwise under applicable law.

11.10 PERMISSIVE INDEMNIFICATION. The Board may establish policies to indemnify members of the medical staff, community boards, employees and others providing service to the Corporation.

11.11 WASHINGTON LAW. Notwithstanding the indemnification provided under this Article of the Bylaws, indemnification to any person by the Corporation shall only occur in compliance with the Washington Nonprofit Corporation Act.

ARTICLE XII
FISCAL YEAR

The fiscal year of this Corporation shall commence on January 1 and end on December 31 of each year.

ARTICLE XIII
PROHIBITION AGAINST SHARING IN CORPORATE EARNINGS

No Member, Director, officer, employee, committee member or other person connected or affiliated with this Corporation, and no other private individual, shall receive at any time any of the net earnings or pecuniary profit from the operations of this Corporation, provided that this Corporation shall not prevent the payment to any such person of such reasonable compensation for services rendered to or for this Corporation in effecting any of its purposes as such compensation shall be fixed by the Board; and no such person or persons shall possess any proprietary right in or to the property of this Corporation or be entitled to share in the distribution of any of the corporate assets upon dissolution of this Corporation.

ARTICLE XIV
DISSOLUTION OF THE CORPORATION

Upon dissolution of the Corporation, the Board shall, after paying or making provision for the payment of all of the liabilities of the Corporation, dispose of all of the assets of the Corporation to Providence Health & Services-Washington or to its designee, provided that such recipient entity is organized and operated exclusively for charitable, educational, religious or scientific purposes, and qualifies as an exempt organization under 501(c)(3) of the Internal Revenue Code ("**Code**") (or the corresponding provision of any future United States Internal Revenue Law). If, at the time of dissolution, Providence Health & Services-Washington is in not existence, is not an exempt organization under the Code, or makes no such designation, the Board shall dispose of all the corporate assets to Providence Ministries or its designee, provided that such recipient entity is still in existence and is organized and operated exclusively for charitable, educational, religious or scientific purposes, and qualifies as an exempt organization

under the Code. If, at the time of dissolution, Providence Ministries is not in existence, is not an exempt organization under the Code, or makes no such designation, the Board shall dispose of all the corporate assets to any other organization(s) selected by the Sisters of Providence, General Administration, Montreal, provided that each such recipient entity is organized and operated exclusively for charitable, educational, religious or scientific purposes and qualifies as an exempt organization under the Code.

ARTICLE XV
INVESTMENTS

Except as otherwise provided in the Articles of Incorporation of the Corporation, this Corporation shall have the right to retain all or any part of any securities or property acquired by it in whatever manner, and to invest and reinvest any funds held by it, according to the judgment of the Board.

ARTICLE XVI
EXEMPT ACTIVITIES

Notwithstanding any other provisions of these Bylaws, no Member, Director, officer, employee or agent of this Corporation shall take any action or carry out any activity by or on behalf of the Corporation not permitted to be taken or carried on without penalty by an organization exempt from federal taxation as now exists or as may hereafter be amended.

ARTICLE XVII
AMENDMENTS

No amendment of these Bylaws shall be effective without the approval of the Members. In addition, the Board shall regularly review these Bylaws and recommend any revisions to these Bylaws to conform to applicable requirements of state or federal law and/or accreditation standards.

ARTICLE XVIII
MISCELLANEOUS PROVISIONS

18.1 DEPOSITORIES. All funds of the Corporation not otherwise employed shall be deposited from time to time to the credit of the Corporation in such banks, financial institutions, mutual funds or other depositories as the Board may designate.

18.2 CHECKS. All checks, drafts, or other orders for the payment of money issued in the name of the Corporation shall be signed by such officer or officers or person or persons (whether or not officers of Corporation) in such manner as shall from time to time be determined by the Board.

18.3 CONTRACTS AND INSTRUMENTS. Subject to any limitations contained in these Bylaws or by resolution of the Board, all deeds, mortgages, bonds and other contracts or

instruments of the Corporation shall be signed on behalf of this Corporation by the President/Chief Executive Officer or any other officer.

18.4 AGENTS AND REPRESENTATIVES. The Board may appoint such agents and representatives of the Corporation with such powers and with the authority to perform such acts or duties on behalf of the Corporation as the Board may deem appropriate, consistent with these Bylaws, the Articles of Incorporation of the Corporation and applicable law.

18.5 ELECTRONIC COMMUNICATIONS. To the fullest extent permitted by law, the Members, Board and Board Committees may utilize electronic communications such as e-mail, faxes and other electronic communications for purposes of distributing notices of meetings, voting by ballot or otherwise, executing unanimous written consents as otherwise authorized by these Bylaws, and for all other legitimate purposes of communicating.

* * * * *

Dated this 26th day of January, 2012 to be effective on February 1, 2012.

ATTEST:

Secretary of the Corporation

FILED
SECRETARY OF STATE

JAN 27 2012

STATE OF WASHINGTON

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RESTATED ARTICLES OF INCORPORATION OF SWEDISH HEALTH SERVICES

Pursuant to the provisions of the Nonprofit Corporation Act, RCW 24.03.183, the following Restated Articles of Incorporation of Swedish Health Services are submitted for filing.

ARTICLE I.
NAME

The name of the corporation (the "Corporation") is Swedish Health Services.

ARTICLE II.
DURATION

The Corporation has perpetual existence.

ARTICLE III.
PURPOSE

The Corporation is organized and shall be operated exclusively for charitable, scientific or educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue Law (the "Internal Revenue Code")). In furtherance of such purposes, the Corporation may:

1. Establish and maintain institutions which provide comprehensive health services; provide medical educational programs; encourage research and ways to save human life, minimize human suffering, and improve health services; and mobilize all community support and resources to serve the comprehensive health needs of the Corporation's community.

2. Erect, maintain and operate public charitable hospitals, nursing homes, homes for the aged, diagnostic facilities, physician clinics and other ambulatory care facilities, medical research and educational centers, and such other buildings and facilities as may be considered by the Board of Trustees of the Corporation appropriate and likely to contribute directly or indirectly to health care, education and research.

3. Purchase, own, sell, convey, assign, mortgage or lease any interest in real estate and personal property, and construct, maintain and operate improvements thereon, as necessary or incident to carrying out the lawful business activities of the Corporation.

4. Borrow or loan money and issue evidences of indebtedness in furtherance of any or all of the objects of its business, and secure the same by mortgage, pledge or other lien on the Corporation's property.

5. Raise funds from the public and from all other sources available, receive and maintain such funds; and expend principal and income therefrom in furtherance of these projects.

6. Contract with other organizations, both for-profit and not-for-profit, with individuals, and with governmental agencies in furtherance of these purposes.

7. Establish deferred compensation plans, pension plans, and other incentive plans for its trustees, officers and employees and make the payments provided for therein.

8. Be a promoter, partner, member, associate or manager of any partnership, joint venture or other enterprise.

9. Make donations for the public welfare or for charitable, scientific or educational purposes, including the making of such donations to organizations that are exempt from federal income tax under Code Section 501(c)(3).

10. Otherwise operate exclusively for charitable, educational, or scientific purposes, including, for such purposes, the making of distributions to organizations that qualify as exempt organizations under section 501(c)(3) of the Internal Revenue Code of 1986 (the "Code"), as amended, or the corresponding section of any future federal tax code; and

11. Engage in any other lawful business activity whatsoever which may hereafter from time to time be authorized by the Board of Trustees; provided, however, that the purposes for which the Corporation is formed shall at all times comply with Section 501(c)(3) of the Code.

ARTICLE IV.
POWERS

The Corporation shall have the power to take any lawful action necessary, appropriate or desirable to carry out its purposes consistent with the Washington Nonprofit Corporation Act, Chapter 24.03 RCW (the "Act") and Sections 501(c)(3) and 170(c)(2) of the Code.

ARTICLE V.
PROHIBITED ACTIVITIES

1. The Corporation shall not:

(a) have or issue shares of stock;

(b) make any disbursement of income to its trustees, officers or other private persons, (this Article V, Section 1(b) shall not be construed to prohibit the making of donations as provided for in Article III, Section 9);

(c) loan money or credit to its officers or trustees; or

(d) engage in any other activity which is prohibited under the Washington Nonprofit Corporation Act, as it may be amended.

2. No substantial part of the activities of this Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation. The Corporation shall not participate in, or intervene in (including the publication or distribution of statements), any political campaign on behalf of or in opposition to any candidate for public office.

3. Notwithstanding any other provision of these articles, the Corporation shall not carry on any activities not permitted to be carried on (a) by a corporation exempt from federal income tax under section 501(c)(3) of the Code, or (b) by a corporation, contributions to which are deductible under section 170(c)(2) of the Code.

ARTICLE VI.
REGISTERED OFFICE

The address of the registered office of the Corporation is 4104 Bank of California Center, Seattle, Washington 98164, and the name of the registered agent at such address is John Ludwick, Esq.

ARTICLE VII.
DIRECTORS

The Corporation shall be governed by a Board of Directors, who are vested with the power and authority of a "board of directors," as defined in RCW 24.03.005(7) (its members are referred to herein as "directors" or "trustees"). The powers of the directors, the number and categories of directors, their term of office, the manner of election and removal of directors, and meetings of directors shall be as provided in the Bylaws of the Corporation.

ARTICLE VIII.
MEMBERS

Western HealthConnect, a Washington nonprofit corporation, is the sole corporate member of the Corporation.

ARTICLE IX.
LIMITATION ON LIABILITY OF TRUSTEES

No trustee of the Corporation shall be personally liable to the Corporation or its members for monetary damages for his or her conduct as a trustee, which conduct takes place on or after the date this Article becomes effective, except for (i) acts or omissions that involve intentional misconduct or a knowing violation of law by the trustee, (ii) voting or assenting to distributions by the Corporation in violation of these Articles, or (iii) any transaction from which the trustee will personally receive a benefit in money, property or services to which the trustee is not legally entitled. If, after this Article becomes effective, the Washington Nonprofit Corporation Act (Title 24 RCW) is amended to authorize corporate action further eliminating or limiting the personal liability of trustees, then the liability of a trustee of the Corporation shall be deemed eliminated or limited to the fullest extent permitted by the Washington Nonprofit Corporation Act, as so amended. Any amendment to or repeal of this Article shall not adversely affect any right or protection of a trustee of the Corporation for or with respect to any acts or omissions of such trustee occurring prior to such amendment or repeal. This provision shall not eliminate or

limit the liability of a trustee for any act or omission occurring prior to the date this Article becomes effective.

ARTICLE X.
INDEMNIFICATION OF OFFICERS, TRUSTEES, EMPLOYEES AND AGENTS

The Corporation shall indemnify its officers, trustees, employees and/or agents from acts or omissions related to their service to the Corporation as provided in the bylaws of the Corporation.

ARTICLE XI.
DISTRIBUTION OF EARNINGS

No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, its trustees, officers or other private persons, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered, make reimbursement for reasonable expenses incurred in its behalf, and to make payments and distributions in furtherance of the purposes stated in Article III hereof.

ARTICLE XII.
DISTRIBUTION UPON DISSOLUTION

Upon the dissolution of the Corporation, all of its assets remaining after payment of creditors shall be distributed to the Member, or if the member is not qualified as exempt from taxation under the provisions of Section 501(a) and 501(c)(3) of the Code, to an organization or organizations selected by the Board of Directors, in accordance with a plan of distribution or otherwise, consistent with Chapter 24.03 RCW, provided that such organization or organizations are qualified as exempt from taxation under the provisions of Sections 501(a) and 501(c)(3) of the Code. Any assets not so disposed of shall be disposed of by a court of competent jurisdiction of the county in which the principal office of the Corporation is then located, exclusively for purposes consistent with the purposes of the Corporation, or to such organizations as said court shall determine, which are organized and operated exclusively for such purposes.

ARTICLE XIII.
AMENDMENT OF ARTICLES AND BYLAWS

No amendment of these Articles of Incorporation or the Bylaws shall be effective without the approval of the Member.

These Restated Articles of Incorporation correctly set forth without change the provisions of the Articles of Incorporation as heretofore amended. These Restated Articles of Incorporation supersede the original Articles of Incorporation and all amendments and previous restatements thereto.

IN WITNESS WHEREOF, the Corporation has caused these Restated Articles of Incorporation to be effective this 15th day of February, 2012.

SWEDISH HEALTH SERVICES

By: Cindy Strauss
Its: VP/Secretary

S:\Legal\DeptShare\Legal Department\Key Corporate Documents\Corporate Documents\SHSarticles Restated 011212.doc

FILED
SECRETARY OF STATE
JAN 27 2012
STATE OF WASHINGTON

01/27/12 2109828-004
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id: 2249976

RESTATED ARTICLES OF INCORPORATION OF SWEDISH EDMONDS

Pursuant to the provisions of the Nonprofit Corporation Act, RCW 24.03.183, the following Restated Articles of Incorporation of Swedish Edmonds are submitted for filing.

ARTICLE I
NAME

The name of the Corporation is SWEDISH EDMONDS.

ARTICLE II
PLACE OF BUSINESS

The principal place of business of this Corporation shall be 21601 76th Avenue W., Edmonds, WA 98206.

ARTICLE III
PURPOSES AND POWERS

Section 1. Purposes. This Corporation is formed exclusively for charitable, scientific, and educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code") or any successor provision, and exclusively for the benefit of, to perform the functions of or to carry out the purposes of, any Member that is exempt from federal income tax under Section 501(c)(3) of the Code. Without limiting the generality of the foregoing, the Corporation is formed to engage in the following:

(a) To operate a public charitable hospital, diagnostic facilities, physician clinics and such other buildings and facilities as may be considered by the Corporation to contribute directly or indirectly to health care, education and research;

(b) To establish and maintain institutions which provide comprehensive health services; provide medical educational programs; encourage research and ways to save human life, minimize human suffering, and improve health services; and mobilize all community support and resources to serve the comprehensive health needs of the Corporation's community;

(c) To purchase, own, sell, convey, assign, mortgage or lease any interest in real estate and personal property, and construct, maintain and operate improvements thereon, as necessary or incident to carrying out the lawful business activities of the Corporation.

(d) To do any and all lawful activities which may be necessary, useful or desirable for the furtherance, accomplishment, fostering or attainment of the foregoing purposes,

either directly or indirectly and either alone or in conjunction or cooperation with others, whether such others be persons or organizations of any kind or nature, such as corporations, firms, associations, trusts, institutions, foundations, or governmental bureaus, departments, or agencies, provided, however, that the purposes for which the Corporation is formed shall at all times be consistent with Section 501(c)(3) of the Code, as it now exists or as hereafter amended, including within such purposes the making of distributions to organizations that qualify as exempt organizations under Section 501(c)(3) of the Code.

Section 2. Powers. The powers of this Corporation shall be those powers granted by the Washington Nonprofit Corporation Act, as amended, including any additional powers granted by amendments to said act after formation of this Corporation.

ARTICLE IV
REGISTERED OFFICE AND AGENT

The address of the initial registered office of this corporation is 1700 Seventh Avenue, Suite 1900, Seattle, Washington 98101, and the name of its initial registered agent at such address is BB&L Corporate Services, Inc. The written consent of such person to serve as registered agent is attached hereto.

ARTICLE V
DIRECTORS

The Corporation shall be governed by a Board of Directors, who are vested with the power and authority of a "board of directors," as defined by RCW 24.03.005(7) (its members are referred to herein as "directors" or "trustees"). The powers of the directors, the number and categories of directors, their term of office, the manner of election and removal of directors, and meetings of directors shall be as provided in the Bylaws of the Corporation.

ARTICLE VI
BYLAWS

No amendment of the Bylaws shall be effective without the approval of the Member.

ARTICLE VII
PROHIBITED ACTIVITY

Notwithstanding any other provision of these Articles of Incorporation, the Corporation shall not conduct or carry on activities not permitted to be conducted or carried on by an organization exempt from federal taxation under Section 501(c)(3) of the Code or by an organization contributions to which are deductible under Section 170(c)(2) of the Code. No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, its

members (if any), Trustees, officers, or other private persons, except that the Corporation is authorized or empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of its purposes. The Corporation shall not have or issue shares of stock and shall not make any other disbursement or any loans to its members, Trustees or officers. No substantial part of the activities of the Corporation shall be devoted to the carrying on of propaganda or otherwise attempting to influence legislation, except as permitted by the Code, and the Corporation shall not participate, or intervene in (including publication or distribution of statements) any political campaign on behalf of or in opposition to any candidate for public office.

During any period of time in which the Corporation is deemed to be a private foundation as defined in Section 509 of the Code, anything contained in this certificate notwithstanding, the Corporation is prohibited from engaging in any act of self-dealing (as defined in Section 4941(d) of the Code) that would subject the Corporation to tax under Section 4941 of the Code; from retaining any excess business holdings (as defined in Section 4943(c) of the Code) in such manner as to subject the Corporation to tax under Section 4943 of the Code; from making any investments in such manner as to subject the Corporation to tax under Section 4944 of the Code; from making any taxable expenditures (as defined in Section 4945(d) of the Code) which would subject the Corporation to tax under Section 4945 of the Code; the income of the Corporation for each taxable year shall be distributed at such time and in such manner as not to subject the Corporation to tax under Section 4942 of the Code.

ARTICLE VIII
MEMBERSHIP

Western HealthConnect, a Washington nonprofit corporation, is the sole corporate member of the Corporation.

ARTICLE IX
EXISTENCE

The duration of the Corporation shall be perpetual.

ARTICLE X
LIMITATION OF TRUSTEE'S LIABILITY

A Trustee shall have no liability to the Corporation or its members for monetary damages for conduct as a Trustee, except for acts or omissions that involve intentional misconduct by the Trustee, or a knowing violation of law by the Trustee, or for any transaction from which the Trustee will personally receive a benefit in money, property or services to which the Trustee is not legally entitled. If the Washington Nonprofit Corporation Act is hereafter amended to authorize corporate action further eliminating or limiting the personal liability of Trustees, then the liability of a Trustee shall be eliminated or limited to the full extent permitted by the

Washington Nonprofit Corporation Act, as so amended. Any repeal or modification of this Article shall not adversely affect any right or protection of a Trustee of the Corporation existing at the time of such repeal or modification for or with respect to an act or omission of such Trustee occurring prior to such repeal or modification.

ARTICLE XII
INDEMNIFICATION OF OFFICERS, TRUSTEES, EMPLOYEES AND AGENTS

The Corporation shall indemnify its officers, Trustees, employees and agents from acts or omissions related to their service to the Corporation as provided in the Bylaws of the Corporation.

ARTICLE XII
DISTRIBUTIONS UPON DISSOLUTION

Upon the dissolution of the Corporation, all of its assets remaining after payment of creditors shall be distributed first to its Member; provided that if the Member should then not be an organization exempt from taxation under the provisions of Section 501(c)(3) of the Code, then the distribution shall be made to a governmental entity or any nonprofit fund, foundation, or corporation that is organized and duly operated exclusively for charitable, educational, religious scientific or literary purposes, and that at that time qualifies for tax exempt status under Section 501(c)(3) of the Code, as determined by the Corporation's board of directors (the "Board"), in accordance with a plan of distribution or otherwise, consistent with Chapter 24.03 RCW. Any assets not so disposed of shall be disposed of by a court of competent jurisdiction of the county in which the principal office of the Corporation is then located, exclusively for purposes consistent with the purposes of the Corporation, or to such organizations as said court shall determine, which are organized and operated exclusively for such purposes.

ARTICLE XIII
INCORPORATOR

The name and address of the incorporator is:

Name	Address
Calvin K. Knight	747 Broadway, Seattle WA 98122-4307

ARTICLE XIV
AMENDMENTS

These Articles of Incorporation may be amended as allowed by the Washington Nonprofit Corporation Act; provided that no amendment may be made unless ratified and approved in the manner provided for in the Bylaws of the Corporation.

These Restated Articles of Incorporation correctly set forth without change the provisions of the Articles of Incorporation as heretofore amended. These Restated Articles of Incorporation supersede the original Articles of Incorporation and all amendments thereto.

IN WITNESS WHEREOF, the Corporation has caused these Restated Articles of Incorporation to be effective this 1st day of February, 2012.

SWEDISH EDMONDS

By: Cindy Strauss
Its: VP / Secretary

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APPENDIX D

handout from Providence / Swedish vice president Andy Cosentino
at 5 March 2015 CAC meeting

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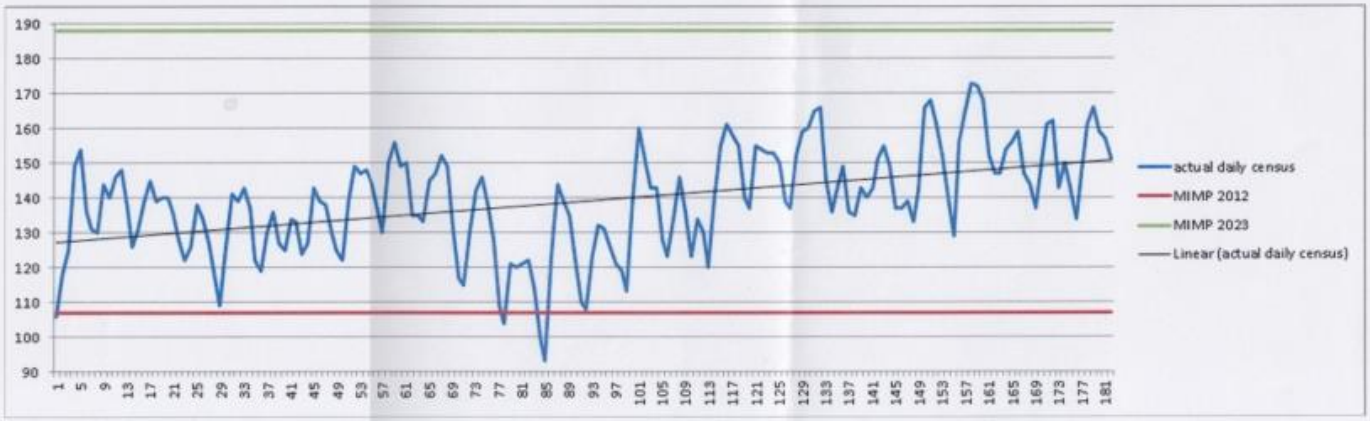
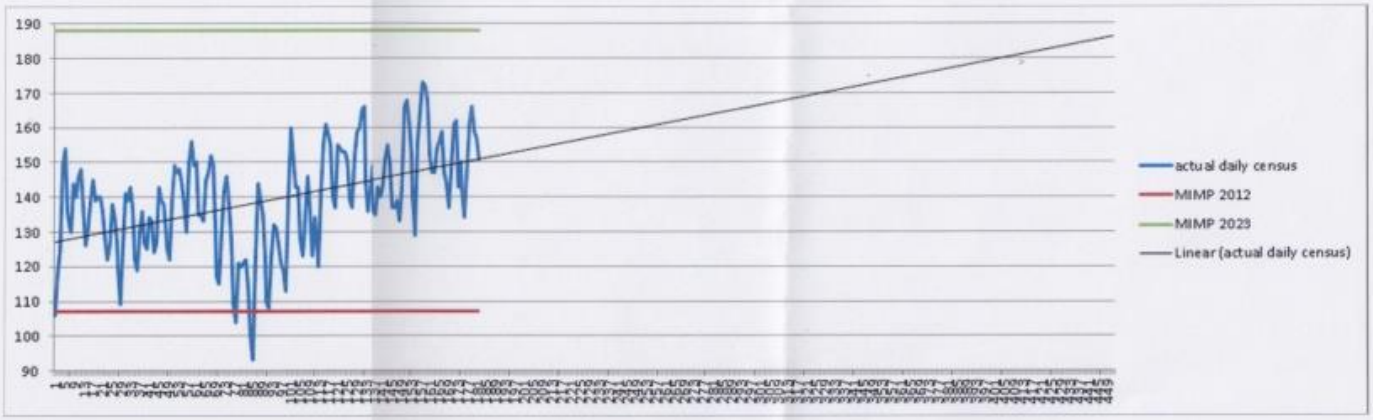
Swedish Cherry Hill: Current Census compared to Final MIMP Bed Need Projections



Actual census for past 180 days compared to 2012 & 2023 MIMP targets



Actual census trend compared to 2023 MIMP targets: Approaching 2023 target (188) in 9 months

APPENDIX C

email message from Providence / Swedish vice president Andy Cosentino
to CAC chair Katie Porter, 27 February 2015

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From: Cosentino, Andy [Andy.Cosentino@swedish.org]
Sent: Friday, February 27, 2015 2:57 PM
To: Katie Porter
Cc: Steve Sheppard (Steve.Sheppard@Seattle.Gov)
Subject: Response to last night's question regarding sq. footage / bed, and benchmarks

Katie, Below is a grid, with the hospitals we used to test sq. footage /bed. Our consultant, based on her experience and expertise identified 3,500 ft / bed as a target appropriate for our population and acuity. Please call if you have any questions.

Volumes/Key Indicators				**% inc**		sq / key indicator				2040 Alt 8	2023 Projected	2040 Projected
	2012	**2023**	**2040**	**2012 - 40**		2012	2040	Benchmark	Alt 8 benchmrk		w/ benchmk	w/ benchmk
Beds	196	290	385	96%		2,762	3,508	3500	3500	1,346,900	1,013,921	1,346,900
						Hospital Benchmarks: BGSF			Source:			
						Prov Everett Colby		2,833	VMMC MIMP/ZGF			
						Swedish Issaquah		3,142	VMMC MIMP/Collins Woerman			
						Seattle Children's		3,500	VMMC MIMP/ZGF			
						Virginia Mason		2,492	VMMC MIMP			
						MCLNO		3,437	Program/NBBJ			
						St Joes Exempla		2,259	Program/KSA & NBBJ			
						NIH Replacement Hosp		3,480	ZGF/NBBJ			
						UCSF Mission Bay		3,038	A&A/Stantac			

						Children's Mem - Chicago		3,994	ZGF			
						Children's Denver		4,444	ZGF			
						LA Co/USC Med Cen		2,500	HOK			
						Parkview Reg Med Cen		3,697	HKS			
						Cap. Health Med Cen, NJ		2,516	HKS			

Andy Cosentino PT, MBA, FACHE

Vice President, Swedish Neuroscience Institute

550 17th Ave, Suite 500

Seattle, Wa. 98122

Office (206) 320-3584

Mobile (520) 481-8981

APPENDIX B

follow-up letter from Squire Park neighbors
to Providence / Swedish vice president Andy Cosentino,
26 February 2015

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c/o Jack Hanson
209 22nd Ave S Apt 32
Seattle, WA 98144
jackhanso@gmail.com

26 February 2015

Andy Cosentino
Vice President, Swedish Neuroscience Institute
Providence Health and Services / Swedish Health Services
550 17th Avenue, Suite 500
Seattle, WA 98122
andy.cosentino@swedish.org

sent via *email and delivered by hand at 26 February 2015 CAC meeting*

Mr. Cosentino –

On 5 February 2015, 16 concerned residents of the Squire Park neighborhood (including me) wrote to you requesting information about the space need projections that Providence Health and Services / Swedish Health Services (Providence / Swedish) included in its proposed new major institution master plan for the Cherry Hill campus.

As of today – three weeks later – we have received no information from Providence / Swedish responsive to our request.

(We did receive, from Steve Sheppard at the City of Seattle Department of Neighborhoods, a file that you sent to the Citizens Advisory Committee (CAC) after CAC members echoed our request for information. However, the file that you forwarded to Sheppard is nothing new – it is not responsive to our request for detailed information about the specific calculations and growth estimates, forecasting assumptions and methods that Providence / Swedish used to arrive at its space need projections. The file that you forwarded to Sheppard is, rather, simply the presentation that Providence / Swedish consultant Terrie Martin made at the 16 January 2014 public CAC meeting. In our original request letter to you, we specifically identified this presentation as one of the documents that we already possess and that offers insufficient detail about the matters in question.)

So, we hereby reiterate our 5 February 2015 request to you for detailed background information about Providence / Swedish's space need projections for the Cherry Hill campus.

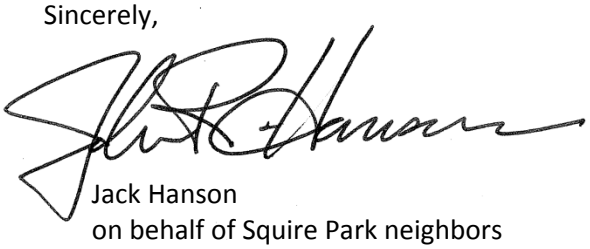
- If there is no such detailed information in Providence / Swedish's possession, please indicate so explicitly, in writing.

- If there is detailed information of the sort that we requested, please forward it to us for our consideration and review.

You may send any information or communication concerning this request to Jack Hanson at <jackhanso@gmail.com>, who will ensure distribution to the other neighbors.

We look forward to your prompt response.

Sincerely,



Jack Hanson
on behalf of Squire Park neighbors

CC: – Cherry Hill Major Institution Master Plan Citizens Advisory Committee
– Steve Sheppard, City of Seattle Department of Neighborhoods

APPENDIX A

information request from Squire Park neighbors
to Providence / Swedish vice president Andy Cosentino,
5 February 2015

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c/o Jack Hanson
209 22nd Ave S Apt 32
Seattle, WA 98144
jackhanso@gmail.com

5 February 2015

Andy Cosentino
Vice President, Swedish Neuroscience Institute
Providence Health and Services / Swedish Health Services
550 17th Avenue, Suite 500
Seattle, WA 98122
andy.cosentino@swedish.org

sent via *email and delivered by hand*

Mr. Cosentino –

We are residents of the Squire Park neighborhood. We have closely followed the process as Providence Health and Services / Swedish Health Services (Providence / Swedish) seeks approval for a new major institution master plan (MIMP) for its Cherry Hill campus.

As residents of the surrounding neighborhood, we are concerned about the size of the institutional expansion that would be allowed under the proposed MIMP. Providence / Swedish claims that, in order to meet demand for services, the Cherry Hill campus will need to grow from its current 1.15 million building gross square feet (BGSF) to roughly 3 million BGSF by 2040.

We would like to review, in detail, the calculations and estimates that Providence / Swedish and its consultants and advisors used to arrive at these space need projections. The information provided thus far by Providence / Swedish to the general public and to the Cherry Hill MIMP Citizens Advisory Committee (CAC) – in section A.3 (pp. 4-6) and in Appendix G (pp. 129-141) of the 11 December 2014 final MIMP document and in the 16 January 2014 presentation to the CAC by Terrie Martin Consulting – is not sufficiently detailed to allow a full and careful critical assessment of the space need projections.

We therefore request that Providence / Swedish provide to us – and to the CAC members – thorough and detailed background information on its space need projections, to include such items as:

1. the assumptions, specific rate of change estimates, and forecast methods that were used to forecast
    a. population growth
    b. demographic shifts
    c. inpatient and outpatient healthcare utilization changes
    d. changes in market share of Seattle-area hospitals (including Cherry Hill)
    e. demand for education services
    f. hotel room demand (including identification of the target clientele for the expanded hotel at the Cherry Hill campus)
2. identification of the sources for those assumptions, estimates, and forecast methods

3. considerations that led to choosing those assumptions, estimates, and forecast methods over others
4. the specific space need standards / planning benchmarks used to calculate
    a. total clinical space needs
    b. total research space needs
    c. total education space needs
    d. total office and clerical space needs
    e. total hotel room space needs
5. identification of the sources for those space need standards / planning benchmarks
6. considerations that led to choosing those space need standards / planning benchmarks over others
7. identification of target occupancy rates for inpatient and long-term care beds at the Cherry Hill campus and considerations that led to choosing those target occupancy rates over others
8. discussion of how the increase in BGSF at the Providence / Swedish First Hill campus allowed under the March 2005 First Hill MIMP influenced, affected, or shaped the projection of space needs for the Cherry Hill campus.

We expect that the requested information already exists in Providence / Swedish's possession – it would have been compiled and reviewed in the course of arriving at the space need projections summarized in the final MIMP document. So transmitting the information to us should not, we believe, impose an undue clerical burden on Providence / Swedish.

The requested information can be sent in electronic format to Jack Hanson at <jackhanso@gmail.com>, who will ensure distribution to the other neighbors.

We request that this information be provided to us by **Friday 13 February 2015**.

We look forward to your cooperation in this matter.

Sincerely,

Ellen Sollod	Bill Zosel	Cindy Thelen
Jack Hanson	Mary Pat DiLeva	Ability Bradshaw
Kenneth H. Torp	Melissa Flynn	Tatiana Masters
Troy Meyers	Jerry Mastui	Vicky Schiantarelli
Sonja Richter	Joanna Cullen	Katherine Yasi
T. Murray Anderson		

CC: – Cherry Hill MIMP Citizens Advisory Committee
– Steve Sheppard, City of Seattle Department of Neighborhoods

Concerning

Space Need Projections for the Cherry Hill Campus

included in the

Swedish Cherry Hill Major Institution Master Plan

(DPD project number 3012953)

Testimony of
Jack Hanson
Healthcare Research and Policy Analyst
13 July 2015

overview

1. my background
2. materials reviewed
3. results of review / analysis
   – clarifications and qualifications
4. examples of inadequacy
5. conclusion

my background

- healthcare industry researcher and policy analyst (since 2003)
  - planning and resource allocation
  - hospital bed need forecasting
- gov. appointee, Technical Advisory Committee

  WA Strategic Health Planning Office (2008-2009)
- member, rules development task force

  WA Department of Health (2009-2011)

a note on names

- “Providence / Swedish”

Studies show that in order for Swedish Cherry Hill to meet the community's growing demand for health care over the next 30 years, we will need to add approximately 1.9 million new square feet....

– Swedish Cherry Hill

final MIMP document, p. 4

materials reviewed

- section A.3 of final MIMP document
- Appendix G of final MIMP document
- 16 Jan 2014 presentation by Terrie Martin
- 27 Feb 2015 email message to CAC Chair
- 5 Mar 2015 handout at CAC meeting

results of review / analysis

Providence / Swedish has failed to provide information or evidence sufficient to demonstrate a genuine need for an expansion of this size to its healthcare facility at the Cherry Hill campus.

clarifications and qualifications

1. Providence / Swedish provided no information in response to our requests.

2. I am not offering a competing space need projection.

3. The burden of proof lies with Providence / Swedish.

concerning
population growth, demographic shifts

- no discussion of method or model that translates general population growth or other factors into patient volume growth
  - current patient volume numbers?
  - ways in which specific factors are driving changes in those numbers?

concerning
utilization changes *re* healthcare reform

A. What is the current payor mix at Cherry Hill?
   – commercially insured, uninsured, Medicare, Medicaid
B. What is the insurance coverage breakdown
   - among residents of the surrounding community?
   - among patients throughout the service area?
C. What is the expected change in the insurance coverage status of these populations from ACA?
D. What is the projected change in numbers of Cherry Hill inpatients and outpatients from now through 2040 as a result of ACA implementation?

concerning
relative market share

- Providence / Swedish First Hill – 2005 MIMP allows for 950,000 BGSF net new space
- Virginia Mason – 2014 MIMP anticipates up to 1.4 million BGSF net new space
- UW Medical Center – 2013 certificate of need allows for addition of 79 new beds

concerning
relative market share

A. Which – if any – planned or potential expansions of other area healthcare facilities did Providence / Swedish consider in projecting service demand at the Cherry Hill campus?

B. How did Providence / Swedish model the likely impacts of these planned or potential expansions on future Cherry Hill volumes?

C. What are the specific “specialty services” that Providence / Swedish mentions in its discussion of future Cherry Hill demands?

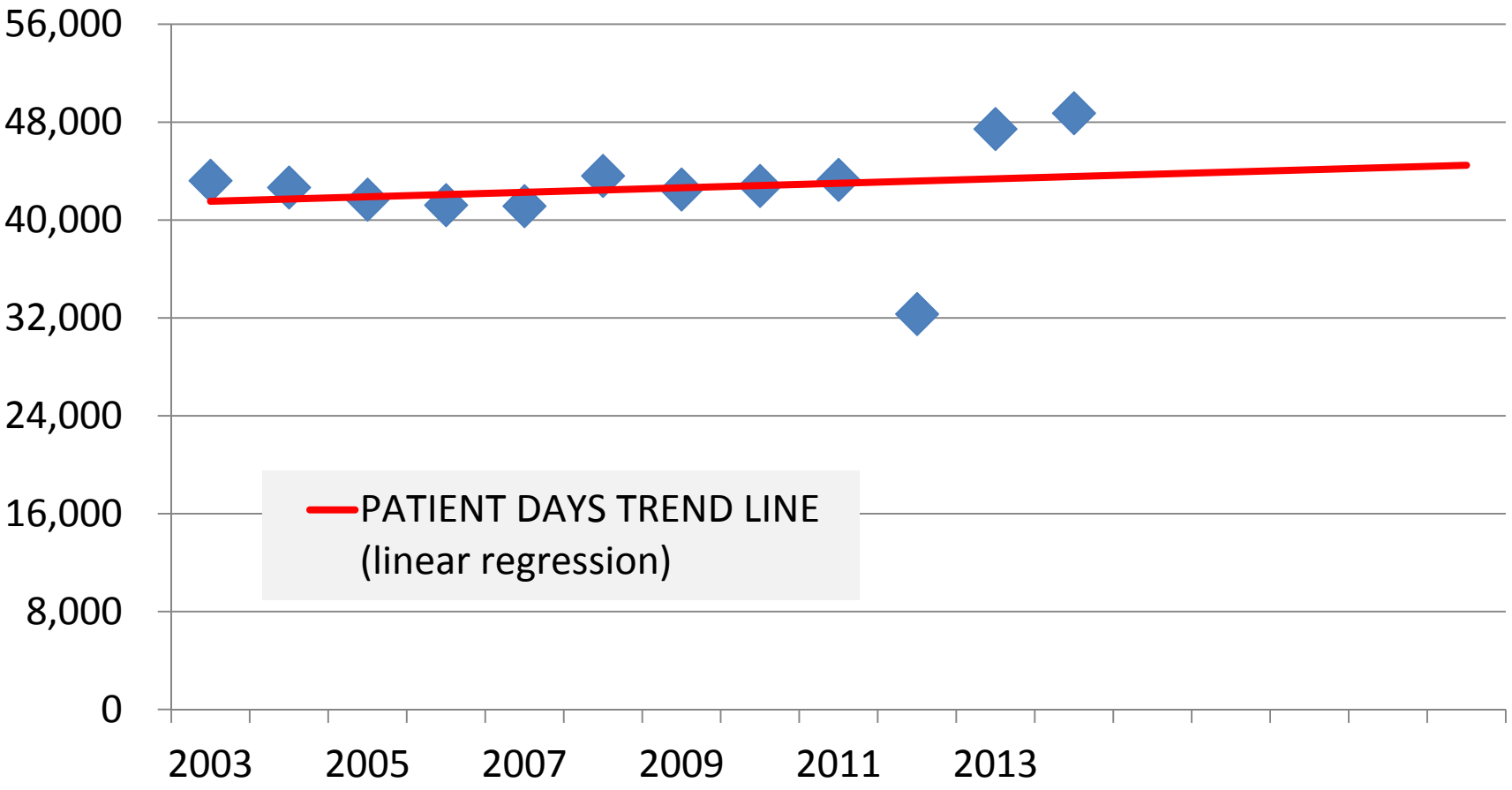
D. With which other area healthcare providers does Cherry Hill compete to attract patients who need these “specialty services”?

E. How much of the total forecast Cherry Hill service demand increase over the coming 25 years is related to the provision of “specialty services”?

concerning
space need projection for the hospital

- Providence / Swedish: The hospital needs to grow from 541,300 BGSF now to 1.4 million BGSF by 2040.
  - need for more hospital beds
  - need for more space for each bed

Cherry Hill total annual patient days, 2003-2014



source: analysis of data provided by Providence / Swedish in hospital year-end financial and utilization reports to DoH, available online at <www.doh.wa.gov/DataandStatisticalReports>

concerning
space need projection for the hospital

Because medical terminology and standards of practice change rapidly, because medical facilities and equipment become obsolete quickly, because communities and their goals change, and because, in general, long-range forecasts are unreliable, forecasts should go only as far into the future as needed to answer the type of policy question being asked. For most purposes, bed projections should not be made for more than seven years into the future.

– 1987 Washington State Health Plan, volume 2: Performance Standards for Health Facilities and Services, p. C-30

concerning
space need projection for the hospital

- Providence / Swedish target occupancy rates
  - 65% in 2023
  - 69% in 2040

- maximum efficiency: 75% to 85%
- single-patient rooms = even higher occupancy rates

FACILITY	BGSF/bed	STATE	NOTES
Prov Everett Colby	2,833	WA	general acute care
Swedish Issaquah	3,142	WA	general acute care
Seattle Children's	3,500	WA	specialty – children's
Virginia Mason	2,492	WA	general acute care
MCLNO	3,437	LA	academic, trauma, public
St Joes Exempla	2,259	CO	general acute care
NIH replacement hosp	3,480	MD	national research, public
UCSF Mission Bay	3,038	CA	general acute care (academic?)
Children's Mem, Chicago	3,994	IL	specialty – children's
Children's Denver	4,444	CO	specialty – children's
LA Co / USC Med Cen	2,500	CA	academic, public
Parkview Reg Med Cen	3,697	IN	specialty – women and children's; regional trauma
Cap Health Med Cen NJ	2,516	NJ	general acute care

concerning space need projection for "clinical and research needs"

- the need for more clinical physicians
  - no discussion of future patient volume numbers
  - no discussion of how growth was modeled
- the need for more space per physician
  - from 1,542 BGSF now to 2,200 BGSF in 2040
  - *e.g.*, recent UNM clinic guidelines call for 1,400 BGSF per physician

concerning space need projection for education functions

- education functions include
  1. continuing medical education
  2. nursing sim lab
  3. nursing conference rooms
  4. orientation classrooms
- But items 1 and 3 and 4 should already be included in 3,500 BGSF per bed benchmark.

conclusion

Providence / Swedish has failed to provide evidence or information adequate to support its claims about future space needs.

Testimony of

Jack Hanson

Healthcare Research and Policy Analyst

concerning

Space Need Projections for the Cherry Hill Campus

included in the

Swedish Cherry Hill Major Institution Master Plan

(DPD project number 3012953)

submitted to

Swedish Cherry Hill MIMP Hearing Examiner

13 July 2015

I am an experienced healthcare industry researcher and policy analyst who has worked on issues such as healthcare facility planning and hospital bed need forecasting for over a decade.[1]

As part of its major institution master plan (MIMP) proposal, Providence Health and Services / Swedish Health Services (Providence / Swedish)[2] claims that it will need to expand the Cherry Hill campus from its current size of 1.15 million building gross square feet (BGSF) to roughly 3 million BGSF by 2040: "Studies show that in order for Swedish Cherry Hill to meet the community's growing demand for health care over the next 30 years, we will need to add approximately 1.9 million new square feet, which amounts to a growth rate of about 3 percent

[1] Since 2003, I have worked as a healthcare policy analyst in Washington state and in Illinois. In connection with my professional work, I was appointed by the Governor's Office to serve on a technical advisory committee at the Washington Strategic Health Planning Office from 2008 to 2009 that worked on developing a statewide health resource planning strategy. From 2009 to 2011, I served on a rules development task force at the Washington Department of Health that was charged with updating the state certificate of need program's hospital bed need forecasting method. Prior to this work in the industry, I was on the faculty of Dartmouth College and the University of Massachusetts, where I taught courses in healthcare policy and ethics, among others.

[2] Though the deal was often described in public relations materials as an "affiliation" or "alliance" rather than an acquisition, in 2012 Seattle-based Swedish Health Services became a subsidiary of multi-state Providence Health and Services. *See* Carol Ostrum, "Swedish Alliance with Providence Is Now Complete", *Seattle Times* 1 February 2012 (included here in Appendix E). Since January 2012, the sole corporate member of Swedish Health Services is Western HealthConnect, a nonprofit corporation whose board of directors is the board of Providence Health & Services – Western Washington. (See Appendix E attached here.) Starting with its 2012 financial reports, Providence includes among its assets those assets formerly held by Swedish; Providence includes outstanding Swedish bond debt among the financial obligations of the Providence obligated group; and financial results from Swedish operations are consolidated with – and reported as part of – the Providence system financial results.

per year."[3] Unfortunately, Providence / Swedish neither includes nor cites to any such studies in its MIMP materials.

After reviewing all of the materials that Providence / Swedish provided to the Swedish Cherry Hill MIMP Citizens Advisory Committee (CAC) concerning its space need projections,[4] it is my professional opinion that **Providence / Swedish has failed to provide information or evidence sufficient to demonstrate a genuine need for an expansion of this size to its healthcare facility at the Cherry Hill campus**.

In what follows I discuss some of the most important respects in which the information and evidence offered by Providence / Swedish falls short.

First, let me note three points:

(1) A group of 15 Squire Park neighbors and I formally requested additional specific information from Providence / Swedish that would allow us to understand more fully and to evaluate more carefully the institution's claims about future space needs.[5] Providence / Swedish refused to provide us information responsive to our request and failed to provide such information to the CAC.[6]

(2) I am <u>not</u> offering a competing estimate of future space needs for the Cherry Hill campus. I cannot do so. I lack access to the sort of detailed inside information that Providence / Swedish used to arrive at its need projections – exactly the sort of detailed information that Providence / Swedish has refused to share with the neighbors.

(3) The burden of proof here lies not with me, nor with the CAC, but with Providence / Swedish, which is claiming that future local healthcare needs will require a healthcare facility in this neighborhood more than twice the size of the existing facility. That claim is, on its face, implausible, so it requires compelling evidence and support – evidence and support that has not been provided.

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[3] Swedish Cherry Hill Final Major Institution Master Plan document, 11 December 2014, p. 4. (Hereafter cited as "2014 Cherry Hill MIMP document".)

[4] Providence / Swedish's future space needs are discussed in section A.3 and in Appendix G of the 2014 Cherry Hill MIMP document; in a 16 January 2014 presentation to the CAC by Terrie Martin Consulting (attached here as Appendix F); in a 27 February 2015 email message from Providence / Swedish vice president Andy Cosentino to CAC Chair Katie Porter (attached here as Appendix C); and in a graph handed out to CAC members at the 5 March 2015 CAC meeting (attached here as Appendix D). I am aware of no other written materials in which Providence / Swedish offers information or evidence in support of its space need projections.

[5] *See* Squire Park neighbors' 5 February 2015 detailed information request to Providence / Swedish vice president Andy Cosentino (attached here as Appendix A) and the 26 February 2015 follow-up letter (attached here as Appendix B).

[6] In a side conversation at the 26 February 2015 CAC meeting, Providence / Swedish vice president Andy Cosentino confirmed to me that Providence / Swedish would <u>not</u> provide information in response to the neighbors' request.

The evidence offered by Providence / Swedish in support of its space need projections falls short in several key respects and raises important questions that remain unanswered:

A. concerning population growth and demographic shifts

1. Providence / Swedish notes that the King County population – both those under age 65 and those over age 65 – is expected to grow considerably from 2010 to 2040 and claims that population growth, especially among those over age 65, will drive large increases in demand for services at Cherry Hill.[7] However, Providence / Swedish does not indicate what proportions of current Cherry Hill inpatients and outpatients fall into the under 65 and over 65 age cohorts; whether those proportions are likely to change over time; and whether Cherry Hill will be gaining or losing older patients with respect to other local facilities, many of which are also developing or expanding services designed to attract older patients. In short, Providence / Swedish does not discuss the method or model it uses to translate general population growth into patient volume growth. Points such as these require explicit discussion in order to establish Providence / Swedish's claim that the aging of the population will drive increased demand at Cherry Hill.
2. Providence / Swedish also does not specify what population growth estimates it is using; it says only that it is using numbers from the Washington Office of Financial Management (OFM).[8] OFM publishes three series of population growth projections every year – high, middle, and low growth projections. Each of these series is appropriate to a different kind of forecasting. One series may be much preferable to the others for forecasting specific healthcare infrastructure needs over a very long range such as 25 to 30 years. However, Providence / Swedish does not discuss which series it uses or why it chose that series. Evaluating the reliability of Providence / Swedish's population growth estimates requires knowing what population growth rate was used and understanding why that rate was chosen.

B. concerning healthcare facility utilization changes due to healthcare reform efforts

1. Providence / Swedish acknowledges that full implementation of the federal Affordable Care Act (ACA) is likely to significantly affect healthcare facility utilization over the coming years.[9] However, Providence / Swedish does not discuss in any detail what the effects of ACA implementation might be on inpatient and outpatient service utilization at the Cherry Hill campus. A number of important questions are left unaddressed:

[7] *See* 2014 Cherry Hill MIMP document, pp. 4-5, 129-130.
[8] *See* footnote 3 in Appendix G, 2014 Cherry Hill MIMP document, p. 133.
[9] *See, for example*, 2014 Cherry Hill MIMP document, pp. 5, 133.

a. What is the current payor mix at Cherry Hill (volume of commercially insured patients, uninsured patients, and Medicare and Medicaid patients)?
b. What is the insurance coverage breakdown among residents of the surrounding community? among patients throughout the hospital's primary service area?
c. What is the expected change in the insurance coverage status of these populations resulting from full ACA implementation?
d. What is the projected change in numbers of Cherry Hill inpatients and outpatients from now through 2040 as a result of ACA implementation?

2. On a related note: Along with – and, in some cases, because of – ACA implementation, the U.S. healthcare system is currently experimenting with a wide variety of potentially far-reaching delivery reforms, including accountable care organizations and other forms of integrated delivery system, medical home models of care delivery, and pay-for-performance schemes. (Indeed, Providence / Swedish itself has formed an accountable care organization and is testing medical homes.) These reforms are intended to fundamentally alter the ways in which healthcare is purchased and delivered in the U.S. However, Providence / Swedish does not discuss in any detail what it has done to model the likely effects of these changes on inpatient and outpatient volumes at the Cherry Hill campus.

C. concerning changes in patient volumes and relative market share

1. In addition to healthcare reform efforts, Providence / Swedish suggests that several other factors will create additional demand for inpatient and outpatient services at the Cherry Hill campus over the coming 25 years.[10] However, Providence / Swedish provides no numbers. It offers no specific information on the number of patients currently receiving services at the Cherry Hill campus, nor does it offer estimates of additional patient volumes expected in the future. A credible presentation of future patient demand requires both current patient volume numbers and a discussion of the specific ways in which different factors are likely to drive changes in those numbers over time. Providence / Swedish offers none of this.
2. It seems that at least part of the reason that Providence / Swedish anticipates higher patient volumes at its Cherry Hill campus in the future is that it expects to draw patients away from other area healthcare providers. Providence / Swedish apparently intends to grow its share of the market for certain "specialty services" in the Cherry Hill service area from the current level of 13% to a level of 20% by 2040.[11] But other healthcare facilities whose service areas overlap with that of the Cherry Hill campus –

[10] *See, for example,* the discussion in section A.3 of the 2014 Cherry Hill MIMP document, especially pp. 4-5.
[11] *See* the section titled "Service Demand" at 2014 Cherry Hill MIMP document, p. 133.

including University of Washington Medical Center, Harborview Medical Center, and Northwest Hospital and Medical Center in the University of Washington Medicine system; the Swedish First Hill campus in the Providence / Swedish system; Virginia Mason Medical Center; and Overlake Hospital Medical Center – all have expansions underway or growth plans in the works. To cite just three examples:

(1) The City of Seattle approved, in 2005, a new MIMP for the Providence / Swedish First Hill campus that allows for some 950,000 BGSF of net new space on that campus over the coming years.[12]

(2) The City of Seattle approved, in 2014, a new MIMP for the Virginia Mason First Hill campus that anticipates up to 1.4 million BGSF of net new space on that campus over the coming years.[13]

(3) UW Medical Center secured a certificate of need from the Washington Department of Health (DoH) in 2013 that allows for the addition of 79 new beds at its flagship Seattle campus.[14]

These considerations raise important questions that Providence / Swedish does not address in its MIMP materials, including:

a. Which – if any – planned or potential expansions of other area healthcare facilities did Providence / Swedish consider in projecting service demand at the Cherry Hill campus?

b. How did Providence / Swedish model the likely impacts of these planned or potential expansions on future Cherry Hill patient volumes?

c. What are the specific "specialty services" that Providence / Swedish mentions in its discussion of future Cherry Hill service demands?

d. With which other area healthcare providers does Cherry Hill compete to attract patients who need these "specialty services"?

e. How much of the total forecast Cherry Hill service demand increase over the coming 25 years is related to the provision of "specialty services"?

3. Apparently, Providence / Swedish also expects to double the proportion of its "specialty services" patients who come from outside the Cherry Hill campus service area – from 6% at present to 13% in some future year.[15] Unanswered questions parallel to those listed immediately above (at C.2.a-e) also attach to this projection.

[12] Swedish Medical Center First Hill Campus Final Major Institution Master Plan document, 14 March 2005, p. 43 (attached here as Appendix G).

[13] Virginia Mason Medical Center First Hill Campus Compiled Major Institution Master Plan document, 5 February 2014, p. 29 (attached here as Appendix H).

[14] State of Washington Department of Health certificate of need #1516, issued 18 November 2013 (attached here as Appendix I).

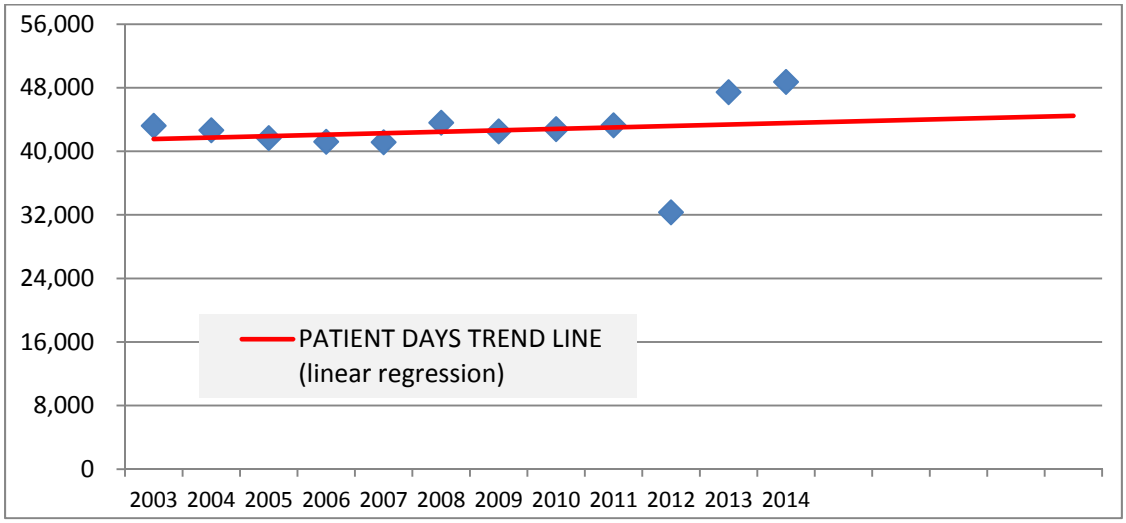
[15] *See* the section titled "Service Demand" at 2014 Cherry Hill MIMP document, p. 133.

D. concerning the space need projection for the hospital

1. Providence / Swedish claims that it will need to expand the hospital part of the Cherry Hill campus from its current 541,300 BGSF to nearly 1.4 million BGSF in 2040.[16] This growth projection seems to be based on two considerations:
   (1) the need for more hospital beds to meet increased inpatient service demand – nearly doubling the hospital inpatient capacity from 196 beds at present to 385 beds by 2040;
   (2) the need to devote more space to each bed – increasing the total building space per bed from the current 2,762 BGSF per bed to over 3,500 BGSF per bed by 2040.

   Neither of these claimed needs is adequately supported by the information Providence / Swedish has provided.
2. Data reported to DoH by Providence / Swedish for the period 2003 through 2014 show that inpatient volumes at the Cherry Hill campus are trending upward, but only slightly and rather slowly.[17] See Figure 1 below.

Figure 1 – Cherry Hill total annual patient days, 2003-2014



source: analysis of data provided by Providence / Swedish in hospital year-end financial and utilization reports to DoH, available online at <www.doh.wa.gov/DataandStatisticalReports>

(The reported data also show that this period of relative stability came after more than 10 years of steeply declining inpatient volumes at Cherry Hill.) So the publicly-available historical data do not indicate that inpatient volumes are on a sustained and significant upward swing at the Cherry Hill campus. As noted above (at C.1), what is

[16] 2014 Cherry Hill MIMP document, pp. 54, 133-135, 141.
[17] Total annual patient days is a standard metric for measuring hospital inpatient volumes. Although the metric does not adjust for patient acuity, it is sensitive to severity of patient needs: A hospital that routinely treats unusually sick or complex patients will have a high average length of stay, which drives up patient days.

needed here is a detailed discussion of patient volume trends and the factors driving those trends – something that Providence / Swedish does not provide.

a. It is worth noting that the official forecasting method used by DoH for Washington's certificate of need program restricts hospital bed need forecasting for bed addition projects to a seven-year planning horizon. According to the State Health Plan:

> Because medical terminology and standards of practice change rapidly, because medical facilities and equipment become obsolete quickly, because communities and their goals change, and because, in general, long-range forecasts are unreliable, forecasts should go only as far into the future as needed to answer the type of policy question being asked. For most purposes, bed projections should not be made for more than seven years into the future.[18]

DoH has, in certain exceptional cases, allowed 10-year projections for "phased" bed addition projects, but DoH has countenanced planning horizons longer than this only in cases involving the establishment of a new hospital. All for good reason: Accurately forecasting facility bed need 15 years or more into the future is simply not feasible.

b. It is also worth noting here that Providence / Swedish's need projections show target occupancy rates at the Cherry Hill hospital of 65% in 2023 and 69% in 2040.[19] But healthcare planners have long held that a large general acute care hospital such as Cherry Hill reaches full occupancy – and maximum efficiency – somewhere between 75% and 85%.[20] Some experts have suggested that, with the move to single-patient rooms, even higher occupancy levels can be obtained safely and efficiently.[21] Providence / Swedish does not explain why it believes, contrary to prevailing expert opinion, that occupancy rates of 65% or 69% are appropriate for the future Cherry Hill hospital.

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[18] *1987 Washington State Health Plan – volume 2: Performance Standards for Health Facilities and Services*, p. C-30 (attached here as Appendix J).

[19] *See* 2014 Cherry Hill MIMP document, p. 134.

[20] *See, for examples*, Linda V. Green (2002), "How Many Hospital Beds?", *Inquiry* **39**, pp. 401 ff., and New Jersey Commission on Rationalizing Health Care Resources (2008), *Final Report*, p. 49, available online at <http://www.nj.gov/health/rhc/reports.shtml>, accessed 2 July 2015. In addition, the bed need forecasting method developed in the State Health Plan – and still used today by DoH for Washington's certificate of need program – favors target *minimum* occupancy levels of 75% for a general acute care hospital with 200-299 beds (the size that Providence / Swedish expects Cherry Hill to be in 2023) and 80% for a hospital with more than 300 beds (the size that Providence / Swedish expects Cherry Hill to be by 2040). *1987 Washington State Health Plan – volume 2: Performance Standards for Health Facilities and Services*, p. C-37. Running a bed need calculation with a lower rather than a higher occupancy standard will yield an apparent need for a larger number of beds to serve a set number of inpatients; so, if one aims to show a "need" for more beds, one chooses a lower occupancy standard.

[21] *See, for example*, Michael Detsky and Edward Etchells (2008), "Single-Patient Rooms for Safe Patient-Centered Hospitals", *Journal of the American Medical Association* **300**, pp. 954-956.

3. Just as Providence / Swedish fails to adequately support a projected future need for nearly twice the number of inpatient beds at the Cherry Hill campus, so too does Providence / Swedish fail to adequately support it's claim that each future bed will require more total facility space. Providence / Swedish briefly canvasses several factors that help to determine the amount of space required for each bed in a modern hospital, but then simply announces that it uses a planning benchmark of 3,500 BGSF per bed in its projection of future space needs for the Cherry Hill campus – 27% more space than the current 2,762 BGSF per bed at the hospital.[22] Providence / Swedish provides no detail about the specific factors or considerations that led it to choose this planning benchmark – no numbers or calculations, no models, no citations to the healthcare facility planning literature, nothing of substance.
    a. The lack of detailed discussion here is particularly troubling because the amount of total facility space needed for each inpatient bed is a matter of ongoing debate among healthcare planners. Much recent work in the field suggests that a standard well below 3,500 BGSF per bed is appropriate – indeed, desirable – for modern hospitals.[23]
    b. Planners have also noted that building smaller rather than larger hospital spaces leaves providers better positioned financially to deal creatively with future technological, operational, and clinical developments that are difficult – if not impossible – to anticipate.[24]
    c. In response to questions from CAC members, Providence / Swedish suggested that a comparison with 13 other medical centers across the country indicates that 3,500 BGSF per bed is an appropriate standard for Cherry Hill. [25] However, all six of the hospitals on Providence / Swedish's comparison list that are near, at, or above the 3,500 BGSF per bed benchmark are specialty facilities – three children's hospitals, one academic medical center, one regional trauma center, and the National Institutes of Health national research hospital. What's more, the only three Washington state general acute care hospitals on the list operate with much less than 3,500 BGSF per bed. The facility at Cherry Hill is a general acute care hospital – not a children's hospital, not an academic medical center, not a trauma center. So, the inter-hospital space-per-bed comparisons on which Providence / Swedish

[22] *See* 2014 Cherry Hill MIMP document, p. 135.
[23] *See, for example,* C. Skolnick (2013), "Beyond 2013: Facility planning in an uncertain environment", *Medical Construction & Design* **9.5**, pp. 48-50.
[24] *See, for example*, H. Scot Latimer, Hillary Gutknecht, and Kimmey Hardesty (2008), "Analysis of Hospital Facility Growth: Are We Super-Sizing Healthcare?", *Health Environments Research and Design Journal* **1.4**, pp. 70-88.
[25] *See* 27 February 2015 email message from Providence / Swedish vice president Andy Cosentino to CAC Chair Katie Porter (attached here as Appendix C).

seems to base its hospital space need projection may not be comparable or relevant at all.

E. concerning the space need projection for "clinical and research needs"

1. Providence / Swedish claims that, in order to meet future demands for healthcare services and research, it will need to grow the amount of building space on the Cherry Hill campus devoted to "clinical and research needs" from the current 427,000 BGSF to nearly 1.3 million BGSF (or 1.1 million BGSF, under Alternative 12) by 2040.[26] This near tripling of the campus space devoted to these purposes reflects both (1) a supposed need for more physicians engaged in clinical and research work and (2) a supposed need for more space per physician. However, again Providence / Swedish fails to provide the sort of detailed discussion and specific information necessary to adequately establish these need claims.
2. Providence / Swedish projects a need for physicians providing clinical services (not counting research physicians) that far outstrips the projected need for new hospital beds at the Cherry Hill campus – a 149% increase in the number of clinical physicians located on campus (from 164 in 2013 to 408 in 2040) versus a 96% increase in the number of inpatient beds over the same period. Providence / Swedish suggests that the principal reason for this disproportional growth is an anticipated influx of patients newly-insured under the ACA seeking primary care and other outpatient services at Cherry Hill.[27] However, as noted above (at B.1), Providence / Swedish leaves unanswered several questions central to understanding this projected change in patient volumes:
    a. What are the numbers of uninsured and underinsured inpatients and outpatients currently served at Cherry Hill? For what proportions of total patient volumes do these populations account?
    b. How many uninsured and underinsured people currently reside in the surrounding community? throughout the Cherry Hill service area?
    c. What is the expected change in the insurance coverage status of these populations resulting from full ACA implementation?
    d. What is the projected change in number of Cherry Hill outpatients through 2040 as a result of ACA implementation?
    e. How did Providence / Swedish model these expected changes?
3. Along with the projected increase in the number of clinical and research physicians working at the Cherry Hill campus, Providence / Swedish also anticipates a 43% increase in the amount of building space allotted to each physician – from 1,542 BGSF

[26] *See* 2014 Cherry Hill MIMP document, pp. 54, 136-137, 141.
[27] *See* 2014 Cherry Hill MIMP document, p. 136.

per physician at present to 2,200 BGSF per physician in 2040. Yet Providence / Swedish nowhere claims that the current allotment of space per physician at the Cherry Hill campus is inadequate or deficient in any way. Why, then, does Providence / Swedish anticipate a future need for significantly more building space for each physician? Providence / Swedish offers no answer.

a. The lack of discussion on this point is particularly troubling because the 2,200 BGSF per physician target that Providence / Swedish employs is much larger than the typical space benchmark for facilities housing physician clinical activities.
b. To take but one example: According to recent planning guidelines for physician clinics developed for the University of New Mexico health system, a freestanding clinic providing primary care and other routine outpatient services requires roughly 1,400 BGSF per physician to accommodate all necessary facility spaces – exam rooms, physician offices, patient reception and waiting areas, electrical and mechanical rooms, and so forth.[28] A physician clinic integrated into a larger healthcare facility such as the Cherry Hill campus would, presumably, need even less space per physician than this because some of the support areas – such as public toilets and electrical and mechanical rooms – would already exist within the campus building that houses the clinic.

F. concerning the space need projection for the campus hotel

1. Providence / Swedish currently provides hotel rooms on the Cherry Hill campus for patients and families of patients receiving care at Cherry Hill and at other Providence / Swedish facilities throughout Seattle. The institution anticipates increasing the number of such hotel rooms from 29 at present to 80 by 2040 (or to 56 rooms by 2040 under Alternative 12).[29] Providence / Swedish claims that 1,000 BGSF per bed is "the space benchmark for a modest hotel"[30] – even though its existing hotel beds require only 431 BGSF per bed and Providence / Swedish itself seems to employ a benchmark of roughly 700 BGSF per bed under Alternative 12[31] – but offers neither support for nor substantive discussion of the appropriateness of this benchmark.
2. If the 1,000 BGSF per bed benchmark is a standard borrowed from the hospitality industry, it may not be appropriate for hotel accommodations attached to a healthcare facility. Typical hotels – even "modest" hotels – that serve the general public routinely

[28] fbt Architects (2010), *University of New Mexico Hospitals – Clinic Standards* (revised 12 April 2010), available online at <https://iss.unm.edu/PCD/docs/UNMH-Clinic-Standards_Revised04-12-10.pdf>, accessed 2 July 2015.
[29] *See* 2014 Cherry Hill MIMP document, pp. 54, 137-138.
[30] 2014 Cherry Hill MIMP document, p. 138.
[31] *See* notes on Alternative 12 and Table C-2 at 2014 Cherry Hill MIMP document, p. 54.

include space for lobbies, gyms or workout rooms, swimming pools, restaurants or lounges or cafeterias, vending machine and ice maker areas, housekeeping and laundry facilities, and the like. But these amenities do not obviously need to be included with guest rooms that exist only to serve a healthcare facility – especially when some of these amenities are already provided elsewhere on the campus.

3. So the question remains: What is an appropriate per bed space benchmark for guest accommodations that are attached to – and serve exclusively – a large healthcare facility? Providence / Swedish does not address this question.

G. concerning the space need projection for education functions

1. Providence / Swedish claims that it will need to increase the amount of building space on the Cherry Hill campus devoted to education functions from 73,000 BGSF at present to 152,300 BGSF by 2040.[32] Providence / Swedish offers a breakdown of its projected future education space needs into several categories, including space for continuing medical education (classrooms?), a nursing sim lab, nursing conference rooms, and classrooms for orientation.
2. However, it would seem that some of the additional education space that Providence / Swedish claims it will need on the future Cherry Hill campus – specifically, space for continuing medical education, nursing conference rooms, and employee orientation classrooms – should already be included in the 3,500 BGSF per inpatient bed that Providence / Swedish says it will need for the hospital. These are routine educational activities of any mid-size or large general acute care hospital, and a hospital space need benchmark (such as the 3,500 BGSF per bed figure that Providence / Swedish uses) is intended to provide for sufficient space for <u>all</u> of the necessary support and ancillary functions of the hospital. So, why does Providence / Swedish claim that it will need yet more additional space on campus for these routine functions?

H. concerning the space need projection for long-term care services

1. In Appendix G of its MIMP proposal, Providence / Swedish anticipates adding 121 new beds for long-term care (both acute rehabilitation services and assisted living services) at Cherry Hill by 2040, while maintaining the 99 rehabilitation beds currently operated by Seattle Rehab Center (now called Seattle Medical Post Acute Care) on the campus.[33] Under the revised Alternative 12, however, Providence / Swedish anticipates adding just 50 new long-term care beds (all of them rehabilitation beds, it seems, none for

[32] *See* 2014 Cherry Hill MIMP document, pp. 138-139.
[33] *See* 2014 Cherry Hill MIMP document, pp. 139-140.

assisted living), claiming that, at 1,000 BGSF per bed, the campus will thus need to add 50,000 BGSF to accommodate the new rehabilitation beds.[34]

2. However, Providence / Swedish does not address a number of important issues related to this projection:
    a. Though it suggests that an increase in the number of King County residents over age 65 will translate directly into increased demand for long-term care services at the Cherry Hill campus,[35] Providence / Swedish does not discuss in any detail this alleged correlation. What method does Providence / Swedish use to model this correlation? How does that model account for expansion of long-term care capacity at other area healthcare providers? for in-migration or out-migration of patients? How is future demand for rehabilitation services modeled differently from future demand for assisted living services?
    b. Similarly, Providence / Swedish provides no information about utilization of the 99 rehabilitation beds run by Seattle Rehab Center on the campus. It is not clear what the occupancy rate of those beds is at present, nor whether that occupancy rate is expected to change in the future. But the current and projected future utilization rate of these existing beds is directly relevant to whether there will be a future need for additional rehabilitation beds on the campus.
    c. The Seattle Rehab Center facility at Cherry Hill apparently operates at present – and is expected to continue operating in the future – in a space that allows 434 BGSF for each rehabilitation bed.[36] But Providence / Swedish claims that it will need 1,000 BGSF for each of its new rehabilitation beds. Providence / Swedish does not explain why its future rehabilitation program at Cherry Hill will require more than twice the amount of space per bed required by the Seattle Rehab Center rehabilitation program.
3. Finally, consideration of Providence / Swedish's space need projection for long-term care services points up a general observation: Although Providence / Swedish has insisted throughout the MIMP process that its plans for the Cherry Hill campus are intended to accommodate future healthcare <u>needs</u>, under Alternative 12 Providence / Swedish decided, apparently, to ignore or discount certain of the needs it originally identified.

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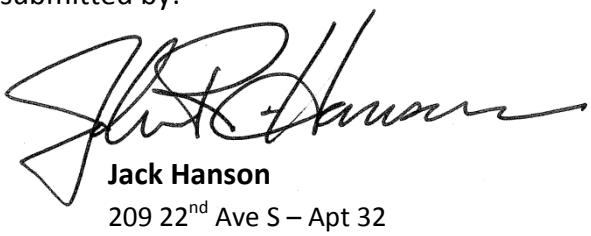
[34] *See* notes on Alternative 12 and Table C-2 at 2014 Cherry Hill MIMP document, p. 54.
[35] *See* the chart titled "Long Term Care Needs compared to Population 65+" at 2014 Cherry Hill MIMP document, p. 140.
[36] *See* the section titled "Space Needs" and the table titled "Long Term Care Needs" at 2014 Cherry Hill MIMP document, p. 140.

a. For example, under Alternative 12, Providence / Swedish no longer recognizes a need for 71 assisted living units on the Cherry Hill campus.[37] So the question arises: On what basis did Providence / Swedish originally determine that it would be necessary – or advisable – to locate 71 assisted living units on the Cherry Hill campus? Most facilities across the country that serve residents who need assistance with activities of daily living but who do not need rehabilitation services are not located on hospital campuses. In fact, Providence / Swedish itself currently operates a dozen or more such assisted living facilities in Washington, Oregon, and Alaska that are not on hospital campuses.
b. This particular case well illustrates a shortcoming that attaches to Providence / Swedish's discussion of its future space needs throughout the MIMP materials: The institution simply does not fully explain its need projections; it routinely fails to provide a thorough, detailed account of the considerations, assumptions, and calculations on which its need claims are based.

CONCLUSION

With this proposed MIMP, Providence / Swedish is seeking zoning variances that would allow it to grow its Cherry Hill campus to well over twice its current size. In pressing its case, Providence / Swedish has claimed that future healthcare needs in the region will require such a large facility at Cherry Hill. However, as the preceding discussion of unanswered questions and unaddressed issues makes clear, Providence / Swedish has failed to provide evidence or information adequate to support its claims about future space needs.

submitted by:



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[37] *See* notes on Alternative 12 at 2014 Cherry Hill MIMP document, p. 54.

LIST of APPENDICES

APPENDIX A – information request from Squire Park neighbors to Providence / Swedish vice president Andy Cosentino, 5 February 2015

APPENDIX B – follow-up letter from Squire Park neighbors to Providence / Swedish vice president Andy Cosentino, 26 February 2015

APPENDIX C – email message from Providence / Swedish vice president Andy Cosentino to CAC chair Katie Porter, 27 February 2015

APPENDIX D – handout from Providence / Swedish vice president Andy Cosentino at 5 March 2015 CAC meeting

APPENDIX E – materials concerning Providence acquisition of Swedish in 2012

APPENDIX F – presentation to CAC by Terrie Martin Consulting, 16 January 2014

APPENDIX G – Swedish Medical Center First Hill Campus Final Major Institution Master Plan document, March 2005

APPENDIX H – Virginia Mason Medical Center First Hill Campus Compiled Major Institution Master Plan document, February 2014

APPENDIX I – State of Washington Department of Health certificate of need #1516 for University of Washington Medical Center, issued 18 November 2013

APPENDIX J – 1987 Washington State Health Plan, volume 2: Performance Standards for Health Facilities and Services

July 19, 2015

RECEIVED BY
2015 JUL 21 PM 4:52
OFFICE OF
HEARING EXAMINER

To: H. E. Tanner,

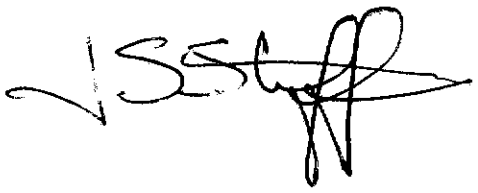
My name is Jeffrey Scott Steffen. I have resided on the 500 block of 19th ave since 1996.

In the past few years traffic on 19th Avenue has greatly increased. Parking has become very difficult during the week. On the weekends though there is ample parking. This leads one to believe that a large portion of people parking on 19th are from the Swedish campus. The fact that many employees are seen walking to their cars parked on 19th in hospital clothes makes this irrefutable.

The amount of accidents, particularly on the corner of 19th and Jefferson has gone up dramatically. Some drivers going at a very high speed, other drivers going at a very slow speed, buses, bicyclists and pedestrians are not a good mix. You add the daily barrage of construction vehicles that will try to vie for space on this two-lane street and the safety of all will un-avoidably be impacted. Drivers are seen daily making **u turns** and **k turns** in the middle of the 19th and Jefferson and 19th and Cherry.

The notion that 2 homes have also have been purchased by Sabey on the west side of 19th between Jefferson and Cherry is peculiar. One of these houses being built under the 1994 MIMP. The other house probably had some historic value. But, all evidence of that was removed immediately after the home was purchased by the current owners. Are these houses going to be torn down and used as access points for the construction project? Sabey or The 17th and James Llc has not registered these homes with the DPD in Seattle's Rental Registration and Inspection Program. Tearing these houses down seems in direct conflict with the MIMP' s purpose to preserve adjacent neighborhoods.

All institutions should have the right to expand. The proposed MIMP is greatly out of proportion with the surrounding Cherry Hill neighborhood. The amount of work that also is taking place inside of Swedish seems to be in direct contradiction with the idea that the hospital has no room for internal growth.



3012953
Project Number: 3012953
Project Name: Swedish Medical Center Cherry Hill Campus Master Plan
C. F. Number 311936

July 16, 2015

Dear Ms Tanner,

Thank you for listening to my brief statement yesterday afternoon regarding the Swedish Cherry Hill MIMP.

As I stated, I have owned and lived in, our home at 732 15th Avenue for 30 years.

I feel that we have a wonderful neighborhood. It is quiet and pleasant with desirable neighbors.

Execution of the proposed MIMP will make our neighborhood a less desirable place to live. Noise, traffic, parking and shadowing will all be detrimental. In fact, although, I have spent a large amount of energy and dollars to make our home safe and attractive (as have many of our neighbors), I would likely move to a different location if the MIMP is allowed to proceed. We currently have a quiet, safe and pleasant single family neighborhood: I believe that, because of its height, bulk and scale, the proposed Swedish development would drastically alter that.

Please consider recommending against any expansion of the Swedish-Cherry Hill campus.

Sincerely

Jerome W Mueller, MD, FACEP(Emergency Medicine), BS, Mechanical Engineering

July 14, 2015

Jerry Matsui
541 19th. Ave
Seattle, WA. 98122

Subject: Statement before the Hearing Examiner.

My name is Jerry Matsui. I live at 541 19th Avenue, in a 1901 house. I am a member of Appellant 19th Ave Block Watch/Squire Park Neighbors. I am a past Board member of Squire Park Community Council and a number of organizations within the Central Area.

I am 71 years old. With the exception of my birth and infancy in one of the Concentration Camps in Idaho and my military service, I have lived my entire life in the Central Area in my current home. My family moved into our current home in about 1946-47. My wife and I raised our children in our home. I would argue that both my house and I have been around a lot longer than the hospital or anyone you will meet this week. If the decisions being made are based on longevity at the site, I think I win.

I was around for the previous 1994 MIMP. We were promised a day care and gym back then too, plus an inn and nursing facility in exchange for giving up the east side of 18th Ave and going to a 105' height within the campus. Those structures were supposed to be built along 18th Ave as transitional structures. It never happened. Instead of the facilities we expected to see, we got "temporary" permitted surface parking lots. That was so long ago, I can remember exactly when, but it's been well over 10 years ago. We do need something, but not parking lots or a massive wall. We also agreed to reducing open space from 14% to 10%. The current campus has less than 6%. The SOV rate was promised to go down from 69% to 50%. They still haven't gotten to the 50%. All the other hospitals are below 40%, including Children's, which has less access to public transportation.

So now we are in 2015, and we are getting these same promises in exchange for more height. This time around Swedish/Sabey started with 240' heights on campus and 65' heights along 18th Ave with no setbacks and every exception or exemption one could ask for in the early Alternatives. One alternative was to expand boundaries. The following CAC meeting, Swedish/Sabey announced that the Alternative to expand along 19th Ave faced so much opposition that it was withdrawn as an Alternative when a couple of folks asked if Swedish/Sabey planned to provide the same consideration as Children's gave their neighbors. To look like you're giving up something in

"negotiations", always ask for the maximum. Drag it out until you wear out everyone. If you're really good, then you'll get more than what you want or need.

There have been lots of problems along the way. My testimony didn't make it into the record at the June 12, 2014 public hearing for the EIS, even though my verbal testimony shows me submitting my written comments. I'm not the only one. I was so concerned about the process, I wrote a letter to the DPD Director. At the hearing Swedish staff confiscated the sign-in sheets and substituted their list of patients and supporters so they could go first. Many of these individuals hadn't even arrived yet. Those of us who arrived early had to wait until after these individuals spoke. Swedish/Sabey videotaped the hearing without announcement or permission. Sabey security guards were in attendance and in uniform. I contacted the police to verify whether there had been a police report. There was none.

of the expansion. I don't think that standing a giant 200-foot house brick up in the middle of a 120-year-old neighborhood is a really great idea. There's probably multiple ways to approach it. I haven't seen that yet and hope to do, and they should take some time and talk about the parking and the big problem with traffic around here.

I did get slaughtered in the crosswalk on 14th and Cherry by an uninsured driver, and I know that just bringing this many people up here and not having any parking or any place to put them seems to be a little bit out of scale. So that's all I got to say about that.

MR. MATSUI: My name is Jerry Matsui. I live at 541 19th Avenue. Tonight I will lead with race and mitigation because race has shaped our institutions and policies, perpetuating racial and social inequities, and we must take responsibility. I've been bothered for a very long time by Swedish/Sabey's attitude and actions in its approach to this neighborhood. It has been deceptive, condescending, obnoxious, arrogant, and dismissive. I have read the draft of DEIS and admit that contains statements that attempt to deny the residential character of our neighborhood, a demonstration of their attitude.

55 Cont.

56

Jerry Matsui

56. A description of the area surrounding Swedish Cherry Hill is included on pages 1-1 and 2-6 of both the Draft and Final EISs. The area is described as: *"Uses in the area north, east and west of the campus are primarily single-family and lowrise multi-family residential, with a mix of some institutional and commercial uses. The eastern boundary of Seattle University's campus faces the western boundary of the Swedish Cherry Hill campus across 15th Avenue."*

57

Our neighborhood is very diverse in ethnicity, sexual orientation, age, religion, education, income, et cetera. Denying while trying to alter the residential character of our neighborhood is institutional racism. When the city creates loopholes in its municipal code so that institutions, through their for-profit developers, can buy up homes and other private properties so they can board up or don't maintain these properties, the city institutions and developers create a new form of red lining that was prevalent in the central area which denied access to housing and/or continued ownership based on race.

I'm a retired city employee and I am -- race and social justice issues have been a city-wide effort to realize racial equity. I own my home on 19th Avenue because I won a housing race discrimination case against Providence when they refused to sell my ancestral home to me when I returned from the military service because I'm NEE-SAY.

I have another statement here that supports Nicholas Richter, Bob Cooper, and Vicki Scantarelli's comments as well. This is in writing. I have a more extensive comment, written document, on the TMP, and that will also be submitted. Thank you.

57. Your comments concerning access to housing are noted.

June 23, 2014

Ms. Diane Sugimura, Director
Department of Planning & Development
700 5th Ave, Suite 2000
P.O. Box 34019
Seattle, WA 98124-4019

Subject: DPD Project Number 3012953, Swedish Cherry Hill MIMP

Dear Ms. Sugimura,

I am deeply concerned about DPD staff's unprofessional actions at the June 12, 2014 public hearing. In accordance with SMC 23.69.032, Master plan process, D. Development of Master Plan,

> 10. The Director and the lead agency shall hold a public hearing on the draft master plan and if an EIS is required, on the draft EIS.

The Code holds DPD responsible for the public hearing, and when there is another lead agency, then DPD is equally responsible for the public hearing. Instead, DPD staff stated this was Swedish/Sabey's meeting and deferred her responsibilities to Swedish/Sabey:

A. One of the neighbors arrived early and signed in on the public testimony sign-in sheets left at the table. He was the very first signature. This neighbor witnessed a Swedish employee gather all of the public testimony sign-in sheets and replace them with sign-in sheets containing only Swedish doctors and patients' names. These individuals had yet to arrive to the public hearing location. When asked, the Swedish employee told the neighbor she was accommodating the Swedish supporters (all white and who lived outside the neighborhood) to testify first regardless of sign-up order so they could leave early. The people who opposed the DMIMP or DEIS because of how difficult it was to get charity care (people of color) or who did live in the neighborhood (racially/ethnically diverse) had to wait at the end of the line to testify. When brought to the attention of the DPD staff, she deemed these actions as acceptable. As a past government employee (City and State), providing specific individuals with preferential treatment based on white privilege is considered an act of institutional racism at best.

B. Swedish/Sabey videotaped the public hearing without informing the public. I did not learn I was videotaped until after I testified. I did not grant Swedish/Sabey permission. When a neighbor who was to testify after me realized she was to be videotaped, she told the DPD staff person she did not give permission. The camera was turned off, but neighbors witnessed the DPD staff person roll her eyes and act

Presented at the June 12,2014 Public Hearing re. the Draft PDEIS and MIMP before the CAC.

This is a preface to my comments regarding the TMP portion of the draft PDEIS and MIMP tonight before the CAC. I have been bothered by the attitude of Swedish/Sabey in its approach to this neighborhood in that it has been deceptive, condescending, obnoxious, arrogant and dismissive. I have read the draft PDEIS and MIMP that contain statements that attempt to deny the residential character of our neighborhood which illustrates their attitude. Our neighbor hood is very diverse in ethnicity, sexual orientation, age, religion, education, income, etc. My impression, by denying the residential character of our neighborhood and its diversity is akin to institutional racial discrimination. And as a corollary, similar to red-ling that was prevalent in Seattle which denied access to housing and/or continued ownership based on race. I am a retired City employee and race and social justice issues have been a citywide effort to realize racial equity because race has shaped our institutions and polices that have prevented us from achieving equity. In order to achieve equity, the underling root causes must be must be addressed to end institutional racism that perpetuates racial and social inequities.

The following is a summary of my written examination of the TMP.
I agree with the comments made by Nicholas Richter, Bob Cooper, and Vicky Schiantarelli. With minimal efforts to attempt to meet Code (in some areas, unsuccessfully) and dismal performance/compliance of its current TMP or the 1994 MIMP, Swedish/Sabey has demonstrated it cannot be trusted and should get no consideration or concessions from the City or neighborhood. The partnering experiment allowed by the City between major institutions and private developers has turned the Code into a mockery and harmed this neighborhood. There is no place in Seattle for commercial enterprises to control or direct non-profit services. It doesn't work with drinking water or prisons; it doesn't work here. This must come to an end.

Thank you,

MIMP COMMENTS
Part D: Transportation Management Plan (TMP)

General Comments

I agree with the comments of Nicholas Richter, Bob Cooper, Vicky Schiantarelli, and other neighbors. My focus is the TMP due to the limited amount of time I've had to review the draft MIMP and DEIS for the public hearing. I will submit in writing my additional comments about the rest of the proposed MIMP and DEIS later during the comment period. My task tonight is to address in as much detail as possible the TMP.

The stated goal for single occupancy vehicle use (SOV) is 50% -- exactly the same goal articulated in the 1994 MIMP that was never met. This is not a good faith goal; this is the absolute minimum goal they can set.

Nicholas Richter did a comparative analysis of different current goals and current SOV rates reported in TMP plans from other MIMPs, including Children's Hospital, Virginia Mason, Seattle University, Seattle Central Community College, Harborview Medical Center, and Swedish First Hill.

According to these documents, SMC is the only major institution that has failed to meet its previous SOV target. All other Major Institutions met or exceeded their goals. While Virginia Mason may be uniquely situated to take advantage of excellent transit service, Children's Hospital, Seattle University, and Seattle Central Community College all are in similar transit services areas with similar levels of connectivity to the surrounding community as SMC.

Being a world class institution means leading the way and striving for excellence in all areas of operation, including the TMP that forms part of the underlying rationale for the type of heights and development standards allowed by a MIO-zoned area. Swedish/Sabey has not lived up to the standards of a prestigious institution in this area, as it has failed to meet the 1994 goals of the TMP. All other institutions have succeeded in reducing their SOV rate below the mandated 50% goal. This might also explain why it has not been ranked well for its health care performance reported by Consumer Reports and other organizations[1]. Adoption and enforcement of Children's Hospital TMP program resulting in a 38% actual SOV should be the starting point. The expertise exists and TMP best practices are no mystery. Successful institutions reflect a culture of excellence and a commitment to their plans - the two least ambitious and least successful TMPs belong to the Swedish campuses.

The adjacent TMP for Seattle University sets a daytime SOV goal of 35%. If anything, the academic institutions have a handicap because they must include students in their standards, not just day-time employees as Swedish does.

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[1] See http://health.usnews.com/best-nursing-homes/search concerning the nursing home facility located on the Campus. Also see Consumer Reports for health care provider and hospitals ratings.

Children's Hospital has cut its SOV use nearly in half (down to 38%) in the last 20 years, but SMC cannot achieve its 50% SOV goal in the same period of time. Children's Hospital is in a potentially more challenging location than SMC. Their success reflects their ability to manage cultural change and adhere to standards that make them leaders in the Major Institution community. Their current goal under its new MIMP is 30% SOV mode share. SMC should use the same goal and adopt the entirety of the Children's Hospital TMP.

Meanwhile, suggestions about testing commuter incentives, more fully subsidizing ORCA card purchases (other employers provide free ORCA cards), and incentivizing employees to live nearby are promising – but only if there is some enforcement mechanism to push for achievement of the SOV goals in the TMP. Sabey must stop its practice of buying housing and let employees purchasing them might also be helpful.

Suggestions have been made in CAC meetings that a more aggressive policy be put in place that would discourage employee and vendor parking in the neighborhood by:

- paying for additional parking enforcement patrols in the area;
- paying for additional bus connections to/from the campus;
- prohibiting vendors from doing business on the property without a ticket from the parking facilities; and
- subsidizing patient parking.

Specific Comments

Page 88

"Subsidize the cost of the restricted parking zone (RPZ) stickers for areas surrounding the campus"

Is SMC proposing to move away from the current practice of fully paying for Residential Parking Zone (RPZ) permits in the surrounding neighborhood to "partially subsidizing" such permits? No subsidy level is listed. Swedish/Sabey has not only failed to keep its promises to the neighborhood, but it has proposed roll-backs as proposed new gains throughout the draft MIMP, we should confirm its exact intentions. According to the proposed TMP, Swedish/Sabey wants to redirect RPZ permit payments into other unspecified neighborhood transportation funding sources[2]. In light of SMC's dismal TMP performance, not only should SMC continue to provide 100% subsidy for RPZ, SMC with SDOT should look to the RPZ and parking changes made on First Hill[3] as part of the TMP and pay for other neighborhood transportation funding sources.

[2] See Swedish Cherry Hill Medical Center Major Institution Master Plan Draft EIS, May 22, 2014.

[3] See SDOT First Hill Community Parking Program Parking Study Findings – June 2009; First Hill Neighborhood On-Street Parking Study, July 13, 2009 for SDOT by Heffron Transportation, Inc.; SDOT Community Parking Program: First Hill website, http://www.seattle.gov/transportation/parking/cp_firsthill.htm.

Page 91

"The 2013 Recommended Bicycle Master Plan identified 18th Avenue as a neighborhood greenway"

In Appendix D Table 1, Policies T6 it indicates that Swedish would provide "pedestrian and bicycle enhancements along the site frontage consistent with the greenway designation". SDOT has determined that 18th Ave through the Swedish/Sabey campus is not a designated greenway.

In contrast, Seattle Children's donated more than $3,000,000 to the City of Seattle to fund bike and pedestrian improvements in the surrounding neighborhood, which resulted in the implementation of the 39th Ave Greenway. These donations were written into their MIMP (page 95) and are a part of their overall TMP. Swedish is encouraged to research the positive results that these efforts have brought to Seattle Children's, both in terms of physical improvement in the neighborhood and the goodwill that has been brought to their institution as a result.

"The campus currently provides 132 bicycle parking spaces for visitors and employees."

None of these appear to be provided on the driveway plaza. There is a concrete slab sized for bike parking in front of the James Tower, but no racks. During several of the CAC meetings, members of the public biking to the meeting were forced to chain their bikes to a lamp pole instead of a secure rack.

"Based on future population projections presented previously in this MIMP for Alternatives 8, 9 and 10, the plan would require 131 to 128 bicycle parking spaces, respectively"

Is 131 to 128 additional bicycle parking spaces being proposed, or after adding millions of square feet of additional space Swedish may remove between 1 and 4 bicycle parking spaces while still meeting the bare minimum required?

If the latter, how does Swedish intend to increase bicycle usage on campus when they make it impossible to park bicycles?

Page 92

"Depending on the overall effectiveness, these programs may be considered for ongoing implementation."

Discussion of "pilot" programs is problematic, as demonstrated by its TMP failure for over 20 years. A program that lacks institutional commitment will fail. Successful TMP programs require consistent and prolonged effort to achieve results. The "pilots" described are not innovative new programs, but tried-and-true, off-the-shelf defaults that nearly every TMP has because they are widely known to be effective. There is no reason to "pilot" these changes.

These "pilots" alone will not cause significant change. Swedish Medical Center needs to demonstrate commitment and the will necessary to implement serious changes to their transportation management. Bold measures are required, not incremental "pilots"

that end up being flashes in the pan. Those neither affect change nor instill neighborhood confidence.

Page 94-96: Table D-4

Transit: Provide all tenants with access to a minimum 50 percent subsidy of transit pass cost including ferry, rail and increase this subsidy, if necessary, to achieve the SOV goal.
A clear new subsidy should be established as part of the MIMP. History has clearly shown that 50% is not sufficient to adjust the SOV rate at Cherry Hill. Seattle Children's provides a 100% subsidy. Seattle University provides a 90% subsidy. As a starting point, Swedish should commit to providing a 100% subsidy for transit passes until the SOV rate drops below 50% through the combined measures contained in the TMP.

Bicycle: Bike lockers for a fee
The fee should be nominal or free.

Bicycle: Commuter Incentive Pilot: Work on a biking and walking incentive program. Work with onsite retail to offer bicycle benefits or other commuter incentives (e.g., Starbucks, gift shop, cafeteria)
As mentioned, we already have examples of success in this area. A successful incentive program would include:

- A cash bonus for each day where the commute is completed by a non-SOV means (Children's Hospital currently pays $65 per month).
- A free bike for employees who commit to using it for their commute.
- A $100 per year bonus for commuters who walk or bike.
- Instead of negotiating with the onsite shops, why not simply deposit money onto Starbucks cards that belong to employees who are biking/walking?

Parking: Restricted access to monthly parking passes.
Access should be severely restricted and priced at least 1.5x a one-zone peak transit pass (currently $90).

Neighborhood Parking Reduction: Regular contact with City parking enforcement to encourage patrolling
Swedish Medical Center should simply pay the City for additional patrolling in the neighborhood or provide the enforcement and security directly.

DEIS COMMENTS
3.7 Transportation

General Comments

It is unclear why certain streets were selected for further analysis and consideration, not others. For example, 13th Ave is referenced, but not 19th Ave, although 19th Ave had higher volumes of traffic and more reported accidents. Explanation as to how these determinations are made should be provided in the DEIS. Otherwise it appears as an oversight.

Table 1-1, Page 1-8: Transportation – Bicycle, "18th Avenue where it bisects the campus has been identified as a potential Greenway in the Bicycle Master Plan, providing enhancements for pedestrians and bicyclists."

The City's greenway will not run through the campus.

Table 1-1, Page 1-8: Transportation – Pedestrians, "Swedish has proposed to create a "Health Walk" or walking path around the Swedish Cherry Hill campus along 15th Avenue, E Cherry Street, 18th Avenue, and E Jefferson Street."

This feature is not an effective mitigation measure, amenity, or an enhancement.

Table 1-1, Page 1-9: Transportation – Traffic Volume, "Assuming the 50 percent SOV rate..."

The assumption should be based on where Swedish/Sabey is, not where it has been able to get to... The same 50% SOV rate was set in the 1994 MIMP. 20 years later the institution has not achieved that goal. In contrast, other institutions both in similar areas and in areas where transportation is arguably more difficult have exceeded this goal and are currently setting targets well below 50%.

Given the TMP presented in the draft MIMP, the lack of commitment expressed ("Pilot" realistically translates into "One time"), and the track record of failure in this area, Swedish must do more. Again, Children's Hospital is ***the*** model for TMP plans in the Seattle area. The institution should adopt this plan on the Swedish Cherry Hill campus. This should be worded with strong language that demonstrates serious commitment because otherwise, the EIS will fail to reflect the realities caused by the TMP.

There is only one element of the TMP that is novel: offering possible subsidies to employees for living near the hospital. This could be incorporated into Sabey and its affiliates selling their residential housing stock to employees who qualify as first –time home buyers, and/or reducing rents they charge to a certain percentage under current market rates.

loading berths. The non-compliance does affect the TMP and the flow of the vehicles and trucks on the campus.

3.7.2.4 Transit and Shuttle Service

Due to the proposed cuts in transit service, it is unwise to presume that transit service will increase; rather it is wise to presume that transit service is likely to be reduced or eliminated. Therefore, Swedish/Sabey should consider how it will subsidize the cost of providing transit service to cover those routes being cut or reduced.

3.7.2.5 Traffic Volumes

Despite repeated neighborhood requests, traffic volumes were not studied to also coincide with staff schedules. These schedules do not follow traditional AM and PM peak hours.

3.7.3 Impacts

Although there are a number of transportation projects underway or proposed, a number of them are not reasonable to consider having direct influence on the Swedish/Sabey TMP:

- 18th Avenue Neighborhood Greenway: SDOT will not be including the campus as part of its Bicycle Master Plan as a greenway.
- First Hill Streetcar: This project is outside of the 0.25 mile walking standard SDOT uses to measure pedestrian usage. This project was designed to address transportation needs with the urban village.

3.7.4 Mitigation Measures

I have included additional mitigations for adoption for the proposed TMP:

- Adopt the Children's Hospital TMP
- Reduce, if not eliminate, company vehicles, campus parking, and trips used for delivery service (e.g., LabCorp)
- Fully fund the RPZ program
- Enhance the RPZ program with the neighborhood
- Sell the current Sabey-owned housing stock to employees to increase the number of employees living in the neighborhood with the proviso that this housing stock remains in the marketplace, not any campus owners, with no reversion to the institution, Sabey Corporation, or any affiliates

3.7.4.2 Physical Improvements

The proposed TMP does not go far enough. Additional physical improvements should be considered for execution including but not limited to:

- left-turn signalization on Jefferson for left turns onto 12th Ave

- left turn prohibition onto Jefferson from 18th Ave and 16th Ave
- left turn prohibition onto Cherry from 16th Ave
- removal of bus rest stop on Jefferson between 18th Ave and 19th Ave, as well as 19th Ave and 20th Ave
- setback of parking along Cherry on both sides of the street to provide adequate sightlines at all cross-sections
- no parking along the major institution campuses boundaries along Cherry during peak hours
- adopt the First Hill RPZ permit policies and parking restrictions for the surrounding campus

Swedish/Sabey should pay for all street and traffic improvements.

Conclusion

I agree with the comments made by Nicholas Richter, Bob Cooper, and Vicky Schiantarelli. With minimal efforts to attempt to meet Code (in some areas, unsuccessfully) and dismal performance/compliance of its current TMP or the 1994 MIMP, Swedish/Sabey has demonstrated it cannot be trusted and should get no consideration or concessions from the City or neighborhood. The partnering experiment allowed by the City between major institutions and private developers has turned the Code into a mockery and harmed this neighborhood. There is no place in Seattle for commercial enterprises to control or direct non-profit services. It doesn't work with drinking water or prisons; it doesn't work here. This must come to an end.

Thank you,

Jerry H. Matsui
541 19th Ave, 98122

Jesse Freedman
1604 E Cherry St
Seattle, WA 98122

City of Seattle
Hearing Examiner
P.O. Box 94729
Seattle, WA 98124-4729

June 29, 2015

Dear Hearing Examiner,

I am writing today to express my strong reservations regarding the Swedish development plan on First Hill.

As a resident of Cherry Street, our home, and those of our neighbors, will - quite literally - be overwhelmed the size and scale of Swedish's plan for vertical expansion.

The scope of the Swedish development plan is simply inappropriate for a residential neighborhood. As I say: our home - like so many others - will be completely overshadowed by Swedish and its expansion upwards. Our home will no longer get suitable amounts of light, and will pale in comparison to a medical complex that dwarfs Cherry Street.

My wife and I moved to this neighborhood specifically because of its skyline, its quiet streets, and family-friendly atmosphere. With a hospital complex as large and brash and expansive as this one, that neighborhood will cease to be a neighborhood, and will instead become a highly trafficked area with a medical facility that trumps all structures around it.

This is simply not the area for such a project: this is a neighborhood, not an industrial park or suburban medical center.

I strongly urge you - indeed, I implore you - to stop this expansion. It is inappropriate for First Hill.

Sincerely,

Jesse Freedman

Statement of Squire Park Community Council

Presented by Joanna Cullen, President of Squire Park Community Council

To: City of Seattle Hearing Examiner in the case of the application of Swedish Medical Center for a Major Institution Master Plan

July 13, 2015

The Squire Park Community Council is the officially recognized community council for the Central Area neighborhood in which is located the institution which is the subject of this hearing. The Squire Park Community Council distributes newsletters to more than three thousand households in our neighborhood. The Community Council is governed by a board consisting of more than fifteen residents who are elected at a public meeting held annually in January. All meetings are open to all and are widely publicized. The members of the Community Council and its board are overwhelmingly in support of a Major Institution Master Plan for this campus of the Swedish Medical Center that results in less development than is called for by the proposed MIMP. It is the position of SPCC that the proposed MIMP fails to property balance the needs of the institution --- Providence Health and Services and its subsidiary Swedish Medical Center--- with the need to protect the livability of the neighborhood. The impacts of height, bulk, and scale, along with the traffic that would be generated are unacceptable and can be avoided if Providence Health and Services, and the Sabey Corporation, the owner of one half of the Swedish campus, locate some of their uses in different locations.

A. THE EIS AND MIMP FAIL TO CONSIDER SOLUTIONS THAT SATISFY ALL OF THE INSTITUTION'S STATED NEEDS AND WHICH ALSO PROTECT THE LIVABILITY OF THE COMMUNITY

You have received much testimony and many documents describing the adverse impacts of the proposed Major Institution Master Plan on community livability and vitality. I will not repeat details here, other than to briefly state that the proposed development would include an additional 1.6 million square feet in buildings up to 160 feet tall, and would generate up to 11,000 daily Single Occupancy Vehicle (SOV) trips per day. This is in a neighborhood which, in Seattle's Comprehensive Plan and in the City's zoning scheme, is small-scale residential.

Ample testimony has made a strong case that the stated needs of the institution could be satisfied if some of them were provided for on this campus and some of them were provided for in other locations. Furthermore, some of the stated needs of the institution could be satisfied in locations in the existing Major Institution Overlay which were sold by Swedish in 2002 to the Sabey Corporation which intended to develop a biotech research center on the portion of the campus declared "unneeded" by the Swedish administration.

The MIMP you are considering is a proposal by a subsidiary of Providence Health and Services, one of the largest health care providers in the United States. Providence, and its subsidiary Swedish have numerous locations throughout the region. The Central Area campus is merely one of them.

The Land Use Code states that the MIMP process "shall include" ... (a) description of ... decentralization options including a detailed explanation of the reasons for considering each alternative, ... SMC 23.69.032 C.1.e.

This is not optional. The Code requires it.

The institution and the drafter of the EIS have refused to provide that required information. In order for the CAC and the Director of the Department of Planning and Development to fulfill their statutory duties, there must be a serious evaluation of alternatives that would locate some of the proposed Providence/Swedish uses in locations other than its Central Area campus.

Most, if not all, Squire Park residents would accept some future changes by Swedish hospital on its campus in our neighborhood. Swedish Medical Center has great social benefit and future changes at the institution's Central Area campus could be necessary. There is an understanding that the community, in the local and larger senses, benefits from the ability of the hospital and essential health care providers associated with it to have modern facilities. We have empathy for the clients and patients of Swedish and, in fact, many Squire Park residents are clients and patients. If Providence's Central Area Swedish has "reached its capacity" it is because it sold half of its campus to a developer with a speculative development scheme that faltered. To alleviate its claimed lack of capacity, Providence should first seek to reclaim that portion of the campus it sold.

At the same time, Providence must consider locating some of its future needs in other locations. Some or all of those locations should be in areas that the Seattle Comprehensive Plan identifies as Urban Villages.

We ask the Hearing Examiner to do what the Director of DPD would not do. That is, to uphold the application of the Comprehensive Plan. The urban village strategy of the Comprehensive Plan is a "comprehensive approach to planning for a sustainable future" that is "intended to maximize the benefit of public investment in infrastructure and services." It "tries to match growth to the existing and intended character of the city's neighborhoods." Plan at 1.2-1.3. "Most residential and job growth is to be directed to urban centers and villages. Areas outside urban villages are to accommodate modest amounts of growth in less dense development patterns." Plan at 1.3, 1.22.

Ample evidence which you have received describes the impact on the livability and vitality of the neighborhood if the institution is permitted to develop according to its proposed MIMP. There has been less attention given to the attack that the proposed MIMP makes on the Comprehensive Plan's goals of "maximizing the benefit of public investment in infrastructure and services."

Transportation issues are a key example of this. If Providence is permitted to go forward with the massive increase in jobs in this residential neighborhood, the public's plan for most efficiently building and maintaining the streets and transit system will be damaged.

The City should not be put in the position of improving and maintaining streets that will handle 11,000 daily trips in a small-scale residential neighborhood because the developer refused to consider locating some jobs in an urban village.

The mass transit system that the region is building should be supported by Providence's locating many of its jobs within walking distance of a light rail station or locations with robust bus service. A

reasonable concentration of density is what the Comprehensive Plan requires. If the Providence/Swedish plan located many of its new jobs in locations where its workers could more conveniently use mass transit, it would serve the interest of not only the immediate Squire Park and Central Area neighborhoods, but also the region's interest.

A Transportation Management Plan (TMP) that relies on punitive measures and a system of private shuttles is not fair and not sustainable. Providence/Swedish employees, and the larger community, are entitled to a development that supports the existing public plans for and investments in mass transit.

Of course the Director of DPD is right when she says that the Comprehensive Plan does not "forbid" the location or expansion of a major institution outside of an urban village. However, it's not reasonable to conclude that the Comprehensive Plan is entitled to *no* respect. There is nothing in the DPD Director's report exploring ways in which a significant number of vehicle trips could be directed to other locations served by mass transit. This might be an acceptable analysis if there were no other alternatives. But that is not the case.

If not now, when? The Comprehensive Plan is intended to be a law whereby many developments are directed in a way that preserves legitimate private and public interests. The response of the Director of DPD in this case seems to be (to the extent that one can divine an explanation) that Providence/Swedish is too big for the Comprehensive Plan to apply. The result should be the opposite. The big land use decisions should especially be subject to the expectations of the Comprehensive Plan.

The narrow alternatives presented so far are not adequate to comply with the requirements of the Land Use Code and the Comprehensive Plan. The Director of DPD continues to construe her duty as only analyzing "alternatives" presented by the institution. The law requires more than that. The law requires actual alternatives, not marginally different versions of the institution's plan labelled as "alternatives.

B. THE MIMP FAILS TO MEANINGFULLY ADDRESS THE HUMAN DEVELOPMENT GOALS OF THE CITY

The MIMP should not be approved until the institution appropriately addresses the Human Development Goals of the city. Seattle Municipal Code mandates that you cannot approve the MIMP unless the residential character of the neighborhood is protected and adverse impacts to the surrounding community are minimized. (SMC 23.69.032.E.2; SMC 23.69.002) DPD must assess how the proposal will address and contribute positively to human development issues in the community. (SMC 23.69.032.E.3) There are also a number of requirements specific to the development program and development standards components of the proposed master plan that call for more specific protections of the neighborhood and community interests. (SMC 23.69.032.E.4 and 5)

The current proposal does not meet these requirements for approval and the Final MIMP is incomplete and inadequate. The information provided about how Swedish will address and contribute positively to human development issues in our community is wholly missing. Contributions to Ballard High School in no way benefit Squire Park students, and while health efforts in Tukwila are laudable, they do not help patients here in Seattle who are suffering from medical debt. Moreover, Swedish frequently describes what it *has* done, without clearly detailing how expansion *will* enhance future efforts to address the

relevant human development policies and goals. The benefits to the institution of this expansion are extraordinarily high while the impacts to the local community are significant and adverse - the proposal is completely out of balance.

Squire Park Community Council proposes that Swedish include in its MIMP proposal, as part of addressing the Human Development Goals, a clear indication of how it will benefit the health and well-being of neighbors who live here and will suffer the adverse effects of the expansion. That includes, at the very least, charity care for our patients, medical debt forgiveness, significant contributions to public bus service, and contributions to other neighborhood services.

J- Cullen, President Squire Park Community Council

February 10, 2015

Katie Porter, Chairperson, Citizen Advisory Committee
Providence/Swedish MIMP

Ms. Stephanie Haines, Land Use Manager
Department of Planning and Development
P.O. Box 34019
Seattle, WA 98124-4019

Ref: Master Use Permit 3012953
Project address: 500 17th Avenue

Dear Ms. Porter and Ms. Haines:

By this letter the 12th Avenue Stewards wish to note for the record their opposition to the proposed expansion of the Swedish Cherry Hill Medical Center as set forth in the Final Major Institutions Master Plan (MIMP) and the Final Environmental Impact Statement (EIS). The proposed expansion is fundamentally incompatible with the low-rise and single family residential character and zoning of the surrounding neighborhood. It is imperative for the future livability of all Seattle neighborhoods for the City of Seattle to follow the recent direction of the City Council designed to preserve and protect the residential nature of Seattle's many neighborhoods. We also oppose the Seattle Department of Planning and Development recommendations that endorse this proposal.

It is essential that the expansion be consistent with the Seattle Municipal Land Use Code that requires:
"A. Permit appropriate institutional growth within boundaries while minimizing the adverse impacts associated with development and geographic expansion;"

NOTE: the operative word here is MINIMIZE adverse impacts on the neighborhood

"B. Balance a Major Institution's ability to change and the public benefit derived from change with the need to protect the livability and vitality of adjacent neighborhoods;

NOTE: This says nothing about the need of the institution. Rather it is the need to protect the livability and vitality of adjacent neighborhoods. It is the institution's ability to change that is to be balanced.

"C. Encourage concentration of Major Institution development on existing campuses, or alternatively, the decentralization of such uses to locations more than 2500 feet from campus boundaries"

NOTE: If there is more growth than can be accommodated without causing adverse impacts, the Code says that the uses that exceed the capacity of the current campus should be located elsewhere.

"I. Make the need for appropriate transition a primary consideration in determining

setbacks. Also setbacks may be appropriate to achieve proper scale, building modulation, or view corridors."

NOTE: Swedish has proposed zero lot line setbacks and minimal upper level setbacks for the vast majority of the campus. The current proposal does not provide appropriate transitions along the perimeter, through ground level or upper level setbacks or building modulations.

Neither the MIMP nor the DPD recommendations honor the intentions of the Land Use Code. They are an existential threat to the livability of the neighborhood. The EIS states there are multiple impacts that are "unmitigatable". The City of Seattle cannot endorse a proposal with these flaws.

The mission of the 12th Avenue Stewards is to advocate for the vitality and livability of the 12th Avenue Neighborhood. We believe that the proposed expansion threatens the neighborhood as a result of increased traffic loads on arterials and other streets, increased parking demands, and increased building heights incompatible with the character of the neighborhood, all documented in the FEIS. A serious issue for the neighborhood is housing affordability and access. We encourage alternative modes of transportation. The expansion proposal to 2.75 million square feet of primarily medical office buildings will bring many more single occupancy vehicles to the neighborhood as daily commuters since no provision for housing or increased mass transit is included as mitigation in the MIMP and the FEIS. Commuting workers are unlikely to contribute to the neighborhood economically and will not be participate as part of the social fabric since they will come to the facility for their shift and leave when work is over.

The 12th Avenue Stewards note with particular concern the proposal to build 160 foot tall structures that will dwarf the adjacent neighborhood and cast shadows that will *eliminate* sunlight during parts of the year for neighbors north of Swedish.

Substantially increased traffic associated with the proposed expansion will make the existing congestion on Cherry/James (especially as it connects with I-5) significantly worse and four additional intersections in the neighborhood will operate at Level of Service "F" (extreme stop-and-go congestion) during PM peak hours. This the estimate of Swedish's own transportation expert. Remarkably, that estimate, while it briefly notes the additional traffic impacts of several proposed mixed-use developments, it also completely ignores a large number of additional mixed-use developments in the vicinity that are already planned, such as six new mixed-use buildings on or near 12th Avenue, future development slated for the King County site, and for Seattle University, including the proposed event center/sports arena only two blocks away.

The FEIS proposes no mitigation for these impacts. It is the essential function of the FEIS to consider reasonable alternatives that would mitigate significant environmental impacts.

Swedish Cherry Hill lies outside of an urban village. Whilet is allowable for such an institution to exist in this location, the Land Use Code demands that the livability and

viability of the neighborhood and transitions to the neighborhood in terms of height, bulk and scale, and transportation impacts be of paramount consideration. The Seattle Hearing Examiner found these concerns to be critical in its findings with respect to the Children's Hospital MIMP. To discount them in this neighborhood raises significant racial, social justice, and equity issues in the treatment of Squire Park relative to the findings for Laurelhurst.

Rather than adding to the vitality and livability of the neighborhood, the proposal will *significantly degrade the environment. It should not be allowed in its entirety.*

The 12th Avenue Stewards recommends the following:
• Maximum height allowed on the campus to be 105' at the center of the campus between 16th and 18th Avenue.
• Maintain the height limit of 65' on the west ½ block of 15th Avenue to match the MIO of Seattle University on the adjacent block.
• Mitigate the development on east ½ block of 18th Avenue by requiring a minimum of 4 buildings and open space. Maximum height of 37' with a 25' rear yard setback.
• Adjacent to Cherry and Jefferson, require 15' ground level setbacks; upper level setbacks at 30'h of an additional 10' (25' from property line).

The Transportation Management Plan for commuters to new uses or new developments established pursuant to the MIMP should require a SOV rate no more than the rate reported by a similar medical institution, Virginia Mason, 29%. The SOV rate for existing uses should be reduced gradually over several years to a rate no more than 35%.

Sincerely,

Ann Schuessler
Chair,12th Avenue Stewards
cc: Citizens Advisory Committee

Statement by Joanna Cullen, 975 21st Avenue, Seattle WA 98122

To: City of Seattle Hearing Examiner in the case of the application of Swedish Medical Center for a Major Institution Master Plan

July 13, 2015

Our neighborhood is small-scale residential in Seattle's Comprehensive Plan and any proposed development that would include an additional 1.6 million square feet in buildings up to 160 feet tall, and would generate up to 11,000 daily Single Occupancy Vehicle (SOV) trips per day will have a profound impact on the livability of the residents and the entire area. I live near 21st and E. Union Street and recently this area between E. Union and E. Marion on 21st was approved for a Swedish RPZ. The signs will be going up this month. This serves to further demonstrate that the transportation impacts of the current Swedish campus are far from being resolved.

During the appeal hearings Swedish admitted that increased traffic for James Street is likely under their proposal. James is not a street that can bear any further impacts.

If Providence's Central Area Swedish has "reached its capacity" it is because it sold half of its campus to a developer with a speculative development scheme that faltered. To alleviate its claimed lack of capacity, Providence should first seek to reclaim that portion of the campus it sold and locate additional needs and services in areas where the planned infrastructure is designed for this scale of development.

Transportation issues are a key example of this. If Providence is permitted to go forward with the massive increase in jobs in this residential neighborhood, the public's plan for most efficiently building and maintaining the streets and transit system will be damaged.

Hearing Examiner for Project: 3012953 Zone: MAJOR INSTITUTION OVERLAY-105'

Madam: Let me begin, please, with some indications of my bona fides as a neighbor directly concerned with the varied environmental-social impacts of the above numbered project. In June 1988, I and my wife purchased a 1909-built mansion at 802 16th Ave. that in 1938 had been doubled in size to serve as a convent for nuns teaching at the near-by Immaculate Conception school. Then in 1978 the convent in this L-R 3 residential zone was sold and converted into a 4-plex one block from the Cherry Hill hospital, then owned and operated by the Sisters of Providenee. That religious order's hospital soon was losing so much money that at the turn of the century the institution was sold to the Swedish Hospital corporation, which in turn years later was absorbed by/consolidated with a greatly expanded, nation-wide Providence corporation.

In 1994 I participated as a watchful citizen (one of the 1989 founders of the Squire Park Community Council on which I have served as a board member and which has the motto "Preserving diversity") in negotiations of Squire Park neighbors and other citizens concerned with a prior MIMP for the Providence Cherry Hill Hospital. What now seems to me most significant for the present MIMP was the 1994 plan for dealing with the environmental impact concerning traffic. The Traffic Management Plan in the CAC- and DPD-ratified 1994 MIMP required that the hospital reduce its reliance on the multitude of workers' use of single occupancy vehicles to get to and from the hospital. However, at no time has the targeted reduction (I believe from 60 or 50 to 30 percent) been achieved, nor has the DPD invoked its powers to effect, or even affect, significant reductions in SOVs serving hospital personnel..

This experience in addition to the actions (or inactions) of the Citizens Action Committee majority and the DPD official serving on it for the present MIMP (rarely questioning, invariably supportive of the Swedish Corporation's plans in all areas) has naturally left me dubious for the final MIMP or for the DPD possibly taking account of the various concerns of the neighbors and the Cherry Hill neighborhood generally about not merely traffic impacts, but other wider environmental impacts There are many affecting the light and shade, sight lines, density and general livability, neighborly sociability, availability, etc., of residential housing that arise from the projected huge expansion (doubling, tripling) of the density of persons (patients, medical, and technical and other supporting staff) during major working hours of the hospital and the projected doubling of the height, bulk, and scale of the buildings themselves.

With reference to the population impacts, neighbors have objected that the project (now, I understand, failed) of the Sabey Corporation (the for-profit developer partnered with Swedish) to institute a "world class" neurological research facility at the Cherry Hill location, drawing patients and researchers from around the world. Such an institute, insofar as it is not necessary for treatment of patients from the Cherry Hill and nearby areas, does not fulfill the requirements for a hospital in this residential area. The "Major Institution" is located in accord with the city-wide 1996 urban plan (on which I also did some work) such that ancillary medical research activities of this sort (and others) should not be established in this L-3 and SF5000 residential

neighborhood zone. Such activities might very well be welcomed in any one of the several other Seattle campuses of the Swedish/Sabey corporation that are in planned urban centers.

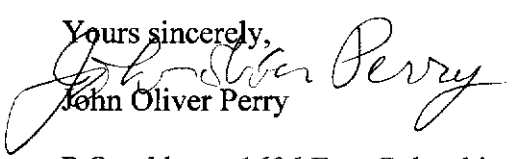
Relevant to the history of the for-profit Sabey Corp involvement in the Cherry Hill hospital campus development (rendering at least debatable its presence there) is the fact, which the CAC pointed out and questioned several months (a year?) ago, that Swedish officials determined (in 2004) that there was excess capacity at the Cherry Hill campus. Thus, obviously mistakenly in general business terms, Swedish sold over 30% of its MIO to Sabey, including the area for the new Kidney Center on 15th Ave at Cherry, the now Sabey-modernized James Tower and what became the Jefferson Tower, both of which to this date are still underused, that is, have high vacancy rates. One proposal raised, therefore, in the CAC was that Swedish reacquire most of the percent of its MIO ceded to Sabey and thus make it able to reduce substantially the height, bulk and scale of the new buildings projected in the current MIMP (then, I believe, #10).

Nothing has come of this proposal, so that the basic requirements for Swedish Cherry Hill potential campus expansion accepted by the CAC and DPD have not changed substantially since the decision not to expand the MIO across Cherry and Jefferson streets nor the midline between 18th Ave and 19th. Many issues regarding the use the west side of that midline were never satisfactorily resolved, such as requiring breaks in the mass on the ground and its set-backs or the proposed uses of the presently idle parking lots. That Swedish should be allowed to construct on this part of their existing MIO a guest hotel to serve the needs of Ballard and First Hill campuses makes no sense at all, Ballard being the far more logical site.

I could object to a number of other proposals in the MIMP before you, but I believe you have been made aware of the many deficiencies in Project 3012953 sufficient to reject it in toto and send it back for a new CAC process with a warning that the next drafting of a MIMP take a better account of the diversity of interests—neighborhood, DPD, corporation, city-wide—involved.

Thank you for your careful attention to neighborhood concerns in this complex matter.

Yours sincerely,



John Oliver Perry

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July 21, 2015

Via E-File

Sue Tanner, Hearing Examiner
City of Seattle
700 Fifth Avenue, Suite 4000
Seattle, WA 98104

Re: Swedish Cherry Hill MIMP—Response to Public Comment

Dear Examiner Tanner:

As you know, this law firm represents the applicant, Swedish Medical Center ("Swedish"), in its effort to obtain approval of a new Major Institution Master Plan ("MIMP") for the Swedish Cherry Hill campus. This letter responds to the public comment letter submitted on July 15, 2015, by the Bricklin-Newman law firm on behalf of its client, Washington Community Action Network ("WashCAN"). WashCAN also filed an appeal of the adequacy of the Final Environmental Impact Statement ("FEIS").[1]

Typically, the applicant's presentation on a pre-decisional MIMP hearing takes place after public comment, which allows the applicant an opportunity to respond to concerns raised by the public. Here, most of the members of the public who testified did so on the first day of hearing, prior to the applicant's presentation. Several WashCAN members offered their oral and written comment at this time. In addition, in an effort to ensure the public had its say, the Examiner allowed the public to submit written and oral comment throughout the consolidated hearing, even after the close of the applicant's responsive testimony.

Despite being present at the entire hearing, Bricklin-Newman did not offer any expert testimony on MIMP transportation issues during the pre-decisional hearing, and withheld its comment letter until *after* the conclusion of the applicant's case on the merits of the MIMP, and after its witnesses testified during the SEPA appeal. The Bricklin-Newman letter is more in the style of legal briefing than public comment, despite the Examiner's decision that legal briefing on the merits of the MIMP would not be accepted. Such gamesmanship does not further the pre-decisional hearing's purpose of providing the Examiner and Council with the information they need to make an informed decision on the MIMP. Under the circumstances, the Examiner could have stricken the WashCAN letter from the record transmitted to Council.[2] However, since the

[1] This letter does not address issues related exclusively to FEIS adequacy, which will be briefed separately according to the briefing schedule set by the Examiner.

[2] The Bricklin-Newman letter also includes as an attachment a letter from a transportation planner who testified on WashCAN's behalf in the EIS appeal portion of the proceeding. The Examiner sustained the applicant's objection

Examiner exercised her discretion to admit the WashCAN letter, the applicant offers this letter to respond to the factual and legal points raised in the Bricklin-Newman letter.

This letter begins by arguing that the height, bulk, and scale are appropriate for major institutional development and consistent with Code requirements. The next section establishes that the Urban Village strategy is not an appropriate consideration on a MIMP decision. The third section demonstrates that the public benefit that will result from Swedish's expansion—similar to the public benefits detailed in MIMPs the Council approved for other institutions—meets the requirements of the Major Institutions Code. The fourth section reiterates Swedish's need for expansion and provides a counter to the testimony of Jack Hanson (upon which WashCAN relies). The letter concludes by discussing the importance and effectiveness of the TMP to address transportation impacts.

The MIMP Properly Addresses Issues Related to Height, Bulk, and Scale

The Major Institutions Code requires the institution to minimize the impacts of the development on the adjacent neighborhood, chiefly at the MIO boundaries. Thus, the proposed MIMP (1) responds to the neighborhood comment that the MIO not be expanded by constraining future development to the existing MIO, with no street vacations; (2) provides adequate transitions at campus edges; (3) provides reasonable mitigation of height, bulk, and scale through campus setbacks proposed by the CAC majority.[3] The tallest height limits are in the center of campus—not visible from the sidewalk of Cherry Street, thanks to generous upper-level setbacks—and on the western (i.e., downhill) parts of campus. Expert testimony established that, but for minor change on 18th and the center of 15th Avenue, the proposed MIMP includes no height limits along the campus edges that exceed existing MIO height limits. In fact, there is a proposed downzone on East Jefferson, directly adjacent to the existing single-family neighborhood.

The WashCAN letter proceeds from a faulty premise: that major institutional development is bound by the development standards of the underlying zone. In fact, the Swedish Cherry Hill campus, in common with many of Seattle's major institutions, was built decades before Seattle enacted a comprehensive zoning scheme that created underlying zoning of lowrise or single family. In recognition of the disparity between the long-established institutional uses (and their accompanying bulk) and the subsequently adopted zoning designations, and in an effort to prevent the major institutions from expanding horizontally to consume ever more of

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to the traffic letter and struck it from the record. The Examiner's exclusion of the traffic letter in this MIMP portion of the proceeding was entirely appropriate. WashCAN made no effort to offer expert traffic testimony during the MIMP portion of the proceeding, even though the same expert testified at length during the SEPA appeal. The Examiner properly rejected WashCAN's tardy attempt to insert its expert's written opinion into the MIMP portion of the hearing, after the close of the applicant's case on the MIMP and with no opportunity for cross-examination—especially where WashCAN had clear opportunity to present this expert witness during the MIMP portion.

[3] The setbacks in the MIMP pre-dated the recommendations of the full CAC. At the hearing on the MIMP, Swedish confirmed that it accepts the ground-level setbacks proposed by the CAC and asks the Examiner to recommend that Council so condition the final MIMP.

their neighborhoods, the Council adopted the Major Institutions Code at Ch. 23.69 SMC. Within the Major Institution Overlay created by this chapter, all design standards may be set by an adopted MIMP.

This was not always the case. Prior to 2001, the Major Institutions Code required MIMPs to comply with at least one underlying development standard: setbacks. *See* former SMC 23.12.120 ("In no case shall a setback from the boundary be less than required by the greater of the underlying zoning, or the zoning for property adjacent to or across a public right-of-way from the institution."). That proved unworkable, so the Council amended the Code to eliminate any minimum setback, in common with all other development standards. Ord. 120691 (2001) (§ 2 repealing Ch. 23.12 SMC; § 21 adopting current setback language without the requirement to match underlying zoning). Now, the Major Institutions Code directs the institutions to establish design standards sufficient to meet their institutional needs while emphasizing transitions from the edges of the MIOs to the neighboring areas.

Under the current Code, setbacks of the underlying zone are not even a consideration when evaluating proper setbacks for the MIO. The Code commands major institutions to:

> Make the need for appropriate transition primary considerations in determining setbacks. Also setbacks may be appropriate to achieve proper scale, building modulation, or view corridors

SMC 23.69.004.*I*. Because the Major Institutions Code does not require any setbacks, any setback provided helps to mitigate the effects of institutional development. The same analysis applies to height limits, façade modulation, upper-level setbacks, lot coverage, open space, and any other development standard found in the SMC.

Dr. Sutton, whose MIMP testimony WashCAN incorporated by reference,[4] may be expert in some areas, but hospital design is not one of them. She has never worked on the design of a hospital or medical center, and her only experience with medical centers was her service on the Virginia Mason CAC.[5] Other than her personal aesthetic sense, she was not able to articulate any basis for her opinion that the bulk proposed by Swedish was too large for the neighborhood. She could point to no industry standard on which the City could rely to set "appropriate" ground- and upper-level setbacks, and instead relied on vague reference to existing conditions (while mischaracterizing existing paved driveways and parking areas as "green open space"). Dr. Sutton's opinions were undermined by the CAC majority's recommendations regarding setbacks, as well as the testimony of John Jex, an architect with 35 years of experience designing medical

[4] Dr. Sutton testified in the EIS appeal and provided public comment during the MIMP hearing. Swedish presumes that WashCAN intended to incorporate only her MIMP public comment rather than seeking to influence the substantive MIMP decisions with SEPA testimony.

[5] The Examiner may recall that Dr. Sutton was the sole member of the CAC minority for Virginia Mason. In that proceeding, she opposed Virginia Mason's plan for 240' bed towers in a neighborhood where the underlying zone allowed 300' towers, arguing that the proposed development was too large for that high rise neighborhood.

institutions. The City may not impose a condition reducing development capacity without reference to specific facts and standards, which this record lacks, a deficiency that Dr. Sutton's testimony does not resolve.

The MIMP Is Consistent With Relevant City Plans, and the Examiner Lacks Jurisdiction to Condition the MIMP to Ensure Consistency

WashCAN, in common with many opponents of Swedish's expansion, argues that the MIMP should be rejected because the MIO is outside the urban village, and therefore, the Comprehensive Plan does not allow institutional growth at this MIO, despite the fact the hospital was established at this location long before the Comprehensive Plan was drafted. These arguments do not succeed because the Council may condition the MIMP in only two ways: to ensure compliance with the Major Institutions Code, or to mitigate environmental impacts identified in the EIS consistent with an adopted SEPA policy. Neither source of authority applies to ensure consistency with the urban village strategy; this section discusses both.

In Washington, a comprehensive plan is only a general guide and not a document designed for making specific land use decisions. The zoning code controls and trumps inconsistent provisions of the comprehensive plan. *See, e.g., Citizens for Mount Vernon v. City of Mount Vernon*, 133 Wn.2d 861, 873, 947 P.2d 1208 (1997).[6] A use must comply with a comprehensive plan only if the zoning code expressly incorporates the comprehensive plan into the decisional criteria for a proposal. Here, the Seattle Municipal Code does not require that an MIMP be consistent with the Comprehensive Plan in order to gain approval. See SMC 23.69.024-.032. Accordingly, the Hearing Examiner and City Council lack authority to condition or deny the MIMP based on the Comprehensive Plan.

The City Council confirmed years ago that the Comprehensive Plan's urban village strategy cannot be considered as part of the Major Institution Master Planning process:

> The City's Land Use Code (SMC Title 23) and substantive SEPA policies (SMC 25.05) authorize reference to the City's Comprehensive Plan as a basis for review of a proposed MIMP only with respect to specific Comprehensive Plan policies identified in those ordinances, neither of which include policies related to the 'urban village' strategy described in that Plan. Therefore **the Council lacks authority to consider those policies** as a basis for its decision whether to approve the proposed MIMP

[6] *See, also, e.g., Tugwell v. Kittitas County*, 90 Wn. App. 1, 8, 951 P.2d 272 (1997); *Hansen v. Chelan County*, 81 Wn. App. 133, 138, 913 P.2d 409 (1996); *Weyerhaeuser v. Pierce County*, 124 Wn.2d 26, 43, 873 P.2d 498 (1994); *Bassani v. Board of County Commissioners for Yakima County*, 70 Wn. App. 389, 396, 853 P.2d 945 (1993); *Lakeside Industries v. Thurston County*, 119 Wn. App. 886 (2004); *Pinecrest Homeowners Association v. Cloninger & Associates*, 151 Wn.2d 279 (2004); *Cingular Wireless v Thurston County*, 131 Wn. App. 756, 129 P.3d 300 (2006).

Ordinance No. 123263 (2010), Attachment A, Findings, Conclusion, and Decision of the City Council at Conclusion 28 (emphasis added). The Council wrote this language in response to the Hearing Examiner's analysis of the relevance of the Urban Village Strategy to MIMP adoption, specifically the Children's MIMP recommendation.[7] The Examiner's jurisdiction to recommend MIMP approval or conditioning is constrained by the Council's quasi-judicial precedent on this point, so the question of whether the campus is within an urban village is irrelevant.

This makes sense; the location of Swedish Cherry Hill was determined in 1910, 85 years prior to the creation of the urban village strategy and delineation of urban villages. Indeed, the hospital stood for decades before the City designated the underlying zoning as "lowrise" and "single family." The MIO recognizes and legitimizes the inconsistency created solely by City regulatory action.

The Major Institutions Code twice references a single section of the Comprehensive Plan. SMC 23.69.030.E.13.a & 23.69.032.E.3. Both instances relate to assessment of the ways the institution plans to achieve the "goals and applicable policies under Education and Employability and Health in the Human Development Element of the Comprehensive Plan." As explained in the MIMP and the Director's Report, the proposal is consistent with the applicable goals of the Human Development Element of the Comprehensive Plan.[8]

The increased development capacity of the MIMP is in line with the letter and spirit of the Major Institutions Code, as well as the rezone criteria (which are relevant only insofar as Swedish Cherry Hill seeks taller MIO height limits within the existing MIO). Consistency with the Comprehensive Plan is achieved through compliance with the rezone criteria of Ch. 23.34 SMC:

> Compliance with the provisions of this chapter shall constitute consistency with the Comprehensive Plan for the purpose of reviewing proposed rezones . . . .

SMC 23.34.007.C. The Director's Report contains an exhaustive, and correct, analysis of the MIMP's compliance with the rezone criteria. No additional conditioning is necessary to meet the requirements of the zoning code in general, or the Major Institutions code in particular.

Under SEPA, mitigation measures or project denial must be based on policies formally designated by the City as a basis for the exercise of its substantive SEPA authority. SMC 25.05.660.[9] The City's substantive SEPA policies are contained in SMC 25.05.675 and do not

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[7] Swedish Cherry Hill borders the urban village on 15th Avenue. Children's Hospital is separated from the nearest urban village by at least 10 blocks.

[8] WashCAN correctly surmises that the MIMP did not address goals that on their face do not apply to a medical major institution. WashCAN letter at 15 n.7. The Major Institutions Code does not require a MIMP to list Comprehensive Plan policies for the sole purpose of explaining that they do not apply.

[9] *Accord* WAC 197-11-660; *see also Nagatani Brothers v. Skagit County*, 108 Wn.2d 477, 739 P.2d 696 (1987); *Maranatha Mining, Inc. v. Pierce County*, 59 Wn. App. 795, 801 P.2d 985 (1990).

include a policy that addresses the urban village strategy.[10] The policies on Land Use and Height, Bulk, and Scale do provide that, subject to the Overview Policy, a decisionmaker may condition or deny a project to achieve consistency with the goals and policies of Section B of the Land Use Element of the Comprehensive Plan (and other policies not applicable here, specifically, the shoreline and critical areas policies). SMC 25.05.675.J, .G. But Section B of the Land Use Code does not forbid major institutions outside urban villages. To the contrary, Policy LU65 recognizes that major institutions are located in single family areas, and provides that their impacts shall be mitigated through the master planning process. This is precisely what is occurring here. In the absence of a SEPA policy addressing major institutional development outside urban villages, the Council lacks authority to impose a SEPA condition to mitigate any perceived inconsistency with the urban village strategy.[11]

Swedish Provides, and Will Provide, Substantial Public Benefit

Major institutions must provide public benefit in exchange for the additional development capacity of an MIO, and in every MIMP the Council has approved heretofore, the main element of the public benefit derived from the change of a major institution is the continuing vitality (and very existence) of the institution itself. Seattle's major institutions provide tens of thousands of jobs, and the health and education opportunities they provide are crucial to the City's quality of life. Swedish Cherry Hill, in particular, provides specialized healthcare such as treatment of brain, spine, and cardiac and vascular disease that is the envy of hospitals the world over. In addition, Swedish Cherry Hill, in common with its sister medical major institutions, provides millions of dollars' worth of uncompensated care every year. WashCAN's letter acknowledges this fact: "Swedish Medical Center provides these benefits – it is a hospital."[12]

Beyond the substantial public benefit associated with the continuing operation of a non-profit specialty hospital, Sherry Williams testified to other public benefits associated with Swedish Cherry Hill operations. Many of these benefits are listed at pages 69-72 of the MIMP. They include several not directly related to healthcare: food donations, employee drives, sponsorship of community charities, and support of athletic programs, among others. They also include healthcare-related benefits, such as: community heart screenings, mobile mammography services, stroke support group meetings, and other services. Ms. Williams testified these benefits will continue under the new MIMP.

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[10] Indeed, SMC 25.05.675 includes no SEPA policy that specifically addresses the "consistency with adopted plans or policies" element of the environment, so the Council lacks authority to impose a condition to ensure such consistency generally.

[11] Swedish does not concede any inconsistency. The Comprehensive Plan identifies the Cherry Hill campus as appropriate for major institutional uses and development.

[12] Some public comment suggested that because hospitals are required to provide uncompensated care, they should not be permitted to count it as public benefit. But the requirement diminishes neither the benefit to the public nor the cost to the institution. Hospitals are required to provide care, but they are not required to exist, and without the additional development capacity allowed by the Major Institutions Code, many of them would not.

In total, the public benefits identified in the proposed MIMP are very similar in kind and scope to the benefits the Council has previously approved for Virginia Mason, Seattle Children's, and a number of other medical major institutions. WashCAN seeks to hold the Swedish Cherry Hill MIMP to a higher standard—a standard not set forth in Code and never before applied to another major institution.

WashCAN members spoke to the effect of healthcare debt on the indigent, and their stories implicate areas of significant public concern and appropriate debate regarding society's allocation of healthcare resources. Swedish agrees that charity care should be readily accessed by those who qualify, but compelling though these stories may be, nothing in the Seattle Municipal Code gives the Examiner the jurisdiction to condition approval of the MIMP based on providing certain levels of charity care.

The Major Institutions Code is not a vehicle for the City to govern the business practices of the institutions. The Council and its Hearing Examiner regulate land use, not hospital functions. The Hearing Examiner does not have jurisdiction over collective bargaining, staffing ratios, or any number of other issues that WashCAN asks the Examiner to address in her recommendation to Council. Nothing in the Major Institutions Code suggests that the City has the authority to condition the land use decision on the MIMP to address impacts unrelated to land use.

WashCAN's letter faults the business practices of Swedish Cherry Hill and Providence generally, invoking issues over which the City has no jurisdiction, while providing no context or standards by which a decisionmaker could evaluate a healthcare provider's practices. How much unrestricted cash should a medical system keep on hand? How much uncompensated care should a hospital system provide? Should the appropriate amount be calculated as a percentage of its operating profits such that it diminishes in years the hospital operates unprofitably? What should the procedure for applying for charity care entail? These questions, and similar questions prompted by WashCAN's letter, are not answered on this record, nor are they issues for the Hearing Examiner to address in this matter in any event.

WashCAN also points out that both the number of charity care patients and the value of Swedish Cherry Hill's uncompensated care decreased from 2013 to 2014, which is correct as far as it goes. It does not indicate, as WashCAN implies, that Swedish Cherry Hill is improperly turning away patients in need. Rather, it represents the impact of the Affordable Care Act (ACA), which was fully implemented in January 2014, resulting in 15 million previously uninsured Americans gaining coverage through the expansion of Medicaid, and by virtue of State Insurance Exchanges. Prior to January of 2014, those persons would have entered the health system through emergency rooms across the country, and many of those related charges would have been written off as unfunded charity care. The ACA's positive effect of increasing the number of insured has lowered the charity care of many non-profit health systems throughout the country, including Swedish Cherry Hill.

The MIMP and Testimony Established Swedish's Need for Expansion

Swedish established its need for growth through expert testimony, emphasizing trends in healthcare, growth of specific patient utilization at Cherry Hill, and through testimony concerning outdated facilities, including ORs and patient rooms. Swedish seeks first to construct modern facilities sufficient to meet its existing licensed bed capacity, which has already been recognized by the State of Washington through the Certificate of Need process. But the MIMP is a plan for campus-wide growth with no expiration date, with a planning horizon of 20-30 years. It anticipates growth in areas that do not require new beds, such as the dental clinic Dr. Winston testified Swedish intends to construct at Cherry Hill, as well as many other areas.

Of course, it is also possible that Swedish will require additional beds in the future and will seek approval for those through the state Certificate of Need system. When it does so, Swedish will likely use some of the MIMP's additional development capacity to accommodate those beds, as well, but it is not appropriate to defer to the state Certificate of [bed] Need analysis to make the determination of total development capacity 20 or 30 years into the future.

WashCAN protests that Swedish should not have been allowed to present evidence of the methods through which need is calculated during the Hearing Examiner hearing, but sufficient information was provided in Appendix G, and insofar as additional explanation is necessary, the pre-decisional hearing is the appropriate venue. By Code, the CAC "may review and comment on the . . . need for the expansion," but need is "not subject to negotiation." SMC 23.69.032.D.1. Swedish explained its need to the CAC early in the process, and further clarification is appropriate at the hearing stage. The evidence received during the hearing establishes that, if anything, Swedish's projected need was conservative.

The MIMP presents Swedish's strategy for the Cherry Hill campus as a specialty hospital including a Cardiac/Vascular Institute and a Neuroscience Institute, supported with general primary care service for the community. The Swedish Cherry Hill methodology (MIMP Appendix G) presents the factors that were taken into account to arrive at a future operational size for these Swedish Institutes, including population growth (total population and over-65), use rates of services being developed, emerging medical and technology trends, assumptions around the consolidation and integrated nature of emerging health systems, market share (current and projected), in-migration of patients, average daily census (ADC) trends (current and projected), occupancy assumptions, and average length of stay of patients (ALOS) all to determine the necessity of the service being delivered at Swedish Cherry Hill. This information has been presented in Appendix G and throughout the MIMP document. Swedish's expert, Jeff Hoffman,[13] testified at length that the assumptions made in Appendix G are reasonable for a health system such as Swedish.

[13] Mr. Hoffman testified as an expert during the MIMP hearing and was subjected to cross-examination by the public, including by WashCAN's attorney. He did not testify during the SEPA appeal.

In spite of all of the information in Appendix G and presented at the hearing, Jack Hanson's written and oral testimony frequently recited that Swedish "has failed to provide information sufficient to demonstrate a genuine need for expansion." Because he held himself out as an expert in medical center planning, and because the WashCAN letter relies on his analysis, Swedish provides the following rebuttal to Mr. Hanson's analysis.

A near neighbor to the institution, Jack Hanson is a policy analyst, not an expert on hospital facilities planning beyond "bed need." Swedish's needs assessment includes much broader needs beyond beds, including lab and research, clinic, education, hotel, and long-term care. Mr. Hanson has no professional experience in these distinct areas, and no master planning experience whatsoever. Swedish does not seek any additional beds at this time, and even if it did, the question of bed need is exclusively within the jurisdiction of the state, not the City. This improper reliance on bed need analysis permeates Mr. Hanson's testimony.

In addition to the fundamental error of relying on bed need methodologies, much of Mr. Hanson's testimony depends on the equally flawed premise that Swedish Cherry Hill is a general acute care hospital, comparable (indeed, interchangeable) with Swedish First Hill or Virginia Mason. As the MIMP and testimony established, Swedish Cherry Hill is actually a highly specialized care facility more similar to children's hospitals, heart hospitals, and obstetrics hospitals. It is the home of Swedish Cardio/Vascular Institute, the home of the Swedish Neuroscience Institute, featuring gamma and cyber knife technology for brain surgery, as well as home to Swedish's critical inpatient rehabilitation and psychiatric services. As Mr. Cosentino testified, these clinical service lines serve members of the Seattle community with the highest level of complex disease and emergencies. In fact, to underscore this definition, patients entering the Swedish First Hill campus for cardiac and neurosciences care are most often transferred to Swedish Cherry Hill to receive this care. Cherry Hill has no routine, general medical/surgical capability.

These two fundamental errors explain many, if not most, of the questions Mr. Hanson raises. Specialty hospitals require more building gross square footage per bed, more space for long-term care services, and more available beds (in the form of lower planning occupancy rates), among others. Planning for future space implicates far more than simple bed counts—and the current license for Swedish Cherry Hill allows 385 beds (compared to 200 currently in use).

On page three of his written comments, in the paragraph titled "Concerning Population Growth and Demographic Shifts," without disputing the demographic data that Swedish put forward in Appendix G, Mr. Hanson requests that this data "require explicit discussion in order to establish Providence / Swedish claim that the aging of the population will drive increased demand at Cherry Hill." The Washington Office of Financial Management demographic data Mr. Hanson seeks was presented in Appendix G. MIMP at 133. The testimony established that the significant aging of our population will substantially drive the need for more health care services, and Swedish Cherry Hill is no different. Mr. Hoffman provided detailed testimony about use rate trends for Cardiac and Neuroscience services that are being served at Cherry Hill.

Also on page three, under the heading "Concerning Healthcare Facility Utilization Changes Due to Healthcare Reform Efforts," Mr. Hanson seeks more detail discussion on the impact of the Affordable Care Act (ACA) than was presented in Appendix G. There, Swedish stated its assumption that while there will be an immediate influx of new patients due to the ACA, once that influx occurred, "service demand will stay about the same." MIMP at 133. Swedish also stated its assumption that it is already taking care of the really sick (just with no insurance or payment), and in the future these very sick people will have insurance. *Id.* Mr. Hoffman agreed with this assumption and if Mr. Hanson disagrees he should present data that refutes that assumption rather than simply request "more discussion."

Rather than present any opinion on how he believes changing delivery reforms, including payment reforms, will impact Swedish Cherry Hill, Mr. Hanson simply suggests that the MIMP does not account for these reforms. Yet, Appendix G does discuss the likely impact of the ACA reforms. Mr. Hoffman testified that these delivery reforms, specifically as they shift to more value-based payment methodologies, will cause smaller community hospitals to eliminate low-volume, high-complexity services, including many cardiac and neuroscience service lines. This will increase the need for high-complexity institutes such as those at Swedish Cherry Hill and thus drive the in-migration of patients to Swedish Cherry Hill.

On page four of his testimony, in the paragraph titled "Concerning Changes in Patient Volume and Relative Market Share," Mr. Hanson states that Swedish Cherry Hill's MIMP provides no data on market share or number of patients treated. Not only is this historical data publicly available, but Appendix G of the MIMP presents the current market share number and current patient volume in terms of an average daily census (ADC) of patients in the hospital. It also projects and presents the estimate of future patient volume based on Swedish's assumptions. While Mr. Hanson may want "more discussion," it is simply not true to state "Providence Swedish offers no numbers" and "no specific information on the number of patients..." and "nor does it offer estimates of additional patient volumes expected in the future." Appendix G offers the current market share, estimates on future market share, current ADC and estimates of future ADC, and patient volume both in numbers and graphics.

Mr. Hanson also presents the size (square footage and bed increases) of approved master plans of other healthcare organizations in the area as evidence of limited need Cherry Hill expansion. Mr. Hanson makes the inaccurate assumption discussed above: that all hospitals are equal and provide the same services. As a highly specialized facility, Swedish Cherry Hill provides services that are not provided at the other hospitals Mr. Hanson lists. Cherry Hill's highly specialized services will also create significant in-migration from outside King County. This in-migration was 8% in 2012, and is now 11% for 2014 and is estimated to continue to increase. In addition, because Swedish Cherry Hill is currently licensed for 385 beds, all other expansions take the Swedish Cherry Hill bed expansion into account when determining incremental new bed need and capacity into their planning.

On page six, in the section titled "Concerning the Space Need Projection for the Hospital," Mr. Hanson argues that Swedish Cherry Hill's MIMP does not provide support for the

need to continue to use its beds and argues further that the bed rooms, some of which are more than 50 years old, do not need to be upgraded to a more contemporary standard to serve today's more complex cases. To the contrary, the MIMP explains why this is necessary, and additional testimony by Swedish witnesses also gave clear and concise reasoning for this need.

Mr. Hanson's graphic of historical inpatient volume shows a rapidly increasing trend of use, but attempts to minimize this import of this increasing trend. Swedish Cherry Hill takes this trend seriously. The MIMP presents data that showed in 2012, Swedish staffed 200 beds. Testimony established that current ADC is now exceeding 168 patients per day (midnight census July 2015), requiring over 240 staffed beds. Only modest future growth will require use of all 385 beds allowed under Swedish Cherry Hill's current license.[14]

Mr. Hanson quotes from Washington State Health Plan to establish the proposition that "bed projections should not be made for more than seven years into the future"—a proposition relevant only if Swedish were seeking additional beds. As a policy analyst, Mr. Hanson has the intellectual luxury to pontificate about the reliability of future forecasts and to suggest that only five-year and seven-year forecasts should be considered. The clinician leaders of Swedish Cherry Hill must live in the real world of healthcare delivery, financing, and hospital construction where facilities must be feasible and functional for 40+ years. Swedish must plan well into the future on hospital facility development, particularly when they need to make $500 million to $1 billion decisions related to a single hospital campus such as Cherry Hill. So using the best analytical tools and methodologies, and making reasonable assumptions about the future, Swedish Cherry Hill must take a longer view on planning for the necessary beds in the future.

Again conflating general acute care facilities with specialized facilities, Mr. Hanson argues that Swedish Cherry Hill should use 75%-80% occupancy for planning purposes.[15] Mr. Hoffman confirmed that such numbers are appropriate for general hospitals, but they are not appropriate for highly specialized facilities such as children's hospitals, heart hospitals, and Swedish Cherry Hill. When such critical care patients needs a bed, they need it immediately, so planners use a lower occupancy of 65%-70% to ensure one will be available. Swedish Cherry Hill used a 69% occupancy to plan future beds in 2040, which Mr. Hoffman confirmed was a reasonable assumption for a specialized, high-complexity care hospital.

Relying again on general acute care facility numbers, Mr. Hanson argues that "a standard well below the 3,500 BGSF per bed is appropriate."[16] Properly comparing Swedish Cherry Hill to other specialty institutions shows that the 3,500bgsf/bed planned for in the MIMP is slightly conservative. Also, as Mr. Hoffman testified, contemporary per bed benchmarks are increasing

[14] Again, Swedish Cherry Hill is NOT requesting additional licensed beds. They are requesting the ability to rebuild beds they already have so they can be of better use for their patients.

[15] Mr. Hanson elides over the difference between planning occupancy percentages and occupancy percentages as a measure of operating performance. The former is used to plan hospital facilities that must be workable for 40+ years, while the latter measures current operating efficiency.

[16] Note that the metric of "building square footage" per bed does not mean Swedish intends to build 3,500 square foot bed rooms. The numerator is the square footage of the entire hospital, including clinical and outpatient space.

even in general acute care facilities as more space is added for outpatient treatment and diagnostics capability. Adding these spaces to a hospital setting creates greater efficiency and flexibility between the outpatient and inpatients but the per bed benchmark increases.

On page nine of his testimony, Mr. Hanson questions the need for more cardiac and neuroscience research—despite the fact that heart disease and stroke are the first and third leading causes of death in the United States. This is one of the lone areas in which Mr. Hoffman testified that Swedish was not conservative in its size estimates, at 2,200 bgsf per physician, but the 1,400 bgsf number that Mr. Hanson suggests is far too low. Mr. Hanson's number rests on a number of flawed assumptions (i.e., that a research facility does not require convenient bathrooms and does not require electrical and mechanical space) and should be disregarded.

On page ten, Mr. Hanson argues that the campus hotel does not require as much square footage as projected. But hospital hotels are not typical hotel facilities. They must all be handicap accessible to accommodate patients and their families and include amenities such as in-room kitchens and living space. Benchmarks of 1,000-1,500 building square feet per room are on the conservative side of the planning range.

On page eleven, Mr. Hanson challenges the space calculation for education functions. While some education space is planned into the hospital BGSF per bed, Cherry Hill is used as the education center for the Swedish system. This is a very efficient way to use education space, auditoriums, simulation labs, etc. By building a co-located training space and using it for a greater number of people, the use of this asset is ultimately more efficient and the Health System can provide better training resources for its employees. So because it is used for more than just Swedish Cherry Hill employees, and for joint classes with Seattle University, additional education space is reasonable to consider.

One of the goals of Chapter 23.69 SMC Major Institutions Code is to "[a]ccommodate the changing needs of major institutions." SMC 23.69.002.H. Neither WashCAN nor Jack Hanson offered a competing needs assessment in response to Swedish's data and testimony. Expert testimony offered by Jeff Hoffman confirmed that the data and assumptions made by the Swedish MIMP consultant, Terrie Martin, were reasonable. The overwhelming evidence in the record supports the analysis of Swedish's need, and the Examiner should reject WashCAN's arguments.

The Proposed TMP Will Reduce Transportation Impacts

Swedish worked with Commute Seattle and transportation consultants to craft a TMP that will reduce SOV trips to and from the campus, thus mitigating the impacts related to future traffic increases associated with build-out of the hospital. Commute Seattle has a proven track record of creating and managing successful TMPs, and both the applicant's and City's experts testified that the proposed TMP has a high likelihood of success, as well.

Furthermore, the significant traffic impacts revealed in the FEIS assumed 50% SOV rate, not the 38% Swedish has agreed to set as its goal. Uniquely among master plans in Seattle, this 50% SOV rate is required to be met prior to the occupancy of any new building on the campus. As the SOV rate declines at a rate thereafter of 1% every two years, fewer SOV trips will further reduce impacts. Mr. Cosentino and Commute Seattle established that Swedish management is committed and determined to decrease the SOV commute rate at the Cherry Hill campus. Expert testimony established that sufficient transit capacity currently exists, and Metro could add additional capacity if necessary.

To that end, Mr. Swenson, Mr. Perlic and Mr. Shaw (for DPD) all testified that, despite WashCAN's assertions to the contrary, there presently exists available capacity for additional ridership on transit routes serving the Cherry Hill campus. All parties agreed that when a transit route approaches capacity, Metro will take steps to add to that capacity. Additional capacity could take the form of more frequent buses and/or larger, articulated buses (which are not currently used to serve the campus), according to Mr. Swenson and Mr. Perlic.

Conclusion

For the reasons listed above and those discussed at the hearing, the arguments presented by WashCAN in its comment letter have no merit. The Hearing Examiner should reject them and recommend approval of the MIMP to the City Council.

Sincerely,

FOSTER PEPPER PLLC

Joseph A. Brogan
Steven J. Gillespie

Date: July 14, 2015

To: Hearing Examiner in the case of Major Institution Master Plan application of Swedish Medical Center

From: Joy Jacobson *318 16th Ave * Seattle, WA 98122 * Resident * Squire Park Community Council

Subject: Comments on proposed Major Institution Master Plan

I am an appellant with Squire Park Community Council, and an Architect.

I have approximately 22 years of experience with Major Institution Master Plans, as a CAC Member, a Standing Advisory Committee Member and as an Institutional participant.

Previous CAC experience:

- 1994-2007 served on the Seattle University CAC and SAC.
- January 2007- December 2012 SU MIMP development as an institutional participant.
- January 2007- December 2012 - SAC member Swedish Cherry Hill
- December 2012 to April 2013 CAC member Swedish Cherry Hill (resignation required due to commencing employment with the City of Seattle)

The CAC and the Department of Neighborhoods:

I would like to commend the CAC and DON for the due diligence applied during the lengthy process.

The **Final CAC Majority Report** rightly acknowledges that "If the Swedish institution did not already exist in this residential neighborhood, it would not be allowed today per "**SMC 23.69.024** *B.) New Major Institutions 6.) A new Major Institution Overlay District may not be established and a Major Institution Overlay District Boundary may not be expanded in single-family or Industrial zones."*

The CAC additionally notes:

***"SMC 23.69.025** The intent of the Major Institution Master Plan shall be to balance the needs of the Major Institutions to develop facilities for the provision of health care or education services with the need to minimize the impact of Major Institution development on surrounding neighborhoods.*

The institution already exceeds allowable height bulk and scale to the surrounding neighborhood and should not be allowed to excessively increase its height bulk and scale. Essentially it should not be in this neighborhood, but since it is the size should be limited to the scale of the surrounding neighborhood, and not to the institutions desires for growth, driven much by a development partner Sabey."

***The Dean Patton Minority Report** requires further reductions in scale and greater setbacks beyond the CAC Majority Report.*

Height, Bulk, Scale, and Transitions:

From the May 22, 2014 Draft EIS:

"Based on scoping comments, DPD determined that the project had the potential to result in adverse impacts on the following elements of the environment: air quality; climate; water quality; ***height, bulk and scale****; historic preservation; housing;* ***land use;*** *light and glare; shadows; noise and environmental health; traffic and transportation (including parking); and public services and utilities."*

It is recognized that institutions are granted higher heights than surrounding and underlying zoning through the MIMP process, however there are multiple requirements for transitions to the residential zoning surrounding Swedish Cherry Hill. The Seattle Municipal Code designated heights range from MIO-37 to MIO-240 spread across nine steps which provide acceptable transitions between heights when done with sufficient depths.

The Swedish Cherry Hill Alternative 12 proposes High Rise zoning heights adjacent to Low Rise and Single Family zoning without appropriate and sufficient transitions and setbacks. The heights are even greater than some zoning areas of downtown.

The height, bulk, scale, setbacks and transitions are incompatible to the surrounding Single Family and Low Rise Neighborhood. The Cherry Hill site does not provide room for adequate transitions to less intensive neighborhood zones, therefore the heights should be further restricted and more appropriate setbacks must be incorporated.

During discussions, demonstrations and deliberations on setbacks at the MIO perimeters and streets, it became clear that the setbacks were inadequate. However it was also difficult to discern the true relationship to the neighborhood as the drawings were out of scale, and tended to omit the surrounding neighborhood context, nor show topography. I had to request that scale drawings be provided to the committee. I am attaching the March 18th letter I submitted to the CAC regarding setbacks.

Swedish First Hill which is located primarily within Mid Rise and High Rise zoning, established along much of its Broadway edge at a lower MIO-70 height than is currently proposed along the Cherry Hill edges on 15th and 16th Avenues, and E. Cherry Street.

The Land Use Code:

The Land Use Code clearly states the requirements for less bulk, less height, greater setbacks, transitions and avoidance of MIO's in single family zoning in at least six sections:

SMC 23.34.008 E. Zoning Principals. The following principals shall be considered:
1. The impact of more intensive zones on less intensive zones or industrial and commercial zones on other zones shall be minimized by transitions or buffer. A gradual transition between zoning categories, including height limits, is preferred.

SMC 23.34.009 Height limits of the proposed rezone.

B. Topography of the Area and its Surroundings. Height limits shall reinforce the natural topography of the area and its surroundings, and the likelihood of view blockage shall be considered.

C. Height and Scale of the Area.

1. The height limits established by current zoning in the area shall be given consideration.

2. In general, permitted height limits shall be compatible with the predominant height and scale of existing development, particularly where existing development is a good measure of the areas' overall development potential.

D. Compatibility with Surrounding Area.

1. Height limits for an area shall be compatible with actual and zoned heights in surrounding areas excluding buildings developed under Major Institution height limits; height limits permitted by the underlying zone, rather than heights permitted by the Major Institution designation, shall be used for the rezone analysis.

SMC 23.34.124 C. Height Criteria.

2. Height limits at the district boundary shall be compatible with those in the adjacent areas.

3. Transitional height limits shall be provided wherever feasible when the maximum permitted height within the overlay district is significantly higher than permitted in areas adjoining the major institution campus.

SMC 23.69.002 Purpose and Intent.

I. Make the need for transition primary considerations in determining setbacks. Also setbacks may be appropriate to achieve proper scale, building modulation or view corridors.

SMC 23.69.008 Permitted Uses.

C. Major Institutions shall be subject to the following:

1. Major Institutions uses which are determined to be heavy traffic generators or major noise generators shall be located away from abutting residential zones;

SMC 23.69.024 Major Institution Designation.

B. 6. A new Major Institution Overlay District may not be established and a Major Institution Overlay District Boundary may not be expanded in single-family or Industrial zones.

<u>The Other Hospital:</u>

Children's Hospital also in Single Family zoning created appropriate transitional zones between the institutional MIO and adjacent residential zoning. The Children's MIO provides graduated zoning heights from SF-5000 to MIO-37, MIO-50 and MIO-65 of sufficient depth before increasing to MIO-70, MIO 160 conditioned to 125, and tops out with maximum heights of MIO-160 conditioned to 140.

I ask why it would be acceptable to create inadequate zoning transitions in the Squire Park neighborhood; and not in the Laurelhurst neighborhood. Is Squire Park a less important neighborhood than Laurelhurst?

Admittedly the Swedish Cherry Hill site does not have the luxury of additional land to acquire, which would also comprise an un-allowed expansion of the MIO. It is time to consider that the site is almost at its maximum zoning capacity and that only minimal further expansion should be permitted.

Major Institution Overlays were not intended for endless unlimited vertical growth. The sites are subject to growth restrictions when abutting surrounding less intensive areas. The code never intended High Rise zoning in a residential neighborhood. If the maximum size is limited at this site, the subsequent negative impacts from looming structures, cars, traffic, and parking will be reduced.

The Draft Comp Plan and Livability of Neighborhoods:

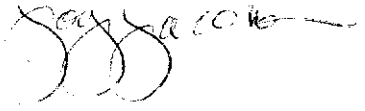
The newly published Draft Comprehensive Plan does not envision increased density in the Squire Park area. It's vitally important to protect the livability of the neighborhood by requiring additional reductions to adequately minimize the impacts associated with future institutional development.

> From the Draft 2035 Comprehensive Plan:
> ***LU8.6*** *Limit the number and types of non-residential uses allowed in single-family residential areas and apply appropriate development standards in order to protect those areas from the negative impacts of incompatible uses.*
> ***LUG14*** *Encourage the benefits that major institutions offer the city, including health care, educational services and significant employment opportunities, while minimizing the adverse impacts associated with development and geographic expansion.*

The final conclusion is that Swedish Cherry Hill may well be near its development limits and should be required to create appropriate transitions to the surrounding residential neighborhood to minimize all impacts.

Sincerely,

Joy Jacobson



Date: March 18, 2015
To: Swedish Medical Center Cherry Hill Major Institutions Master Plan Citizen's Advisory Committee
From: Joy Jacobson, resident: 318 16th Ave
Subject: Comments on Draft CAC Recommendations and Street Sections

First and foremost I would like to acknowledge the hard work and dedication of the Citizens Advisory Committee (CAC) over two years and truly appreciate your attention to mitigating the impact of the proposed Swedish MIMP.

The Major Institution Master Plan (MIMP) proposed by Swedish Medical Center will have a profound impact on Squire Park and the Central Area, the outcome is of great concern to the surrounding community.

After reviewing the recently revised sections submitted by the institution on March 12, 2015 and the MIMP Alternate 12, along with the current CAC recommendations I would like to further stress the importance of setbacks both at ground level and upper stories.

The following is my response to the new sections, and I urge the CAC to consider further enhancements to setbacks and height in their report.

Regarding 18th Avenue and E. Cherry and E. Jefferson

I agree that heights on the block of 18th Avenue which abuts residential development should be limited to MIO 37 feet, removing the need for upper level setbacks at the proposed MIO 50 heights. It is rare for a Major Institution Overlay boundary to be placed mid-block, without a buffer of a natural feature or major arterial. More consideration should be done to ensure compatibility with the abutting single-family zone. This could include limits on the maximum lot coverage, and modulation which could break up the massing of the building façade.

Section A-A - I agree with the CAC recommendation to limit the height to MIO 37, and feel the 25 foot setback is appropriate. Further break-up of the almost 600 foot long building mass should be addressed as it abuts 11 Single Family lots, and one condominium lot.
Section B-B - I agree with the CAC recommendation to limit the height to MIO 37, and feel the 10 foot setback is appropriate with the lowered height.
Section C-C - I agree with the CAC recommendation to limit the height to MIO 37, and feel the 10 foot setback is appropriate with the lowered height.
Section D-D - I agree with the CAC recommendation to limit the height to MIO 37, and feel the 0 foot setback is appropriate along 18th in order to maximize the distance from the Single Family lots due east of the MIO.

Regarding E. Jefferson from 15th Ave to 18th Ave:
E. Jefferson Street faces single family zoning with a mix of single family homes, low rise apartments, and duplexes; remnants from an earlier brief period of multifamily zoning, which subsequently was restored to single family zoning, reaffirming the neighborhoods desire to remain as an urban single family zone.

Section E-E - I request that the CAC consider increasing the ground level set back from 5 feet to 10 feet at the property line, and increasing the CAC proposal of a 15 foot setback above MIO 37 to 20 feet. This edge of the institution faces Single Family Zoning, though some of it has been developed as Multi Family, it is still a much lower height and in scale with the surrounding single family development.
Section F-F - I request that the CAC consider increasing the proposed upper story setback of 15 feet to 20 feet, or the closest structural grid line of the existing structure(should it remain). This location is across the street from existing single family homes, the scale of the homes and their privacy should be respected. Much care was taken during the design of the existing parking facility to provide modulation, screening, fenestration, and light shielding. Input was received from the affected homes at the time of design, additionally they had concerns with privacy from the parking structure, setting additional stories further back will help alleviate privacy intrusion.

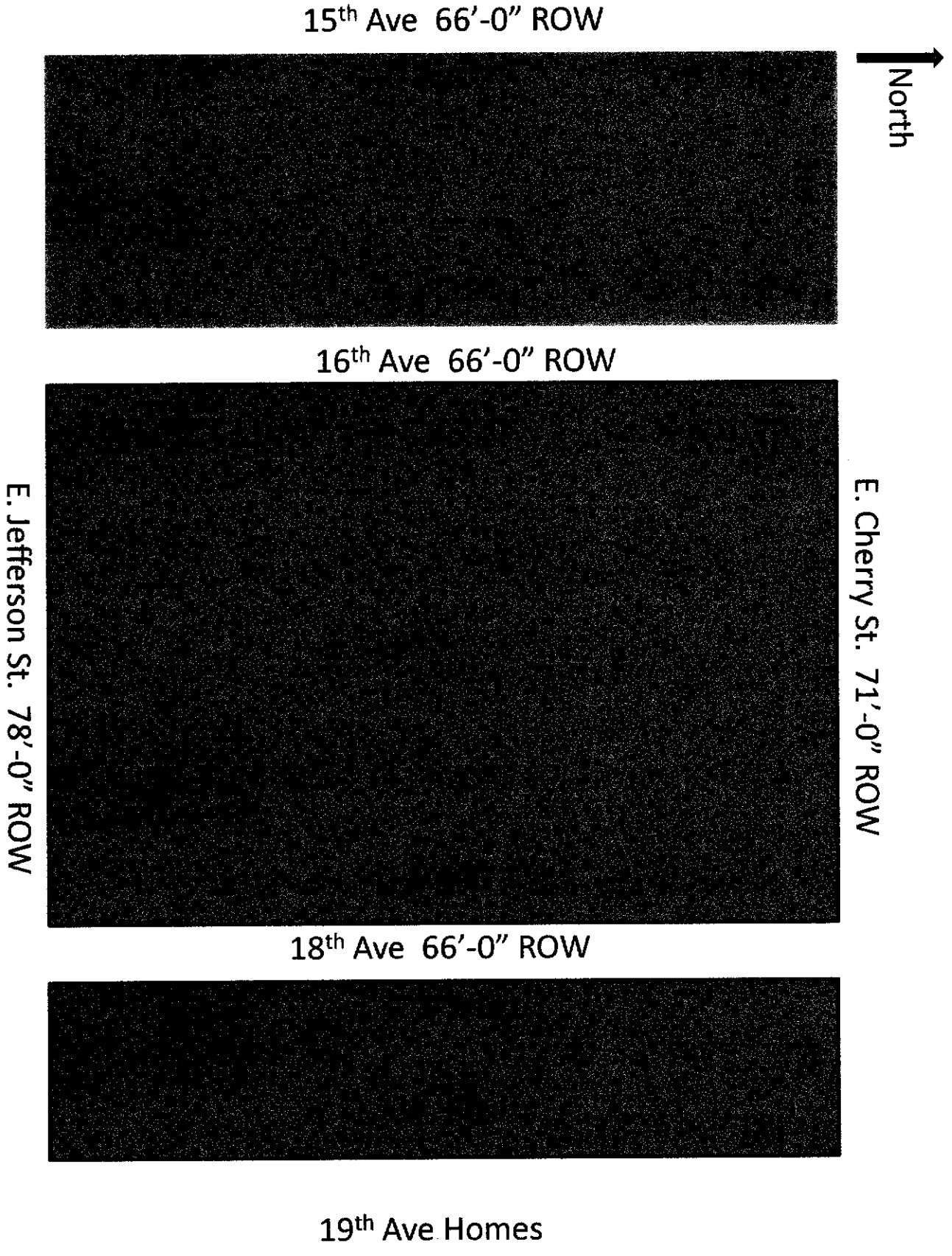
Regarding 15th Avenue:
15th Avenue is an important north south connector street in the neighborhood which has great potential to be something more than parking for the institutions it is sandwiched between. Unfortunately it has had back door treatment from both Seattle University and Swedish, other than the Kidney Center there is limited interaction by people because they face a harsh environment of either a solid 400 foot or so long blank wall, or parking structures. If addressed properly, this street has the potential to become more humane for pedestrians.

Section G-G 1 - I request the CAC consider increasing the at grade set back from 5 feet to 10 feet. The west side of the street (Seattle University property) is providing a 15 foot setback for future construction, the east side of the street should achieve 10 feet.
Section G-G 2 - I fully support the CAC proposal to lower the height from MIO 160(150) to MIO 125. I recommend increasing the at grade set back from 5 feet to 10 feet. Additionally revise the upper story setback percentage so that above MIO 65 to 60% of the facade is setback 30 feet, and 40% of the facade is setback 15 feet. This reverses the proposal set forth in Alternative 12; 40% at 30 feet and 60% at 15 feet.
Section G-G 3 - This proposal is acceptable and is in alignment with the proposed changes to GG 2 and GG 3.

Regarding E. Cherry from 15th Ave to 18th Ave
East Cherry is currently a challenging environment, with speeding cars, utilitarian facades, minimal transparency and poor landscaping. This has the potential to become more pleasant, starting with adequate setbacks, and reduced heights.

Section H-H - This proposal is acceptable and aligns with other proposals along E. Cherry St.
Section J-J - I request that the CAC consider increasing the at grade setback from 5 feet to 10 feet - Cherry is a narrower Right of Way and the buildings should be set back further to minimize neighborhood shadowing and bulk at grade. I encourage the CAC to press for MIO 105 feet, though agree with CAC, for a minimum lowering of overall maximum height from MIO 160 to MIO 140.

Regarding 16th Ave:
I agree with the CAC's concern regarding the creation of a canyon effect along 16th Avenue and agree that the setbacks along this block should be increased both at the ground level and at upper levels. Preventing a canyon


15th Ave 66'-0" ROW
North
16th Ave 66'-0" ROW
E. Jefferson St. 78'-0" ROW
E. Cherry St. 71'-0" ROW
18th Ave 66'-0" ROW
19th Ave Homes

effect along this section of the site is imperative to preventing a single family and low rise neighborhood from being fractured further by high rise construction and the effect of cutting off light, views and bisecting a neighborhood. Establishing a substantial setback at MIO 37 feet will maintain a human and pedestrian scale to this important north-south connecting street in the community. Additionally, I recommend that the design of future development attempt to create transparency at the street level for human interaction and pedestrian scale, and limit large expanses of blank facades or driveways. Transparency can be achieved in areas of hospitals such as corridors, similar to the south facing corridor paralleling E. Jefferson near vacated 17th Ave.

Sections:

Section KK-1 East I request that the CAC consider an increase at the ground level setback to 10 feet on each side of the street. Lower the upper story setback on the east side from MIO 65 to MIO 37 with a minimum 20 foot setback. Limit the height to preferably MIO 105, or a maximum of MIO 140.

Section KK-1 West I request that the CAC consider an increase at the ground level setback from 0 to 10 feet the west side of the street.

Section KK-2 East I request that the CAC consider an increase at the ground level setback from 5 feet to 10 feet for the 45% proposal. Maintain the proposed 55% upper story setback starting at MIO 37 with the minimum 30 foot setback and limit the total height to preferably MIO 105, or a maximum of MIO 140.

Section KK-2 West I request that the CAC consider an increase at the ground level setback from 0 to 10 feet. Increase the upper story setback at MIO 37 with from 5 feet to 20 feet . I support the CAC proposed height limit the of MIO 105(100) conditioned to 100 feet with a mid block average.

Section KK-3 I request that the CAC consider increasing the at grade setback to 10 feet on the west side of the street to match the east side. I agree with the proposed heights as shown.

As the CAC acknowledges, development within this Master Institution Overlay (MIO) is complicated in part because of its location outside of an area with a higher underlying zoning, land use designation, or Urban Village classification. The land use code consistently refers to transitions between zoning types. The inherent implication is a gradual transition from low heights to higher heights, as well as low intensity uses to higher intensity uses. The land use code recognizes the need for higher limits allowed to institutions with the designation of MIO districts as compensation to restrain horizontal spread. However it likely did not intend to allow high-rise construction adjacent to residential neighborhoods without appropriate transition. Because there is neither available land nor existing environmental buffers to create appropriate gradual transition to the surrounding residential neighborhood, the transitions must occur with at-grade setbacks, upper story setbacks, and lower perimeter heights to establish the transitional zone. It's imperative that appropriate transitions be created between the institution and the neighborhood.

Sincerely,

Joy Jacobson
318 16th Ave
Seattle, WA 98112

TESTIMONY
KENNETH H. TORP
APPELLANT MEMBER OF THE SQUIRE PARK COMMUNITY COUNCIL
BOARD MEMBER OF THE 12TH AVENUE STEWARDS
NEAR NEIGHBOR/HOMEOWNER
724 15TH AVEUNE
JULY 15, 2015

Subject: Final Major Institution Master Plan
DPD Project No. 3015953

Transportation Section of the EIS

Policies and the Comprehensive Plan:

Note that the policy of the City of Seattle (3.7-2) is that "excessive traffic can adversely affect the stability safety, and character of Seattle communities."

Also, regarding adverse impacts outside of the downtown area, policy states that "...the decision-maker may reduce the size and/or scale of the project" when mitigation measures "would not be adequate to effectively mitigate the adverse impacts of the project. (3.7-2)"

The Comprehensive Plan encourages development in urban villages and around major transit infrastructure.

Deficiencies:

Alternative 12 of the EIS does not include reducing the "size and/or scale" of the project in the context of mitigation measures that do not adequately and effectively mitigate adverse (traffic) impacts. The traffic operations section of the EIS (3.7-59) notes that: "The increase in Swedish Cherry Hill's traffic along the street system, even with a successful TMP, may result in related congestion that could be considered significant." An additional four (4) intersections would operate at Level of Service "F" [1]during PM peak hours (3.7-23). Further, (3.7-58): "The increase in traffic volumes for Alternative 12 and the resultant impacts of traffic operations are considered *significant and unavoidable adverse* impacts [emphasis added]."

Given the policy that requires consideration of reduction in the size and scale of the project when mitigation measures do not adequately mitigate adverse impacts, the EIS appears to be deficient in not analyzing that strategy for mitigation.

[1] LOS "F" is defined as traffic demand greater than capacity with very long queues and delays. Most vehicles would require more than one green light phase to negotiate the intersection.

TESTIMONY
KENNETH H. TORP
APPELLANT MEMBER OF THE SQUIRE PARK COMMUNITY COUNCIL
BOARD MEMBER OF THE 12TH AVENUE STEWARDS
NEAR NEIGHBOR/HOMEOWNER
724 15TH AVEUNE; SEATTLE, WA 98122
JULY 14, 2015

Subject: Final Major Institution Master Plan
DPD Project No. 3015953

Role of Sabey:

I find it unusual, if not inappropriate, that a private sector developer, Sabey Corporation, is listed in the final MIMP as having participated in the preparation of the MIMP. (See cover page of the MIMP document). This is supposed to be a *Major Institution Master Plan,* not a plan for a private sector development corporation's aspirations for expansion on the Swedish Cherry Hill Campus.

By way of background, Swedish sold 40% of the land within its Cherry Hill Campus to Sabey in 2002, ostensibly because it did not need the additional room for its own medical purposes[1]. Now, Swedish wishes to almost double its square footage, resulting in issues of height, bulk, and scale that would have been easily accommodated in the 40% that it sold to Sabey. One is left with the inevitable conclusion that the size of the proposed expansion is largely attributable to that fact that Sabey now owns 40% of the Campus land. Also, the credibility of Swedish's projection of *need* must be viewed with some skepticism given historical miscalculations that led Swedish to sell 40% of its Campus to Sabey in 2002.[2]

In other MIMP's, private developers have participated with educational and medical institutions as developers of land *owned* by the institution. Ultimately, as in the case of Seattle University, the ownership of the land and the improvements thereon revert to the institution. This is not the case at Swedish. Here a private sector developer's continuing drive to attract rent-paying tenants appears to be driving a level of expansion that is not directly related to the needs of Swedish hospital. And, the ownership of 40% of the Cherry Hill Campus will remain with Sabey.

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[1] A Puget Sound Business Journal article, dated August 7, 2002 quotes Swedish spokesperson, Sally Wright, as saying; "Maybe we don't need all the real estate we're sitting on."

[2] For an alternative view of Swedish's need, see that attached calculation entitled "Simple Math." This calculation suggests that Swedish's core functions, including 808,700 *additional* square feet, can be accommodated without expanding to a total of 2.7 million square feet.

Clearly, the Land Use Code did not contemplate this kind of relationship with a private developer when it accorded Major Institutions extraordinary flexibility and latitude to plan and develop. That special treatment was accorded specifically because the institutions were non-profit educational and medical institutions with presumptive public benefit. Sabey is neither and it is driving a level of expansion at Cherry Hill that is fundamentally inconsistent with the Land Use Code and the Comprehensive Plan.

Submitted with this testimony is a series of four formal requests I submitted to DPD and the CAC soliciting data on the extent to which the current proposed expansion is attributable to Sabey Corporation. *Not one of those requests received any reply whatsoever.*

Community Opposition to the Current MIMP:

I wish to point out the *not one* of the established and recognized community organizations supports the Swedish/Sabey MIMP. All of the following have *formally rejected* Swedish/Sabey's final MIMP:

- The Squire Park Community Council
- The Central Area Land Use Review Committee
- The Citizen's Advisory Council
- The 12th Avenue Stewards
- Washington CAN
- Every neighbor who testified before the CAC for two years

Support for a Reasonable Alternative:

I, and many of my neighbors, recognize a legitimate and reasonable need for Swedish to plan for some expansion over the next 30 years. That is why many, if not all, of us support the minority report of the CAC that was submitted by the following CAC members:

Dean Paton
Patrick Angus
Maja Hadlock
James Schell
J. Elliott Smith

An important element of this kind of reasonable alternative might logically include some re-prioritization on Swedish's part of current and proposed uses on its Cherry Hill Campus. For example, if developing a neuro-science institute is a very high priority, some of Sabey's tenants could relocated elsewhere, e.g., the Northwest Kidney Center, Lab Corp., or the Institute for Complementary (naturopathic) Medicine.

SIMPLE MATH

SWEDISH MIMP
QUESTIONABLE NEED FOR PROPOSED EXPANSION
PER
ALTERNATIVE 12

Simple Math:

385 beds x 3500 square feet per bed= 1,347,500 total, comprised of

Existing hospital square footage	541,300
New Square footage	808,700
Total hospital square footage	**1,347, 500**

So why do they "need" 2,753,000 square feet?
"Want to but not have to be located at Cherry Hill"

Hotel that serves First Hill and Ballard	80,000
Education	100,000
Facilities and Central Plant	50,000
Doctor offices, Lab Core, Northwest Kidney Center, clinical research, long term care	1,175,500
Total other square footage	**1,405, 500**
Total proposed square footage	**2,753,000**

The Land Use Code

The MIMP should be reviewed in the context of the City's Land Use Code. To approve the proposal, it should be consistent with the Code. There are four elements under the Purpose and Intent section of the Code that are particularly relevant.

"A. Permit appropriate institutional growth within boundaries while minimizing the adverse impacts associated with development and geographic expansion;"
NOTE: the operable word here is MINIMIZE adverse impacts on the neighborhood
"B. Balance a Major Institution's ability to change and the public benefit derived from change with the need to protect the livability and vitality of adjacent neighborhoods;
NOTE: This says nothing about the need of the institution. Rather it is the need to protect the livability and vitality of adjacent neighborhoods.
"C. Encourage concentration of Major Institution development on existing campuses, or alternatively, the decentralization of such uses to locations more than 2500 feet from campus boundaries"
NOTE: If there is more growth than can be accommodated without causing adverse impacts, the Code says that the uses that exceed the capacity of the current campus should be located elsewhere.
"I. Make the need for appropriate transition primary considerations in determining setbacks. Also setbacks may be appropriate to achieve proper scale, building modulation, or view corridors."

NOTE: Swedish has proposed zero lot line setbacks and minimal upper level setbacks for the vast majority of the campus. The current proposal does not provide appropriate transitions along the perimeter, through ground level or upper level setbacks or building modulations.

724 15th Avenue
Seattle, WA 98122
July13, 2015

The Hearing Examiner

Re:

Swedish Cherry Hill MIMP
Master Use Permit No. 3012953
Project Address: 500 17th Avenue

Dear Madame Hearing Examiner:

Attached are four letters that I addressed to the Department of Planning and Development and the Citizen's Advisory Council concerning the role of the Sabey Corporation in the proposed expansion of the Swedish Medical Center's Cherry Hill Campus.

As you will note, my initial question in my letter of February 26, 2015 and my underlying concern related to the extent to which a private developer should be allowed to take advantage of the preferential treatment accorded to major institutions under the Land Use Code. I specifically asked for information on the extent to which the proposed expansion was attributable to the Sabey Corporation. My initial request was followed by three (3) additional requests (dated March 12, March 18, and March 26) for the same information. Those letters were hand delivered to CAC meetings that took place on those dates.

I received NO RESPONSE to my repeated written requests for this information. Neither the CAC nor DPD ever mentioned my requests.

While Sabey's role in the proposed expansion is, in my opinion, contrary to the intent and spirit of the Land Use Code, the shroud of secrecy that apparently cloaks Sabey's role further exacerbates this important issue.

Sincerely,

Kenneth H. Torp
Near Neighbor

724 15th Avenue
Seattle, WA 98122
February 26, 2015

To: Ms. Stephanie Haines, Land Use Manager
Department of Planning and Development
Attn: Public Resource Center
700 5th Avenue (Suite 2000)
P.O. Box 34019
Seattle, WA 98124-4019

Ref: Master Use Permit No. 3012953
Project Address: 500 17th Avenue

Dear Ms.Haines:

I wish to request that Swedish provide me, and other concerned neighbors, with the following data regarding the proposed expansion of the Cherry Hill campus:

- What percent of the proposed expansion, under the latest version of the MIMP, will be owned, used, or leased by the Sabey Corporation (and/or its subsidiaries)?

The underlying issue here is whether or not the Swedish/Sabey partnership meets either the letter or the intent of the Land Use Code that grants major institutions preferential treatment because they are "educational or medical institutions." Clearly, Sabey Corporation is neither an educational or medical institution. The extent of Sabey's participation in the MIMP process suggests that it is exploiting its partnership with Swedish to further its profit-seeking motive as a private developer.

Sincerely,

Kenneth H. Torp
Near Neighbor

Cc: Citizen's Advisory Council
Steve Shephard, DON

724 15th Avenue
Seattle, WA 98122
March 12, 2015

To: Ms. Stephanie Haines, Land Use Manager
Department of Planning and Development
Attn: Public Resource Center
700 5th Avenue (Suite 2000)
P.O. Box 34019
Seattle, WA 98124-4019

Ref: Master Use Permit No. 3012953
Project Address: 500 17th Avenue

Dear Ms. Haines:

The attached letter was delivered by hand to you, CAC Chairperson Porter, and Mr. Steve Shephard at the February 26 meeting of the CAC. That letter asked the following question:

- What percent of the proposed expansion, under the latest version of the MIMP, will be owned, used, or leased by the Sabey Corporation (and/or its subsidiaries)?

I have yet to receive any reply to my request for this fundamental data about Swedish's proposed expansion. So, I again request an answer. If Swedish is unwilling to provide this data, it should respond accordingly.

Sincerely,

Kenneth H. Torp
Near Neighbor

724 15th Avenue
Seattle, WA 98122
March 18, 2015

To: Ms. Stephanie Haines, Land Use Manager
Department of Planning and Development
Attn: Public Resource Center
700 5th Avenue (Suite 2000)
P.O. Box 34019
Seattle, WA 98124-4019

Ref: Master Use Permit No. 3012953
Project Address: 500 17th Avenue

Dear Ms. Haines:

This is my third request that Swedish/Sabey provide me, and other neighbors, with the following information:

- What percent of the proposed expansion, under the latest version of the MIMP, will be owned, used, or leased by the Sabey Corporation (and/or its subsidiaries)?

Again, I also request that if Swedish/Sabey is unwilling or unable to provide me with this information, it should respond to me accordingly.

I also ask that this letter, and my previous two letters (attached) be part of the record for the Hearing Examiner.

Sincerely,

Kenneth H.Torp
Near Neighbor

Cc: Citizens Advisory Committee
Steve Sheppard, DoN

724 15th Avenue
Seattle, WA 98122
March 26, 2015

To: Ms. Stephanie Haines, Land Use Manager
Department of Planning and Development
Attn: Public Resource Center
700 5th Avenue (Suite 2000)
P.O. Box 34019
Seattle, WA 98124-4019

Ref: Master Use Permit No. 3012953
Project Address: 500 17th Avenue

Dear Ms. Haines:

This is my FOURTH request that Swedish/Sabey provide me, and other neighbors, with the following information:

- What percent of the proposed expansion, under the latest version of the MIMP, will be owned, used, or leased by the Sabey Corporation (and/or its subsidiaries)?

My other written requests were delivered to the CAC, Steve Sheppard, and DPD on the following dates:

February 26, 2015
March 12, 2015
March 18, 2015

Again, I also request that if Swedish/Sabey is unwilling or unable to provide me with this information, it should respond to me accordingly.

I also ask that this letter, and my previous three letters (attached) be part of the record for the Hearing Examiner.

Sincerely,

Kenneth H. Torp

Near Neighbor

Cc: Citizens Advisory Committee
Steve Sheppard, DoN

Lavina Sadhwani
618 20th Avenue
Seattle, WA 98122

Sue Tanner
Hearing Examiner
Office of Hearing Examiner
700 5th Ave., Suite 4000
P.O. Box 94729
Seattle, WA 98124-4729

July 20, 2015

RE: Major Institution Master Plan for Swedish Medical Center, Cherry Hill Campus

Dear Ms. Tanner:

I am writing to you, as a 15 year resident of the Central District, to express frustration, disgust and disagreement with the City of Seattle in failing to implement the **intent** of the Land Use Code and for the city's callous disregard for the interests of the residents of the Central District with regards to MIMP for Swedish Medical Center, Cherry Hill Campus.

There are several issues that have introduced repeatedly by the residents at public hearings that have either not been addressed, or apparently ignored by city officials:

- Traffic and congestion are problems today in the Central District. Swedish medical campus visitors and employees continue to use residential parking spaces. The construction of over 1,000,000 sf of development will bring upwards of 3000 more employees and visitors to the campus. The MIMP fails to address how the transportation system will need to change to address this development. What is Swedish/Sabey's contribution to correcting the existing problem and addressing future issues?
- The hospital has failed in the past expansion to deliver promised usable amenities to the neighborhood; a pocket park, bounded by congested Cherry Street and 16th avenue, is not a benefit that has ever been used by the neighborhood. The new plan equally contains lifeless unusable amenities for the neighborhood. Large scale developments will also cast dark shadows on adjacent residential homes. How will the city ensure the residential homes maintain their value and community amenities will desirable to and be of use to the neighborhood?
- The original hospital was a not-for-profit institution, run by a religious order that served the needs of the community by providing medical services for the community. Since then, the hospital was purchased by Swedish Providence --a for-profit institution. Swedish, in partnership with a commercial real estate office developer, Sabey Corporation, is looking to expand OFFICE space expansion in an existing residential neighborhood, not medical services designed to help residents in a neighborhood. The central district is not a commercial office park. While the expansion may be allowed by the strict land-use code, this is not a development that meets the intent of the land use code and neighborhood development.

The central district was a neighborhood that historically was a redlined; it was a neighborhood where underserved and discriminated populations were forced to live. The community in the Central district survived redlining and today, a strong middle-class community lives and thrives in the neighborhood. Families built roots are new middle class families, many of which are immigrant families, are moving in, and continuing to grow the family. Today, the Central District still includes the most diverse communities in the city: Ethiopian, Japanese, Chinese, Indian, and African American. By allowing the Swedish expansion into the central district, the city is de-valuing and destroying one of the last middle-class communities in city of Seattle, and continuing to redline out diverse and middle class communities that live in the Central District.

The Department of Planning and Development has repeatedly demonstrated partiality to commercial businesses and has disregarded the interests and well-being of residential neighbors by hiding behind the Land Use Code. It is time for some common sense to be re-introduced and just admit that this is not a development that serves the community, neighborhood, or city planning. It is only a project that will continue to line the coffers of already wealthy corporate institutions by taking away a piece of the America Dream from average citizens.

Regards,
Lavina H. Sadhwani

Lisa Welsch
1128 16th Ave.
Seattle, WA. 98122

7-13-15

Re: Sabey/Swedish Neighborhood Expansion Master Plan

I have lived in the Squire Park Neighborhood for over thirty years.
During this time I have witnessed much change as the City of Seattle has grown in substantial ways. Long an advocate for change that is beneficial for the community I realize we live in the city and that the Squire Park Neighborhood has been a particular focus for increased development.

With this in mind, I take issue with the current plans for the Sabey/Swedish expansion on the Cherry Hill Campus. In view of the overwhelming scope of the proposed expansion, it is difficult to comprehend its existence in the context of our neighborhood. The project is not suitable in scale to the areas surrounding it. Oppressive and overwhelming, the campus will rise 130 feet above the defined current height zone for our area. The current zone allows for 30 feet. How can one justify such a height increase?

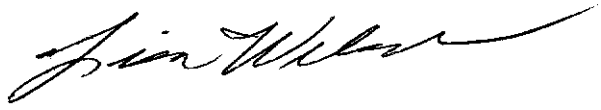
I view this as a reckless proposal that will dramatically impact the neighborhood in the following adverse ways:

Not just my neighborhood but also all neighborhoods with overlapping corridors that lead to major throughways, will suffer from unbelievable congestion. The current traffic situation is already maddening. Without the proper infrastructure in place for transportation we are looking at daily misery for untold thousands of commuters.

We do not live in an industrial and/or commercial park. We live in a place with beautiful leafy trees and lovely family homes, a neighborhood that has been in existence for over a hundred years. This campus will loom 160 feet above a neighborhood that is comprised basically of single-family residences with a mix of townhomes and apartments. The shadow effect from the proposed height for this campus shows the impact to the North will be at least four blocks long. For those residents that live north of Cherry Street the southern sky will be blocked from 15th Avenue going east to 18th Avenue. The result of this expansion will be a city canyon ringed by gridlocked cars that may well be wondering how this development occurred.

Please listen to reason and not allow this to happen.

Respectfully,
Lisa Welsch



Hearing Examiner Testimony
MUP 15-010 – MUP 15-015
DPD #3012953

I'm an applicant member of the Cherry Hill Community Council and am here as a neighbor of the institution who has volunteered my time to attend CAC meetings for two years. During that time it became very clear to me and all the neighbors that the MIMP proposed by Sabey/Swedish was based on faulty premises.

When Swedish entered into an agreement with Providence Health Services and when they sold 50% of the Cherry Hill Campus to Sabey Corporation they knew the campus was located in a residential single family and lowrise neighborhood. They also knew that the land use code relevant to major institutions, requires that new development be compatible with the existing community.

The 160' heights requested by Sabey/Swedish are too tall and will loom over our neighborhood, blocking views especially the view of beloved neighborhood landmark the James Tower Bell Tower. Although Sabey/Swedish state that these heights will be concentrated towards the center of the campus in reality they are proposing these heights along 15th Avenue, and although they are across from SU the proposed SU buildings are of a much lower height. These heights need to be reduced to provide transition from the SU campus. The other proposed 160' heights are so close to E. Cherry and E. Jefferson that any tourists walking by the campus will be dwarfed by them and might reasonably think they were in Belltown. Heights along the east side of 18th should not exceed those of the neighboring homes which would serve as a reasonable transition to the neighborhood as required by the SMC.

The proposed setbacks are far too inadequate to provide a reasonable transition to the existing residential neighborhood surrounding the campus. The proposed façade modulation and street trees do nothing to provide transition. Transitions need to be meaningful and provide minimal visual impact between the near neighbors and the institution. There needs to be ground level setbacks that provide garden green space to mimic the yards of the surrounding community. The upper level setbacks need to be large enough to mitigate any height.

In the SMC, Sabey/Swedish are expected to consider other locations for their proposed expansion but they have refused to do that. It seems that some of their proposed growth could be accommodated in the additional 2 million square feet they are building on First Hill or at any number of their other locations.

Our neighborhood's livability will be severely compromised if this MIMP goes forward as proposed. I ask that you seriously consider the neighbors desire to preserve livability by approving the CAC Alternative Proposal submitted by Advisory Council members Patrick Angus, Maja Hadlock, Dean Paton, James Schell and J. Elliott Smith.

Thank you.
Mary Pat DiLeva
712 15th Ave

July 20, 2015

MUP 15-010 – MUP 15-015
DPD #3012953

Dear Hearing Examiner Tanner:

I'm an appealant member of the Cherry Hill Community Council and a neighbor of the institution who has volunteered my time to attend CAC meetings for two years. During that time it became very clear to me and all the neighbors that the MIMP proposed by Sabey/Swedish was based on faulty premises.

When Swedish entered into an agreement with Providence Health Services and when they sold 50% of the Cherry Hill Campus to Sabey Corporation they knew the campus was located in a residential single family and lowrise neighborhood. They also knew that the land use code relevant to major institutions, requires that new development be compatible with the existing community.

It is very troubling that a private, for profit developer is participating in a process that was specifically designed for major institutions such as schools and hospitals. This conflict was evident during testimony of a dentist who, in conjunction with Swedish who provides the space, runs a free dental clinic and the Swedish First Hill campus. At this point all they can do is extractions but they'd like to expand but don't have the space on the First Hill vampus. She said it was important to have this expansion so there would be space to expand her clinic. The concerning part of this is that the Sabey Corporation, which owns about 50% of the Swedish Cherry Hill campus has ample empty space in their existing buildings. If they want to be a partner as far as developing the campus they should also be a partner in providing the required charity care that Swedish must provide due to their non-profit status. That they didn't even consider providing the free space is an indictment of this type of partnership.

During expert witness testimony one of the Sabey/Swedish expert witnesses compared the Sabey/Swedish relationship to successful public/private partnerships. A rather disingenuous comparison since neither Sabey nor Swedish are governments so don't qualify as a public entity. They don't have the oversight or ethical constraints put on governments. The same witness said these types of relationships were common practice in other parts of the county; again disingenuous as the land use and municipal codes of the mentioned areas are not the same as the City of Seattle's land use and municipal codes. What is allowed in one locality may not be allowed in another.

The 160' heights requested by Sabey/Swedish are too tall and will loom over our neighborhood, blocking views especially the view of beloved neighborhood landmark the James Tower. Although Sabey/Swedish state that these heights will be concentrated towards the center of the campus in reality they are proposing these heights along 15th Avenue, and although they are across from SU the proposed SU buildings are of a much lower height. These heights need to be reduced to provide transition from the SU campus. The other proposed 160' heights are so close

MUP 15-010 - MUP 15-015
DPD #3012953

'Right-Sizing' Swedish Medical Center on the Cherry Hill Campus:

An Alternative Recommendation from the Citizens Advisory Council

"I would call it right-sizing the campus."
~ Marcel Loh, Chief Operating Officer
Swedish Medical Center/Providence
Quoted *in The Seattle Times*, August 8, 2002

Submitted to the City of Seattle by Citizens Advisory Council members
Patrick Angus, Maja Hadlock, Dean Paton, James Schell and J. Elliott Smith
April 2, 2015

In 2002, when Swedish Medical Center announced its plan to sell off about a third of its properties on the Cherry Hill Campus to the Sabey Corporation, its then COO, Marcel Loh, said the $37 million sale would allow Swedish to continue operating the hospital while jettisoning properties it would not need. This "right sizing" of the Cherry Hill Campus, as Loh called it, allowed Swedish to profit and pay down debt, permitted Sabey Corporation to begin developing a biotech center in properties Swedish considered surplus, and suggested a scope of redevelopment that did what the City of Seattle's Land Use Code requires: balance a major institution's ability to change and grow with the livability and vitality of adjacent neighborhoods. Ironically, the 1994 MIMP that was in place during 2002 required any institution's uses to be approved per structure or facility. Sabey's proposed biotech center was never an approved use for the campus.

Now, 13 years later, Swedish, along with its corporate owner, Providence Health & Services, as well as the same private commercial developer, Sabey Corporation, say they want to nearly triple the square footage of buildings on the Cherry Hill Campus, expanding from about 1.2 million square feet to about 2.75 million square feet of space (down from their original proposal of 3.1 million square feet). They have, for more than two years, been presenting multiple versions of their Major Institution Master Plan (the MIMP), making their case for expansion to the Citizen's Advisory Committee (CAC), chartered under the auspices of the city's Department of Neighborhoods.

After some 32 community meetings, these five CAC members now are convinced that the Swedish/Sabey plans violate not just the spirit but also the rule of the city's Land Use Code. We also believe the Environmental Impact Statement submitted by Swedish/Sabey is inadequate and deficient.

In fact, in its official comments on the scope of the EIS, dated April 4, 2013, the Citizens Advisory Committee pointed out deficiencies to the EIS and asked for specific additional information and answers. Many, if not most, of these questions remain unanswered to this day. One particularly significant request the CAC made of the EIS is this:

> "A full discussion of decentralization options that would accommodate the identified need on a Swedish/Providence system-wide basis utilizing available development space at both Swedish's Cherry Hill and First Hill campuses, or more broadly within the Swedish/Providence System, and that might therefore result in the allocation of less square footage to the Cherry Hill Campus and more to the First Hill Campus; and b) the re-capture of space occupied by non-Swedish/Providence uses for direct SMC occupancy or to provide redevelopment opportunity."

In other words, the CAC asked DPD, and, by extension, the drafter of the EIS, to provide additional discussion of other potential sites—not on the Cherry Hill Campus—where some of the planned services and research facilities might be located if it is determined the campus cannot accommodate these and still preserve the livability of the surrounding neighborhood.

No satisfactory answer has yet been provided. In addition, the April 4 letter asked DPD and the drafter of the EIS to tell us more about:

> "The effects of inclusion of privately-owned non-SCM uses within the MIO's on non-SMC development and maintenance decisions."

This, too, has never been addressed.

Without a full and unbiased examination of those issues, the CAC simply has not had the information and analysis necessary to reach an informed recommendation. The drafter of the EIS simply brushed off the CAC's clear and unambiguous requests and produced an EIS that evaluated only the alternatives presented by the institution.

This has prevented the CAC from doing its job. The questions the CAC asked in April, 2013, were and are appropriate. If the CAC were to ignore the fact that those questions were not addressed, the CAC would fail to do the job it agreed to do.

We believe that the CAC has an obligation to demand the analysis requested two years ago. We cannot in good conscience accept a document that failed to satisfy the requirements established by the Environmental Protection Act.

Therefore, we believe, that, before the deadline of April 2, the CAC should file a formal request with the Hearing Examiner asking that the Hearing Examiner find the EIS to be legally insufficient and order the completion of an adequate EIS.

For far too many CAC meetings, the committee was asked to look at multiple alternative designs provided by Swedish/Sabey. At no point were we given the analysis by an unbiased EIS that would allow us to make a proper evaluation. As a result, we spent the bulk of our time looking at and ultimately rejecting 11 different plans—and this drawn out process left us with far too little time, and too little unbiased information, for a comprehensive study of the MIMP as a whole.

If the shortcomings of the EIS are not correct, and if it's necessary to make a recommendation based on the existing incomplete EIS, we are recommending a scaled-back version of development for the Cherry Hill Campus smaller in height, bulk, intensity, and scale than that which has been recommended recently by the Department of Planning and Development. Our recommendations are also, at present, somewhat smaller in height, bulk, intensity, and scale that what the CAC, before today, has been prepared to recommend. We believe our proposal is a contemporary version of "right sizing" that also does what the Land Use Code requires—balances institutional needs with neighborhood livability.

Note that there are three differing documents at play here: One is the Major Institution Master Plan submitted to the CAC by Swedish/Sabey; the second is the set of recommendations from the CAC (approved by a slim majority of members); and the third is this document, the recommendations of a large minority of CAC members. You will find on page 12 a table that makes useful comparisons of the major differences in height, bulk, and scale recommendations by each of these three proposals/reports. And you will see, at the end of this document, on page 15, a map of the Cherry Hill Campus that details the recommendations for heights of buildings on different parts of the campus made by the five members who have created this report.

Note that wherever this report does not differ from the multitude of smaller-issue recommendations made by the whole of the Citizens Advisory Committee over the past few months—design guidelines, numerous setbacks and such—the creators of this report support those positions as recorded in the final CAC majority report.

Herewith, our recommendations as well as the logic and laws supporting them:

Violations of the City of Seattle Land Use Code:

We call attention to the following:

The CAC is charged with reviewing the proposal for the Swedish MIMP in the context of the City's Land Use Code. To approve the proposal, the CAC must find it consistent with the Code. There are four elements under the Purpose and Intent section of the code that are particularly relevant.

To begin with, the MIMP must:

"A. Permit appropriate institutional growth within boundaries while minimizing the adverse impacts associated with development and geographic expansion;"

Rather than minimize adverse impacts on the neighborhood, as called for by the Land Use Code, the current Swedish/Sabey MIMP goes to the opposite extreme: Projected traffic congestion/gridlock will rise to levels unduly burdensome and destructive to the quality of life in the surrounding neighborhood; the proposed heights, bulk and scale of the planned buildings are incompatible with the low-rise neighborhood (if anything, they are of a height, bulk and scale more appropriate for the city's downtown core); design setbacks are minimal, or, in some places nonexistent, providing nothing close to the appropriate transitions from this out-of-scale new construction to the low-rise, single family neighborhood in which the campus sits.
An acceptable MIMP must minimize these impacts. The current version presented by Swedish/Sabey does not. An acceptable MIMP would also:

"B. Balance a Major Institution's ability to change and the public benefit derived from change with the need to protect the livability and vitality of adjacent neighborhoods;

Note that this section of the Code says nothing about the needs of the institution; rather, it speaks to the need to protect the livability of adjacent neighborhoods.

Significantly, the Land Use Code says the MIMP/CAC process should:

"C. Encourage concentration of Major Institution development on existing campuses, or alternatively, the decentralization of such uses to locations more than 2500 feet from campus boundaries"

After studying the Environmental Impact Statement as well as the MIMP, it seems clear to us that Swedish/Sabey is intent on placing more services or products on the Cherry Hill Campus than it can accommodate, causing significant adverse impacts to the neighborhood. In accordance with the dictates of the Land Use Code, it seems appropriate to ask that some of these services or products be located on other properties owned by Swedish or Sabey in other parts of the city.

The city's Land Use Code also stresses that any MIMP:

"I. Make the need for appropriate transition primary considerations in determining setbacks. Also setbacks may be appropriate to achieve proper scale, building modulation, or view corridors."

Sadly, Swedish has proposed zero lot line setbacks and minimal upper level setbacks for the majority of new campus buildings. The current proposal does not provide appropriate transitions along the perimeter, through ground level or upper level setbacks, or building modulations.

The Significance of the Seattle Children's Precedent

In applying the Land Use Code to the recent Seattle Children's MIMP, the city's Hearing Examiner demonstrated how these Code elements should be applied. We believe these findings in the Seattle Children's MIMP process relevant to the Swedish/Sabey MIMP.

(1) As regards the issue of height, the Hearing Examiner found the proposed heights of 140'/160' to be "...inconsistent with two of the [Land Use] Code's zoning principles and two of the criteria that must be used to select appropriate MIO height districts." Please keep in mind that the proposed heights in the Swedish MIMP are greater than those that were proposed, and rejected, for Children's Hospital. **The Cherry Hill campus has no space for transitions and the heights qualify as high-rise per the City's definition.**

(2) The Hearing Examiner found that the proposed heights could not "...be minimized by the use of transitions in height, upper level setbacks and 20-40 foot setbacks. Additionally, the proposed height limits "...would not be compatible with the adjacent single-family and lowrise multifamily and commercial heights." And, "...transitional height limits of MIO 37 and MIO 50...are of insufficient depth to reduce the impact of the adjacent 140-foot and 125-foot towers."

(3) The Hearing Examiner also found that exceeding the height of 40 feet "...may be considered outside an urban village only if the proposed heights would be consistent with an adopted neighborhood plan, a major institution's adopted master plan, or the existing built character of the area." The expansion proposed by Swedish/Sabey, and the proposed heights, do not occur within an urban village and do not meet the criteria set forth for exceeding the 40-foot limit. The Hearing Examiner ultimately found that Seattle Children's proposed heights were "stunning" and that they were "...inconsistent with two of the [Land Use] Code's zoning principles...." One would expect the Hearing Examiner to conclude that some of the heights proposed by Swedish/Sabey, and approved by the Department of Planning and Development, also are inconsistent with the Land Use Code's principles.

In this regard, it is difficult to imagine a justification for allowing Swedish to do to the Squire Park neighborhood what the Hearing Examiner disallowed for the Laurelhurst neighborhood. Any such differential treatment of the Squire Park neighborhood would raise the issue of unequal treatment of neighborhoods by the city.

(1) In terms of setbacks, the Hearing Examiner found that Seattle Children's' proposed setbacks of 20 feet, and upper level setbacks, "...would not provide an adequate transition..." to the adjacent neighborhood. More importantly, the

Hearing Examiner found that "...no reasonable setback and/or landscaping could mitigate the impact in this location."

We point out that the setbacks proposed by Swedish are either nonexistent or less that those vetoed by the Hearing Examiner in Seattle Children's case.

(2) In one Area of the Seattle Children's' proposal, the Hearing Examiner found that a more reasonable setback would be 75 feet if it were combined with reasonable landscaping.

Alas, Swedish/Sabey proposes nothing of the sort. We find most of the setbacks called for in the Swedish/Sabey MIMP inadequate.

Again, it is difficult to imagine approving the Swedish proposals for height and setbacks without being inconsistent with previous findings of the Hearing Examiner in the related case of Seattle Children's.

Traffic Increases

Regarding traffic increases, the Land Use Code states that Major Institution uses shall be subject to the following:

Major Institution uses which are determined to be heavy traffic generators or major noise generators shall be located away from abutting residential zones;

According to the Swedish Cherry Hill MIMP's Final EIS (3.7-42), under Traffic Volumes, Alternative 12 will generate 5,503 additional trips, which is a 100 percent increase in traffic volume. We believe Swedish Cherry Hill already is a heavy traffic generator, and the height, bulk, and scale proposed in this MIMP will increase traffic volumes far beyond anything that should be deemed acceptable because of the "abutting residential zones."

Beyond this, the MIMP and its Final Environmental Impact Statement fail to consider, or even acknowledge, a key element in the City of Seattle's Comprehensive Plan. Indeed, encouraging major traffic generators to locate or expand in urban villages where the public has made considerable investment in infrastructure, such as light rail and robust bus service, is clearly a major goal of the Comprehensive Plan. For the Swedish/Sabey EIS to note that traffic will get a lot worse—even if Swedish/Sabey is able to successfully implement a transportation master plan—and then leave out consideration of any alternatives that might send some of the new, projected jobs (and the resultant traffic) to an urban village elsewhere is deficient.

More About the Final Environmental Impact Statement

When the EIS mentions the worsening of traffic and a decrease in levels of service at various intersections that will be caused by the development it proposes for Swedish Cherry Hill, the document supposedly takes into account other nearby developments. Several of them are listed. However that list is quite incomplete. Not only is it impossible to know what number of vehicle trips are attached to these future projects the EIS lists, there are other planned projects that are known *today* which are not listed. One example: Between 12th Avenue on the west and 14th Avenue on the east, and between Spruce Street and Fir Street, three developments of approximately 360 units are on the drawing boards. It is not mentioned in this EIS.

Furthermore, the EIS's prediction about future intersection levels of service purports to relate to a time in the rather distant future, yet in making that prediction it only includes some of the known proposed developments. To be more accurate, this prediction would have to take into account some reasonable estimate that assumes the number of future housing units within the zoned capacity of the neighborhood.

The EIS predicts bad traffic congestion as a result of this proposed development, yet it surely will be much worse than the EIS implies. An acceptable EIS would describe what steps might be necessary when the traffic is that bad—which likely could included widening city streets by taking away existing landscaping and parking. If Swedish/Sabey intends to propose that the city depart from the Land Use Code as well as its Comprehensive Plan and allow high-intensity development in this mostly residential neighborhood, then the EIS needs to describe the changes to streets, sidewalks and parking that will be necessary to accommodate this growth. Cherry and Jefferson, for example, will need to be more like Madison and Boren—major thoroughfares. This would fundamentally change the residential character of the area by introducing the characteristics of major arterials dividing the neighborhood.

These three or four deficiencies with the EIS only hint at the document's failings. We could cite multiple other examples where the document is inconsistent or does not ask questions that need to be asked. But instead of ticking off a litany of problems, we'll focus instead on what is likely the main problem with this Environmental Impact Statement. To do that, it is important to refer to Seattle's Land Use Code again, as well as the Seattle Master Plan:

The Land Use Code states that the MIMP process "shall include" ... *(a) description of ... decentralization options including a detailed explanation of the reasons for considering each alternative,* ... SMC 23.69.032 C.1.e.

This is not optional. The Code requires it.

Indeed, the CAC requested a description of decentralization options in its first written comments on the proposed MIMP in April, 2013. The institution as well as the drafter of the EIS have failed to provide this required information.

The Code, in setting forth the requirements of an Environmental Impact Statement, *SMC 25.05.030, states the following:*

B. Agencies shall to the fullest extent possible:

3. Prepare environmental documents that are concise, clear, and to the point, and are supported by evidence that the necessary environmental analyses have been made; and

7. Identify, evaluate, and require or implement, where required by the act and these rules, reasonable alternatives that would mitigate adverse effects of proposed actions on the environment.

The EIS has not satisfied the purpose of an Environmental Impact Statement. That purpose is to provide the decision maker with unbiased information and analysis upon which a decision can be made. The information contained in the EIS is almost entirely provided by Swedish and the Sabey Corporation. Reasonable alternatives are not identified and evaluated. In fact no alternatives are evaluated—only the various proposals of the applicant are evaluated.

Relevant Requirements From SMC 25.05.400 Purpose of EIS

The Seattle Land Use Code should be a lens through which the Swedish/Sabey EIS is evaluated. The Code says:

A. The primary purpose of an environmental impact statement is to ensure that SEPA's policies are an integral part of the ongoing programs and actions of state and local government.

B. An EIS shall provide impartial discussion of significant environmental impacts and shall inform decision makers and the public of reasonable alternatives, including mitigation measures that would avoid or minimize adverse impacts or enhance environmental quality.

D. The EIS process enables government agencies and interested citizens to review and comment on proposed government actions, including government approval of private projects and their environmental effects. This process is intended to assist the agencies and applicants to improve their plans and decisions, and to encourage the resolution of potential concerns or problems prior to issuing a final statement. ***An environmental impact statement is more than a disclosure document.*** *It shall be used by agency*

officials in conjunction with other relevant materials and considerations to plan actions and make decisions. (Emphasis added.)

There are ways in which a reasonable plan for future growth of Swedish Medical Center could be consistent with and support the goals of Seattle as expressed in the city's Comprehensive Plan, but the EIS fails to explore those ways.

This EIS, in fact, is merely a "disclosure statement" and a discussion of how to fit into the neighborhood the amount of development the applicant has chosen. The question that the EIS should explore, but does not, is: "To what extent should Providence Health & Services, through its subsidiary, Swedish Medical Center, be encouraged to meet its future predicted needs at the location in the Central Area it calls the Cherry Hill Campus, and to what extent should Providence be required to plan to satisfy some of its future needs in other locations?"

The EIS should be a document that the Department of Planning and Development can use to assist it in planning actions and making decisions that are consistent with the Seattle Comprehensive Plan.

Besides the failure of the EIS to analyze mitigating the impact of height, bulk, and scale, another notable example of the inadequacy of the EIS is found in what passes for analysis of alternatives that might mitigate the impacts of traffic and greenhouse gas emissions. The EIS admits that "(t)ransportation plays a major role in climate change...," page 3.1-9. The alternative most effective in mitigating the impact that would be caused by 11,000 daily vehicle trips is the alternative that would direct the functions that generate many of those trips to an area close to a light rail station or area of robust transit service. The final EIS should analyze an alternative that moves some jobs to transit centers rather than speculate on the effectiveness of methods proven to be less than adequate in serving the present campus, which is only a fraction the size of that which Swedish plans for the future.

Swedish is presenting a variation on an argument so often heard today: that a serious response to climate change must defer to other more important plans. This approach assumes that, perhaps later, when it's more convenient, we can do something about climate change.

The city asks Individuals in households throughout Seattle to take steps that are sometimes inconvenient or more—all to do a small part to further the city's goals to reduce greenhouse gas emissions. However, in this case, a large project that would generate 11,000 vehicle trips a day is not asked to consider directing some of those trips to rapid transit in the most effective way possible— by locating near a rapid transit station.

It should be the job of the Environmental Impact Statement to analyze alternatives that would allow future Swedish development to be consistent with the Comprehensive Plan.

To summarize our general concern with this environmental impact statement: The point of an EIS is to consider reasonable alternatives. The Swedish/Sabey EIS considers only "alternatives" that were proposed by Swedish/Sabey. It omits any discussion of other possible locations where some of this proposed development could be placed. Because an EIS is supposed to give the decision-makers—the Department of Planning and Development and the City Council—unbiased information about additional alternatives, this EIS has abandoned its primary function.

Cherry Hill is Not A Designated Growth Center or an Urban Village

The type and scope of development projected for the Cherry Hill Campus, in the middle of the Squire Park Neighborhood, is compatible only in a designated Urban Village. Placing a development of such height, bulk and scale in a non-Urban Village section of the city should, on its face, cause the Hearing Examiner to reject the Swedish/Sabey MIMP.
Under Seattle's Comprehensive Plan, "Toward a Sustainable Seattle," the neighborhood surrounding Swedish Medical Center is a "Residential Urban Village." Accordingly, it is intended "...for predominantly residential development...(UV policy #12).

Important Questions About the Transportation Plan

Swedish/Sabey has created a transportation plan impressive in its thoroughness. We applaud those efforts. Nonetheless, even if all elements of this plan were to somehow work precisely as proposed, the traffic impacts on the surrounding neighborhoods would, in our view, be significant and unacceptable.

To quote from the final Environmental Impact Statement, "Alternatives 11 and 12 would result in two additional intersections operating at LOS F and one less intersection operating at LOS E during the weekday AM peak hour and four additional intersections operating at LOS F during the weekday PM peak hour, the same as with Alternative 8." (page 3.7-43)

The TMP does consider adding traffic signals at two intersections, but there is no guarantee that it would happen, nor is there an analysis of how that would affect the LOS.

The EIS projects that daily trips will double due to Alternative 12 by 2040 (5,439 now vs. 10,942in 2040; see Table 3.7-12)—in our view, an unacceptable increase in traffic and gridlock.

Swedish and its tenants have done some work recently to try to improve their transportation and get closer to their Single Occupancy Vehicle goal. But this work was

only started during their MIMP renewal process. First Providence, and now Swedish, have had decades to work on their TMP compliance yet have done almost nothing—until now, when they seek to create a new and overlarge MIMP. Such last-moment behavior does not inspire confidence, and we feel justifiably circumspect about prospects that Swedish/Sabey will have the will to meet their current Transportation Master Plan's SOV goal or a new proposed TMP SOV goal.

Accommodating Reasonable Growth

We believe reasonable growth that balances the needs of the major institution with the livability and continued well being of the neighborhood is possible. To accomplish this, we propose solutions based on the current capacity of the campus as well as its recent history:

All campus uses should directly support hospital functions. Other services, whether nonprofit or for-profit, should be relocated to other parts of the city, so that the neighborhoods surrounding the Cherry Hill Campus are better able to maintain their livability as additional construction as well as more employees and more patients come to the campus.

Space on the Cherry Hill Campus that currently is leased to other enterprises, nonprofits or individuals not directly associated with hospital and inpatient services Swedish provides should, over time, be reclaimed for the needs of Swedish, and not maintained as primarily real estate ventures, as is today the case. For example, Jefferson Tower, on the campus at the corner of 16th and East Jefferson, is a building with multiple floors of medical offices, many of these rented out to non-Swedish tenants. As these leases expire, we urge Swedish to use them for its own physicians and outpatient research facilities. The space in the Jefferson Tower and James Tower that is not currently rented should be used by Swedish for its own physicians and outpatient research. Other tenants such as Lab Corp., on 16th Avenue and East Cherry Street, or the Northwest Kidney Centers facility on 15th Avenue and East Cherry Street, should also be relocated off campus. This would permit the growth Swedish says it requires, but with less adverse impacts on the surrounding neighborhoods.

It should go without saying that the 40,000 square foot "hotel" Swedish is proposing for the Cherry Hill Campus—which Swedish says would serve not only Cherry Hill but also its First Hill and Ballard campuses—ought to be the first element of the current MIMP eliminated and moved elsewhere in the Greater Seattle Swedish enterprise.

Had Swedish not been short sighted in 2002, when COO Loh wanted to "right-size" the Cherry Hill Campus—had it not sold off some 40 percent of its square footage to Sabey Corporation—it could today attain much of what it now says it wants for this campus, yet without the unacceptable damage to the surrounding single-family neighborhoods.

Here are the primary changes to the MIMP that we propose:

Height, Bulk, and Scale

18th Avenue Half Block:

Maximum Height: 37'

Bulk: 4 buildings

Create mid-block open space the equivalent of two single-family residential lots (80 feet by 120 feet) that Swedish/Sabey would be developed by Swedish /Sabey as a healing/meditation garden for use by staff, patients and neighbors. Sabey, which currently owns this section of the campus, must provide 24/7 safety and security systems, maintenance and insurance to protect the adjacent neighbors and possible claims. The garden must adhere to city parks department hours of closure and access. Fencing along the property line between Sabey and the adjacent neighbors must be of sufficient height, materials, and other factors to ensure adjacent neighbors safety, security and privacy. The Standing Advisory Committee will consult with adjacent neighbors about fence design and materials.

Heights of Buildings Bounded by East Cherry Street and East Jefferson on the North and South, and by 16th Avenue and 18th Avenue on the East and West:

Excluding the historic landmark tower, the building designated in the MIMP as the patient-care tower would be the tallest on campus at 105 feet The rest of the property would have the same heights that were designated in the 1994 MIMP, which was 105 feet. The tallest building on the 16th Avenue half-block, on the west side, would be a maximum of 105 feet. The remaining buildings along the west side of 16th Avenue would be 65 feet.

There would be one sky bridge (current amount of street coverage) for use by patients, their caregivers, and hospital personnel. All others would use street circulation for campus access.

Heights of Buildings Along 15th Avenue:

The tallest building on the 15th Avenue half-block, on the east side facing Seattle University, would be a maximum of 65 feet. This would harmonize heights along both sides of 16th Avenue, from Jefferson north to Cherry and be in keeping with the Seattle University MIMP.

Setbacks

All existing ground-level setbacks would remain. That is, there should be no reduction in ground-level setbacks.

Upper level setbacks of 25 feet from the property line at a height of thirty feet for any new development along Cherry and Jefferson—LR1 and LR2 allowed building heights. (Basic Floor-to-Floor hospital heights are 15-20 with the first floor typically 19-26.) Rear setbacks on 18th Avenue half block would be a minimum of 25 feet. This would be a landscaped buffer and provide appropriate security and privacy for the adjacent single-family homes.

COMPARISON OF KEY DIFFERENCES IN SCALE BETWEEN SWEDISH MIMP and CAC *

KEY CAMPUS LOCATIONS	Swedish MIMP Proposal	CAC Majority Recommendation	CAC Minority Recommendation
18th Avenue east ½ block	Maximum height 45', one continuous building	Maximum height 37', one continuous building	Maximum height 37', 4 separate buildings plus significant open space
East side of 16th to west side of 18th Avenue	Maximum height 160' for the hospital patient-care tower	Maximum height 140' for the hospital patient-care tower	Maximum height 105' for the hospital patient-care tower
16th Avenue west ½ block	Maximum height 150 (MIO conditioned to 125')	Maximum height 105'	Maximum height 105'
15th Avenue east ½ block	Maximum height 150'	Maximum height 105'	Maximum height 65'

***This table compares the key difference of the Swedish MIMP Proposal to the CAC and CAC Minority Report recommendations relative to height. Other heights not mentioned are the same as those proposed by Swedish/Sabey. This does not include differences on setbacks.**

Traffic Mitigation

1. Expand the Residential Parking Zone south to Yesler Way and north to Union Street, as well as from 23rd Avenue on the west and to the boundary of RPZ Zone 1 on the west.

2. Swedish would continue to subsidize RPZ permits at 100 percent of cost.

3. Swedish will pay the city for increased parking enforcement.

4. Swedish will pay for increased bus hours for route numbers 3 and 4, and also contribute to Metro to jumpstart bus service on 12th Avenue.

5. Swedish will increase the frequency and number of shuttles to the First Hill campus so that its employees, patients, and neighbors can connect with the First Hill street car.

6. Swedish will provide subsidized bus passes for its employees: funding ORCA passes and walk-on ferry passes at 100 percent.

7. Swedish will contribute funds to the city to help pay for the Central Area greenway. (Note: This is not traffic mitigation.)

8. If there is underground parking on 18th Avenue, it would be accessed from Jefferson Street and include a right-turn only egress.

9. Reducing SOV rate, since Group Health achieved 55 percent in 2012. Swedish/Sabey should not get a pass because of what they have *not* done. From the 2011 (updated 2013) Virginia Mason Medical Center, First Hill campus 2012 MIMP ANNUAL REPORT: "The 1992 Master Plan established an SOV goal for Virginia Mason employees of 50% or lower. By 1998, Virginia Mason had achieved a rate of 28% and that number has continued to drop. Virginia Mason continues to provide one of the most successful Transportation Demand Management Programs in the City. Only 23% of employees use SOVs and over 49% use mass transit or rail. The service is promoted to all new employees, and updates are offered regularly via on-site transportation fairs and other promotional events."

Transportation Management Plan

To insure that the TMP is a working document and lives up to the substantial promises it makes in the MIMP and the EIS, we strongly suggest a written agreement that requires Swedish/Sabey to demonstrate measurable progress, with agreed-upon benchmarks and with enforcement mechanisms clearly stated and responsibility for enforcement specifically delineated before the institution may secure building permits.

Views

The current MIMP calls for buildings so tall they would obscure views of the historic James Tower and cupola from many directions. We believe the MIMP needs to be rewritten so that views of the James Tower and cupola would be preserved in a 360-degree radius. This will, of course, limit the heights of some buildings that, if built to current specifications, would obscure the Tower.

Design guidelines

Current MIMP design guidelines are vague and lack enforcement mechanisms. Final design guidelines should be re-written to provide measurable standards that ensure any future CAC has teeth when it comes to reviewing specific proposals for new buildings. This would include such measures as minimum percent of fenestration in building facades, quality and character of materials, and such. Design guidelines would also include specific standards for perimeter streetscape improvements.

Amenities

Swedish/Sabey has proposed a plethora of "community amenities," from a public laundry to a daycare center. In our opinion, these are side issues that do not mitigate the altogether too-large heights, bulk and scale of the campus in the MIMP Swedish

now proposes. As a nonprofit, mission-driven healthcare provider, Swedish can and should be doing more to be a better neighbor and a more responsible corporate citizen. To this end, Swedish should heed the calls of local community groups to expand healthcare access to low- and moderate-income residents of the neighborhood by increasing the availability of free and reduced-price care ("charity care") at the Cherry Hill Campus and by forgiving the medical debt of low-income area residents. In addition, Swedish should provide financial support to local groups and institutions already doing good work to address important unmet needs in the surrounding community—Centerstone, the Carolyn Downs Family Medical Center and Odessa Brown Children's Clinic, Central Area Youth Association, and Bailey Gatzert Elementary School.

Replacement of Housing

1. To replace housing units displaced by the Swedish expansion along 18th Avenue, we would require Swedish to provide subsidies for rents of multifamily units for the employees of Swedish hospital.

Conclusion

As the time this report was written, the Citizens Advisory Committee had met 30 times. At each of these meetings, time was set aside for public comment. During these 30 public-comment periods, hundreds of neighbors came to give their testimony to the CAC. All of these testimonies remain part of the public record.

We think it both telling and unusual that of these hundreds (and perhaps thousands of public testimonies), not a single resident of the Squire Park/Cherry Hill/Central District neighborhood spoke in support of the current version of Swedish/Sabey's MIMP.

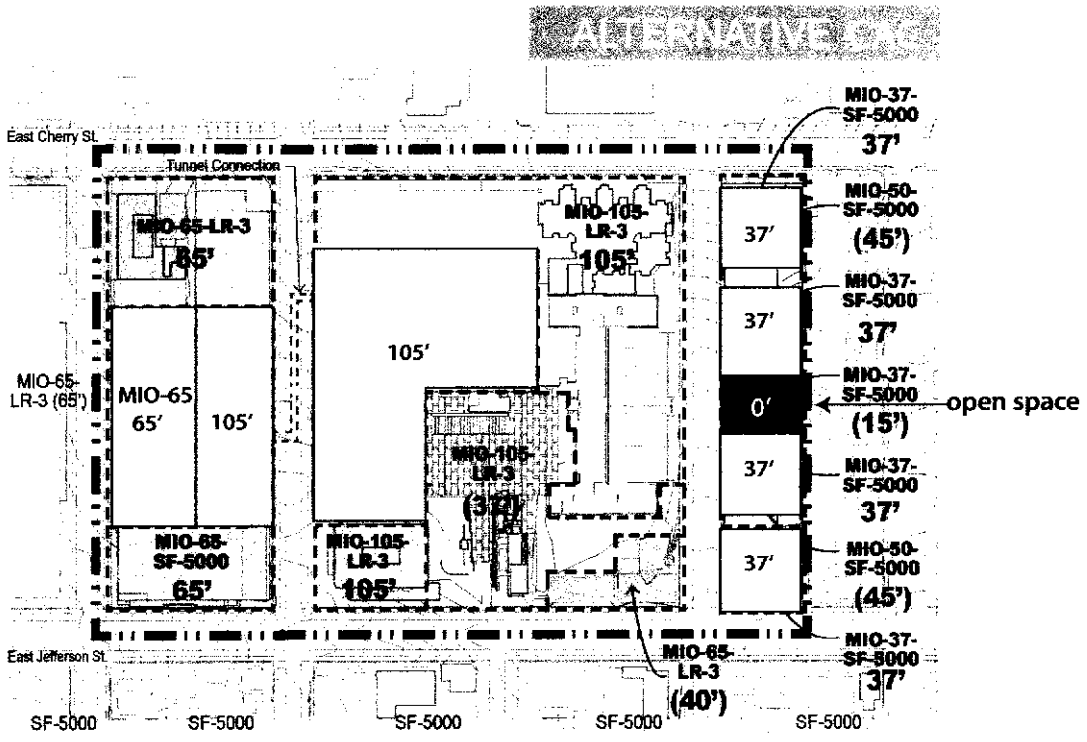
Not one resident.

What just about every one of these neighbors did say, in all manner of ways, can be condensed into a single passionate sentence: The height, bulk, intensity and scale of what Swedish/Sabey has continuously proposed are simply too much for this neighborhood.

Swedish/Sabey spread 12 different versions of its plans out for most of the 30 meetings, and with each new version the message from the community was essentially the same: the buildings were too tall, the bulk too big, the scale too massive for this part of Seattle.

We believe our proposal does the best job yet—presented by anyone or any group—of meeting the stated needs of Swedish/Sabey to change and grow while also maintaining the livability and vitality of the surrounding neighborhoods that have long lived in partnership with whatever major institution has occupied this campus.

We believe the current Swedish/Sabey MIMP, as well as the report prepared by the City's Department of Planning and Development, violate both the spirit and the intent of the City's Land Use Code. We also believe the ideas presented in this document do a fair job of "right sizing" the Swedish Cherry Hill Campus today.



July 20th, 2015

Re: Swedish MIMP 2015

Dear Examiner Tanner,

I have lived in the 112 year old home that I started buying with my wife since 2006. She has lived on the property since 1980. Our home shares fence-lines with the Sabey Corporation on two sides: the rear on 18th Avenue, where construction is imminent, and our southern fence borders a low-income home that was sold about five years ago. The home was a forced sale because the owner had hurt her back months before and was in jeopardy of loosing it to foreclosure. As neighbors, we were shocked that a corporation was allowed to buy it as income property, rather than it being preserved for another low-income family to purchase. We understood it had been built as affordable housing for first-time home-owners. It was heart-breaking to see her family struggle and then be forced to sell and leave the block. And we had a sense of dread that developers now controlled the lot. We fear what their long-term plans are for the property.

We, too, have had a very difficult time buying our home. We have scrimped and saved and been creative in maintaining the mortgage, plus upkeep, through the recession, job loss and other financial challenges. We love our home and our neighborhood and have made great personal sacrifices to keep the property. Back in 2006 when we were signing on the house, we had no idea the hospital was planning an expansion of such scale. I was aware that several low-rise buildings to support patients and neighbors were proposed on the other side of our fence. They sounded like nice amenities: a day care center, a gym and Ronald McDonald House. Sensible amenities that I understand were offered as mitigation and "in trade" for granting the hospital a larger parking structure on 16th Ave.; that all made sense and seemed fine. My, how the picture has changed: the promised amenities were never built. The prime two-block swath of land on 18th Ave. is now an iconic battle front: a modern struggle of David and Goliath. The trilogy of Providence Hospital, Swedish Hospital and Sabey Corporation vs. the residents of the central area: Squire Park, Madrona, and Leschi neighborhoods. We are fighting with heart and grit because we have a terrible fear the out of scale MIMP will be approved and our lives as they are, will be negatively changed forever. We anticipate for years we will be choked by construction dust, suffer from noise and project lights, have less mobility on our streets clogged by traffic, endure sleepless nights from anxiety about flooding and lost privacy. Not to mention our property values being devastated.

I have attended 90% of the CAC meetings in the last two-plus years. During that time, I became aware that Providence/Swedish/Sabey care only about the profit to be made by adding hospital-support-services to their campus. Although they say that these support services are vital to the operations of the hospital, as well as for the good of the neighborhood, we can see these are excuses to build more and add more. Seattle is rich with hospitals and clinics and excellent medical facilities. Competition is fierce, I am sure. Yes, the Cherry Hill campus needs redesign and modernizing. I have heard from a nurse on staff the space is actually not functional for quality care in some areas. That may be why it was rated 17 out of 18 for patient safety in Seattle in 2014. But not all services and great new ideas need to be located at this campus. Especially when not all the space available is being used now.

I was present for the MIMP hearing each day last week. I experienced stress and anxiety listening to witnesses that Swedish scheduled to testify about their patient care or their work at Swedish Cherry Hill. These witnesses have not attended any CAC meetings, they don't know neighbors, and they either work there or have been encouraged by Swedish to testify. One example of this was the public testimony by dental professional Dr. Amy Winston. She was speaking about a low-income, volunteer dental program she coordinated with Swedish Hospital on Broadway. A wonderful program indeed: they offered a million dollars in free dental care to nearly 900 patients in 2014. Wonderful. But the clincher was when she said that even though they share office space with Northwest Access, they really want to be able to move the services to the Cherry Hill campus. Why? "Because of the neighborhood—the demographic is a perfect match for the program". I take great issue with her suggestion. In order to be treated in the clinic, patients must be 200% below the poverty level. Our neighborhood is not a ghetto! We are hard-working families who are diverse in every way. And then she went on to say that even though they looked high and low on Cherry Hill, "there was *no room to be found on campus—even in broom closets(!)*". In her mind, development of the MIMP is essential to the future of her noble clinic. Again, I take issue with her suggestion. There is and has been vacant room for lease in the Jefferson Tower at Swedish Cherry Hill *for years.*

From the Sabey webpage: http://sabey.com/jefferson-tower/

SPACE AVAILABLE

Fourth Floor | 2,896 rsf

B Level | 1,268 rsf

Why can't the dental clinic be housed in this opportune space available in the location that is so desirable to Dr. Winston? Why didn't she know about it? Or perhaps it is just an excuse. I suspect there are more examples of "proposed needed space" that can be found in other parts of the Swedish Hospital system such that the size of the MIMP could be greatly scaled down.

It is outrageous that this project necessitates 1.55 million additional square feet. It needs to be scaled down. Or it needs to be rejected outright.

Please save our cherished neighborhood, this diverse, vital, historic, central district, from being ruined by over zealous developers.

Thank you for your service,

Melissa Flynn
529 19th Avenue
Seattle WA 98122
206-708-3526

Michael Welsch
1128 16th Ave
Seattle, WA 98122

7-13-15

Re: Swedish/Sabey Neighborhood Expansion Master Plan

I am strongly opposed to the Sabey/Swedish development plan at the Cherry Hill Campus. I have a long history in the neighborhood: born at Providence Hospital, a graduate from Seattle University, have worked in the Capital Hill area, and own a home at my current address for over 30 years. This neighborhood is a combination of single family, condos ,apartments and multi-family residences- a Seattle jewel for over a hundred years. There have been many changes in growth and development that we have adjusted to, yet this proposal is a threat to its basic livability.

The current Swedish/Sabey proposal raises the height code is 160 feet and increases the building footprint to 3 million sq ft . The justification for this expansion is the questionable corporate pretense it is a medical necessity for the health care community. The increase in the total footprint is out of proportion the existing neighborhood. The building height will limit light/air exposure for blocks to the North. Parking and traffic problems are already a major complaint. Adding 1,800 parking spaces is not going to solve this problem. It will just add to more congestion for all Seattle. Cherry/James Street is already a nightmare to get to and from I- 5. Responsible growth requires having an infrastructure to accommodate the needs of the community. Responsible community organizations have strongly opposed the Swedish/Sabey neighborhood expansion. So far ,nobody has listened to them. Will you?

Respectfully submitted,
Michael Welsch

Michael Welsch

Mike Murphy
315 15th Ave Seattle, WA 98122
206-949-8437
Mikemurphy2011@gmail.com

July 1, 2015

City of Seattle
Hearing Examiner
P.O. Box 94729
Seattle, WA 98124-4729

To whom it may concern,

I oppose the current version of the MIMP and Swedish Cherry Hill expansion for the following reasons.

I have lived near the Swedish Cherry Hill campus for the past 7 seven years. For 5 years, I rented a house at 311 20th Ave. until August 2013, at which point my partner and I were able to purchase our dream home at 315 15th Ave. By living on two different streets, both of which are near the campus, I believe I can provide a unique perspective on how expansion will further impact my neighborhood.

Parking

The house I lived in on 20th Ave. did not have off-street parking and was located on a section of the street that does not have zoned parking. I believe it may be one of the closest streets to the campus without zoned parking. Every morning there would be cars circling this area eagerly awaiting a spot to open. I cannot say all, but a majority of these cars belonged to employees of Swedish; they were quite easy to identify as Swedish employees as they were dressed in hospital scrubs and wearing Swedish ID badges. Overall, the parking was in short supply and greatly exacerbated by these employees trying to avoid paid parking in campus lots.

The 315 15th Ave. house again does not have off-street parking, but it is zoned. Since the zones allow up to one hour of free parking, it is now the hospital patient's and other clientele who park along this street, again to avoid paid parking in the hospital garage. Unless these new garages are free for employees, patients, and other clientele, any expansion of the campus will continue to make parking on residential streets in the area worse for the residents.

over

Scale

I am a construction manager who works on projects similar to the proposed hospital expansion, so overall I support change and development. Some expansion to the Cherry Hill campus is to be expected, but the size of the proposed expansion is markedly out of scale for the surrounding neighborhood. Swedish's argument that expansion is necessary is misleading and their current space limitation is self-inflicted due to them selling off 50% of the campus to a development company. This is not downtown or even First Hill, this is Cherry Hill in Squire Park, which is predominately a residential neighborhood. Again, some growth is to be expected, but not to this extent. Adding up to 1.5 million square feet of new office space on this campus would congest the area greatly and further exacerbate the already existing parking crisis. Lastly, the proposed increases to the building heights will tower over the neighborhood of primarily single family homes and is unreasonable.

I do not support the DPD recommendation that this MIMP should be approved. Please consider my thoughts concerning this project when you make your decision on this appeal.

Warm regards,

Mike Murphy, homeowner

July 9, 2015

Office of Hearing Examiner
P.O. Box 94729
Seattle, WA 98124-4729

Re: Swedish Cherry Hill MIMP Master Plan
Project number – 3012953 Project address – 500 17th Avenue, Seattle

Dear Hearing Examiner:

I am a Seattle resident and business professional and I am writing this letter to express my full support for the Swedish Cherry Hill master plan.

As a member of the local banking community I can speak with firsthand knowledge of the vital need for quality jobs and economic development in our neighborhoods. Investment in the Swedish Cherry Hill Campus has reversed years of decline and improved safety within the Squire Park neighborhood. The campus is a source of excellent family wage jobs for the neighborhood's young people as well as an important asset for all those in need of medical care.

In addition to providing direct jobs, the hospital supports local businesses through its patronage of our services and products. From gas stations to restaurants and service providers, Swedish and it employees are the economic lifeblood of this area and we welcome and need the hospital to continue to grow and thrive.

In addition, Swedish Cherry Hill provides invaluable healthcare services to our community and the region. From primary care to specialized services for neuroscience, multiple sclerosis, stroke, brain cancer and other debilitating diseases, the campus serves a broad population of patients and their families who depend on it for care. As my generation grows older and new people continue to move to the area, our hospitals must expand to keep up with demand.

For all these reasons and more, I urge you to approve the Swedish Cherry Hill Master Plan as quickly as possible.

Sincerely,

Moussa Samb

Ladies and gentlemen on the board

My name is Nate Miles lifelong Washington State resident, and long time Seattle civic leader. I write to you today in support of the efforts of Swedish-Providence Medical Center to expand and enhance their facility and services. My apologies for not being there in person as I had planned, however, I felt this issue was so very important, that I had to at least to at least address you even if it only via my written statement.

As a recent brain surgery patient at their facilities I can testify firsthand about the quality of care and and the dignity with which they treat all of their patients. I can also tell you how stretched they are in the specialty areas of including neuroscience, integrated care, intensive care units, and after hours emergency clinics.

This causes some very unique challenges for the Seattle region See, Seattle is a hub for quality healthcare delivery, especially in the aforementioned areas and is dependent on attracting quality talent from around the country.

Not being able to expand this facility would put this region at a significant disadvantage to some of our competitors in California and other cities who are competing for some of the same talented individuals.

I realize that some of the neighbors don't see it as I do, but as chair emeritus of the Seattle Urban League Board, which is located very close to the facility, I personally think that their mitigation plan will help alleviate most of everyone's concerns.

Further Swedish has been a great neighbor and a fair and welcoming facility over the years to the constituency we serve. It is for these and many other reasons that I am happy to support their efforts and believe their expansion should be approved. Thank you so much for your time and consideration in this effort

Sincerely.

Nate Miles

Office of the City of Seattle Hearing Examiner
P. O. Box 94729
Seattle WA 98124-4729

RE: **Swedish Hospital Cherry Hill Major Institution Master Plan**

It was a miracle. I'd died and they brought me back my life.

I'd suffered a series of life-threatening epileptic seizures. I'd stopped breathing, I'd died and the exceptional staff at Swedish Hospital Cherry Hill not only brought me back to life, they brought me back my health as if my seizures had never occurred.

I was lucky. I received in-hospital and out-patient care from the best neurological doctors, nurse practioners, nurses and staff in Seattle. I was lucky. When my crisis occurred, three years ago, they were able to treat me and save me. Since then, their facilities have reached the capacity point where they can no longer provide the best care for all who desperately need and depend upon their care unless they can expand and update the Cherry Hill Campus. Please approve their expansion plan.

I was blessed with a miracle. I'd died and they brought me back my life. Please approve their expansion plan so that others will be as lucky as I am; so that others will receive the miracle of their exceptional dedication and care; so that others will have their lives saved.

Nathaniel H. Stahl 6/28/15

Nathaniel H. Stahl June 28, 2015
1501 17th Avenue, #1114 Seattle WA 98122
(206) 324-6223 knatieknate@gmail.com

Ku, Tiffany

From: Tanner, Sue
Sent: Monday, July 20, 2015 1:23 PM
To: Ku, Tiffany
Subject: FW: Final Letter Regarding Swedish Cherry Hill MIMP #3012953
Attachments: 2015-07-20 Public Comment Letter - Nicholas Richter.pdf

Sue A. Tanner
Hearing Examiner
City of Seattle
(206) 684-0521 (phone)
(206)684-0536 (fax)

From: Nicholas Richter [mailto:nicholas.richter@gmail.com]
Sent: Monday, July 20, 2015 1:12 PM
To: Tanner, Sue
Subject: Final Letter Regarding Swedish Cherry Hill MIMP #3012953

Dear Examiner Tanner,

Thank you again for the opportunity to speak at the hearing last week. Please accept my final written public comment letter for the Swedish Cherry Hill MIMP (DPD Project #3012953). I believe that a paper copy will be delivered to you today, but just in case please accept this PDF copy.

Sincerely,

Nicholas Richter
MS, Spatial Planning

DPD # 3012953 MUP 15-010 – MUP 15-015

Dear Hearing Examiner Tanner,

Thank you again for permitting me the opportunity to speak at the recent hearing on the Swedish Cherry Hill MIMP. Before I begin with my written comments on the MIMP and EIS, I wish to address a pressing community need that was identified by the doctor that testified on the same day that I did and offer an immediate solution that is available to her. Her effort to being a dentistry clinic to the central district is laudable, even if this service does not appear to be consistent with the long term concept of a "specialty" hospital that Swedish has stated is an aim of this campus. In her testimony, she stated to effect that she had looked for space on Cherry Hill Campus, "in every broom closet and cubby hole", and was unable to locate the 3,500 square feet of space needed. She claimed that the new MIMP would provide the space need to bring this service to the neighborhood.

I am happy to inform you that I have located space on Swedish Cherry Hill campus that appears sufficient for her needs. Presently, as of 2015-07-17, there is a total of 4,164 square feet available in two office spaces[1] for rent in the Jefferson Tower. This tower is located on the Cherry Hill campus and is managed by Sabey Corporation. Given the intimate relationship between Sabey and Swedish, providing this space for the benefit of the hospital and community should be a feat accomplishable in short order. For her convenience, a copy of the notice of availability retrieved on 2015-07-18 and the floor plans are attached at the end of this letter. While it does seem that locating a dentistry clinic in Cherry Hill would not reach many new potential clients (The city does not build fire stations next to each other for this same reason), she seems genuine about her intent. I look forward to hearing more.

In effort to better provide clearer commentary, I will divide this letter into two parts and attempt to address each document in isolation to the others. The MIMP section will cover the final MIMP and the public process associated with it. The EIS section will address the EIS and the appendix to the EIS.

This analysis is based on experience gained through my work in transportation (both as a professional employed in the transportation planning field and as an advocate for healthy transportation options), my work as a member of the citizen's advisory committee, my long residence in the neighborhood, and finally on my extensive academic work. Of particular importance is my degree from the Royal Institute of Technology (KTH), which is in the field of Urban and Regional Planning. KTH is well known in the Seattle transportation community and many transportation professionals have received at least part of their education at KTH in Sweden. These professionals include Adam Parast of Transpo Group, a likely contributor to the transportation technical report included in the EIS for Swedish, and Dr. Ryan Avery. Dr. Ryan Avery sits on the advisory committee for Commute Seattle and teaches sustainable transportation planning at the University of Washington. KTH provides impeccable training, as the many members of the Northwest transportation planning community trained there demonstrate.

Please enter this document into the record for DPD project #3012953.

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[1] One is located on the 4th floor with 2,896 square feet and the other is located on the ground floor with 1,286 square feet.

Comments on Final Major Institution Master Plan, Dated 2014-12-11, for Swedish Medical System Cherry Hill

I ended my testimony by stating that the citizens of Seattle deserve better than the proposed master plan presented by Swedish Medical Center. This plan is inappropriate for any residential community in Seattle, but it is especially objectionable when this residential community in particular is not being treated on parity with other neighborhoods. In particular, it is informative to compare the master plan adopted by Seattle Children's, located in a traditionally (and continuingly) affluent neighborhood, versus the present master plan proposed by Swedish, located in a neighborhood with more limited means. Squire Park is not a community of lawyers and the median income is notably lower. The public process is meant to act as a way to mitigate these differences in power between different neighborhoods and provide an area where local knowledge and community needs is balanced against the desires of an institution to respond. When functioning properly, the outcomes of the process should present a similar level of benefits, sacrifices, and impact for the near neighbors of each major institution.

This is not the case today. There is a clear disparity between the benefits and mitigation measures that are provided to the Laurelhurst community and the Squire Park community from their respective plans. Although the neighborhood has undergone significant changes in the past two decades, the median income of a household located in the vicinity of Swedish Cherry Hill remains half of the median income of a household located in the vicinity of Seattle Children's and more than $12,000 below the median household income for the City of Seattle (Based on the American Community Survey, 2008-2012). The benefits and mitigation measures provided to each are of such vastly different quality and quantity that it is clear that the public process has not delivered on the promise of equalizing power relationships and providing citizens with quality plans, regardless of the overall demographics and resources of the neighborhood.

Every citizen of Seattle deserves a better plan that was has been delivered for consideration by Swedish, and importantly no community should be treated the way that it was under the course of this public process. While the Seattle Municipal Code (SMC 23.69.002) intends to create a public process where a master plan can be created collaboratively and with "significant community involvement", the public process stewarded by Swedish and Sabey has routinely displayed antagonistic and anti-participatory behavior during this process. These behaviors include;

1. Failing to provide information requested by CAC members on the DEIS/MIMP;
2. Refusing to provide electronic copies of documents to CAC members in a timely manner, which directly hindered the ability of the CAC to perform their duty to review and comment on the plans by the deadlines imposed;
3. Advancing alternatives that were bellicose and harassing towards near neighbors after their fully unacceptable nature was well communicated to Swedish by the CAC and the public;
4. Suggesting that it would be "outside the code" and a "distraction" for CAC members to provide alternative concepts for discussion that were not already presented by the institution;

5. Relocating a critical public meeting off campus for frivolous reasons –a behavior that was stopped only by an amendment to the CAC bylaws that was adopted by the CAC;
6. Adding a security guard and video recording equipment to public meetings and refusing to remove them after members of the public expressed their uneasiness about the presence of such features at public meetings and their chilling effects on discourse at the meetings;
7. Irregularities with sign-in sheets at the public meetings;
8. Failing to regularly update the cherryhill.swedishmimp.org website, including as of 2015-07-18 failing to provide the final master plan, final EIS, and DPD Director's Report on the website;
9. Permitting members of the public with potential conflicts of interest or previous business relationships with Swedish and/or Sabey to participate as CAC members;
10. Demonstrating a clear disregard for CAC and public commentary by presenting minor variations of the same concept as "alternatives", requiring the CAC to reject the draft MIMP and draft EIS in order to affect a minor change of behavior.
11. Refusing to present and study a decentralized alternative that would minimize adverse impacts via decentralization option for CAC consideration, despite clear requests by the CAC[2].

This behavior is unacceptable and taints the end result of the process. The CAC was not able to deliberate the full range of alternatives that it requested and institution took action that, intentional or not, hindered the ability of the public and CAC to participate in meaningfully contributing to the development of the final MIMP. For these reasons alone, I reiterate: The citizens of Seattle deserve better, as do the residents of this neighborhood. When combined with the stark imbalance of benefits that the institution derives versus the impacts to livability that the neighborhood is must bear, it is clear that there has been a miscarriage of this process on the part of the institution.

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[2] Some tenants and services at Cherry Hill are not location sensitive. LabCorp is a prime example of this. LabCorp serves a myriad of healthcare providers in the region and uses a fleet of vehicles to provide courier services for samples for healthcare providers. We are told, however, that LabCorp's presence at Cherry Hill is vital for patient needs. A couple of observations follow from this:

1. Swedish First Hill serves far more patients to serve, given that First Hill has nearly three times as many patient beds and is a much large campus. LabCorp and Swedish could, by the logic that LabCorp proximity is critical to patient care, provide better care for more patients by facilitating LabCorp's relocation to the First Hill Campus.
2. A relocation to First Hill would also provide superior access to I-5 and avoid the future failed intersections that are identified as being a result of the Cherry Hill master plan (See Transportation Technical Report). These adverse traffic impacts are "significant and unavoidable" (Page C-122) and will affect patient care across the region, since courier vehicles will be necessarily delayed trying to access Cherry Hill.
3. Providing reserved parking for a fleet of courier vehicles increases the demand for parking at Cherry Hill Campus. Facilitating a move to superior facilities through a decentralization alternative for Cherry Hill services would reduce the pressure and need to build parking structures on campus. This was not studied or presented as an alternative.
4. As noted before, there are pressing other services that Swedish wishes to provide on the Cherry Hill campus, including the laudable dentistry program. A facilitated relocation of LabCorp to First Hill would provide all of the above benefits and allow for the charity care such as the dentistry program that was so eloquently advocated for on 2015-07-17 to have a permanent home (presuming the currently available facilities that Sabey is offering for rent on the Cherry Hill campus are insufficient for the dentistry program's needs).
5. The only disbenefit in this case would be a rent paying tenant to Sabey. However, I am sure that Swedish's commitment to patient care and non-profit healthcare would rise above such concerns.

In order to demonstrate these disparities, the proposed Swedish Cherry Hill MIMP will be compared directly with Seattle Children's MIMP. Seattle Children's master plan is a critical comparison because the two campuses share many similarities:

- Both are bordered by residential neighborhoods.
- Both are affected by relatively poor transit connections (Children's more so).
- Both seek final campuses of similar total facility sizes (2.1msf for Children's 600 bed total build out versus 2.75msf for Cherry Hill's 385 beds on total build out).
- Both are plans created recently, providing the most current view on hospital needs and considerations during the MIMP process.

The differences are summarized in the following table. Changes forced on the institution by the City of Seattle via the DPD Director's Report is addressed briefly on page 11.

	Seattle Children's Hospital	Swedish Cherry Hill
1. MIMP Approval Date	2010-05-10	N/A
2. Square Footage Requested	2,400,000 sf[3]	2,750,000 sf (+350,000 sf)[4]
3. Total MIO Area	30.2 Acres[3]	13.28 Acres[5]
4. Beds on Total Build-out	600[6]	385[7]
5. Square Feet per Bed *(Calculated)*	4,000	7,142
6. Usable Open Space	12.27 Acres[8]	0.0017 Acres[9]
7. Usable Open Space as % of MIO	40.63%	12.75%
8. Usable Open Space as % of Requested SqFt[10]	22.3%	2.7%
9. Total Lot Coverage	51%[11]	76.5%[12]
10. Floor-Area Ratio	1.9[8]	4.74[13]
11. Predominate Neighboring Zoning	SF 5000[14]	SF 5000[15]
12. Maximum Height Proposed	140'[16]	150'[17]

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[3] Children's Final EIS, 2009-05-20, page 3.7-7
[4] Swedish Final MIMP, page 52
[5] Swedish Final MIMP, page 37
[6] Children's Final MIMP, page 15
[7] Swedish Final MIMP, page 134
[8] Children's Final MIMP, page 75
[9] Swedish Final MIMP, page 42 – Converted from 74,025.
[10] Calculated: 12.29 Acres = 535352.4 SqFt / 2.4m SqFt vs. 74,025 / 2.75m SqFt
[11] Children's Final MIMP, page 70
[12] Swedish Final MIMP, page 21
[13] Swedish Final MIMP, page 55 – *Note: excludes all server space. Sabey is in the business of running server farms.*
[14] Children's Final MIMP, page 53 – *Approximately 50% the campus perimeter is bordered by SF 5000.*
[15] Swedish Final MIMP, page 7 –*Approximately 54% of the campus perimeter is bordered by SF 5000.*
[16] Children's Final MIMP, page 55
[17] Swedish Final MIMP, page 36

	Seattle Children's Hospital	Swedish Cherry Hill
13. Minimum Distance from Tallest Height to SF 5000[18]	Approx. 500 feet	Approx. 185 feet
14. Minimum Distance from Tallest Height to Any Residential Zoning	Approx. 175 feet (L3)	Approx. 185 feet (SF 5000)
16. Minimum Distance from Any MIO 100' plus Zone to Any Residential	Approx. 175 feet (140' to L3)	Approx. 75 ft (105' to LR3)
17. MIMP Contains a Phasing Plan with Schedule for all Phases	Yes[19]	No[20]
18. Total instances of the word " shall " in MIMP[21]	100	26
19. Total instances of the word " will" in MIMP	275	131
20. Combined instances of commitment words (shall + will)	375	157 (-58%)
21. Total funding pledged for transportation mitigation and amenities in MIMP	$3.9m + $250,000 per year for additional Metro transit service[22]	$0[23] [24]

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[18] Based on Swedish Final MIMP, page 36 and Children's Final MIMP, page 55, with analysis done via Google Earth Pro. Zoning taken from MIMP documents.

[19] Children's Final MIMP, page 70

[20] Swedish Final MIMP, page 62 – "The timing of projects on the Cherry Hill Campus is subject to extreme variability due to the uncertainty of funding and the rapid changes in the healthcare environment." Or, paraphrased: "We have no real plan outside of building on the 18th half-block." This alone should point to the inadequacy of the MIMP and EIS: Without a plan, you cannot predict effects and cannot determine if those impacts can be mitigated. You are being asked to approve a blank check. It also fails to provide the neighborhood with "advance notice of the development plans of the major institution" because there are no specifics.

[21] The word "shall" indicates a clear legal commitment. The word "will" does not have the same strength as "shall" and is often used as part of a phrase, such as "will be reviewed". These do not indicate a commitment to the same extent. Text extracted to Microsoft Word from the PDF and then analyzed for rate of occurrence.

[22] Children's Final MIMP, pages 63, 81, 89, and 90

[23] The Swedish MIMP only includes phrases such as "will work to plan", "increased levels of incentives" without specifics (1%? 100%? 1000?), "promote use of alternative methods" without specifics, "consider alternative ... parking policies" without commitment to specifics (Children's includes specifics on disincentives and incentives in this area), "will work with parking partner to explore", "work with on-site retail to offer". **These are not actionable or enforceable commitments due to their vagueness and lack of specifics.** For example, I considered

[24] It was noted that the director's recommendations is forcing the institution to accept a condition that requires partial implementation of safety improvements around intersections. This is not included here because 1) Acceptance of these recommendations and incorporation of the recommendations into the MIMP that will be approved has not happened, 2) Swedish/Sabey have not publically posted information about their commitment to building these projects, 3) The recommendations require that the improvements be completed before the permit is issued. **However, responsibility for paying for improvements is not discussed.** It is not safe to assume that Swedish will accept fiscal responsibility for these improvements or to what level. This is not specified in the EIS or MIMP, as I testified to at the hearing. I maintain my assertion that Swedish has not to date materially and specifically committed to implementing needed transportation mitigation measures in a meaningful manner.

	Seattle Children's Hospital	Swedish Cherry Hill
22. Total non-SOV benefit to employees pledged in MIMP	Full subsidized regional transit card for all employees. Transit pass for contractors. Up to $880 per year monetary incentive bicycle/walking. Up to $1,780 monetary incentive for vanpool drivers. All employees have guaranteed ride home benefits worth up to $1200 per year.[25]	50% subsidized transit card. Parking subsidies for vanpool (50% or 100%).[26] Rideshare Online Network.[27] May not include tenants.
23. MIMP provides written commitment to patrolling neighborhood parking and punishing infractions	Yes[28]	No
24. Total subsidized or uncompensated care provided	$108.6m (Reported value for 2009, adjusted to 2013 dollars)[29]	$44.9m, **Systemwide** (2013, Benefit from Cherry Hill **alone not** identified)[30]
25. Total pledge for compensating loss of residential units/land use	Either 136 fully constructed unit or $10,920,000 or 35% of a replacement project cost[31]	Asserts that mitigation is not required for removing 1.75 Acres of land from future residential use.[32]
26. Total number of meetings held with community groups	28 (From Appendix C-1)	3 (Based on cherryhill.swedishmimp.org)

This list is not complete or exhaustive. Further analysis would continue to reveal clear disparities in commitments and mitigation measures between the Seattle Children's MIMP and the current MIMP under consideration. The Swedish MIMP does not include actionable commitments to the community. The most clearly defined commitment made to the community –an unwanted and unneeded "health

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[25] Children's Final MIMP, pages 89, and 90

[26] Swedish MIMP, page 79 to 81

[27] Referred to as "Rideshare Online Network" in existing list of benefits and "Facilitate rideshare match-ups for carpools and vanpool" in new TMP description.

[28] Children's Final MIMP, page 90

[29] Inflation adjustment done using CPI adjustment using FTA's TERM Lite methodology. Children's Final MIMP, Page 13 The amount of uncompensated care is not reported separately from undercompensated care.

[30] Swedish Final MIMP, page 69. Note that the *entire Swedish system* only provides $142 million in uncompensated care! Includes values reported for "Non-Billed Services", "Charity Care", and "Negative Margin Services".

[31] Children's Final MIMP, Page 61

[32] The EIS states that the proposed alternative "would permanently remove approximately 1.75 acres of land area from available supply that could be redeveloped for residential uses in the future" and then proceeds to state that "no significant unavoidable adverse impacts are anticipated". However, the removal of residential properties and residents from this half-block has already been implemented by the hospital and only one residential building currently remains. There is no impact because the hospital has already acted. The 1994 MIMP does not appear to address the loss of housing, and therefore this impact is wholly unmitigated. This is similar to the owner of a historic building destroying historic features ahead of a ruling on whether the building should be protected under historic preservation laws.

walk"[33]- is even attempts to place responsibility of potential failure to deliver on other entities with phrases such as "Note, further design coordination with SDOT / Metro will be necessary" and "Design elements of the proposed perimeter health walk must be reviewed and approved by SDOT". This is communicating clearly that unless there is a champion within SDOT for this sham of an amenity, there is a clear risk that the design coordination and approval will simply not occur. This will provide a convenience excuse for why implementation of this amenity will not happen.

The Seattle Children's MIMP provides a model for how master plans should be. Seattle Children's also demonstrated a much larger degree of responsiveness to community concern, including jettisoning a proposed 240' MIO zone from consideration, and a clearer commitment to amenities. The TMP plan presented as part of Children's MIMP stands in clear contrast to Swedish. In the former, concrete and actionable details that follow established and known transportation planning and engineering principles are committed to, as well as a significant level of funding for transportation elements off campus. The transportation managers at Seattle Children's understand that transportation effects (and required mitigation measures) are not limited to the boundary of their MIO. This is obvious in the fact that there is $3.9m clearly and unequivocally committed to local transportation projects.

In the latter, what is committed to tepid and the majority of their "plan" is to do research on TMP and have "discussions". This provides no actionable commitments and nothing to hold the institution accountable. Any criticism will be deflected by pointing to the fact that some meetings were held, even if the meetings do not lead to what the presumed intended outcome is[34]. We do not need studies about the effects of TMP strategies. A healthcare institution is not equipped with the expertise to take on this type of study and the effects of specific incentives are well established in the transportation planning community. Presumably Swedish hired Commute Seattle to gain access to this type of expertise to avoid the cost of conducting original research (although Commute Seattle does not employ any Professional Engineers and should not be considered experts per the arguments made at the hearing[35]). What is needed in a transportation management plan is commitment to implementation, which requires in Swedish's case a significant cultural change. One should be very

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[33] No community member spoke out in support of this proposal during my time on the CAC. It also defies logic, as every other residential street is a superior walking facility than Cherry and Jefferson. There is no logical user base. There is no community support. This is not a community amenity. The money would be better spent providing amenities inside of the residential neighborhood that surrounds the hospital. It is a waste of money, unless Swedish plans to market the walk to their patients. In that case, however, it is a facility of the institution.

[34] This is similar to the public process around the MIMP. The meetings were held, but the intended purpose of allowing the institution to listen and respond to members of the public and CAC did not happen. Afterwards, they point to the fact that public meetings happened as proof that there was public participation. The public process, however, needs to be treated as more than a legal checkbox to be checked.

[35] Many members of Commute Seattle have backgrounds in marketing or communications. Although the institution has sought to undercut their professionalism by insisting that experts in this area must be trained transportation engineers, the fact is that they are qualified to work on TMP development and implementation as judged by members of the transportation planning community.

suspect about the sudden rush of efforts that have emerged in the past year and their longevity without specific enforceable language in the MIMP.

If all things were equal and specific mitigations for power differences were functioning, we would naturally expect that these plans would deliver specific benefits of roughly proportional and equal value. This is not the case. As there is a difference, there must be a cause. In this case, the difference can be attributed to the difference in the approach and willingness of the institution to mitigate their impacts, a public process where public input was predominately ignored, and the difference in resources available in the community to defend itself (due to differences in demographics and income). We have been given a bad deal. It is bad in itself, but it is appalling when compared to what other institutions are willing to commit to. Our communities deserve equal treatment and in this case, there is a clear disparity in treatment between the central Seattle communities and Laurelhurst.

It is also a clear issue that Swedish has chosen to isolate out the Cherry Hill campus only when it serves them. Swedish treats the Cherry Hill campus as an extension of their First Hill campus when it suits them, for example when they decide that they want to move a public meeting or reporting public benefit, but as an independent campus when elsewhere, for example the claim that a dentistry clinic is needed there and that it is too far from First Hill (It would serve more people and provide better access to those in need with a location in Pioneer Square or Rainer Beach –a traditionally underserved community for healthcare–, rather than a mile away from their main practice). The fact is that if Swedish were to treat the campus for master planning purposes the way it treats it for business purposes, there should only be one MIMP for the First Hill and Cherry Hill campus.

To be clear, we are very glad that the public process worked well in that case and that Seattle Children's has the leadership and commitment that is expected of a world-class institution. I am happy that the campus has been successful as it is and that they have been so successful in their TMP goals. Their efforts are to be commended and their plan is to be the standard that others are held to. What I am asking, and what other residents of central Seattle are requesting is equal treatment and consideration. We are being asked to accommodate a project that will result in a campus with a FAR over twice Seattle Children's, have significant and unavoidable traffic impacts, and a height bulk and scale that is unprecedented on the West Coast.[36] The neighborhood deserves equal treatment. All residents of Seattle deserve a better and more specific plan than this and clear mitigation for the effects that it will cause.

All residents of Seattle deserve to ***not*** have this plan be the new low bar that other institutions with less leadership than Seattle Children's aim to exceed. This plan does not deserve your support, if not

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[36] A review of 175 medical facilities with a similar amount of beds in Washington, Oregon, and California using publically available facility lists and Google Earth Pro reveals that approximately 3 institutions are located in reasonable comparable contexts. None exist within a mile of another major intuitional healthcare zone, such as what is found on First Hill. There is no real parallel for this proposal on the West Coast.

for the tainted process that ended in it coming before you then for the vague non-committal language that permeates it and the clear lack of public benefit that is derived[37].

We deserve better.

[37] This institution is not the magnificent actor that it portrays itself as. Consider that Seattle Children's ***alone*** provides uncompensated care equal to 76% of the ***total system wide benefit*** identified by Swedish Medical Center ($108.6m vs $142).

Comments on Final Environmental Impact Statement, Dated 2014-12-11, for Swedish Medical System Cherry Hill

My primary interest and expertise is in transportation, as demonstrated. As a result and due to the limited amount of time between the hearing and the due date for public commentary, I am forced to focus my particular comments on the transportation technical report, which underwrites the transportation mitigation section. During the hearing, the DPD Director's report was brought up and is not included here because there has been no public response to which of the conditions Sabey and Swedish are willing to adopt without contention. This response and information is not available via the City of Seattle Website or the swedishmimp.org website. The Director's Report is also not available on the swedishmimp.org website. As a result, my commentary is limited to what has been publically published and where a response from Swedish has provided clear indication what their commitments are. The following list should be considered a partial and incomplete catalog of my issues with the EIS. The issues identified in the CAC minority report (to which I am a signatory) should be considered part of this list and my public commentary.

Figure 47 and 48: See Appendix – Re: LOS on intersections in area[38]

> The transportation analysis shows that the as a result of Alternative 12, 3 additional intersections will be at LOS F in the morning and an additional 4 will be at LOS in the evening peak. While LOS D is acceptable for urban environments (slow, but moving), LOS F represents a failed state that starts to impact a greater range of the network. The location of these three additional failed intersections are directly adjacent to the campus and clearly caused directly by the campus. The ability of the neighborhood to use Cherry as an arterial or enter the flow of traffic will be significantly impacted, as noted by the Transo Group analysis. This affects the livability of the neighborhood and would also affect accessibility to the campus that would likely impact patient care.

Page C-111: Depending on the overall effectiveness, these programs may be considered for ongoing implementation. These pilot projects would be implemented incrementally so the effectiveness of each pilot project can be evaluated.

> This is not a commitment. Implementing each of these in isolation is unlikely to achieve any significant results because a TMP is about cumulative effects on mode share, not the impacts of individual programs. Also, Swedish should leave transportation studies to the University of Washington and other research institutions in the region. It is not appropriate to conduct these studies when the types of projects proposed have been studied *ad nauseum* in academia and the transportation community. What is needed is commitment to lowering their

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[38] The methodology of this findings is not being directly challenged, so knowledge of VISSIM or other highly specialized modeling software is not required.

SOV percentage and decisive action, not incremental, half-hearted, and ultimately temporary pilots where a cumulative impact of action is never achieved.

Page C-111: "The intent of this pilot project is to increase transit usage at the Cherry Hill campus by working with King County Metro Transit to expand the ORCA passport program to all campus employees. The ORCA business passport program is a comprehensive, annual transportation pass program for employers. The passport program allows employers to manage their transportation benefits and gives employees access to bus, light rail, and ferry as well as subsidizes vanpool and vanshares and provides guaranteed rides homes."

This action item for this point is ultimately unclear. The ORCA passport program is a program for employers. This passage does not commit to the various tenants being required to participate once they have access to the program. Many employers in Seattle elect to not participate due to the modest costs associated with providing those benefits. No clear commitment to change is provided here.

C-112: "The intent of this pilot would be to explore the potential of providing incentives to all employees to encourage alternative commuting as well as enhancing commuter incentives for the overall campus. The pilot would evaluate commuter incentive options campus-wide which could overlap with the Transit pilot's evaluation of the ORCA passport program. In addition, an evaluation of campus-wide biking and walking incentives including benefits such as stipends for bicycle and walking equipment and free tune-ups for bicycles. Lastly, contact will occur with the on-site retailers (e.g., Starbucks, gift shop, cafeteria) to see if benefits such as discounts on products could be offered for bicycle commuters."

Attention should be directed to the verbs of this passage. Swedish will "explore", "evaluate", and "contact". This is not a commitment to anything more than holding a couple meetings. Swedish would, if after "exploring" and "evaluating" to a point where it looks costly, be free from any further obligations under this language.

C-112: "Working with the parking garage operators, this pilot project would explore a campus-wide flexible daily parking program with benefits such as on-demand carpool discounts and Smartcard access tied to parking debit accounts for employees. Parking policies would be reviewed for employees and visitors/patients and recommendations would be made to potential adjustments to encourage employees to use alternative modes while minimizing parking along neighborhood streets."

Again, attention should be directed to the verbs used: "explore", "reviewed", and "recommendations would be made". These sentences do not demand actual changes or action. Swedish would, after "reviewing" "recommendations", be promptly free to ignore the results of this "exploration". The only commitment being made here by the institution is to hold some additional meetings.

C-115: "Specific mitigation and the level of responsibility for each location would be identified at the time of the MIMP approval or during the MUP review. Potential improvements for each location are identified in Table 20 and the level of responsibility could include construction of physical improvements, a proportional cost contribution to improvements, and/or no impact may be identified with a specific project"

This does not contain any commitments to implementation. In fact, what it promises is that at each and every step of this master plan Swedish will have to debate the city (and neighbors) with what they are willing to pay. Given the efficacy of highly paid land-use attorneys, there is no reason to expect that the institution will voluntarily commit to funding these projects. They will comply when the City uses coercion (withholding permits, etc), but this clearly indicates that the institution intends to take a little responsibility as necessary. If this was not the case, we would expect, as with Children's, specific commitments written into the MIMP or EIS. Instead there is only a commitment to fight the city over the level of responsibility they must bear. The director's report includes specific lists of improvements that much be built, but even with the DPD Director's report, the presentation made at the hearing (based on the documents made public via the Swedishmimp.org website, City, and a printed copy of the presentation provided by Vicky S.) does not identify the institutions intention to take responsibility for implementing those improvements or at what level.

Of the 20 improvements, only a small subset are included as a condition of a future permit. Swedish and Sabey have not committed to building anything else and these small subsets remain a mystery about how they will ultimately be built and funded. If this information exists, it is not available to the public at this time. Ultimately, this approach serves the stakeholders of Sabey which would likely be on the hook for these capital improvements, not the city. It is also a clear lack of leadership on their part.

C-119: Swedish will work with the City to plan a neighborhood greenway in Squire Park. Swedish should continue to coordinate with SDOT on the location of the neighborhood greenway and work to minimize campus impacts on users of the facility. To the extent possible, the greenway features should be incorporated into the proposed health walk.

Here we have Swedish stating that they will engage SDOT *in order to minimize the impact of the Neighborhood Greenway on Swedish and their facility*. This is complete backwards and seeks to undo the public outreach and grassroots work done by Central Seattle Greenways members. It is not supporting healthy transportation in the neighborhood, it directly seeks to minimize the impacts of the greenway on the hospital.

C-122: Swedish would provide pedestrian and bicycle enhancements at the Cherry Hill campus including along the 18th Avenue where SDOT will study a neighborhood greenway.

Combined with the statement above, a reader should not expect anything over what they would offer as part of the misconceived "health walk". Again, no specifics or levels of support are indicated, either here or in the MIMP. If the citizens of Seattle want Swedish to support

this type of transportation enhancements, the best tool available is to use the permitting process to force the institution to provide it. Otherwise, it is highly optimistic to expect the institution to suddenly start leading in this area.

Thank you for reviewing my comments. When I started as a member of the CAC, my intention was always to balance the needs of the institution with the needs of the neighborhood. However, this plan is wholly one sided and is one that I cannot support. Swedish has truly squandered this opportunity to mend fences with the neighborhood and craft a plan that gives both it and the neighborhood a common vision for the future. As a student of communicative planning and a firm believer in the ability for engaged actors to both reduce costs and achieve better outcomes for sustainability and social justice through a public process, I am disappointed in Swedish's approach to this process and ultimately the uninspired master plan that was delivered.

If Swedish had the type of leadership and community focus that Seattle Children's does, I have no doubt that I would be writing to you to support a MIMP that better reflects a balance between the needs of residents to be able to continue to genuinely enjoy their neighborhood and the vibrant area of Seattle where they life and the needs of the institution to expand and provide care. During my time on the CAC, I advocated for positions that were unpopular with the people who ultimately called me to testify on their behalf against the plan. I advocated for smart expansion of the MIO and a street vacation on 16th Avenue. Swedish took these ideas and came back with sabotaged alternates that did not seriously utilize these ideas[39]Swedish has been unimaginative and unwilling to adjust their vision. Their "plan" shows this.

Please recommend against this plan. Swedish has not been a serious about public engagement and does not seriously consider protecting the livability of the neighborhood to by a priority. This plan does not contain the language needed to have a basis for holding Swedish accountable and their past behavior does not inspire confidence in their ability to implement mitigation measures. This is not the plan of a leader; it is the plan of a laggard. We deserve to have the same consideration as other neighborhoods in Seattle. All of Seattle deserves better than to have this set the new low bar for institutional master planning.

Sincerely,

Nicholas Richter

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[39] One placed a 37' MIO height on the area in the expanded border, undermining the intention to even out heights across the campus with a moderate height building along Cherry. The other used the street vacation to propose a private driveway instead of using the land to concentrate mass in the central area of the campus and reduce heights. Both these might have had better outcomes if they had spoken with us.

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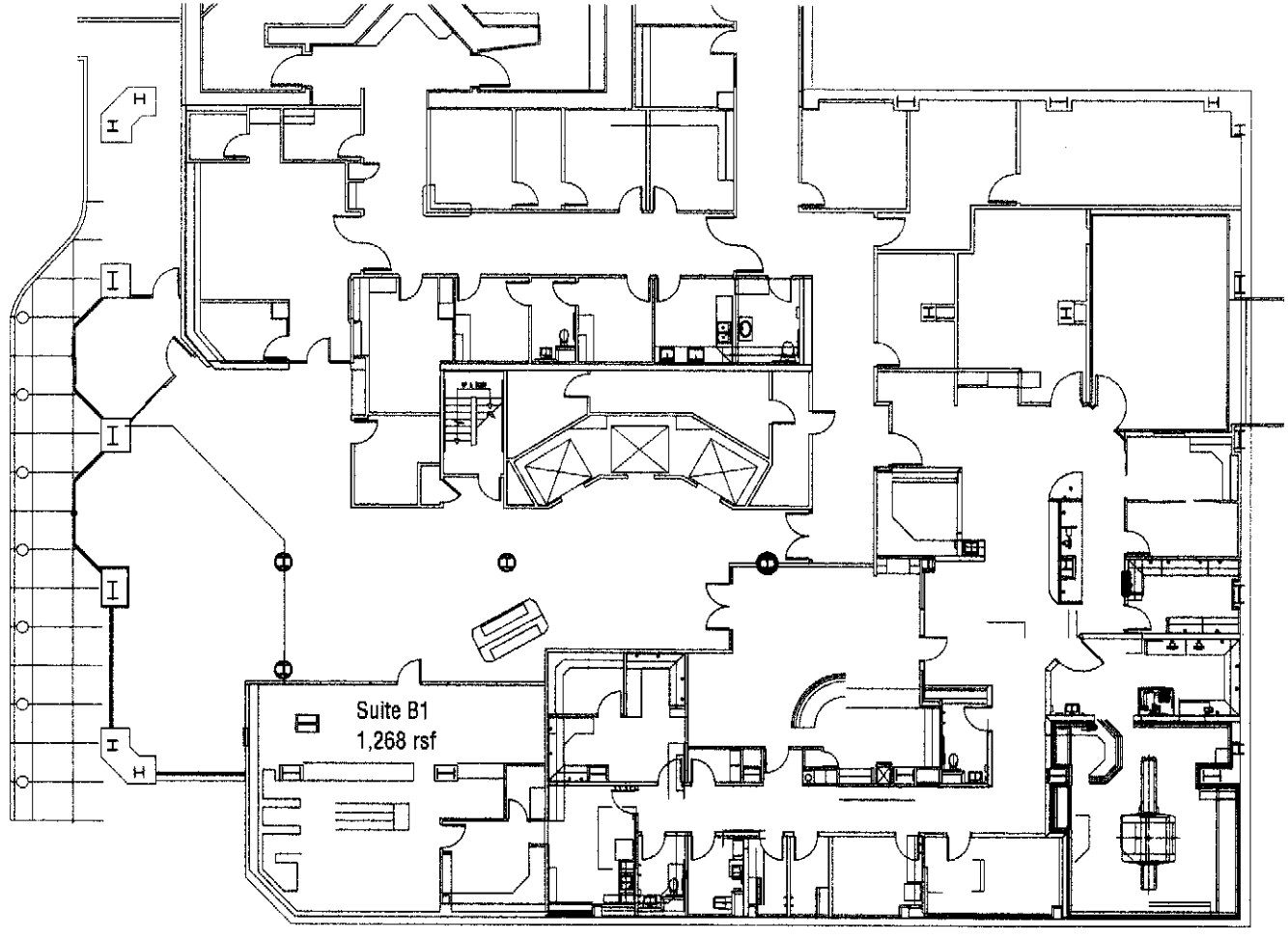

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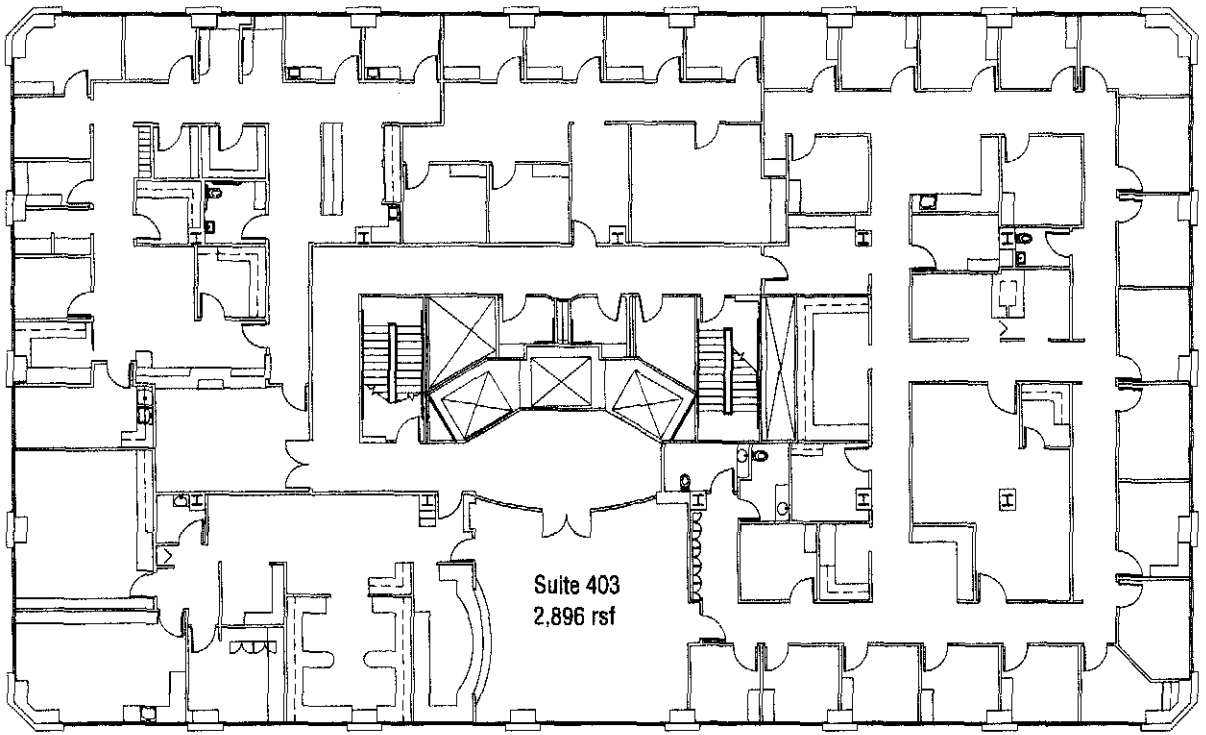

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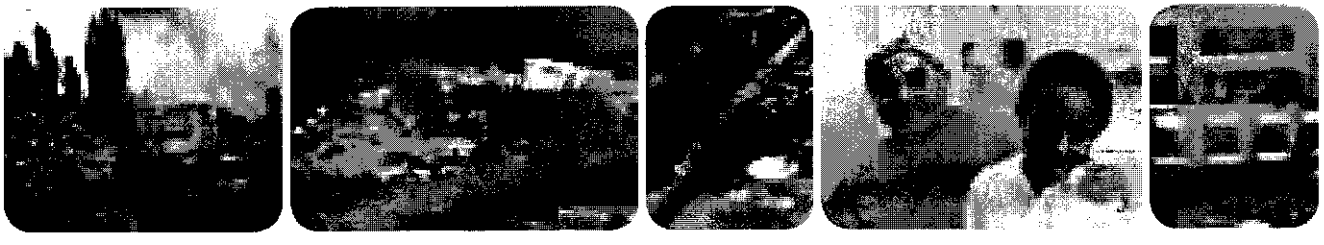
MAJOR INSTITUTION MASTER PLAN

Seattle Children's Hospital

Compiled Final Master Plan

SUBMITTED TO: City of Seattle

APPROVED: **May 12, 2010**



Seattle Children's

MAJOR INSTITUTION MASTER PLAN

Seattle Children's Hospital

Compiled Final Master Plan

SUBMITTED TO: CITY OF SEATTLE
Department of Planning and Development

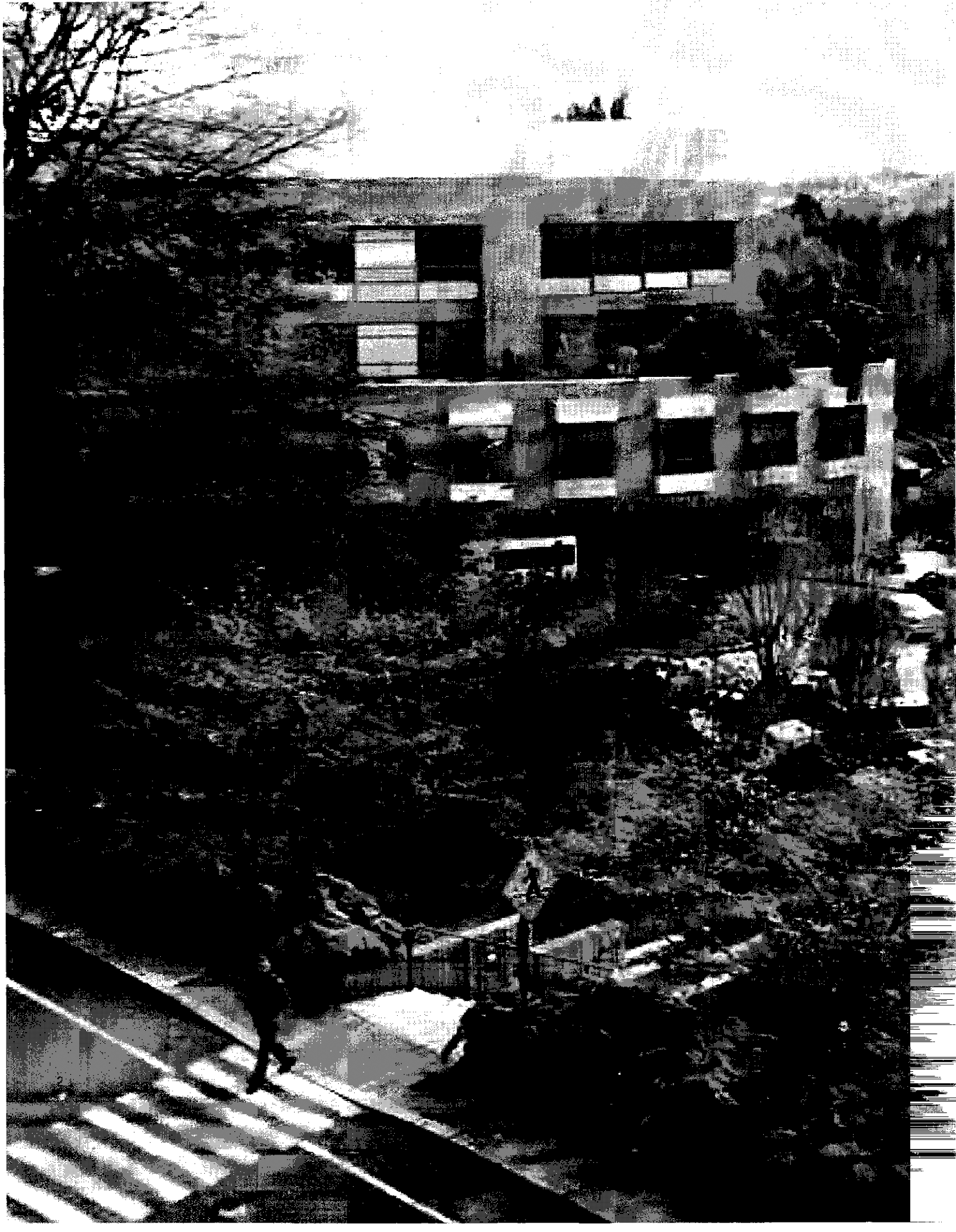
PROPOSED BY: SEATTLE CHILDREN'S HOSPITAL

PREPARED BY: ZIMMER GUNSUL FRASCA ARCHITECTS LLP

DPD PROJECT NO. 3007521

APPROVED: May 12, 2010

Seattle Children's



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I. EXECUTIVE SUMMARY

SEATTLE CHILDREN'S MISSION: We believe all children have unique needs and should grow up without illness or injury. With the support of the community and through our spirit of inquiry, we will prevent, treat and eliminate pediatric disease.

HISTORY, VALUES AND VISION: The driving force behind Seattle Children's Hospital (Children's) is the vision of a better future for sick and injured children. For more than a century, Children's has provided specialized healthcare services to the children of the Northwest who needed care, regardless of race, religion or their family's ability to pay.

Treatments and medical technologies have changed dramatically during that time, and Children's has evolved to become a highly specialized academic medical center that serves children and youth from Washington, Alaska, Montana and Idaho who are referred to Children's for complex health problems. More than 200,000 patient visits are made to Children's clinical sites each year. These children receive the highest quality care from physicians, nurses and other skilled professionals who are specially trained to meet their unique needs, in facilities that are specifically designed with them in mind.

Children's commitment to caring for all children, regardless of their family's ability to pay, has earned the institution respect and goodwill throughout the region. A well-established network of volunteer guilds supports the hospital in the fundraising that is essential to its mission. In 2007, Children's provided $65.4 million in uncompensated and under-compensated care for children whose families lacked the ability to pay, a 57% increase from the previous year. In 2008, that amount climbed to over $86 million and, in 2009, it reached $96.4 million.

Teaching is also central to Children's mission: Children's pediatric residency program — in partnership with the University of Washington School of Medicine — is one of the most highly sought-after programs of its kind in the United States. Sixty-five percent of the pediatricians currently practicing in the Puget Sound region were trained at Children's. During the past decade, Children's has also greatly expanded its role in medical research, and is now engaged in major research projects that address many of the most important diseases of childhood, including asthma, diabetes and HIV AIDS, as well as depression, gene repair and neurodevelopment.

As Children's entered its second century, it created a new Strategic Plan to guide the organization's future. The Strategic Plan envisions that Children's will:

- Provide patients and families throughout the region with easy access to specialty care
- Build programs that set national standards for quality
- Provide the best possible service to families and referring physicians
- Develop the next generation of health-care leaders through its teaching programs
- Conduct research that contributes to the prevention, treatment and elimination of diseases that affect children
- Preserve the organization's financial health, while keeping the promise to provide care regardless of a family's ability to pay

THE NEED FOR GROWTH: Children's created its Strategic Plan in the context of regional growth and national health trends that point to increasing need for pediatric specialty care. Four key factors point to the need for growth:

1. ***The number of children in our region is projected to grow.*** During the next 20 years, the population 21 years of age and younger in Washington is projected to increase by 21%, as the children of the "baby boom echo" enter their child-bearing years, setting off a third wave of births, and in-migration from other states and other nations continues.

2. ***Children with serious health problems are living longer.*** Thanks to advances in pediatric medicine during the past 20 years, more children with serious chronic illnesses — such as cystic fibrosis or sickle cell anemia — are living into adulthood. With multiple and lengthy hospital admissions, these children now account for half of the patients at Children's on any given day. Thankfully, children with severe chronic diseases are now living longer, but this good news carries with it a growing need for highly specialized medical facilities to care for them.

3. ***The nature of and prevalence of pediatric diseases are changing.*** The increasing prevalence of chronic conditions such as diabetes, developmental disorders and the rising rates of infant prematurity and childhood obesity are placing added stress on pediatric hospitals nationwide. A 2007 study published by the Child Health Corporation of America (CHCA) projects inpatient days for pediatric diseases will grow at 3.1% annually through 2010. At Children's, the growth in 2007 was double this amount — 6%. The need in areas such as neonatology, transplantation, infectious disease and endocrinology is growing even faster — at more than 3.5% per year, and diabetes admissions increased nearly 17% between 2000 and 2003.

4. ***Children's is already overcrowded.*** With just 250 beds, Children's is small when compared to other pediatric hospitals in cities of comparable size, yet it serves a larger geographic area than any other children's hospital in the country. This has become all too apparent in the high occupancy rates at Children's. National standards of care set the optimal occupancy rate for pediatric specialty hospitals at 65%. This standard is to ensure that the appropriate types of beds are available for emergency admissions and to reflect the unpredictable nature of pediatric disease outbreaks. Today, Children's is operating at unprecedented levels, ranging from 85% to 100% occupancy year-round. On several recent occasions, Children's has had to turn sick children away because there were no intensive care beds available, in spite of the fact that Children's was the only hospital in the region with the expertise and technology to provide the critical care they required. During 2008, Children's had to send four children who needed life-sustaining heart-lung mechanical support to another state because our intensive care beds were completely full. While high volumes are typical during the winter months when outbreaks of viral diseases generally occur, the patient volumes at Children's are now consistently high throughout the year. During 2008, our Emergency Department experienced a 22% increase in visits, with one in five of those visits resulting in admission to the hospital. Many of our outpatient clinics are also reaching the limits of their capacity. Additionally, 50 of the hospital's 200 rooms currently have two inpatient beds, which makes preventing the spread of infectious disease more difficult, reduces privacy and makes it more challenging to provide family-centered care. For these reasons, the national standard of care now calls for single-occupancy rooms throughout the hospital.

CHILDREN'S PLAN FOR GROWTH: Children's must expand its current facility to meet the needs of the region it serves. Children's has developed a three-part strategy to meet these needs:

Children's will further decentralize its outpatient services to bring pediatric specialty services closer to families in communities throughout the region. In addition to a clinical and ambulatory surgery center currently being constructed in Bellevue, future outpatient clinics are being planned in Snohomish County and South King County, and additional outpatient services in specialties such as cardiology, cancer, endocrinology and neurology will be offered through Children's outreach clinics in Yakima, Wenatchee, Kennewick and Missoula, Montana.

Children's relocated its research facilities near South Lake Union in downtown Seattle to take advantage of the concentration of biomedical research resources at that location and to relieve pressure on the hospital campus.

Children's development at the hospital campus is focused on inpatient care and those highly specialized services that are most difficult to replicate in more than one location. This will provide the most effective care for children with complex, chronic conditions who require multidisciplinary specialists and 24-hour access to care.

THE MAJOR INSTITUTION MASTER PLAN (MIMP): Three Years of Community Involvement Culminates in a New Proposal

During the past three years, Children's worked with its partners in the Citizens Advisory Committee (CAC), city agencies and the surrounding neighborhoods to create a plan for development that will reduce the hospital's physical impact on the people who live nearby and the community at large. The Master Plan process afforded Children's the opportunity to solicit comments and ideas from neighbors and other interested citizens, and to work intensively with the members of the CAC in a search for the best solutions for all concerned. This resulted in improvements, refinements and enhancements to the plan at each stage of the process.

As a result of this collaborative effort, the Seattle City Council adopted a modified version of Master Plan Alternative 7R as Children's Master Plan. This choice carefully balances the urgent need for additional capacity at the hospital with innovative programs and plans that respond to community concerns. Children's commitment to purchase Laurelon Terrace, thus moving the bulk of its expansion "downhill" and adjacent to the Sand Point Way NE arterial and refining the proposed development through transitional heights and building setbacks, represented an extraordinary mitigation measure to reduce the impact of the expansion on neighbors.

The Master Plan allows Children's to:

- Place the majority of new development on the Laurelon Terrace site
- Keep heights at or below 140 feet
- Maintain the overall height of the new facilities at an elevation that is lower than the highest elevation on the existing campus
- Limit the entrances to Sand Point Way NE and 40th Avenue NE
- Reduce the bulk and scale of proposed facilities through transitional heights and building setbacks
- Reduce the impact of construction on hospital operations and the neighborhood
- Create community gathering places and green space, including access to rooftop gardens and courtyards
- Create an innovative transit hub on both sides of Sand Point Way NE to make it easier for people to get safely to and from the hospital and the neighborhood without an automobile
- Redevelop the street frontage and the north and west property lines of the Hartmann property to provide transit service, an inviting streetscape and access to the Burke-Gilman Trail
- Create facilities that are adequate to meet the healthcare needs of the children of our region

The acquisition of the Laurelon Terrace property for expansion purposes created the opportunity to enhance the way people travel into and within the community by providing a better environment for pedestrians, bicyclists and transit riders. Children's is fully committed to developing replacement housing in northeast Seattle, creating the opportunity to improve other areas of the community as well.

Children's believes strongly in minimizing the impacts of expansion on the environment. In order to provide a healing place for our patients and their families, as well as be a responsible steward of natural resources, Children's included measures in the Master Plan to expand upon the environmentally friendly practices already in use at the hospital. The new buildings will be designed to reduce energy use and create healthy environments. The landscape plan creates tranquil settings for patients, families and neighbors to enjoy, while providing a natural shield to minimize noise and glare in the nearby neighborhoods.

Increasing the size of the campus will mean more staff, more patients and, consequently, more traffic. Children's has an excellent track record of working to reduce automobile trips generated by our employees, cutting the percentage of commutes by single-occupancy vehicles from 73% in 1995 to just 38% today, one of the lowest rates of any large employer in the state.

Children's Master Plan includes a comprehensive strategy to meet the needs of staff, patients and their families with creative transportation programs that contribute to solving the transportation challenges facing the immediate vicinity and the region as a whole. Children's will continue to invest in transportation improvements by continuing sponsorship of increased bus service on the routes serving its neighborhood and creating a growing system of shuttles — like the new Green Line — to connect the hospital to key transportation hubs. Children's will invest in new technology and other improvements in the major corridors serving its area, and in bicycle and pedestrian programs that create better and healthier ways of getting to and from work.

The Seattle Children's Hospital Major Institution Master Plan is the culmination of three years of planning, over 25 Citizens Advisory Committee and subcommittee meetings and ongoing community involvement, including over 25 outreach activities or meetings (see Appendix C and page 17). It represents a collaborative vision for the hospital and the surrounding neighborhood. This vision is supported by substantive standards which guide future development through subsequent environmental review and the corresponding decision making and public permit approvals. It is responsive to the community need for increased pediatric healthcare, environmental stewardship and the livability of the neighborhood. It will be further refined through a Standing Advisory Committee (SAC) of community representatives who assist the institution in the review of subsequent phases of the facility's design.

The balance of this document describes the Master Plan in detail. It is organized into five sections:

Part I, this Executive Summary, presents an overview of Seattle Children's Master Plan.

Part II, the Introduction, describes the need and vision for the Master Plan.

Part III, the Development Program, describes the basis for the program and planned improvements.

Part IV, the Development Standards, sets forth Children's standards by which future development will be controlled.

Part V, the Comprehensive Transportation Management Plan, describes the proposed measures to mitigate traffic and parking impacts associated with the Master Plan.

It also includes the following Appendices:

Appendix A: Legal Descriptions

Appendix B: Citizens Advisory Committee Member List

Appendix C: Community Outreach Overview

Appendix D: Adopting Ordinance

Appendix E: Approved Design Guidelines

Appendix F: Comprehensive Transportation Plan

Appendix G: Sound Transit Letter of Intent

Appendix H: Community Transit Letter of Intent

Figure 1 Distant View Eastward of Existing Children's Hospital

Figure 2 Major Institution Overlay Boundaries

II. INTRODUCTION

A. BACKGROUND

Founded in 1907, Seattle Children's is a regional pediatric academic healthcare center serving Washington, Alaska, Montana and Idaho (WAMI), the largest service area of any children's hospital in the country. Children's is currently ranked among the top ten pediatric hospitals in America by a number of published sources, and received a number eight ranking on the ***U.S. News & World Report*** Best Children's Hospitals 2008 Guide. To continue to provide this level of care to all of the region's children who need it, Children's must expand its facilities on its hospital campus and across the region.

Children's is committed to improving access to quality pediatric healthcare by decentralizing outpatient services to bring them closer to patients and families. Due to the national shortage of pediatric specialists, Children's doctors travel throughout Washington, Alaska, Montana and Idaho to provide services at community clinics that are closer to our patients living in these areas. Children's currently operates regional clinics in Bellevue, Everett, Federal Way, and Olympia; outreach clinics in Yakima, Wenatchee and Kennewick, Washington; and sites in Alaska and Montana.

Children's is committed to expanding its clinic network. It opened a regional clinic in the Tri-Cities area in May 2008, and a major new outpatient facility near downtown Bellevue is slated to open in July 2010. Similar facilities are planned for Snohomish County and South King County.

Children's relocated its rapidly growing research programs to downtown Seattle (1900 Ninth Avenue) in close proximity to South Lake Union and other key research centers, such as the Fred Hutchinson Cancer Research Center, the Seattle Cancer Care Alliance and the University of Washington. Children's also purchased additional property (1000 Stewart Street) in downtown Seattle to enable the organization to develop 1.5 million square feet of space for medical research into the diseases that afflict children here and around the world.

While decentralizing its outpatient services and research facilities, Children's is consolidating the most highly specialized clinical services and inpatient beds on the hospital campus in northeast Seattle. This concentration of services allows complex pediatric procedures to be performed in highly specialized diagnostic and treatment facilities 24 hours a day.

A cornerstone of Children's mission is our historic commitment to provide the highest quality care for all children who need our services, regardless of their family's ability to pay. To meet that commitment, generous community support enabled Children's to provide $65.4 million in uncompensated and under-compensated care in fiscal year (FY) 2007 to patients whose families were unable to pay all or part of their medical bills. This amount climbed to over $86 million in FY 2008 and reached $96.4 million in FY 2009. In FY 2009, Children's provided 291,912 patient visits, including 227,901 outpatient visits, 38,414 emergency room visits, 14,106 inpatient admissions and 11,491 short-stay visits.

B. STRATEGIC PLAN

Children's strategic plan, developed in 2006, provides a foundation for the next 100 years and a road map for integrating the growth of clinical, research and educational programs during the next five years. The strategic plan sets six key goals:

1. Build programs that set national standards for quality care.
2. Improve clinical access and service to families and physicians.
3. Prevent, treat and eliminate pediatric disease.
4. Recruit and retain the best staff at all levels.
5. Develop the next generation of healthcare leaders.
6. Secure Children's financial future while keeping its promise to provide high-quality care, regardless of a family's ability to pay.

The strategic plan serves as the guide for the development of the facilities that will be needed to support these goals.

C. HEALTHCARE NEEDS

Population growth in our region is one of several key factors driving the need for growth at Seattle Children's. According to the State Office of Financial Management, the number of children and youth in Washington state, for example, is projected to increase by 21% by 2030, as the children of the Baby Boom Generation enter their child-bearing years. Nationally, the need for children's healthcare is growing for other reasons as well. A recent study by the Child Health Corporation of America (CHCA), a national association of free-standing pediatric hospitals, shows that the demand for inpatient pediatric services overall is estimated to grow 3.1% annually through 2010. Causes include:

- Increased severity of pediatric illnesses
- Increases in prematurity and low birth weight
- Increased prevalence of chronic conditions, such as diabetes and developmental disorders
- Growing prevalence of obesity, which complicates care
- More patients surviving childhood diseases and utilizing healthcare services longer
- The need for single-bed rooms to control the potential spread of infectious diseases

Demand for certain areas of pediatric care, such as the treatment of infectious diseases, premature birth and endocrinology, is growing at even faster rates. Admissions for diabetic conditions increased nearly 17% between 2000 and 2003. Because the illnesses treated at academic pediatric medical centers such as Children's tend to be more critical and complex, they often involve longer hospital stays and require the collaboration of many sub-specialists.

Children's experience reflects and in fact exceeds the national trends. A recent study by Dr. John Neff, medical director, Center for Children with Special Health Care Needs, shows that in the past five years, Children's patient population has become more chronic and complex, older and more expensive to care for, requiring more frequent hospital and Emergency Department admissions. More than half of the inpatients at Children's on any given day have lifelong chronic illnesses and often require specialized pediatric medical care.

Caring for these complex patients requires more staff, more types of specialists, more technology and more equipment and space to store equipment, which often varies with patient sizes. The specialists provide care in patient rooms, in clinic exam rooms, in offices and in other settings on campus so that they can respond to the changing conditions of young patients. When a child is more seriously ill, there will also be more family members who need to be housed close to the child — often in the patient room or lobbies. Teaching functions also bring more students and residents to the patient care area. All of these factors lead to more people and more equipment, all of which drives the need for more space for each hospital bed, compared to the hospitals of the past.

In addition, the scope of conditions Children's treats and the wide range in ages of the patients (premature through 21 years) requires a variety of types of beds. For example, a critically ill premature newborn and a teenager undergoing psychiatric evaluation cannot be housed in the same unit. Children's bed mix includes:

- Neonatal Intensive Care Unit
- Pediatric Intensive Care Unit
- Cardiac Intensive Care Unit
- Inpatient Psychiatric Unit
- Rehabilitation and Complex Care Unit
- Seattle Cancer Care Alliance Unit (for patients undergoing stem cell transplant and other cancer treatments)
- Surgical Unit
- Medical Unit

As a national standard of care, the recommended average inpatient occupancy level is 65% because pediatric illness is unpredictable (patients with chronic lifelong diseases are more likely to have unplanned admissions) and patients must be admitted to units appropriate to their age and acuity level. Today, Children's is consistently operating at 85% to 100% occupancy, which is an unprecedented and precariously high level for Children's. This high occupancy strains the entire system — and is particularly difficult for patients, their families and our staff. For many of the most seriously ill patients, there is nowhere else in the region that can provide the care they need.

The Master Plan is designed to address those challenges and meet the future needs of our region. To project the need for facilities over the next 20 years, Children's conducted an in-depth analysis of the historical patient volumes, service by service, and developed an estimate of future needs that is based upon:

- The changing demographics of its service area
- The increasing severity of Children's patients, especially those with complex or chronic conditions
- The technology, equipment and staff required to care for such critically ill children
- The need to control the spread of infections
- The need for caregivers to be located close at hand to respond to any emergency
- The healing comfort of allowing families and loved ones to stay with their sick child

To further validate key assumptions for the Master Plan, Children's conducted an in-depth analysis of the historical patient volumes and services, and consulted regional and national leaders in pediatric healthcare regarding our analysis and growth projections. As a result of that analysis, Children's Master Plan emphasizes six service areas — cardiovascular, general surgery, hematology/oncology, neonatology, orthopedics and transplantation — as the major areas in which new facilities will advance the quality and accessibility of the services Children's patients will need in the future.

Using industry standards for academic pediatric medical center space needs, the necessary amount of space for each service at Children's Hospital was calculated, resulting in a total of 2.4 million square feet for the next 20 years. This estimate provides 4,000 gross square feet to support each pediatric bed (this includes operating rooms, diagnostic and therapeutic space, faculty offices, etc.). This figure is well within the square-feet-per-bed range of peer institutions and is, in fact, at the lower end of that range due to Children's efforts to decentralize services and maximize efficiency in care delivery.

Currently, Children's has 250 beds within 200 rooms (50 double-occupancy rooms). To meet the projected need, Children's plan adds 250 to 350 beds over the next 20 years, bringing the total bed count to around 600. These additional beds would be phased in over time to ensure that Children's development meets and does not lag behind or exceed the needs of the region.

III. DEVELOPMENT PROGRAM

A. PROGRAM AND MASTER PLAN

1. NEIGHBORHOOD CONTEXT

Children's is located between the Laurelhurst and Ravenna/Bryant neighborhoods and is 0.5 mile from the Ravenna portion of the University Community Urban Center. The surrounding neighborhoods include a mixture of single- and multi-family residences, retail/commercial businesses, institutions and recreational opportunities, such as the Burke-Gilman Trail and Magnuson Park. The retail/commercial businesses are located primarily south and west of Children's along Sand Point Way NE, and include University Village, restaurants and shops, an exercise gym, office space and the Virginia Mason Sand Point Pediatrics Clinic. There are several institutions in the area, including the National Archives & Records Repository, Children's 70th and Sand Point Way administrative offices, churches, Talaris Research and Conference Center, Laurelhurst Elementary School and Villa Academy. The nearest major institution in the area, the University of Washington, is less than a mile to the west.

Beginning in spring 2007, Children's initiated dialogue with the surrounding community regarding the strategic plan and necessary expansion. Prior to submitting its Concept Plan, Children's conducted two community meetings, inviting over 10,000 households in northeast Seattle and to solicit concerns, advice and recommendations on how growth should occur on the hospital campus. In addition to the Citizens Advisory Committee regular and subcommittee meetings from the summer of 2007 until the present, Children's met with numerous neighborhood and other groups to discuss its proposed plans:

- Laurelhurst Community Club Board of Trustees (March 2007)
- Children's Standing Advisory Committee for Major Institution Master Plan (March 2007)
- Children's 70th and Sand Point Advisory Committee (April 2007)
- Community-wide meeting in Laurelhurst sponsored by Children's (May 2007)
- View Ridge Community Council Annual Meeting (May 2007)
- Laurelhurst Community Club Annual Meeting (June 2007)
- Community-wide meeting in Laurelhurst sponsored by Children's (June 2007)
- Laurelon Terrace Representatives (September 2007)
- Virginia Mason physicians based at the Hartmann Building (October 2007)
- Two model presentations in Laurelhurst (October 2007)
- Montlake Community Club Board Meeting (December 2007)
- Burke-Gilman Public Development Authority (January 2008)
- Laurelcrest Condo Association Board Meeting (April 2008)
- Odessa Brown Community Clinic Open House (April 2008)
- NE District Council Meeting (June 2008)
- Montlake Community Club (June 2008)
- Children's 70th and Sand Point Advisory Committee (June 2008)
- University District Farmer's Market Q and A (June 2008)
- West Seattle Farmer's Market Q and A (June 2008)
- View Ridge Community Council (June 2008)
- Ravenna/Bryant Community Club (June 2008)
- Four model presentations at Laurelhurst Community Center (June, July and two in October 2008)
- Ravenna/Bryant Focus Groups (August 2008)
- Hawthorne Hills Community Council (September 2008)
- View Ridge Community Council (September 2008)
- Ravenna/Bryant Community Council (September 2008)
- Laurelhurst Community Club Board of Trustees (October 2008)
- Model presentation at the NE branch of the Seattle Public Library, Ravenna/Bryant (November 2008)

For more information about the development of the plan, please see Children's Master Plan project Web site at http://masterplan.seattlechildrens.org.

Figure 3 Campus Is Designed to Screen Views of Buildings from Single-Family Areas

2. CAMPUS DEVELOPMENT PROGRAM

The Master Plan will provide the facilities needed to accommodate a total of 600 beds, with approximately 3,542 gross square feet (gsf) of development per bed, inclusive of the patient bed rooms themselves as well as the necessary ancillary services, facilities and utilities that are common in pediatric healthcare facilities. The Master Plan will allow for a total of 2.125 million gsf of hospital facilities and 3,100 parking spaces. (Developable building area does not include rooftop mechanical space and above- and below-grade parking.)

Under the Master Plan, the existing hospital campus will be expanded to the Laurelon Terrace site for future hospital facilities. The Laurelon Terrace site is immediately adjacent to the west property boundary of the existing hospital campus. Children's and Laurelon Terrace have negotiated the major terms for a sale of the Laurelon Terrace property to Children's, conditioned on approval of this Major Institution Master Plan. In addition, in order to develop this property for major medical institution uses, the City has been asked to approve the vacation of the public rights-of-way and Seattle City Light easements within the boundaries of Laurelon Terrace.

Children's will continue to lease office space at Springbrook and potentially other space within 2,500 feet of the Major Institution Overlay (MIO) boundary, and will continue to own and use the Hartmann property located across Sand Point Way NE. This is in compliance with the requirements of the Major Institution Code. The Code allows Children's to locate such uses as long as they comply with applicable street-level use restrictions in any commercial zones, follow the use and development standards of the underlying zone, include such uses in its Transportation Management Plan (per Code, Transportation Management Program) (TMP), and apply for an administrative conditional-use permit for any medical service uses over 10,000 square feet in area.

The open-space system will be expanded by the inclusion of Laurelon Terrace within the Major Institution Overlay Boundary, and provide the opportunity for public open space at the western portion of an expanded and contiguous hospital campus. The edges of the campus will be designed to screen views of campus buildings and parking areas from nearby single-family residential areas (see Figure 3). Subject to patient privacy needs and hospital security, pedestrian pathways will be provided across the site where feasible.

The existing helistop will be relocated from its current location to the rooftop of the first bed unit constructed on the Laurelon Terrace property.

The mechanical and electrical components of the Central Utility Plant (CUP) will be distributed throughout the existing campus and proposed buildings and parking structures. It is not intended for the CUP to be built in its entirety at a consolidated location. The mechanical and electrical components will be incorporated and treated to prevent noise, exhaust and vibration impacts within each building during the buildout of the campus.

Circulation improvements will be made to distribute peak-period traffic movements. The City of Seattle is planning to install a signalized intersection on Sand Point Way NE at 40th Avenue NE. This will help reduce impediments to traffic flow and the delay at existing signals serving Laurelhurst and View Ridge along Sand Point Way NE.

3. MASTER PLAN

Children's Master Plan provides the following benefits:

- The overall height of the new facilities will be lower than the highest elevation for the existing campus buildings. The greatest building height is 140 feet.
- Eliminates need for entrances on neighborhood streets (NE 45th Street and NE 50th Street)
- Reduces bulk and scale of facilities through transitional heights and building setbacks
- Reduces construction impact on hospital operations and the neighborhood
- Creates community gathering places and green space, including access to rooftop gardens and courtyards
- Creates an innovative transit hub on both sides of Sand Point Way NE to make it easier for people to get safely to and from the hospital and the neighborhood without an automobile
- Provides new access to the Burke-Gilman Trail along the north and west property lines of the Hartmann property, within the applicable zoning constraints
- Allows a first phase development that balances scale and profile without encumbering later phases with undesirable building mass near campus edges
- Minimizes the visual impacts from the Ravenna/Bryant Neighborhood
- Minimizes the visual impact of buildings along Sand Point Way NE
- Consolidates access to the Emergency Department with service and parking from 40th Avenue NE
- Sets taller bed units farther away from the hospital campus edges

The benefits listed above respond to the items raised in the Citizens Advisory Committee's letter of July 25, 2008, to Children's and DPD, as well as to community concerns raised since May 2007.

See Figure 4, Master Plan.

FIGURE 4:
MASTER PLAN

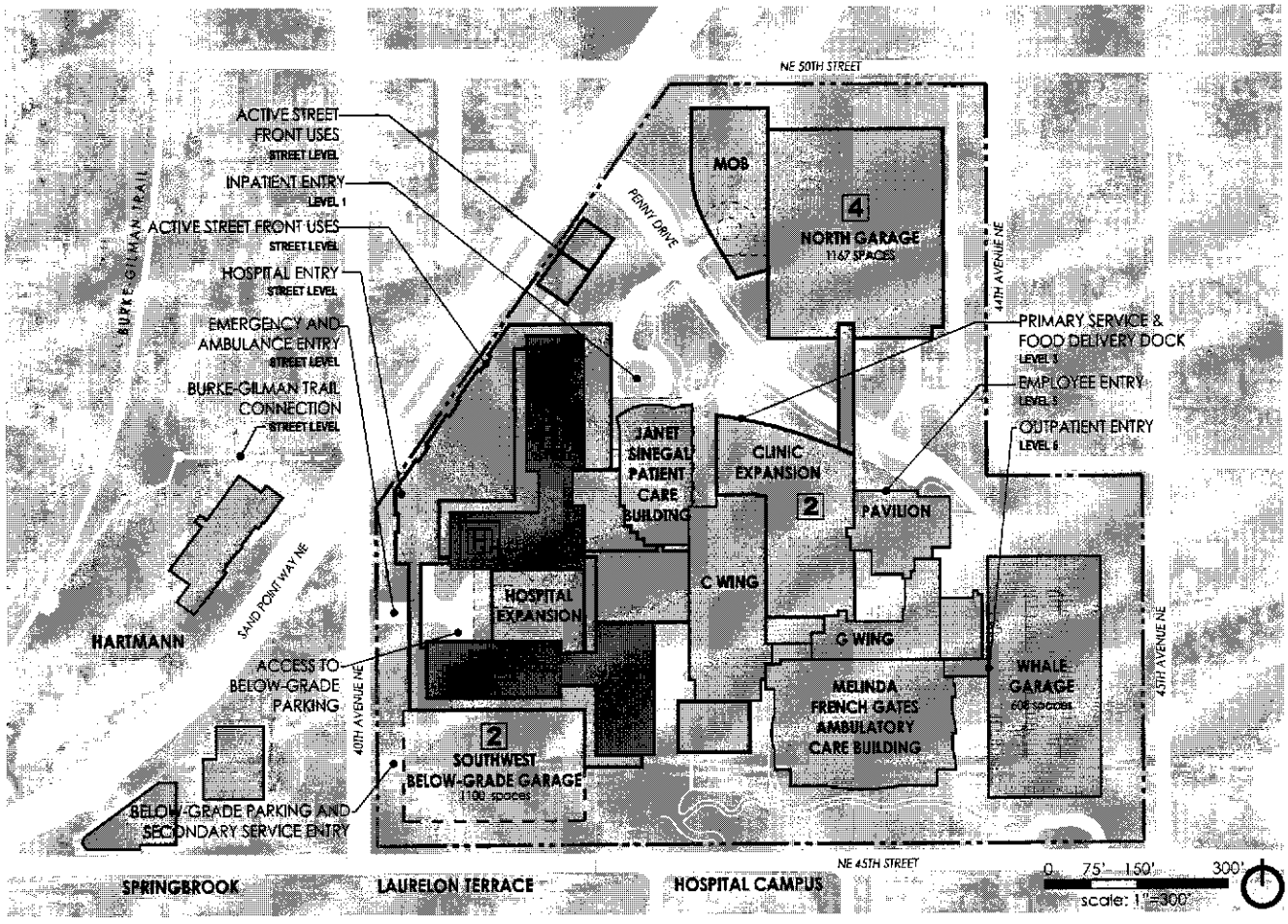
STATISTICS

Hospital Campus	
Beds	500 - 600*
Building gross floor area	2.125 million gsf
Parking spaces	3,100

addition of 250 - 350 beds

LEGEND

- Property Line
- Campus Grounds
- Existing Buildings and Parking Garage
- Lower Buildings and Parking Garages
- Taller Buildings
- Covered Walkway
- Roadways and Surface Parking
- 1 Proposed Construction Sequence
- H Helicopter
- Service and Fire Access



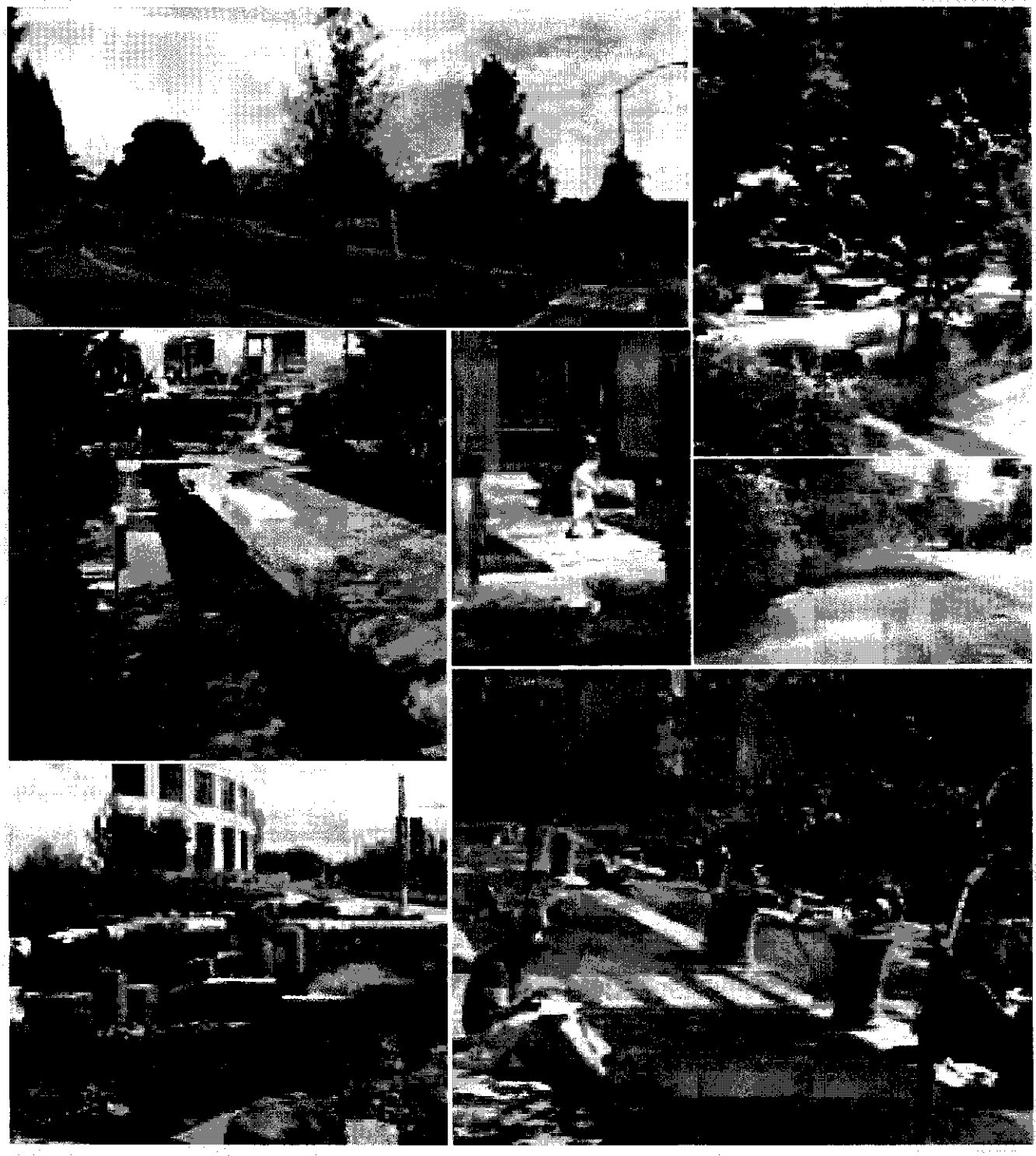


 Figure 5 Montage of Images Describing the Proposed Garden Edges

a) Campus Character

The character of the campus will be defined by the appearance from public streets at its edges. Two edge treatments will be developed. The first is the "garden edges" where landscaped buffers are planned. The second is the "street frontage edges" where buildings are built to the street property line and where significant pedestrian and bike activity are anticipated. The image of the existing hospital campus along the northern, eastern and southern edges of the campus will remain intact and maintained as garden edges. Street frontage edges will be developed along the western edges of the campus on Sand Point Way NE, 40th Avenue NE and the western reach of NE 45th Street.

GARDEN EDGES

Garden edges will be locations where outdoor program areas and plantings will be used to screen or open views of the campus from adjacent residential uses. At locations where buffers include pedestrian, bike or vehicle access, special consideration will be given to the visibility and security of landscape and building areas. Following current practice, Children's will work collaboratively with the adjacent property owners and nearby neighbors to improve the garden edges of the campus.

See Figures 5 and 6.

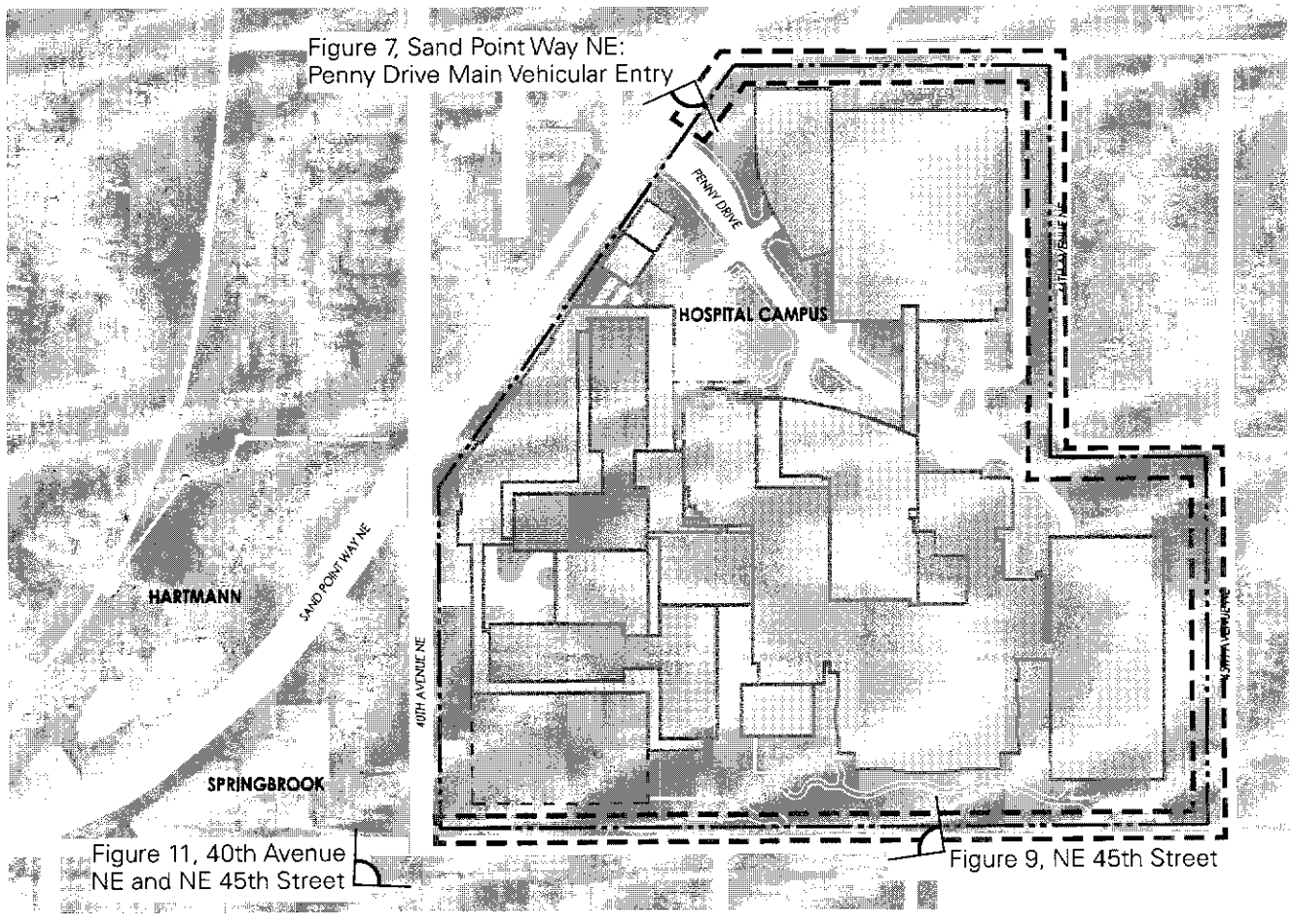


Figure 6 Location of Garden Edges

Sand Point Way NE: Penny Drive Main Vehicular Entry
The intersection of Penny Drive and Sand Point Way NE will be improved with additional gardens and other landscape elements. The planned building at this location will have a thin edge toward the street, surrounded by green rooftop plazas cascading to ground-level gardens. Accessible pedestrian routes will be improved as Penny Drive is widened. See Figures 7 and 8.

Figure 7 Artist Illustration of Sand Point Way NE: Penny Drive Main Vehicular Entry, Looking Southwest

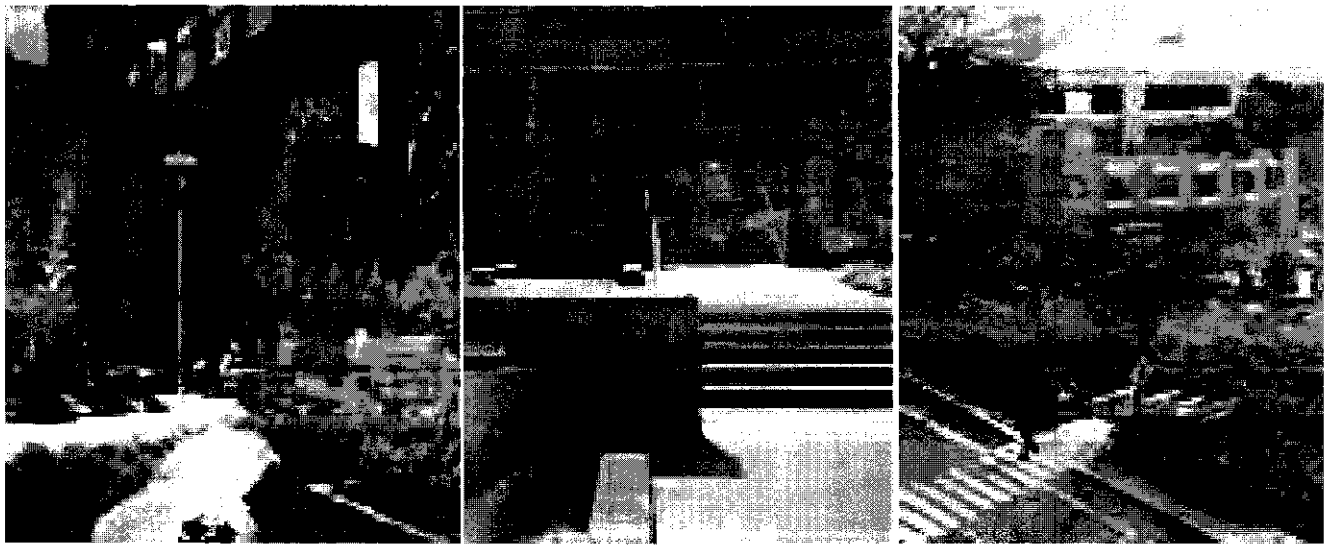


 Figure 8 Montage of Images Describing Potential Improvements

NE 45th Street
A 75 foot buffer will extend along the entire length of the campus edge on NE 45th Street. Buildings will be set back behind the dense plantings at the street edge. In this area, gardens and pathways will be located. In some cases the plantings might be opened up to take advantage of views from raised landforms on campus. In other locations, more densely planted screens may be desirable. See Figures 9 and 10.

Figure 9 Artist Illustration of NE 45th Street, Looking West

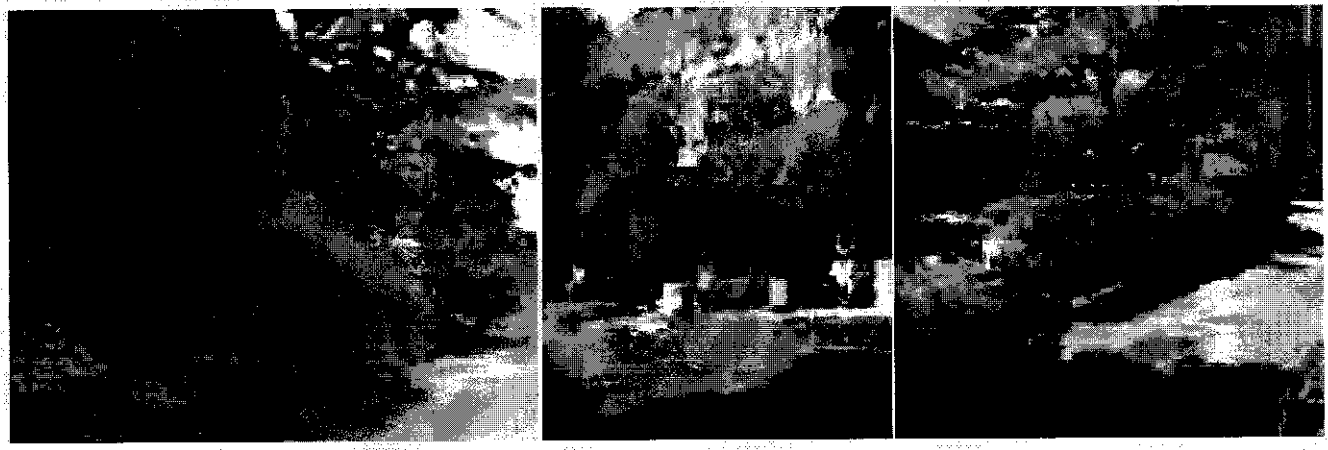


Figure 10 Montage of Images Describing Existing Qualities and Potential Improvements

40th Avenue NE
The eastern frontage of 40th Avenue NE will provide pedestrian open space areas. Here, landscaped areas and stormwater treatment could be configured in a garden. See Figures 11 and 12.

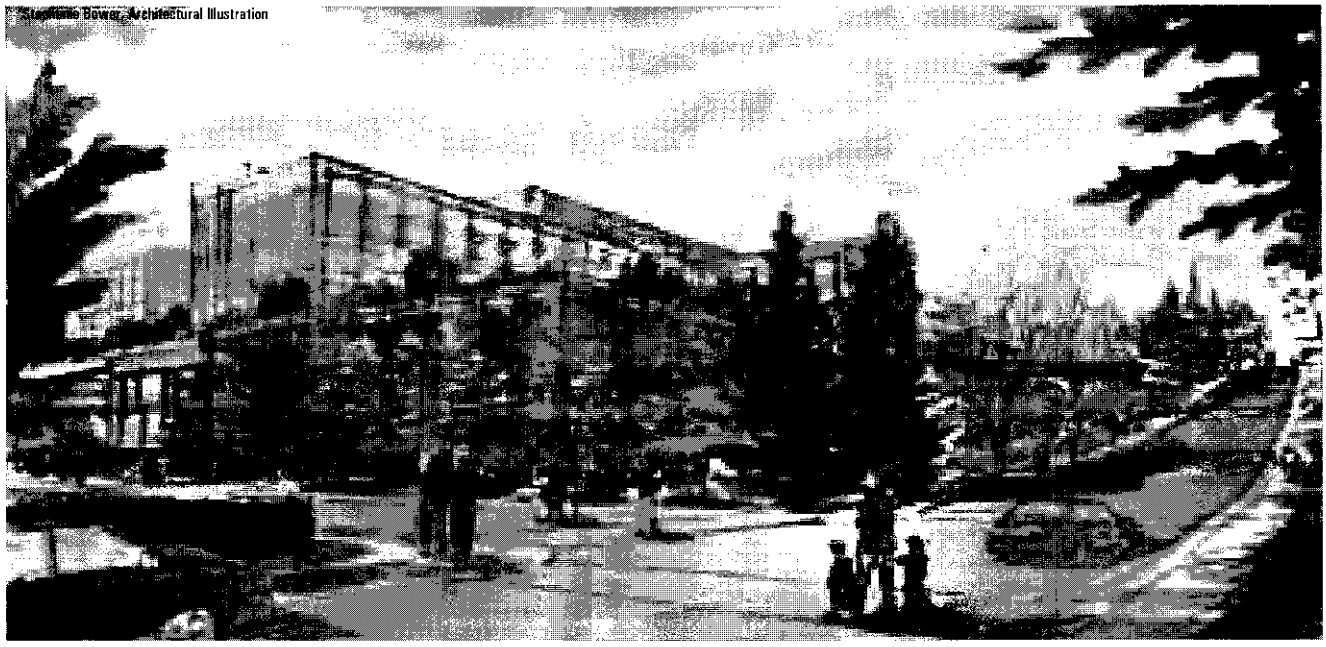


Figure 11 Artist Illustration of 40th Avenue NE and NE 45th Street

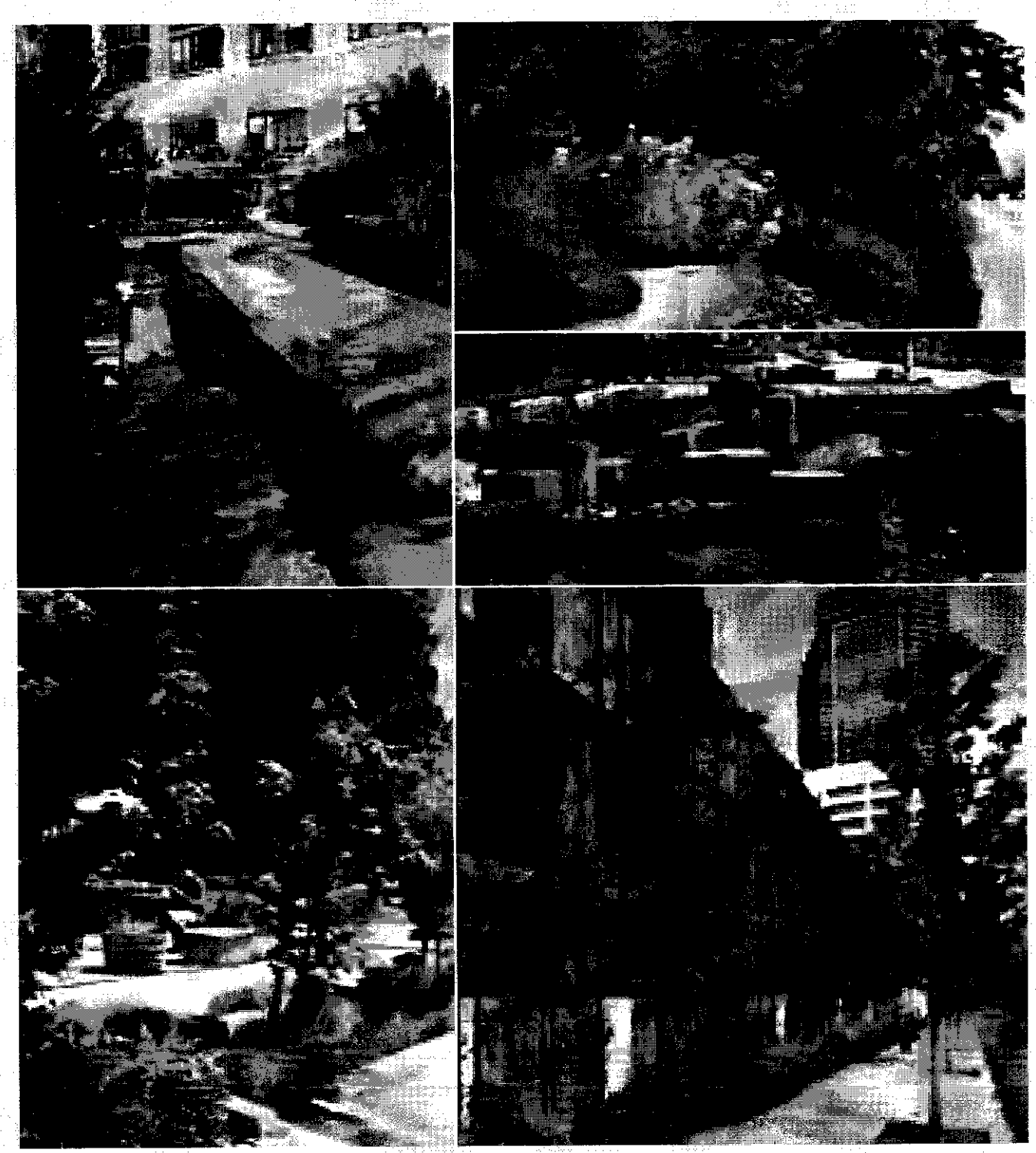


Figure 12 Montage of Images Describing Potential Improvements

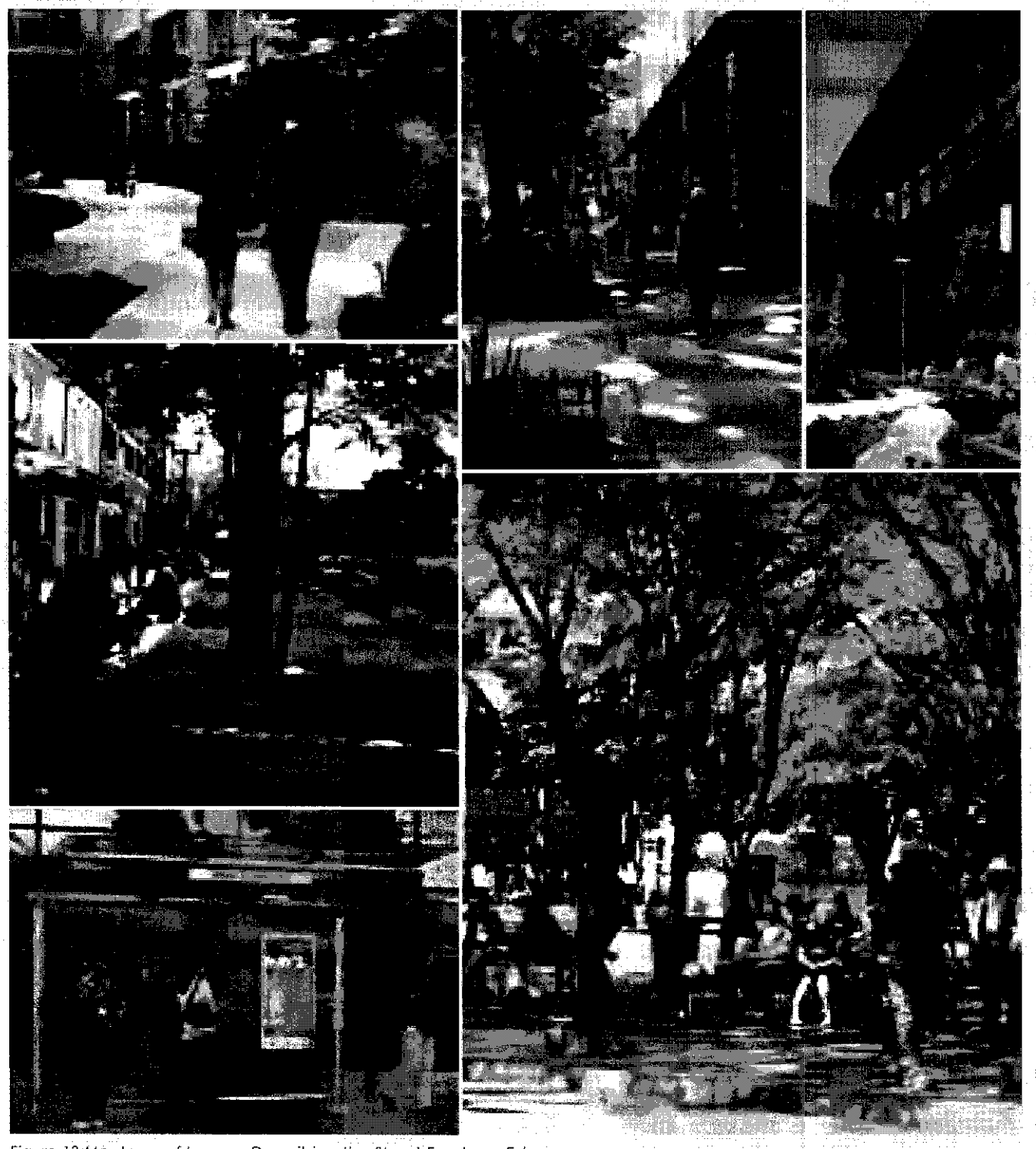


 Figure 13 Montage of Images Describing the Street Frontage Edges

STREET FRONTAGE EDGES

Street frontages are located where pedestrian and bike activities are anticipated in conjunction with transit or building entries. Here, the transit component will be built into the public right of way and will include furnishings, pocket garden and landscape improvements organized to enhance transit rider experience and promote transit ridership. These spaces will form useable pathways accessible to neighbors for access to transit service at 40th Avenue NE and Sand Point Way NE. Active hospital and community service uses that primarily and directly serve Children's users will be provided along the building frontage of Sand Point Way NE. These improvements and the design of plazas and garden areas, including canopies for weather protection, will support transit use, neighborhood activities and building functions.

See Figures 13 and 14.

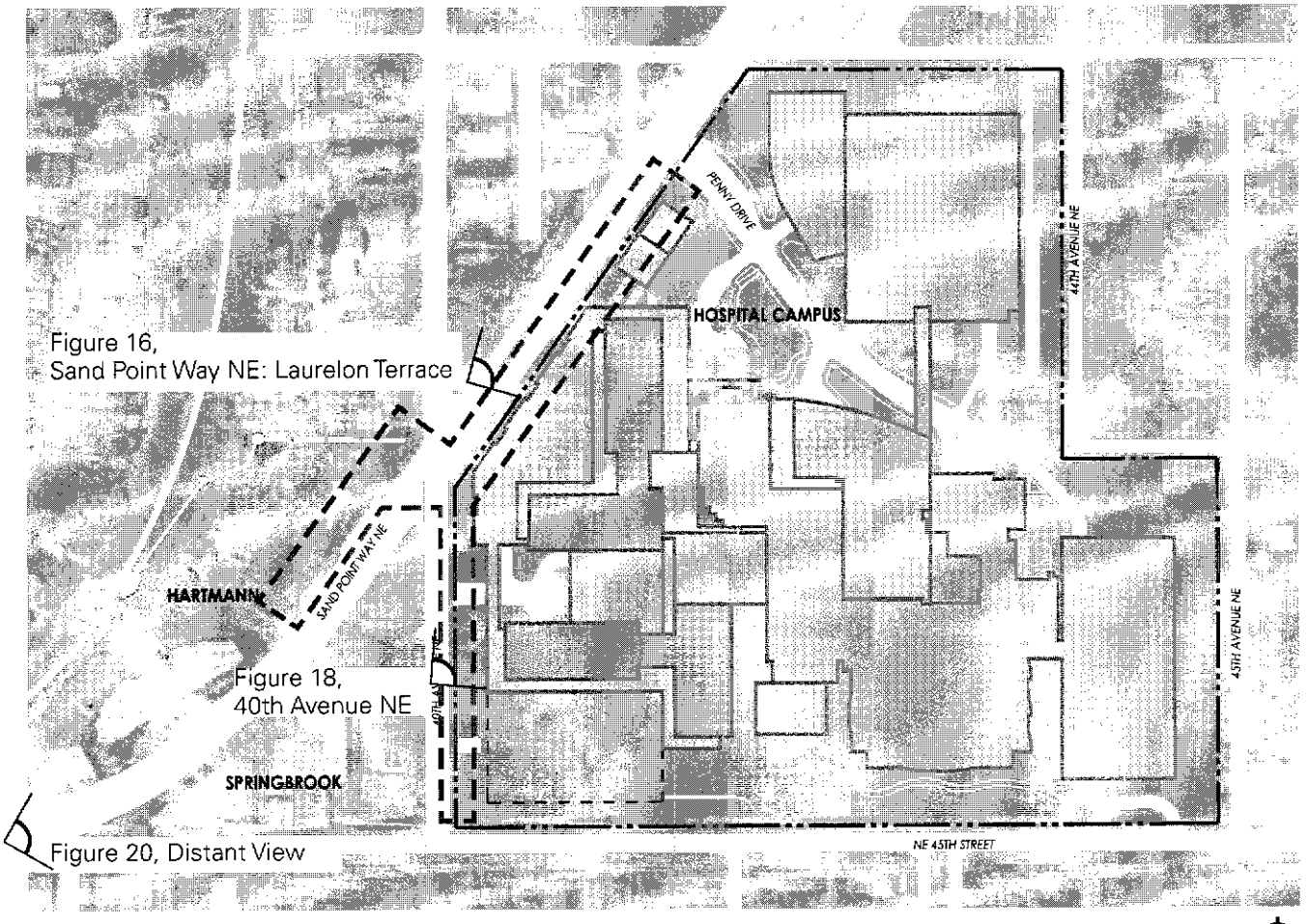


Figure 14 Location of Street Frontages

Sand Point Way NE: Hartmann

The street frontage along Hartmann will be the southbound transit stop of the transit hub at the intersection of Sand Point Way NE and 40th Avenue NE. This will be an intermodal transit stop for public transit with landscape improvements. A link between the Burke-Gilman Trail and the Sand Point Way NE street frontage will preserve the existing Sequoia trees and make a direct pedestrian and bike connection. See Figure 15.

 Figure 15 Montage of Images Describing Potential Improvements

Sand Point Way NE: Laurelon Terrace

The Laurelon Terrace frontage of Sand Point Way NE will serve as the northbound transit stop of the transit hub at the intersection of Sand Point Way NE and 40th Avenue NE. The hospital buildings will step down in height as they reach the street edge. Building canopies will protect pedestrians along active hospital amenities and hospital entries. Access to rooftop gardens will be through plazas leading through accessible pathways connected to the crossing point along 40th Avenue NE between the northbound and southbound transit stops. See Figures 16 and 17.

Figure 16 Artist Illustration of View from Sand Point Way NE onto the Laurelon Terrace Frontage

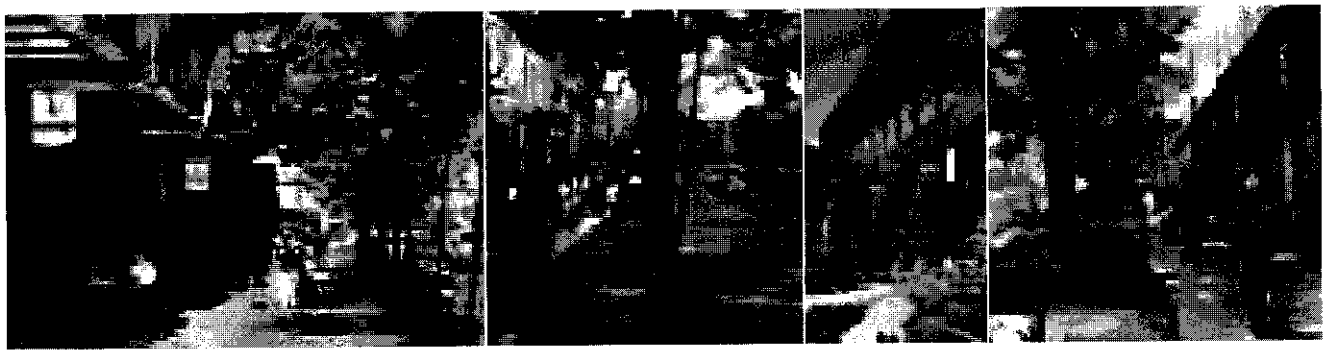


Figure 17 Montage of Images Describing Potential Improvements

40th Avenue NE

The Emergency Department ancillary parking and service access will be built alongside an intensely landscaped frontage. Here the street-fronting buildings will be set back. Plantings will be used to mark building entries and to provide public-accessible gardens near NE 45th Street. More active street frontage uses will be developed closer to Sand Point Way NE. This frontage will form a visually calming pedestrian and bike pathway around the west boundary of the campus, connecting southern residential areas to the transit hub at the intersection of Sand Point Way NE and 40th Avenue NE. See Figures 18 and 19.

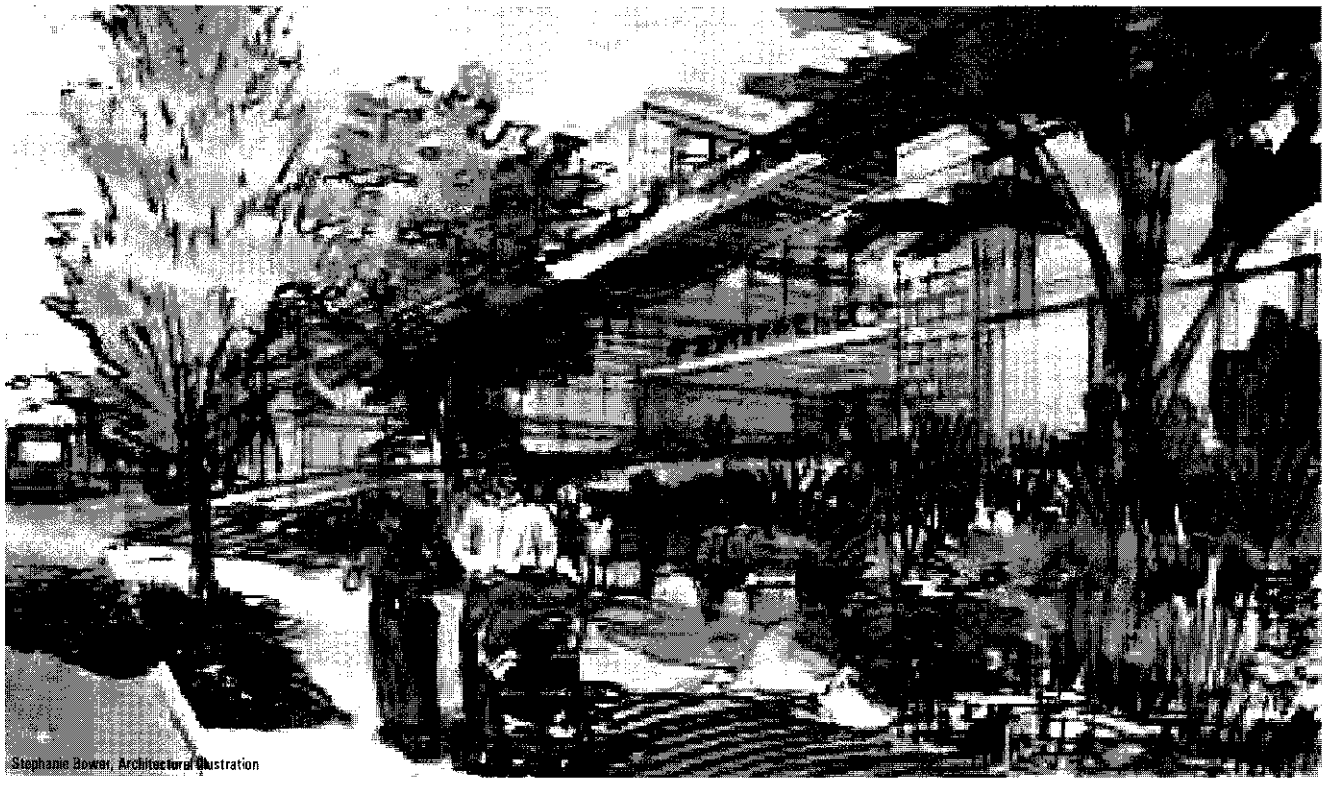


Figure 18 Artist Illustration of Hospital Campus Street Frontage along 40th Avenue NE

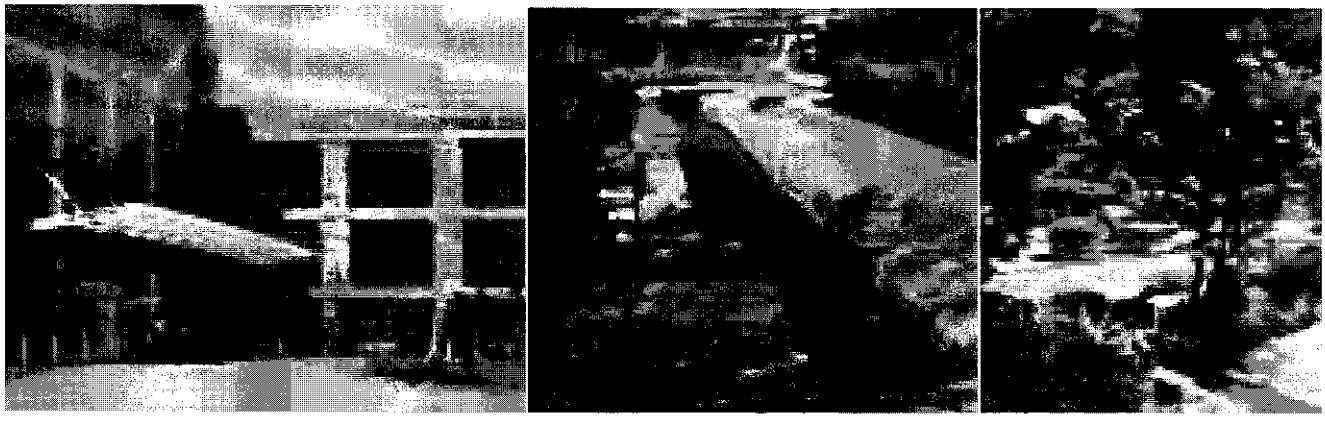


Figure 19 Montage of Images Describing Potential Improvements

Distant Views

Distant views of the hospital buildings and site improvement will be defined by the color, texture and pattern of the building materials and how they complement their surroundings. The goal is for the overall color, texture and pattern of the campus to fit in with the background land forms, surrounding buildings and density of plantings. See Figures 20 and 21.

Figure 20 Artist Illustration of Hospital Campus Looking from Sand Point Way NE, South of Springbrook

Figure 21 Views of Hospital Campus from Different Areas

b) Additional Plan Components

Three additional Master Plan components will address community needs and hospital operations and facilities. They are facility design, planned activities and uses on campus, and interim construction conditions to minimize impacts in the neighborhood, as illustrated in Figure 22.

i. Transportation Management

COMPREHENSIVE TRANSPORTATION PLAN (CTP)

For over a decade, Children's has recognized the complex transportation issues facing the region, and northeast Seattle in particular. In response, the hospital has established an award-winning Transportation Management Plan (per Code, Transportation Management Program) (TMP) that has substantially reduced the number of employees driving alone to work. Among daytime employees affected by Washington's Commute Trip Reduction (CTR) law, the percentage traveling to campus via single-occupant vehicle (SOV) fell from 73% in 1995 to a remarkable 38%. This accomplishment is significant both for a hospital and for an employer located in a neighborhood with limited public transit service.

With the input from the Citizens Advisory Committee, Seattle Department of Transportation (SDOT) and the Department of Planning and Development (DPD), Children's developed a Comprehensive Transportation Plan (CTP) with the goal of being a leader in sustainable transportation programs. The CTP includes a TMP to mitigate vehicle traffic related to MIMP expansion by shifting even more employees and visitors from single-occupancy vehicles (SOV) to bicycling, walking, shuttle and transit. In addition, the CTP goes above and beyond the traditional TMP elements by including a substantial investment in transportation infrastructure improvements outside the hospital campus. See Part V, for a discussion of the Transportation Management element of the Master Plan.

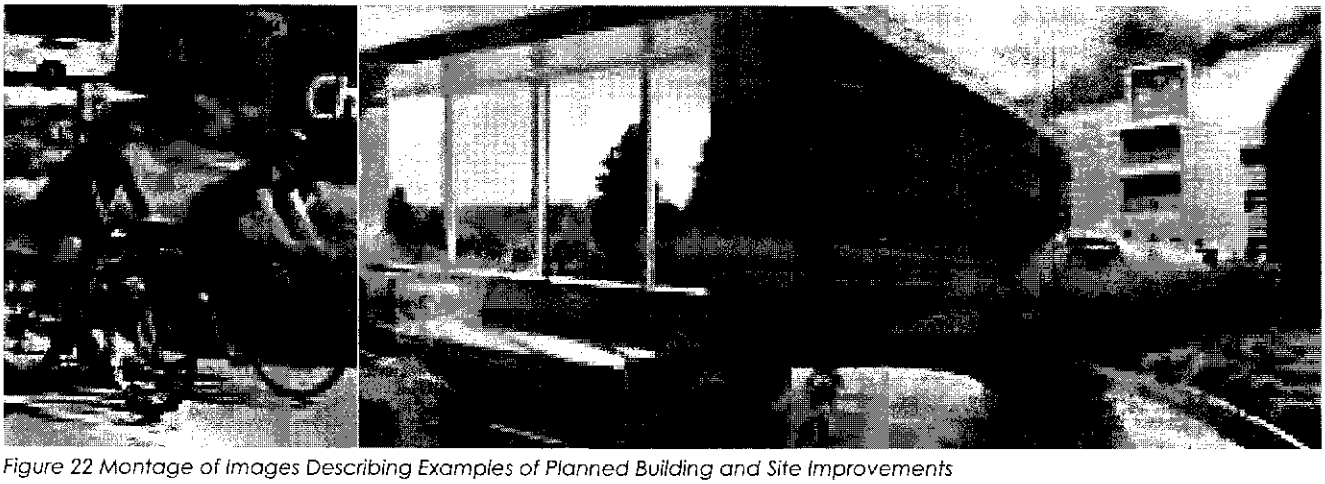


Figure 22 Montage of Images Describing Examples of Planned Building and Site Improvements

ii. Construction Management

Children's will develop a Construction Management Plan that will be reviewed by the Standing Advisory Committee (SAC) and approved by DPD prior to the construction of projects under the Master Plan to address the following issues:

- Construction impacts due to noise
- Mitigation of traffic, transportation and parking impacts on the surrounding neighborhood, including the provision of temporary off-site parking lots for construction workers and displaced Children's employees, together with shuttle vans and buses
- Mitigation to impacts to pedestrians and bicyclists along the edges of the campus, including temporary sidewalks or pathways around construction areas if needed
- Installation of temporary modular buildings on Children's property for displaced Children's functions
- Survey of existing street conditions and post-construction conditions and commitment to repairing any damage caused by Children's construction contractors

iii. Housing

The livability of the neighborhoods near Children's is vitally important to Children's as well as to the community for a variety of reasons:

- A safe home is necessary for the healthy development of every child. Children who experience homelessness or live in substandard housing are at greater risk of significant health problems.
- As an employer, Children's is committed to attracting the very best talent, but is at a competitive disadvantage when employees must commute long distances to find housing they can afford because of the high cost of housing in Seattle.
- Children's commitment to care for all children in the region who need our services, regardless of the family's ability to pay, means that families with limited means travel from throughout the region for care at Children's. Once in Seattle, families often experience significant difficulties securing housing so they can be near their child during their care at Children's.

Children's is committed to meeting the City of Seattle's replacement housing requirements listed as Condition 19 in the "MIMP Conditions for MUP Approvals" in Part III.F.

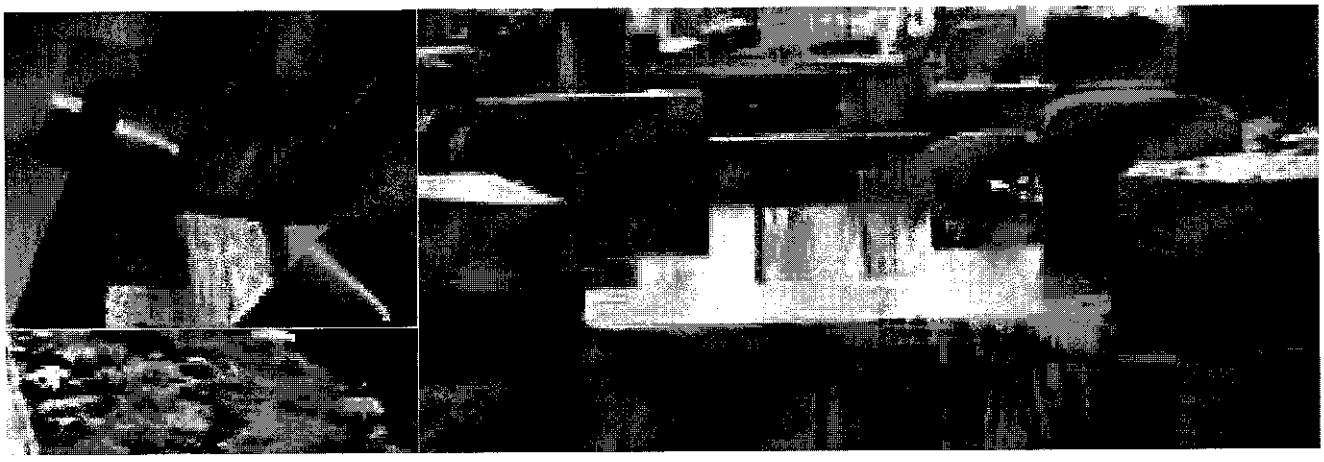


Figure 22 continued

B. DENSITY AND OVERALL FLOOR AREA

The density of the Master Plan, as defined by total maximum developable gross floor area ratio (FAR) for the MIO District, is 1.9 (excluding below-grade developable floor area, below-grade parking structures and rooftop mechanical equipment).

C. MAXIMUM PARKING SPACES

Children's Master Plan, consisting of total development of 2.125 million square feet and 600 beds, will allow a maximum parking supply of 3,100 parking spaces. See calculations of both the minimum and maximum parking supply allowed by Seattle City Code in the Transportation section of the Final Environmental Impact Statement (FEIS). Children's is proposing a total of 3,100 parking spaces in the Master Plan. See "Transportation Management Plan" in Part V.

D. EXISTING AND FUTURE PHYSICAL DEVELOPMENT

1. EXISTING BUILDING AND FACILITIES

Children's owns the existing hospital campus and the Hartmann property located across Sand Point Way NE at 4575 Sand Point Way NE. The existing campus extends roughly 1,300 feet in a north-south direction and 900 feet in an east-west direction. The facilities on-site include approximately 846,000 square feet of hospital uses. The parking supply includes 1,462 spaces on campus, 80 spaces at Hartmann and 640 leased spaces at remote lots.

See Figure 23, Existing Site Plan.

HOSPITAL CAMPUS

The existing hospital campus is bounded by NE 50th Street to the north; 44th Avenue NE, NE 47th Street and 45th Avenue NE to the east; NE 45th Street to the south; and Sand Point Way NE to the west. The western edge of the hospital is adjacent to the Laurelon Terrace multifamily development. The elevation of the site slopes from Elevation (El.) 170' at NE 45th Avenue to El. 60' on the western property line with Laurelon Terrace. Due to the 110' grade change, the buildings appear low on the eastern edge of the campus but commensurably taller on the western edge of the campus. The floor area ratio (FAR) on the existing hospital campus is 0.9.

The existing facilities are separated by Penny Drive. On the south side are the inpatient and outpatient facilities for patient care. On the north side are parking, administrative offices in trailers, a nursery for plants and evaporative cooling equipment. There is one primary vehicle entrance to the campus from Sand Point Way NE at the Sand Point Way NE intersection with Penny Drive. All of the building entries are accessible from this drive. A secondary egress is located along the southeastern corner of the campus, accessible from NE 45th Street. This is a drive-through bus layover area, with a pedestrian and service vehicle connection to the Whale Garage and fire access along the south face of the building.

The tallest rooftop elevation on the south side of Penny Drive is at Elevation 218'. On the north side of Penny Drive, the one-story temporary trailers are the highest buildings.

OWNED AND LEASED SPACE

Children's owns the Hartmann property, located at 4575 Sand Point Way NE. The Hartmann property is zoned Lowrise 3 (L3) and is developed with a one-story clinic and office with 80 surface parking spaces. The west edge of the property fronts the Burke-Gilman Trail. The east edge is adjacent to Sand Point Way NE. The north and south edges are adjacent to multifamily developments, the tallest of which is a building with a height of approximately 90' located on the south side of Hartmann along Sand Point Way NE. The multifamily development to the north is lower, at approximately 35' along 40th Avenue NE.

Children's currently is a part owner and leases 6,700 of the 49,500 square feet of space in the Springbrook office buildings at 4500 and 4540 Sand Point Way NE. The Springbrook property is zoned Neighborhood Commercial (NC2) and fully developed as office buildings. There are two buildings; one is a two-level structure and the other has three levels. The property is surrounded by commercial and multifamily residential uses within the neighborhood commercial center for Laurelhurst.

FIGURE 23: EXISTING SITE PLAN

STATISTICS

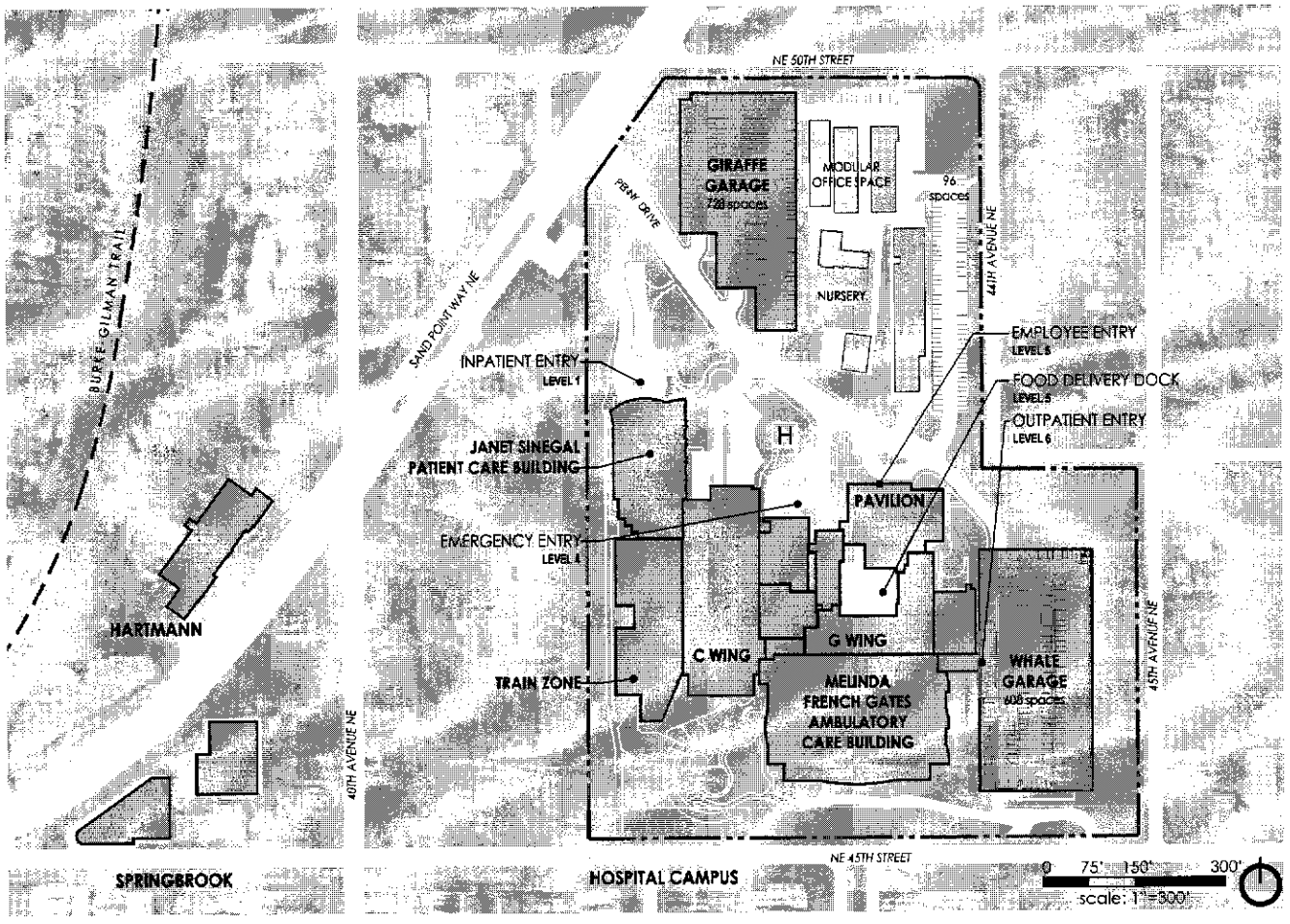
Hospital Campus	
Beds*	250*
Building gross floor area	846,000 gsf
Parking spaces	1462
FAR	0.9

**including 50 double rooms*

LEASED SPACE	
Springbrook	6,700 gsf
OWNED SPACE	
Hartmann	16,228 gsf
Parking spaces	80
FAR	0.2

LEGEND

- Property Line
- Campus Grounds
- Existing Buildings and Parking Garage
- Roadways and Surface Parking



Children's is allowed by City code to locate major institutional uses in Springbrook and maintain existing major institutional uses at Hartmann, which are within 2,500 feet of Children's MIO, as long as it complies with certain street-level use restrictions and with the standards in the NC and L3 zones, includes such uses in Children's Transportation Management Plan and obtains an administrative conditional-use permit for new medical service use in excess of 10,000 square feet.

2. FUTURE BUILDINGS AND FACILITIES

HOSPITAL CAMPUS

The Master Plan includes the facilities needed for 600 beds, at approximately 3,542 gross square feet (gsf) of major institution space per bed, inclusive of ancillary services, patient beds and utilities that are common in pediatric healthcare facilities. It will allow for total campus development of 2.125 million gsf of hospital facilities (excluding rooftop mechanical space, and above and below ground parking) and will require a total of 3,100 parking spaces. This will be an increase of approximately 1.23 million gsf over existing levels authorized on the current hospital campus. The additional space will be developed over the next 20 years. As the hospital is redeveloped, parking will be built in corresponding increments, up to 3,100 total parking spaces on the expanded hospital campus. When existing floor space and parking spaces must be demolished, such floor space and parking spaces can be replaced. The floor area ratio for the hospital campus will be 1.9 (excluding below-grade developable floor area, below-grade parking structures and rooftop mechanical equipment).

The Master Plan will relocate emergency facilities and some inpatient access to the Laurelon Terrace portion of the campus. Inpatient access will continue at the existing Giraffe entry (Janet Sinegal Patient Care Building). The outpatient entry is split between two building access points, one above the Whale Garage and the other near the Pavilion entry. Emergency access will be on 40th Avenue NE near Sand Point Way NE. The existing loading docks will be expanded at or near their current locations on Penny Drive and an additional loading dock will be created on the Laurelon Terrace property to service the buildings being built there. Secondary service access to the hospital campus will occur off 40th Avenue NE. Overall the majority of arrivals and departures on the campus will be expected from the entry at Sand Point Way NE and Penny Drive.

The Master Plan will include a new North Garage and a new below-grade garage on the Laurelon Terrace site.

Campus circulation will be coordinated with visual screening and public open-space goals along hospital campus edges. New vehicular access points on 40th Avenue NE will distribute peak period traffic movements, lessening the impacts on Sand Point Way NE and Penny Drive.

Pedestrian and bike circulation improvements will connect the hospital and surrounding areas across Sand Point Way NE to Ravenna/Bryant and the Burke-Gilman Trail at existing and future signalized intersections. While this improvement serves Children's needs, it will also benefit the surrounding neighborhoods in northeast Seattle.

The existing helistop will be relocated from its current location to the rooftop of the first bed unit constructed on the Laurelon Terrace site.

OWNED AND LEASED SPACE

Children's owns the Hartmann property and will continue to use the property for medical support services and surface parking.

Children's will continue to lease office space for temporary relocation during construction or until new campus space becomes available. The leasing of space within 2,500 feet of the MIO boundary would be done in compliance with the requirements of the Major Institution Code.

See Figure 24, Master Plan.

FIGURE 24:
MASTER PLAN

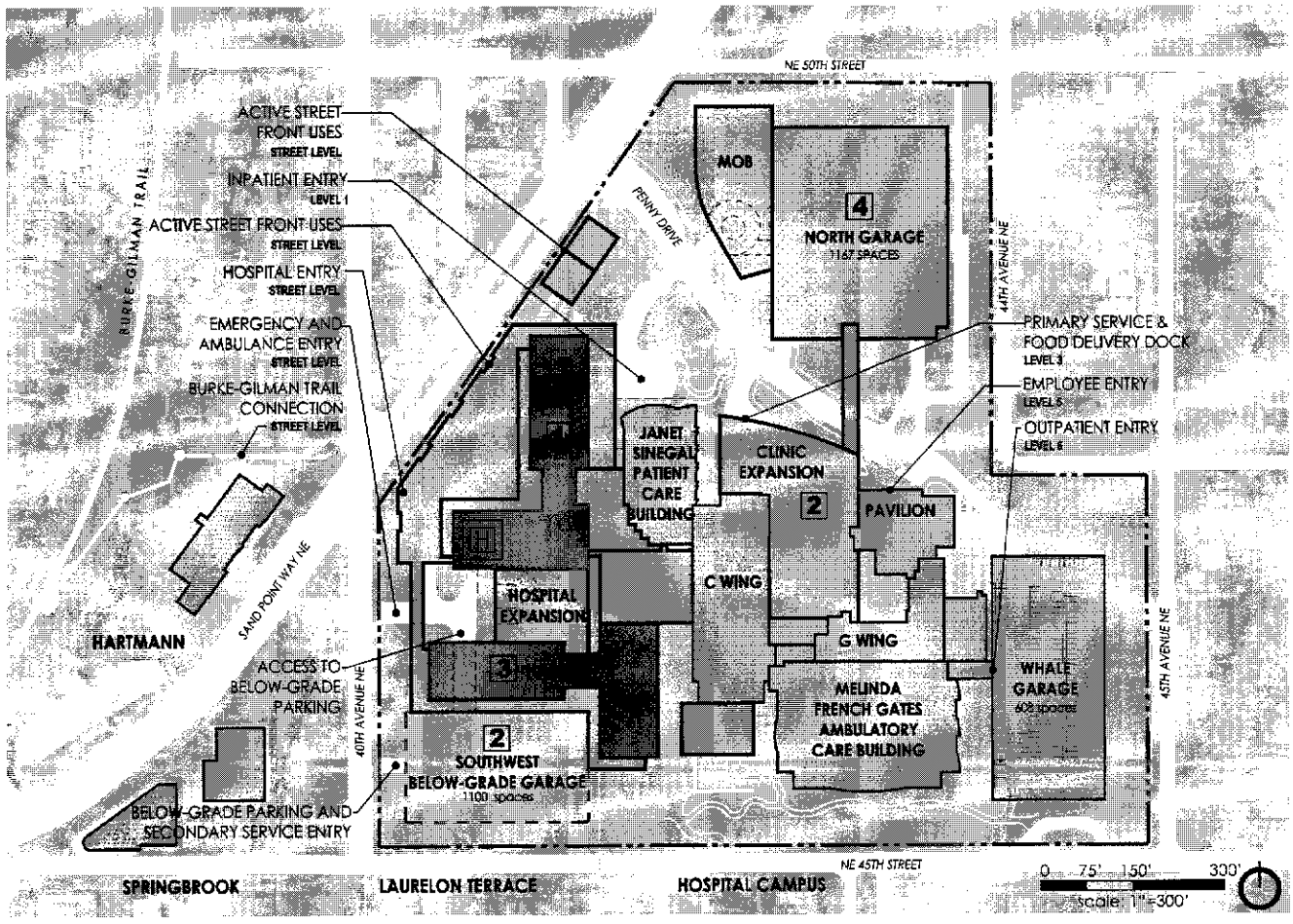
STATISTICS

Hospital Campus	
Beds	500 - 600*
Building gross floor area	2.125 million gsf
Parking spaces	3,100
FAR	1.9

addition of 250 - 350 beds

LEGEND

- Property Line
- Campus Grounds
- Existing Buildings and Parking Garage
- Lower Buildings and Parking Garages
- Taller Buildings
- Covered Walkway
- Roadways and Surface Parking
- 1 Proposed Construction Sequence
- H Helicopter
- Service and Fire Access



3. HEIGHT

The height of the buildings on campus can be described in two ways. First is the elevation, or height above sea level (designated as El.). By subtracting two elevations, one can determine the difference in height. The second measurement of height is defined by the City of Seattle Land Use Code. This measurement is taken between the roof and the ground. This latter measurement cannot exceed the MIO-designated height parallel to the ground plane. This is represented in all the site elevations shown below. The bulk and form is determined by existing and proposed development standards, such as MIO Districts, which are discussed here, and structure setbacks, height and scale transition and lot coverage, which are discussed in Part IV, "Development Standards."

a) Existing Hospital Campus Heights

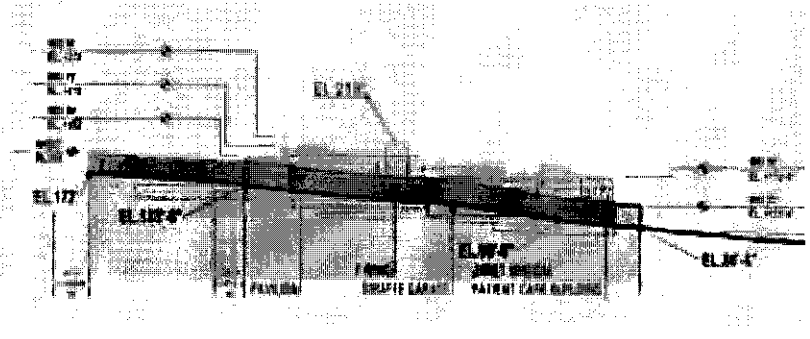
The existing buildings on the hospital campus are within the MIO-designated height, as adopted in the prior Major Institution Master Plan. The buildings step down the grade of the campus, which drops 110' from east to west. See Figure 26, Existing Building Elevations.

The highest point on the existing hospital campus is atop the rooftop penthouse on the G Wing at El. 218. This is located near the center of the existing hospital campus and surrounded by progressively lower buildings from the center to the property line. On the north and south elevations, the buildings on campus step down with the hillside. Along the Laurelon Terrace property line, the hospital's buildings are lower than the eastern campus areas. The height of the Janet Sinegal Patient Care Building is El. 150' and the Train Building is El. 148' along the west elevation. See Figure 26, Existing Building Elevations.

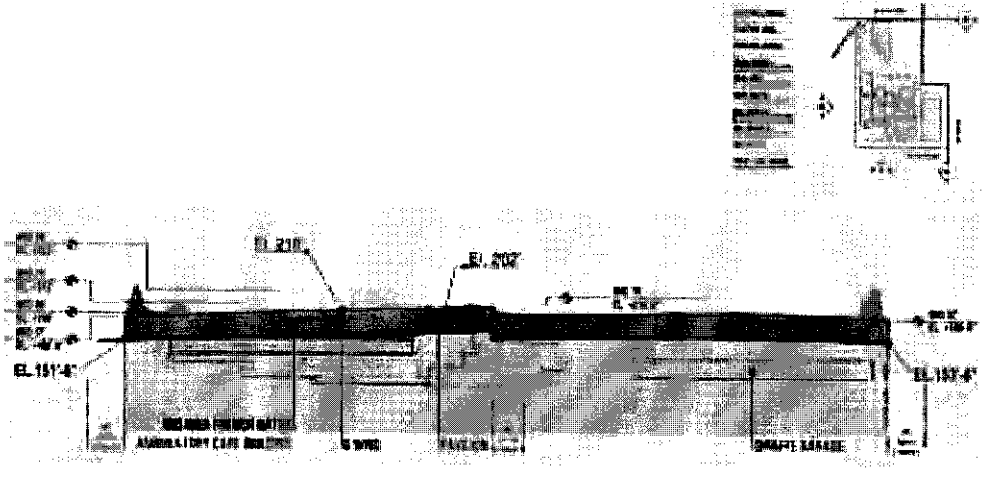
The tallest existing hospital campus buildings are set back from single-family buildings along the east and south edges of the hospital campus. Most of the perceived campus building bulk and form can be seen along the west building elevation, adjacent to Laurelon Terrace. Because these buildings are set back from public streets and largely screened by mature plants from single-family areas, they are primarily visible only from distant views of the campus. See Figure 25, Oblique View of Existing Hospital Campus.

Figure 25 Oblique View of Existing Hospital Campus

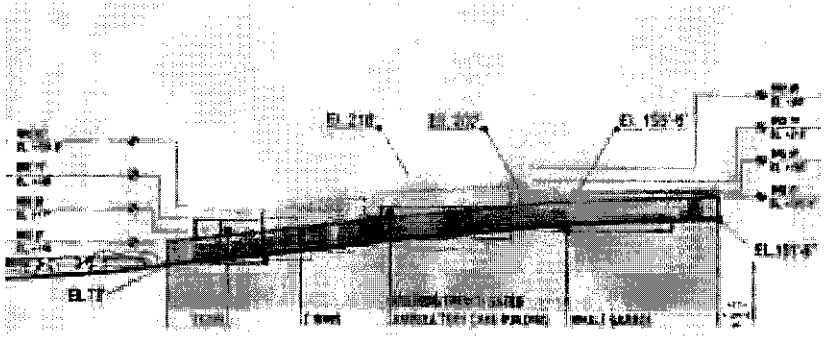
FIGURE 26: EXISTING BUILDING ELEVATIONS



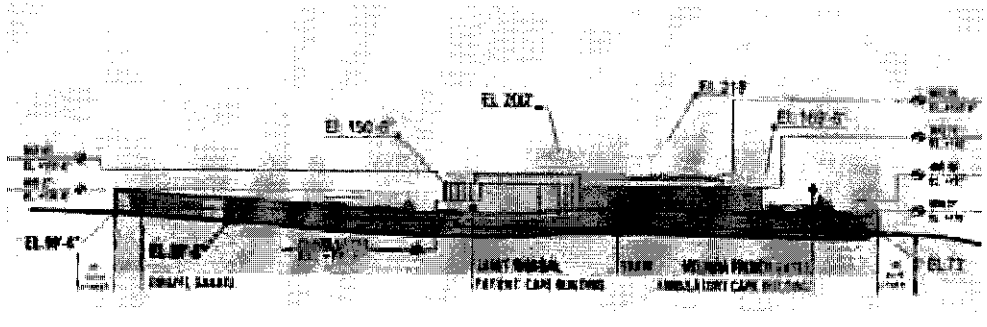
NORTH ELEVATION FROM NE 50TH STREET AND SAND POINT WAY NE (LOOKING SOUTH)



EAST ELEVATION FROM 44TH AVENUE NE AND 45TH AVENUE NE (LOOKING WEST)



SOUTH ELEVATION FROM NE 45TH STREET (LOOKING NORTH)



WEST ELEVATION FROM LAURELON TERRACE AND SAND POINT WAY NE (LOOKING EAST)

0 50 100' 200'
scale: 1"=200'

c) Future Hospital Campus Heights

The Master Plan will primarily utilize the lower elevations of the expanded campus for new development. At hospital campus frontages, the buildings will be set back as they increase in height from the street-fronting property line. The existing height limits will be largely maintained on the existing hospital campus. On the lower portion of the campus, the Laurelon Terrace property, a new MIO boundary will merge the two sites. The highest point on the existing campus is located on top of the roof penthouse of the G Wing at El. 218'. Buildings lower than this elevation will be planned on the western areas of the existing hospital campus and on Laurelon Terrace and step down to designated densely planted setback areas along garden edges and street frontage edges.

The majority of the new buildings will be located on the lowest areas of the expanded hospital campus and closest to Sand Point Way NE and 40th Avenue NE on Laurelon Terrace. Buildings will be located near the sidewalk along street frontage edges, such as Sand Point Way NE. On portions of the campus that face single-family areas, setbacks will separate buildings from those areas through garden edges. Within the MIO 160' district, buildings will be limited to a 125' and 140' height, excluding rooftop mechanical equipment. Along the streets in the western portions of the expanded campus, the hospital buildings will step back with incremental increases in height. The base will be no taller than four exposed stories or 50' near the sidewalk.

See Figure 28, Future Building Elevations.

The tallest buildings will be located near the center of the campus and away from single-family residences. The buildings facing along Sand Point Way NE and 40th Avenue NE, the west elevation, will have upper level setbacks of 30 feet and 80 feet respectively for portions of the buildings taller than 50 feet. Other campus elevations to the north, east and south will have landscaping planted to screen or limit views of buildings.

See Figure 27, Oblique View of Future Hospital Campus.

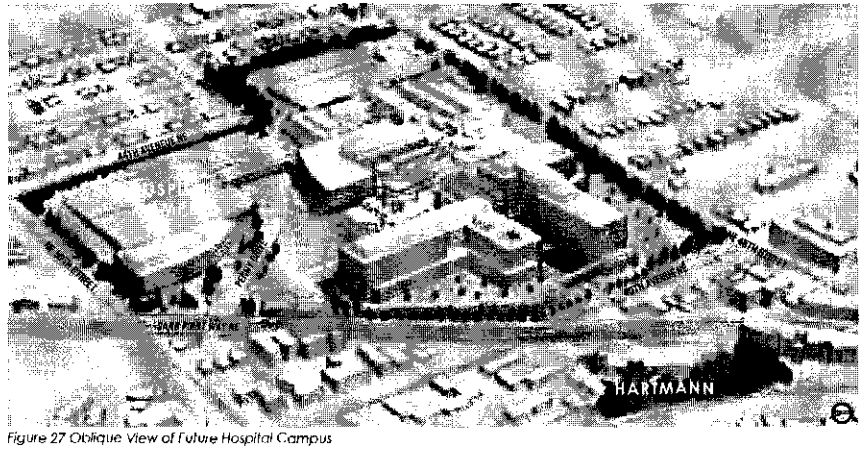
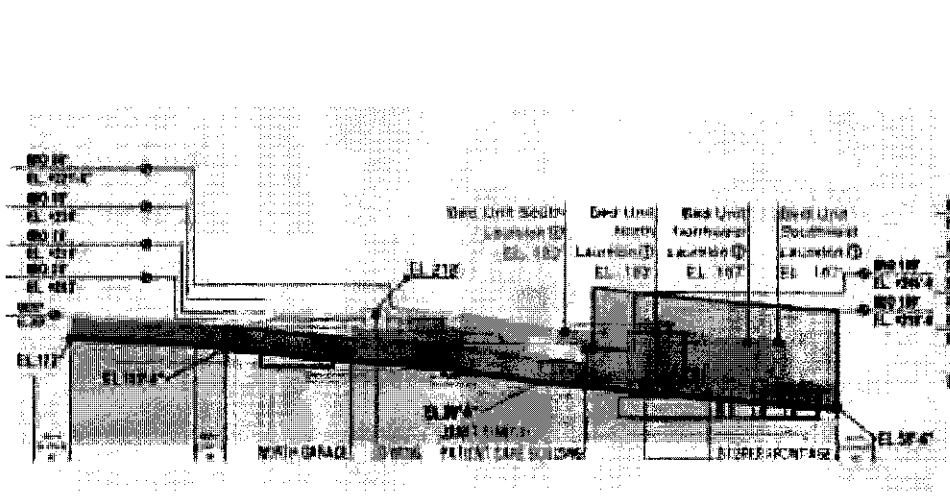
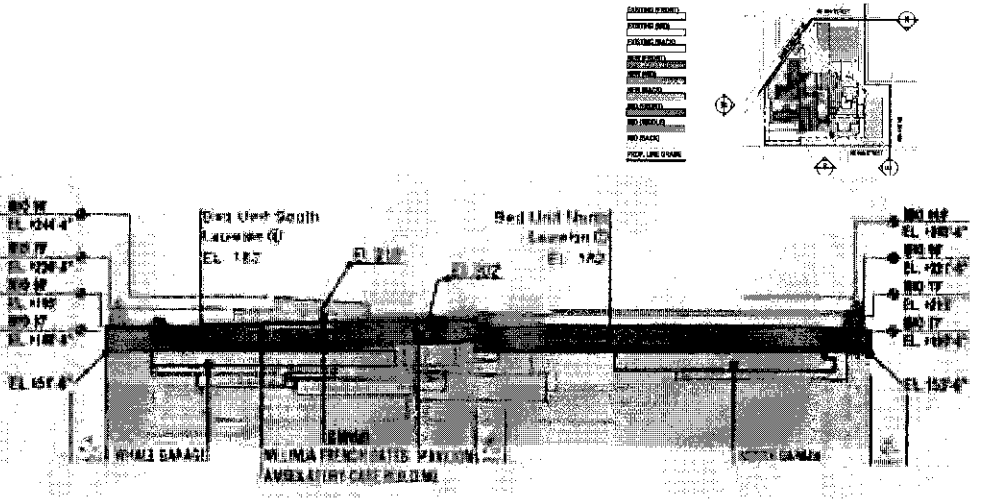


Figure 27 Oblique View of Future Hospital Campus

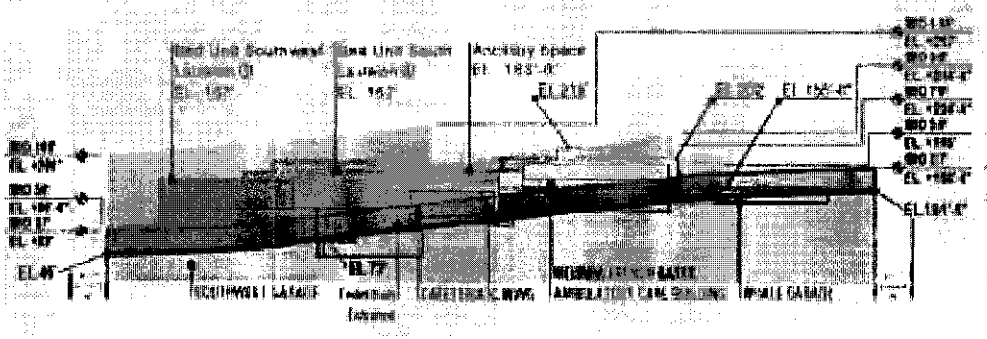
FIGURE 28: FUTURE BUILDING ELEVATIONS



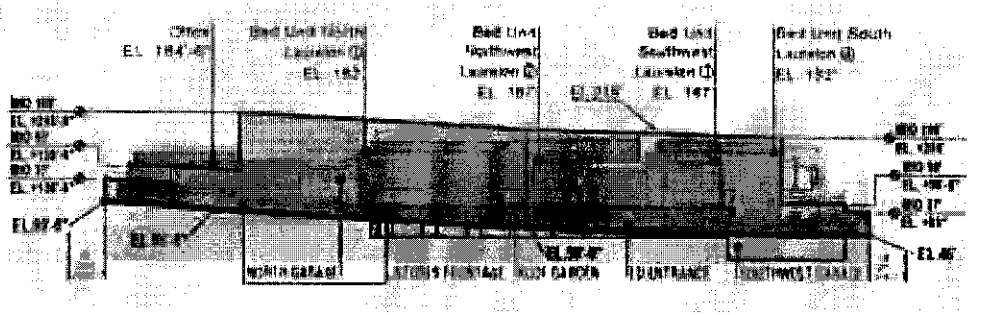
NORTH ELEVATION FROM NE 50TH STREET AND SAND POINT WAY NE (LOOKING SOUTH)



EAST ELEVATION FROM 44TH AVENUE NE AND 45TH AVENUE NE (LOOKING WEST)



SOUTH ELEVATION FROM NE 45TH STREET (LOOKING NORTH)



WEST ELEVATION FROM LAURELON TERRACE AND SAND POINT WAY NE (LOOKING EAST)

0 50 100' 200'
scale: 1"=200'

4. OPEN SPACE, LANDSCAPE AND SCREENING

a) Existing Open Space, Landscape and Screening

EXISTING HOSPITAL CAMPUS

Children's open-space system includes plazas, roof gardens, gardens, play areas and roadways.

Plazas

Plazas are located at the front of each building entry. Building entries for patients, staff or materials arrivals have designs and features that are appropriate to the use. The main entry plazas for inpatient arrivals are the Giraffe Entrance of the Janet Sinegal Patient Care Building and the Whale Entrance of the Melinda French Gates Ambulatory Care Building from the Whale Garage. Currently, the Emergency Department is a primary entry that is set back from Penny Drive and not readily visible from surrounding public streets.

Gardens

There are more than 2,000 different plant varieties within the gardens on campus. There are several garden types:

Courtyards, such as that built between the Whale Garage and the Melinda French Gates Ambulatory Care Building at the fourth floor, provide enclosed gardens.

Garden edges provide vertical plantings to buffer the neighbors from the building facilities along designated edges of the campus.

A roof garden is provided on a portion of the Whale Garage top level — as a part of the Melinda French Gates Ambulatory Care Building entry plaza — with raised planters and garden ornaments.

Another garden is provided on the first floor of the Janet Sinegal Patient Care Building (Giraffe Zone), an outdoor space adjacent to hospital services and public areas of the hospital.

A sculpture garden is located along the south face of the Melinda French Gates Ambulatory Care Building.

Pocket gardens are located throughout the campus, where land can be made into terraces, providing restful places for patients, visitors, caregivers and neighbors to congregate.

Play Areas

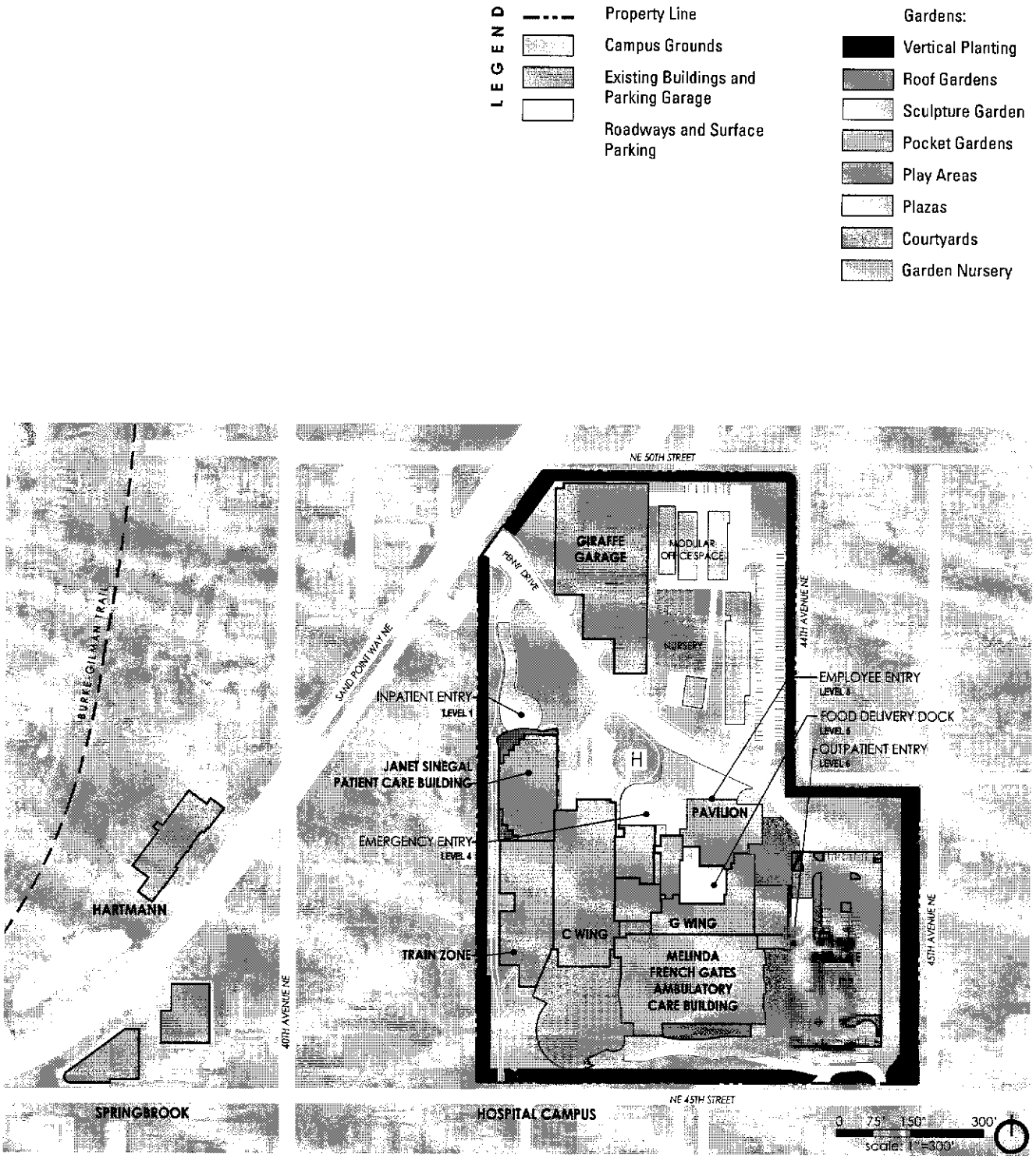
Children's has two outdoor play areas on campus available to patients and siblings. They are located on grade at the southwest corner of the campus.

Roadways

Penny Drive is a roadway that is flanked by foundation plantings and pocket gardens. The plantings serve a dual purpose for vehicles and pedestrians in defining the roadway edge and providing a refuge from traffic for pedestrians.

See Figure 29, Existing Open Space, Landscape and Screening.

FIGURE 29: EXISTING
OPEN SPACE, LANDSCAPE AND SCREENING



b) Future Open Space, Landscape and Screening

The system of existing plazas, gardens, courtyards and pathways will connect buildings with the surrounding public spaces around the campus.

Plazas

Plazas will be expanded at the Giraffe inpatient entry (Janet Sinegal Patient Care Building), the Pavilion entry, and the existing Whale outpatient building entry. A fourth plaza will be developed along 40th Avenue NE for the Emergency Department.

Gardens

The garden edge surrounds the campus and will be designed to minimize the visual presence of the hospital while marking entries to the campus and its associated gardens. The quality of the existing landscape screen along the south, east and north edges of the campus will be continued.

Garden spaces similar to those that now exist on campus will be programmed for activities and organized in concert with interior building functions to promote restorative spaces on campus, which may be used by the neighborhood.

Roof gardens visible to patient rooms will be placed on the lower roofs. These will also provide outdoor space for patients, visitors and staff. The upper roofs will have eco-roof opportunities around mechanical penthouses.

Frontages

Development on the Laurelon Terrace portion of the hospital campus will include landscaping suitable to the pedestrian/transit-friendly active street frontage environment envisioned on Sand Point Way NE and 40th Avenue NE.

Play Areas

Children's will provide additional play areas for children in rooftop gardens above new buildings on the Laurelon Terrace property.

Roadways

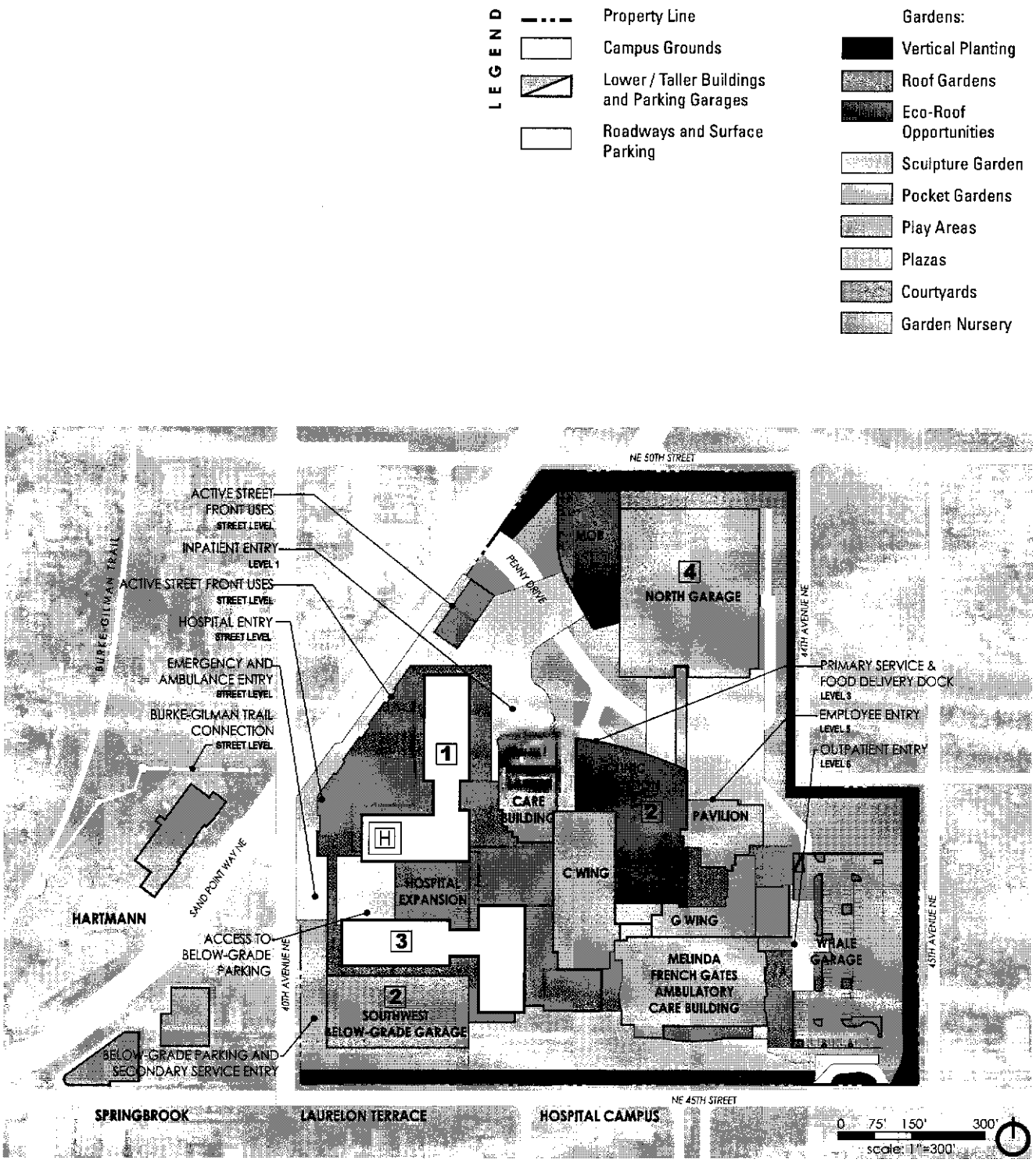
Penny Drive will continue to be flanked by foundation plantings and pocket gardens. The plantings will continue to both define the roadway edge and provide a refuge from traffic for pedestrians.

CONNECTION TO BURKE-GILMAN TRAIL

A new pedestrian connection between Sand Point Way NE and the Burke-Gilman Trail will be created along the north and west property lines of the Hartmann property, within the applicable zoning constraints. Along this pathway's length will be landscaping and a preserved grove of Sequoias.

See Figure 30, Future Open Space, Landscape and Screening.

FIGURE 30: FUTURE
OPEN SPACE, LANDSCAPE AND SCREENING



c) Public and Private Roadways and Parking

i. Existing Public and Private Roadways and Parking

HOSPITAL CAMPUS

Sand Point Way NE is the primary arterial serving Children's. The hospital campus entry is at the signalized intersection of Sand Point Way NE and Penny Drive. Most vehicle trips related to hospital operations use this access point to Penny Drive.

The second access point to the campus is a driveway from NE 45th Street near the southeast corner of the campus. This is a secured access point that is not available to the public. Service vehicles can enter the Whale Garage via a secured gate. In addition, an apron at this location allows Metro buses to lay over on Children's property. This entrance also provides access to a utility lane on the south side of the Melinda French Gates Ambulatory Care Building.

Penny Drive distributes vehicles to all parking areas, entry points and loading docks. The roadway has two through-lanes with a two-way center turn lane and 10-mph speed limit. At-grade crosswalks are located along Penny Drive, connecting the parking and campus facilities areas to the north with the primary hospital areas to the south. Most deliveries are handled at two separate loading docks, one for general receiving and one specifically for food deliveries. Neither loading dock is configured to allow larger trucks to turn around. Therefore, most delivery and service vehicles must back in from Penny Drive.

The existing Giraffe Garage provides 728 parking spaces for patients, visitors, staff and physicians. The garage has four levels, which are not currently interconnected with ramps between floors; direct access to each level is via separate garage entrances off Penny Drive. The Giraffe Garage is located on Penny Drive across from the hospital. ADA-accessible parking is located at the Janet Sinegal Patient Care Building entry plaza. The existing three-level Whale Garage has 608 parking spaces for patients, visitors and physicians. The Whale Garage serves the main entrance of the Melinda French Gates Ambulatory Care Building and provides direct access to ADA-accessible parking. Automobile access to the Whale Garage is primarily from Penny Drive, although a secured service access is located off NE 45th Street. In the northeast portion of the campus, there are 126 surface parking spaces which provide parking for the Emergency Department, patient/family motor homes and other visitors. The number of surface parking spaces has been reduced due to interim modular office units and landscape maintenance operations. Children's currently provides a total of 1,462 parking spaces on campus.

Shuttles provide access to Children's off-campus parking as well as off-campus work locations, and operate from 5:30 a.m. to 9 p.m., Monday through Friday. During peak commuting hours, two shuttles serve each lot; during off-peak commuting hours, a single shuttle serves each lot. On campus, the Children's shuttle drops off shuttle riders at the Giraffe Entrance. Frequent weekday shuttle service is provided to off-campus parking locations. Shuttles also serve interfacility transportation needs between Children's main campus and other Children's facilities in Seattle. This service reduces traffic and parking congestion. Guest Services transportation is provided to patients and families via a separate fleet of ADA-equipped vehicles.

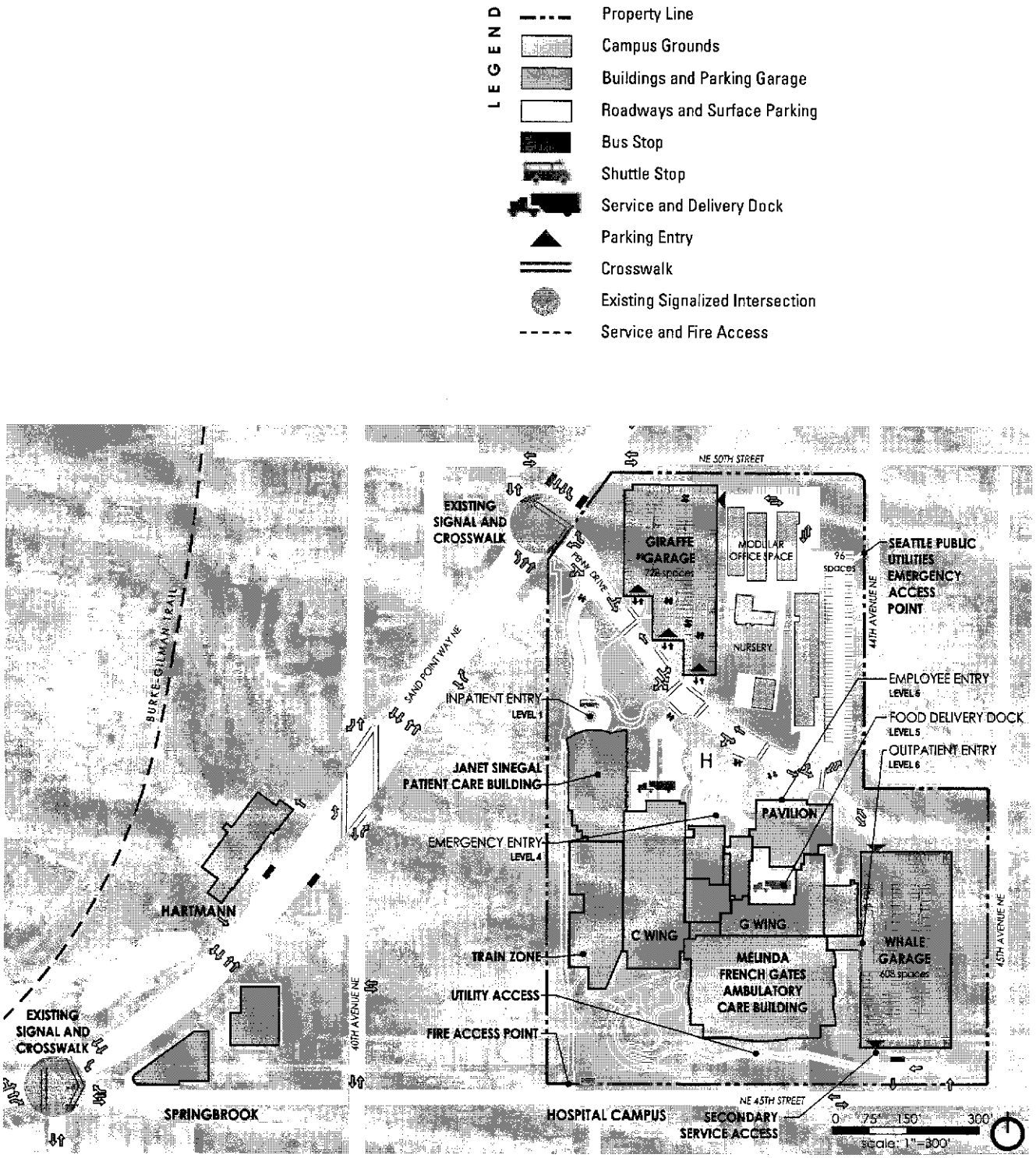
The hospital campus is served by Metro Transit routes #25 and #75. The #75 serves the main entrance of the campus on Sand Point Way NE. Sheltered bus stops are located in both the northbound and southbound directions, and an ADA-accessible ramp system provides access from Sand Point Way NE to the Giraffe Entrance. The #25 serves the secondary access point of the campus, along NE 45th Street. A single, sheltered bus stop on Children's property serves both incoming and outgoing trips. A covered, ADA-accessible walkway through the Whale Garage provides access to the Whale Entrance.

See Figure 31, Existing Transportation and Parking.

OFF CAMPUS

Access for vehicles to the hospital campus is via the signalized intersection of Sand Point Way NE and Penny Drive. It is served by left-turn lanes without dedicated signal phases for left turns from any approach. The next nearest signalized intersection is located to the south, at Sand Point Way NE and NE 45th Street. Other important intersections providing neighborhood accessibility to Sand Point Way NE are not signalized, including 40th Avenue NE and NE 50th Street.

FIGURE 31: EXISTING
TRANSPORTATION AND PARKING



ii. Future Public and Private Roadways and Parking

HOSPITAL CAMPUS

Penny Drive will be improved to accommodate more vehicle stacking capacity and safe non-vehicle crossings along its length. The loading dock access will be expanded for consolidated service truck movements. In addition, two new ADA crossings will be provided. One will be located at the intersection of Penny Drive and Helen Lane (access drive leading to the Giraffe inpatient entry), and the other crossing will be located between the new North Garage and the Pavilion. The secure access to the Whale Garage and service drive, within the south setback and connected to NE 45th Street near the southeast corner of the campus, will remain.

New hospital vehicle access points will be provided to distribute peak period traffic movements from campus onto streets fronting the hospital campus. Two new access points will be located on 40th Avenue NE. Including Penny Drive, a total of three access points will be maintained closer to Sand Point Way NE and away from single-family residential areas. This will afford improved efficiency and utilization of existing and proposed signals along Sand Point Way NE.

In addition to the 608-space existing Whale Garage, new parking structures are proposed. A new North Garage with 1,392 parking spaces will be built on the northeast corner of the campus. The parking levels in the new garage will align with floors of a redeveloped and expanded Giraffe Garage, which will be connected by an internal ramp and circulation system. In addition to the North Garage, a new underground garage will be built on the Laurelon Terrace site with 1,100 parking spaces. The total amount of parking on the hospital campus will be 3,100 spaces.

The existing service and loading areas will be expanded. An additional loading dock will be added on Laurelon Terrace to service the buildings built on that portion of the campus. Existing access driveways from Penny Drive will be modified to accommodate improved pedestrian crossings and roadway geometry.

Public transit will continue to serve the hospital campus from Sand Point Way NE and NE 45th Street.

OFF-CAMPUS

A number of local traffic improvements have been identified, which will facilitate campus access and, in many cases, contribute to improved neighborhood accessibility to Sand Point Way NE. These improvements will include, but may not be limited to:

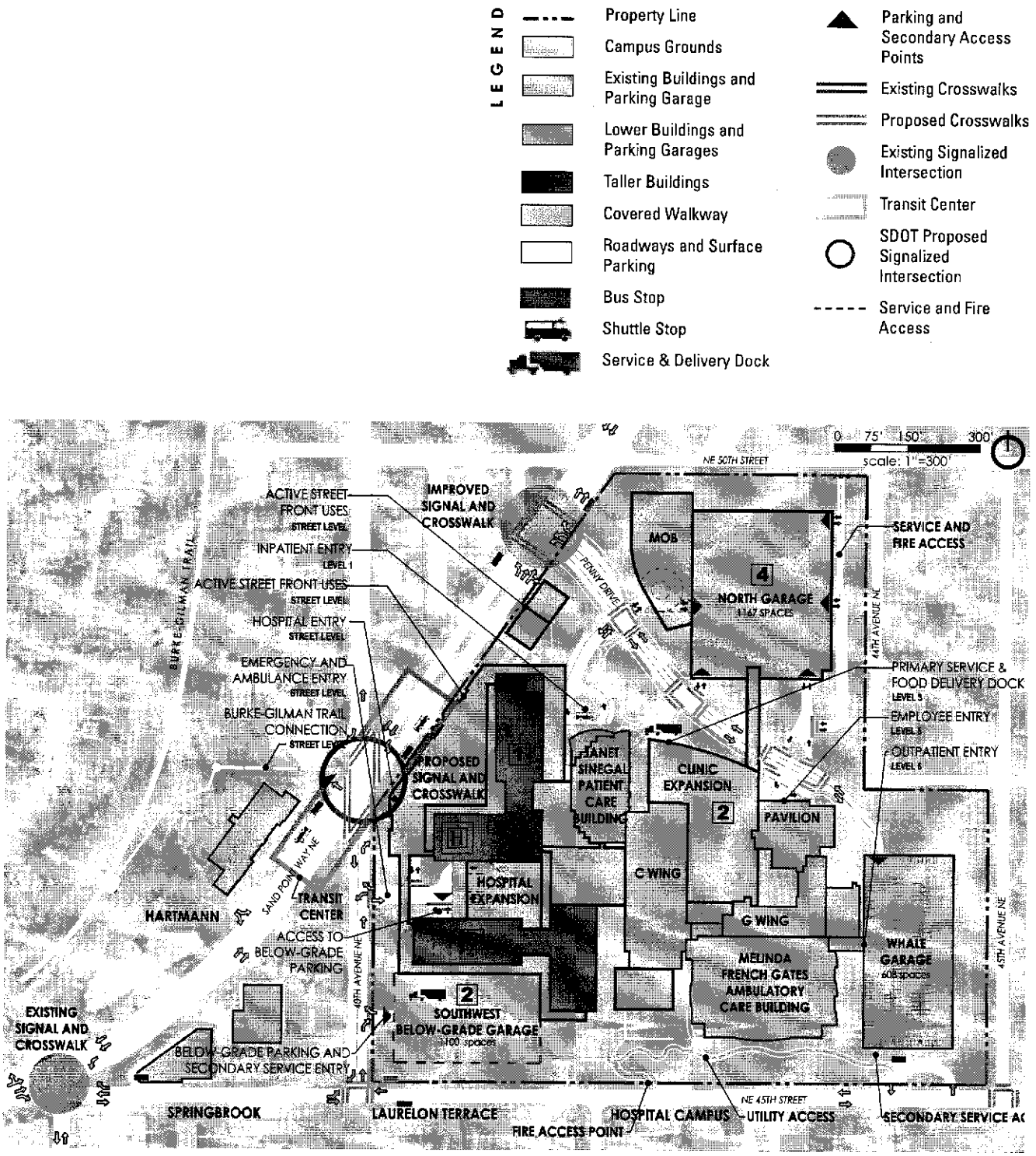
- Sand Point Way NE/Penny Drive. Realignment of the Penny Drive intersection with Sand Point Way NE to the north and add left-turn traffic signal phasing to enhance the safety of turns to and from the hospital campus.
- Sand Point Way NE/NE 40th Street. The City of Seattle has a plan to install a signal at the intersection to enhance vehicular and pedestrian accessibility to Sand Point Way NE and the Burke-Gilman Trail.

The specific configuration of these improvements will be subject to further study and ultimately review and approval of the Seattle Department of Transportation (SDOT) and Washington State Department of Transportation (WSDOT).

As part of its Comprehensive Transportation Plan and as necessary to mitigate future transportation impacts, Children's intends to identify out-of-area, off-site parking spaces per phase of development. It is expected that every 100 cars parked at out-of-area facilities will result in a 5% reduction in traffic impacts surrounding the hospital. See discussion in Comprehensive Transportation Management Plan, Part V.

See Figure 32, Future Transportation and Parking.

FIGURE 32: FUTURE
TRANSPORTATION AND PARKING



E. MAJOR INSTITUTION OVERLAY HEIGHT DISTRICTS

1. EXISTING MAJOR INSTITUTION OVERLAY HEIGHTS

Children's campus now includes four height districts: MIO 37' around the periphery of the campus, MIO 50' along the south to form a transition to the MIO 70' and MIO 90' in the interior of the campus. The higher MIOs are centered at the core and southern parts of the campus and transition down to a lower height at the campus edges. The site generally slopes downward from east to west and from north to south. The existing buildings are approximately 20' from the northern property edge, 40' to 75' from the eastern property edge of the campus and also 40' on the west side of campus at the base of the slope. On the southern and southwestern edges, buildings are 75' from the property line. All of the setbacks are heavily landscaped to create a screen between the campus and surrounding neighborhood. Landscaping around the campus also provides open space and sidewalks as public amenities.

In addition to the height limits shown in Figure 33, the Seattle City Council further conditioned the heights of two buildings on the campus: the Janet Sinegal Patient Care Building and portions of the Melinda French Gates Ambulatory Care Building. The Janet Sinegal Patient Care Building is located in the MIO 90' area of the campus and was limited in height to 74', with an additional 15' allowed for mechanical equipment (a total of 89' with mechanical). The Melinda French Gates Ambulatory Care Building is located in an MIO 70' district and portions of this building were limited in height to 54.5'.

See Figure 33, Existing Zoning and Major Institution Overlay.

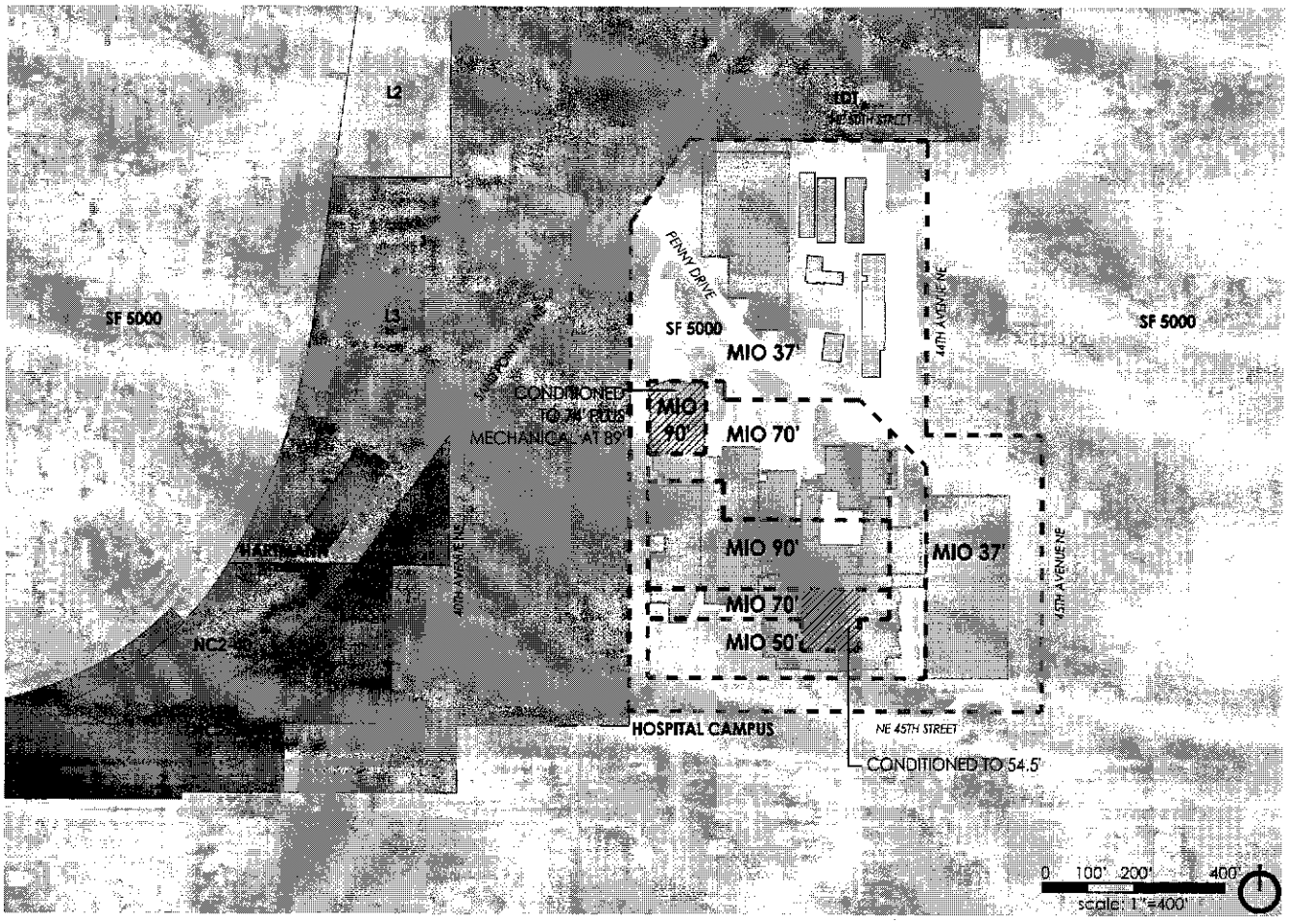
FIGURE 33: EXISTING
ZONING AND MAJOR INSTITUTION OVERLAY

STATISTICS

ZONING	
SF 5000	Single-family Residential 30' height limit
LDT	Low-rise Duplex/Triplex 25' height limit
L3	Multifamily Residential, Low-rise 3 30' height limit
L2	Multifamily Residential, Low-rise 2 25' height limit
NC2-30	Neighborhood Commercial 2 30' height limit
NC2-40	Neighborhood Commercial 2 40' height limit

LEGEND

- MIO Height District Boundary
- Roadways and Surface Parking
- Buildings



2. FUTURE MAJOR INSTITUTION OVERLAY HEIGHTS

Five changes in the location and height of MIO districts from what was approved in the previous Major Institution Master Plan have been approved for the existing campus in the new Master Plan:

1. On the north, setbacks are increased from 20' to 40' and 75'. East setbacks, previously 40' and 75', are now all 75'. The existing south setback of 75' will be retained on the existing campus, and a new setback of 75' is added on the south side of Laurelon Terrace. In the setbacks, no above-grade structures are allowed.
2. On the existing campus, the existing MIO 37' district to the northwest has been changed to MIO 65'. An MIO 37' district is maintained on the northeast, over the Whale Garage, on the southeast corner and on the south edge of the hospital campus.
3. On the north edge of the existing hospital, a small portion of the existing MIO 37' district and a portion of the existing MIO 70' district along Penny Drive have been changed to MIO 90'. This change also applies to the area previously conditioned to 74' plus 15' for mechanical.
4. On the south edge of the existing hospital, a portion of the existing MIO 50' and MIO 70' districts have been changed to MIO 90'.
5. The approximately 40'-wide area now bordering the east side of Laurelon Terrace has been increased from MIO 37' to MIO 160' (conditioned to 140'/125'), as the area is no longer a perimeter buffer and the new MIO matches the MIOs for Laurelon Terrace.

Other MIO heights for the expanded campus areas include:

6. MIO heights for the Laurelon Terrace site include an MIO 160' transitioning to the south with MIO 50' and then MIO 37'. Building heights will be limited to 140' in the northern portion of the MIO 160' height district and 125' in the southern portion of the MIO 160' height district, not including screened mechanical equipment or penthouses.
7. Development on Sand Point Way NE and 40th Avenue NE shall be placed adjacent to the street to foster an environment conducive to transit and shuttle use by the community and Children's visitors and staff.
8. Along the western edge of the expanded campus on 40th Avenue NE from Sand Point Way NE south to NE 45th Street, an upper level setback of 80' in depth shall be applied to portions of buildings higher than 50'; and 30 feet deep on Sand Point Way NE from 40th Avenue NE to Penny Drive.

See Figure 34, Future Zoning and Major Institution Overlay.

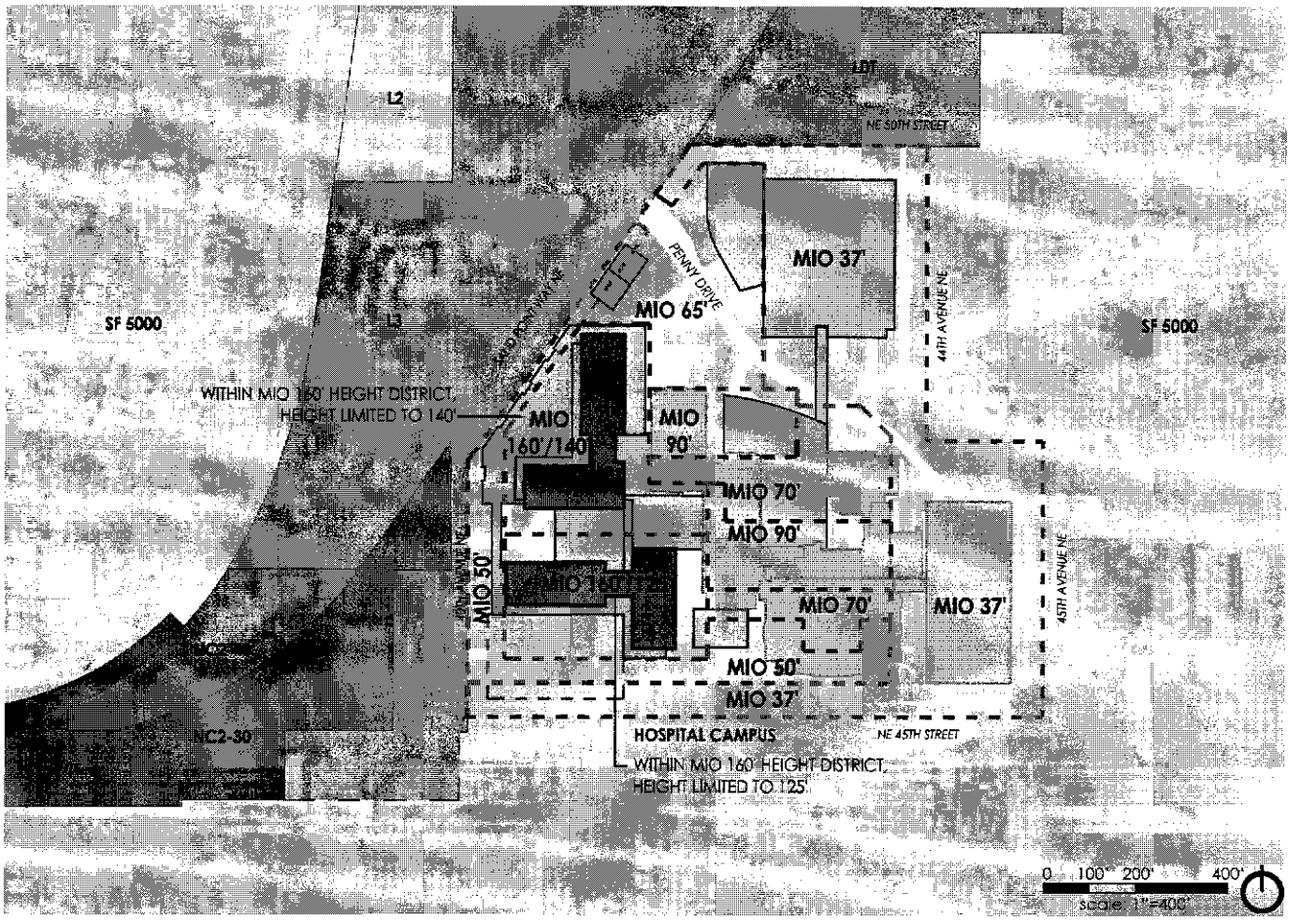
FIGURE 34: FUTURE
ZONING AND MAJOR INSTITUTION OVERLAY

STATISTICS

ZONING	
SF 5000	Single-family Residential 30' height limit
LDT	Low-rise Duplex/Triplex 25' height limit
L3	Multifamily Residential, Low-rise 3 30' height limit
L2	Multifamily Residential, Low-rise 2 25' height limit
NC2-30	Neighborhood Commercial 2 30' height limit
NC2-40	Neighborhood Commercial 2 40' height limit

LEGEND

- MIO Height District Boundary
- Roadways and Surface Parking
- Lower Buildings
- Taller Buildings



F. DESCRIPTION OF PHASED CAMPUS DEVELOPMENT

Children's intends to phase the construction of facilities improvements to its campus over the next 20 years. Overarching goals of the phasing plan are to meet the hospital's growth needs predictably while minimizing development impacts to existing facilities and surrounding neighborhoods.

Phasing Sequence

Children's anticipates four major phases of development, illustrated in Figure 35 Proposed Phasing, including the following projects:

(1) Bed Unit North

(2) Ambulatory Expansion and Below-grade Southwest Garage

(3) Bed Unit South

(4) North Garage and Office Building

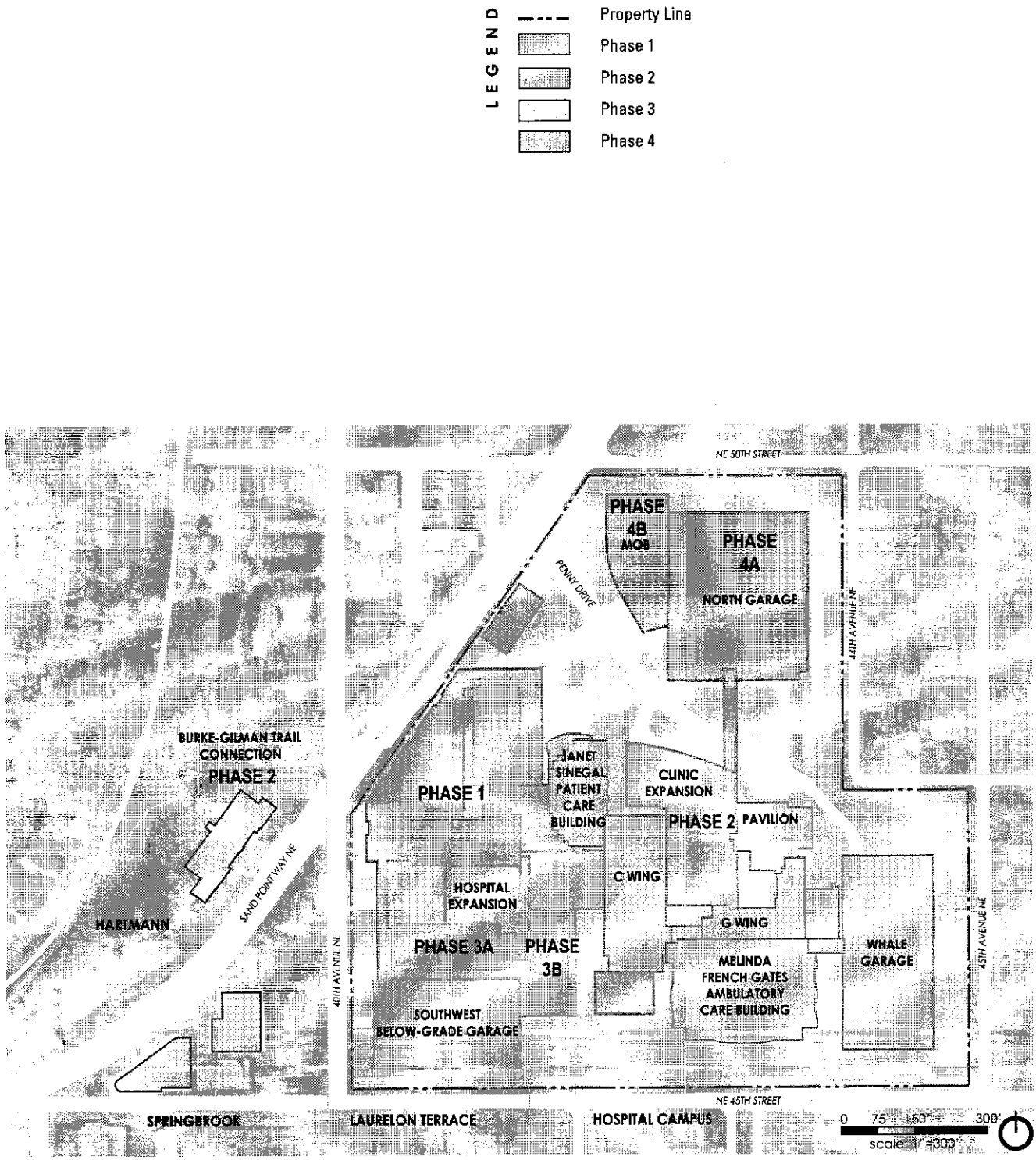
The proposed periods for construction of each phase, together with the estimated square footage of new construction, square footage of demolition of existing campus facilities, added parking spaces and total cumulative parking spaces and square footage of development, are shown in the following table:

Table 1. Proposed Master Plan Phasing

	Phase 1	Phase 2	Phase 3A & 3B	Phase 4
Construction Timeline*	3rd Qtr 2010 - 4th Qtr 2012	4th Qtr 2013 - 4th Qtr 2016	(3A) 2nd Qtr 2017 - 4th Qtr 2019 (3B) 1st Qtr 2022 - 4th Qtr 2024	2nd Qtr 2025 - 4th Qtr 2027
Building Square Footage	592,000 GSF	177,000 GSF	592,000 GSF	65,000 GSF (plus 54,000 GSF from current MIMP)
Existing Campus Demolition Square Footage	0 GSF	65,000 GSF (D Wing 47,000) (F Wing 18,000)	136,000 GSF (Train 3B)	0 GSF (Giraffe Garage demolition 728 stalls and 126 surface stalls)
Parking Spaces Added	300 surface stalls on campus	1,100 spaces Southwest Garage	0 spaces	1,392 spaces North Garage expansion
Total Parking Spaces (cumulative)	1,762 spaces	2,562 spaces	2,562 spaces	3,100 spaces (includes spaces previously targeted for Hartmann)
Total Campus Square Footage (cumulative)	1,492,000 GSF	1,604,000 GSF	2,060,000 GSF	2,125,000 GSF

* Demolition, excavation, shoring and building exterior envelope construction comprises 60% to 70% of the construction timeline duration for each phase.

FIGURE 35: PROPOSED PHASING



Phase 1 Proposed Development

Children's plans to build Phase 1 between the third quarter of 2010 and the fourth quarter of 2012. Phase 1 will include the construction of a new Emergency Department, new diagnostic and treatment facilities, adding new patient rooms to meet Children's projected initial bed needs, and the relocation of the existing helistop to the top of the new building to facilitate access to the new Emergency Department.

Children's has projected the following total bed needs, all in single-bed rooms:

- Year 2012 336 beds
- Year 2017 408 beds
- Year 2019 460 beds
- Year 2030 600 beds

Children's currently has 197 rooms, with 53 rooms holding two beds each, to provide the current supply of 250 beds. These double-bed units will be converted to single-bed units. Other existing bed units will require updating to new bed standards which will mean a loss in total number of existing beds. The new construction will require demolition of some existing patient bed rooms in order to provide connections between the new and old bed units. These changes will leave Children's with 144 single-bed rooms.

There are two key considerations that go into determining how many beds are located on a floor. The first is that every patient room must be located on an exterior wall in order to have a window (which is a Department of Health requirement). The second is that patient bed units are designed in clusters of 24, 32 or 48 beds in order to maintain the appropriate ratio and access between staff and patients. These clusters also help maximize staff and equipment access efficiency on each floor and help keep the number of needed floors as low as possible.

As described above, Children's needs an additional 264 new beds by 2017 (total needed beds of 408 less supply of 144). If designated with 48 beds-per-floor, this will require 5.5 floors of new construction for the bed units alone.

Monitoring and Agency Oversight of Phased Development

Children's is required to provide the following status reports and engage in further environmental and project review for each phase of its proposed development:

- MIMP Annual Status Report shall be submitted to Department of Planning and Development (DPD) and Standing Advisory Committee (SAC) each year.
- Project-based SEPA review shall be performed by DPD for each phase of construction.
- State Department of Health (DOH) Certificate of Need is a requirement for each phase of new bed development. Where additional beds are proposed, this information would also be provided to the SAC.
- DPD Master Use Permitting (MUP) public notification and comment will be done for each major phase of construction that requires discretionary approval by DPD (called a Type II MUP). Type II MUPs are subject to extensive posting and publishing of notice, with opportunity for written comment. Prior to submitting any MUP application, Children's will review any proposed major construction project with the SAC for purposes of discussing the nature of the project, its proposed location and design.
- Transportation Management Plan Annual Report shall be submitted to Seattle's Department of Transportation.
- Commute Trip Reduction Annual Report shall be submitted to King County Metro.
- Commute Trip Reduction biannual surveys shall be made to evaluate compliance with city- and state-mandated trip reduction targets.

Content of Monitoring Reports

Children's annual status report to the DPD Director and the Standing Advisory Committee (SAC) shall provide the following:

- Status of current and proposed construction projects
- Status of applications to the DOH for Certificates of Need
- Status of all land and property acquisition, ownership and leasing outside the MIO but within 2,500 feet of the MIO district boundary
- Status of compliance with TMP goals and mitigation requirements
- Proposed contingencies for mitigating unanticipated problems or worsened conditions attributable to institution's development

MIMP Conditions for MUP Approvals

Seattle City Council Ordinance No. 123263, adopted April 5, 2010, and included as Appendix D to this Compiled Final Master Plan, imposed the following conditions as a part of its approval of Children's Major Institution Master Plan (where section, figure and table references have changed in this Compiled Final Master Plan document, correct references are provided parenthetically):

1. Total development on the existing and expanded campus shall not exceed 2,125,000 gross square feet, excluding above and below grade parking and rooftop mechanical equipment.
2. The Floor Area Ratio (FAR) for the expanded campus shall not exceed 1.9, excluding below grade developable floor area, below-grade parking structures and rooftop mechanical equipment.
3. No more than 20% of the land area within the MIO, approximately 264,338 square feet, may include structures that exceed 90 feet in height. No more than 10% of the land area within the MIO, approximately 142,596 square feet, may include structures that exceed 125 feet in height. No structure in the MIO shall exceed 140 feet in height, excluding rooftop mechanical equipment.
4. MIO heights shall be measured in accordance with SMC 23.86.006 as now or hereafter amended.
5. Children's shall amend Section IV.D.1 of the Master Plan ***(section IV.D.1 in this Compiled Final Master Plan document)*** to add upper level setbacks 80 feet deep, applied to portions of buildings higher than 50 feet, along the western edge of the expanded campus on 40th Avenue Northeast from Sand Point Way Northeast south to Northeast 45th Street, and 30 feet deep on Sand Point Way from 40th Avenue Northeast to Penny Drive.
6. Children's shall amend Section IV.D.1 and Master Plan Figure 50, "Proposed Structure Setbacks" ***(section IV.D.1 and Figure 38 "Structure Setbacks" in this Compiled Final Master Plan document)***, to increase the south setback to 75 feet along the entire Northeast 45th Street boundary.
7. Children's shall amend Section IV.C.1 of the Master Plan ***(amended in Section IV.D.1 in this Compiled Final Master Plan document)*** to expressly prohibit above-ground development within the setback areas, as shown on revised Figure 50 ***(Figure 38 in this Compiled Final Master Plan document)***, except as otherwise allowed in the underlying zone.
8. The Hartmann site as originally proposed in the MIMP is not included within the MIO boundary and is not subject to this MIMP.
9. A minimum of 41% (being 507,000 square feet) of the combined total area of the expanded campus shall be maintained as open space. In addition:
   a. Open Space should be provided in locations at ground level or, where feasible, in other spaces that are accessible to the general public. No more than 20% (being 101,000 square feet) of the designated 41% open space, shall be provided in roof top open spaces;
   b. Open Space areas shall include existing and proposed ground level setback areas identified in the Master Plan, to the extent that they meet the criteria in the proposed Design Guidelines;

c. The location of open space, landscaping and screening as shown on Figure 42 of the Master Plan ***(Figure 30 in this Compiled Final Master Plan document)*** may be modified as long as the 41% figure is maintained;

d. To ensure that the 41% open space standard is implemented with the Master Plan, each planned or potential project should identify an area that qualifies as Open Space as defined in this Master Plan;

e. Open Space that is specifically designed for uses other than landscaped buffers or building setback areas, such as plazas, patios or other similar functions, should include improvements to ensure that the space contains Usable Open Space as defined under SMC 23.84A.028; and

f. Open space shall be designed to be barrier-free to the fullest extent possible.

10. For the life of the Master Plan, Children's should maintain open space connections as shown on Figure 56 of the Final Master Plan ***(Figure 44 in this Compiled Final Master Plan document)***, or similar connections constituting approximately the number and location of access points as shown in the Master Plan. During the review of all future buildings, Children's should evaluate that building's effect upon maintaining these connections. If Children's proposes to change the open space connections from surrounding streets from that shown on Figure 56 ***(Figure 44 in this Compiled Final Master Plan document)***, it shall first provide notice to DPD and DON, and formally review the proposed changes with the SAC.

11. The City's tree protection ordinance, SMC 25.11, applies to development authorized by this MIMP. In addition, to the extent feasible, any trees that exceed 6 caliper inches in width measured three feet above the ground and that are located within the Laurelon expansion area shall be used on Children's campus.

12. Children's shall amend Section V.D, "Parking" on page 104 of the Final Master Plan ***(Section V.B.2 "Parking" on page 80 of this Compiled Final Master Plan document)*** to add the following at the end of that subsection: "As discussed in the TMP, the forecasted parking supply including the potential leasing of off-site spaces, exceeds the maximum allowed under the Land Use Code. Therefore, if Children's continues to meet its Transportation Master Plan goals, the Master Plan authorizes parking in excess of the Code maximum to minimize adverse parking impacts in the adjacent neighborhood."

13. Children's shall amend Table 3 "Development Standard Comparisons" in the Master Plan ***(Table 3 "Development Standard Comparisons" in this Compiled Final Master Plan document)*** to be consistent with all modifications to development standards made by this decision.

14. Prior to the submittal of the first Master Use Permit application for Phase 1, Children's must draft a more comprehensive set of Design Guidelines for planned and potential structures, to be reviewed by the Seattle Design Commission and approved by DPD. The Design Guidelines are not a part of this approved MIMP, but shall be an appendix to the Master Plan, and shall address issues of architectural concept, pedestrian scale, blank wall treatment, tower sculpting, nighttime lighting, and open space and landscaping, among others.

15. Children's shall create and maintain a Standing Advisory Committee (SAC) to review and comment on all proposed and potential projects prior to submission of their respective Master Use Permit applications. The SAC shall use the Design Guidelines for their evaluation.

16. Prior to issuance of any MUP for any project under Phases 2, 3 and 4 of the Master Plan, Children's shall provide documentation to the Director and the SAC clearly demonstrating that the additional construction requested is needed for patient care and directly related supporting uses by Children's, including administrative support.

17. The TMP will be governed consistent with Director's Rule 19-2008, or any successor rules. In addition, Children's shall achieve a 30% SOV goal at full build out of the MIMP. The 30% SOV goal shall be achieved in increments, as Children's moves from its current 38% SOV mode split to the 30% goal at build out of the MIMP.

18. No portion of any building on Children's extended campus shall be rented or leased to third parties except those who are providing pediatric medical care, or directly related supporting uses, within the entire rented or leased space. Exceptions may be allowed by the Director for commercial uses that are located at the pedestrian street level along Sand Point Way Northeast, or within campus buildings where commercial/retail services that serve the broader public are warranted.
19. Before Children's may receive a temporary or permanent Certificate of Occupancy for any structure that is included in any phase of proposed development described on page 66 of the MIMP ***(page 56 in this Compiled Final Master Plan document)***, DPD must find that Children's has performed either of the following options:
    a. That Children's has submitted an application for a MUP for the construction of comparable housing, as defined below, in replacement of the housing demolished at Laurelon Terrace. In the event that Children's will construct more than one housing project to fulfill the housing replacement requirement, then Children's must have applied for a MUP for the first housing replacement project, which shall include no fewer than 68 housing units. A MUP application must be submitted for all of the remaining replacement units before a temporary or permanent certificate of occupancy may be issued for any project authorized in Phases 2-4 of the MIMP. The MUP application(s) for the replacement housing project(s) may not include projects that were the subject of a MUP application submitted to DPD before Council approval of the MIMP. Children's may seek City funds to help finance the replacement housing required by this condition, but may not receive credit in fulfillment of the housing replacement requirement for that portion of the housing replacement cost that is financed by City funds. City funds include housing levy funds, general funds or funds received under any housing bonus provision.
    b. That Children's has either 1) paid the City of Seattle $10,920,000 to help fund the construction of comparable replacement housing or 2) paid the City of Seattle 35% of the estimated cost of constructing the comparable replacement housing, as determined by DPD and the Office of Housing. In determining the estimated cost, DPD and the Office of Housing shall consider at least two development pro-forma, prepared by individual(s) with demonstrated expertise in real estate financing or development, and submitted by Children's. DPD and the Office of Housing's determination of the estimated cost is final and not subject to appeal. Money paid to the City under this option b shall be used to finance the construction of comparable replacement housing, as defined below, and subject to the provisions of the City's Consolidated Plan for Housing and Community Development and the City's Housing Levy Administrative and Financial Plan in existence at the time the City helps finance the replacement housing.

    For purposes of this condition 19, the comparable replacement housing must meet the following requirements:
    1) Provide a minimum of 136 housing units;
    2) Provide no fewer than the number of 2 and 3 bedroom units as those in the Laurelon Terrace development;
    3) Contain no less than 106,538 gross square feet;
    4) The general quality of construction shall be of equal or greater quality than the units in the Laurelon Terrace development; and
    5) The replacement housing will be located within Northeast Seattle. Northeast Seattle is bounded by Interstate 5 to the west, State Highway 520 to the south, Lake Washington to the east, and the City boundary to the north.
20. Children's shall develop a Construction Management Plan (CMP) for review and comment by the SAC prior to the approval of any planned or potential project discussed in the Master Plan. The CMP must be updated at the time of site-specific SEPA review for each planned or potential project identified in the MIMP. The CMP shall be designed to mitigate impacts of all planned and potential projects and shall include mitigating measures to address the following:
    a. Construction impacts due to noise

b. Mitigation of traffic, transportation and parking impacts on arterials and surrounding neighborhoods
c. Mitigation of impacts on the pedestrian network
d. Mitigation of impacts if more than one of the projects outlined in the Master Plan are under concurrent construction

21. Prior to the issuance of a Certificate of Occupancy for any project associated with development of Phase 1 of the MIMP, the proposed traffic signal at 40th Avenue Northeast and Sand Point Way NE shall be installed and functioning.

SEPA CONDITIONS

GEOLOGY

22. To minimize the possibility of tracking soil from the site, Children's shall ensure that its contractors wash the wheels and undercarriage of trucks and other vehicles leaving the site and control the sediment-laden wash water using erosion control methods prescribed as City of Seattle and King County best management practices for construction projects. Such practices include the use of sediment traps, check dams, stabilized entrances to the construction site, erosion control fabric fences and barriers, and other strategies to control and contain sediment.
23. Children's shall ensure that its contractors cover the soils loaded into the trucks with tarps or other materials to prevent spillage onto the streets and transport by wind.
24. Children's shall ensure that its contractors use tarps to cover temporary on-site storage piles.

AIR QUALITY

25. Prior to demolition of the existing housing units at Laurelon Terrace, Children's shall perform an asbestos and lead survey and develop an abatement plan to prevent the releases into the atmosphere and to protect worker safety.
26. During construction, Children's shall ensure that its contractors spray exposed soils and debris with water or other dust suppressants to reduce dust. Children's shall monitor truck loads and routes to minimize impacts.
27. Children's shall stabilize all off-road traffic, parking areas, and haul routes, and it shall direct construction traffic over established haul routes.
28. Children's shall schedule delivery of materials transported by truck to and from the project area to minimize congestion during peak travel times on adjacent City streets. This will minimize secondary air quality impacts otherwise caused by traffic having to travel at reduced speeds.
29. Children's shall ensure that its contractors cover any exposed slopes/dirt with sheets of plastic.
30. Around relevant construction areas, Children's shall install perimeter railings with mesh partitioning to prevent movement of debris during helicopter landings.

NOISE

31. Construction will occur primarily during non-holiday weekdays between 7:00 am and 6:00 pm, or as modified by a Construction Noise Management Plan, approved by DPD as part of a project-specific environmental review.
32. Children's will inform nearby residents of upcoming construction activities that could be potentially loud. Children's shall schedule particularly noisy construction activities to avoid neighborhood conflicts whenever possible.
33. Impact pile driving shall be avoided. Drilled piles or the use of a sonic vibratory pile driver are quieter alternatives.
34. Buildings on the extended campus are to be designed in such a way that noise received in the surrounding community is no greater than existing noise based on a pre-test of ambient noise levels and subsequent annual noise monitoring to be conducted by Children's.

TRANSPORTATION

35. Consistent with the Transportation Management Plan (TMP), onsite improvements shall include: a shuttle hub; an enhanced campus pathway to connect to transit along Sand Point Way Northeast and/or 40th Ave Northeast; and bicycle parking.
36. Consistent with the TMP, near-site improvements will include: working with Seattle Department of Transportation and Washington State Department of Transportation (WSDOT) to improve intersections such as Penny Drive/Sand Point Way Northeast and 40th Ave Northeast/Sand Point Way Northeast; improve connectivity between the Burke-Gilman Trail and Children's; enhance the Sand Point Way Northeast street frontage.
37. Consistent with the TMP, and as necessary to reduce future transportation impacts, Children's may provide off-site parking that reduces the level of required parking on site and reduces traffic on Northeast 45th St, Sand Point Way Northeast and Montlake Blvd/SR 520 interchange area.
38. Children's shall enhance its TMP to achieve a 30% single occupancy vehicle (SOV) mode split goal or lower.
39. Prior to the issuance of any construction permits for any project outlined in Phase 1 of the MIMP, Children's shall pay the City of Seattle its fair share to the future installation of traffic signals at 40th Ave Northeast/Northeast 55th St. Prior to the issuance of any construction permits for any project outlined in Phase 2 of the MIMP, Children's shall pay the City of Seattle its fair share, ~~based on the~~ [*sic*] to the future installation of traffic signals at 40th Ave Northeast/Northeast 65th St. These intersections shall be monitored by the Seattle Department of Transportation over the life of the Master Plan to determine the timing of the mitigation implementation.
40. Prior to the issuance of any construction permits for any project outlined in Phase 1 of the MIMP, Children's shall pay the City of Seattle $500,000 to build Intelligent Transportation System improvements through the corridor from Montlake Blvd/Northeast 45th St to Sand Point Way Northeast/Northeast 50th St. The contribution shall be used to fund all or part of the following projects:
    a. Install a detection system that measures congestion along southbound Montlake Boulevard, linked to smart traffic control devices that adapt to traffic conditions;
    b. Install variable message signs to give real-time traffic information for drivers, including travel time estimates, updates of collisions and other traffic conditions, and to implement variable speed limits throughout the day to keep traffic flowing as smoothly as possible;
    c. Optimize signal coordination and timing to move vehicles most efficiently and optimize signal performance;
    d. Upgrade signal controllers as needed to allow signals to be interconnected, and/or
    e. Install traffic cameras as identified by the City of Seattle
41. Children's shall pay the Seattle Department of Transportation (SDOT) a pro rata share of the Northeast Seattle Transportation improvement projects identified from the University Area Transportation Action Strategy, the Sand Point Way Northeast Pedestrian Study, and the City of Seattle Bicycle Master Plan. This amount is estimated at approximately $1,400,000 or approximately $3,955 per bed, over the life of the MIMP (adjusted for inflation as beds come online). Each pro-rata share payment shall be made prior to the issuance of any construction permits for the first project constructed under each phase of the MIMP. The total payment of $1,400,000 shall be completed by the issuance of any construction permit for a project outlined in Phase 4 of the MIMP.
42. Children's shall pay the Seattle Department of Transportation (SDOT) a total of $2,000,000 for pedestrian and bicycle improvements in Northeast Seattle over the timeframe of the Master Plan development. A pro-rata share payment shall be made prior to the issuance of any construction permits for the first project constructed under each phase of the MIMP. The total payment of $2,000,000 shall be completed by the issuance of any construction permit for a project outlined in Phase 4 of the MIMP.

G. STREET OR ALLEY VACATIONS

A vacation of the internal streets on the Laurelon Terrace site — 41st Avenue NE and NE 46th Street — is necessary in order to use this property for major institutional development. Children's has requested City Council approval of this vacation request.

See Figure 36, Street and Alley Vacation.

H. PLANNED AND POTENTIAL DEVELOPMENT

Based on planning done in 2007, Children's Phase 1 Bed Unit and Emergency Department facilities, straddling the Laurelon Terrace property and existing campus property, are designated as a planned physical development. Phases 2, 3 and 4 are designated as potential physical development.

See Figure 35, Proposed Phasing.

I. DECENTRALIZATION

Children's strategy is to decentralize its facilities and services wherever possible, providing pediatric specialty care at clinics throughout the region. This brings outpatient services to patients closer to where they live and reduces the number of outpatient-related vehicle trips to and from the hospital campus.

Children's currently operates regional clinics in Bellevue, Everett, Federal Way and Olympia; outreach clinics in Yakima, Wenatchee and Kennewick, Washington; and sites in Alaska and Montana. Children's has acquired 6.6 acres near downtown Bellevue for a new outpatient facility, expected to open in July 2010. Similar facilities are planned for Snohomish and South King counties. A regional clinic in the Tri-Cities area opened in May 2008.

Research functions have already been consolidated away from the hospital campus. Children's purchased research facilities and land in the Denny Triangle area of downtown Seattle with the expectation that it will develop 1.5 million gsf of research space.

As Children's continues its decentralization plan over the coming years, the percentage of vehicle trips to and from the existing hospital campus related to outpatient care will be reduced. This will enable facilities, transportation access and parking to be prioritized for inpatient care and related clinical support services.

Growth in Children's outpatient services locally and in the wider region as well as future research advances, is likely to result in increased demand for inpatient services at the hospital campus.

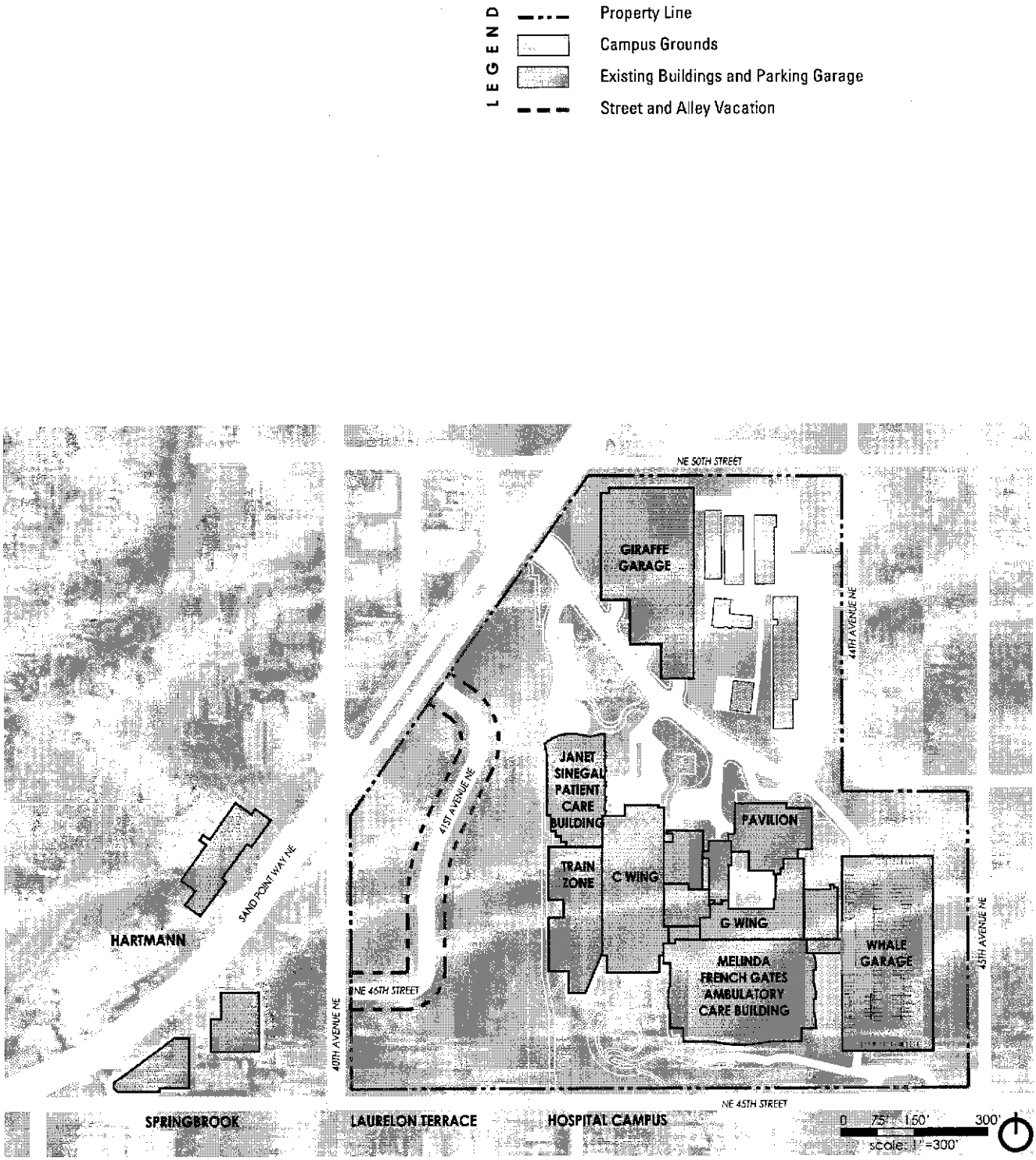
J. PURPOSE AND PUBLIC BENEFIT

As noted in the Executive Summary on page 7, Children's mission is that we believe all children have unique needs and should grow up without illness or injury. With the support of the community and through our spirit of inquiry, we will prevent, treat and eliminate pediatric disease. We provide an immeasurable public benefit to the City of Seattle, region and state of Washington by providing access to unique pediatric specialty care. To meet this commitment, we provided $65.4 million of uncompensated care in FY 2007, over $80 million in FY2008, and $96.4 million in FY2009.

K. DURATION OF MASTER PLAN

Children's Master Plan will remain in place until the allowed developable square footage is constructed.

FIGURE 36:
STREET AND ALLEY VACATION



IV. DEVELOPMENT STANDARDS

The development standards set forth in this Master Plan govern physical development within Seattle Children's MIO boundaries. As a supplement to the development standards, Children's Design Guidelines direct qualitative architectural and engineered design. (See Approved Design Guidelines in Appendix E.) These qualitative guidelines will direct design within the limits of the development standards to achieve the character envisioned for the campus.

The development standards and design guidelines are based on design principles identified during community meetings, Citizens Advisory Committee deliberations and Children's facility Master Plan programming.

A. DEVELOPMENT PRINCIPLES

The development standards and design guidelines in this Master Plan are based on the following design principles:

- Consolidate the footprint of the hospital to maximize the amount of open space around the campus.
- Set back higher buildings to the center of the campus and away from single-family residential areas.
- Build lower buildings at the perimeter that compliment the architecture of and provide transition to the adjacent neighborhood.
- Connect neighborhood pedestrian circulation to Children's campus while accommodating patient and family requirements for privacy and security.
- Provide amenities (e.g., bike storage, showers) that make commuting to Children's by means other than SOV the preferred choice of transportation.
- Enhance portions of the campus garden edge with desirable and usable places, benefiting patient care, caregivers and the surrounding neighborhood.
- Minimize exhaust, light and noise resulting from hospital operations.

See Figure 37, Examples of Well-Designed and Executed Development Prinicples.

B. SUSTAINABILITY AND ENVIRONMENTAL STEWARDSHIP

Children's believes that green buildings are healthier environments for their occupants, and building green is integral to the core mission of providing top-quality healthcare. Children's received the 2008 Governor's Award for Sustainable Practices. Children's demonstrates its continuing commitment to environmental stewardship through its successful Transportation Management Plan, its improvements to the environmental quality on campus, reduced energy use and conservation of natural resources. The hospital reduces the vehicle trips of patients and caregivers to and from the hospital by providing services at clinics throughout the region, bringing care closer to the communities where its patients live. Children's aggressive, Diamond-award–winning Commute Trip Reduction program minimizes the number of single-occupant vehicle trips by its staff.

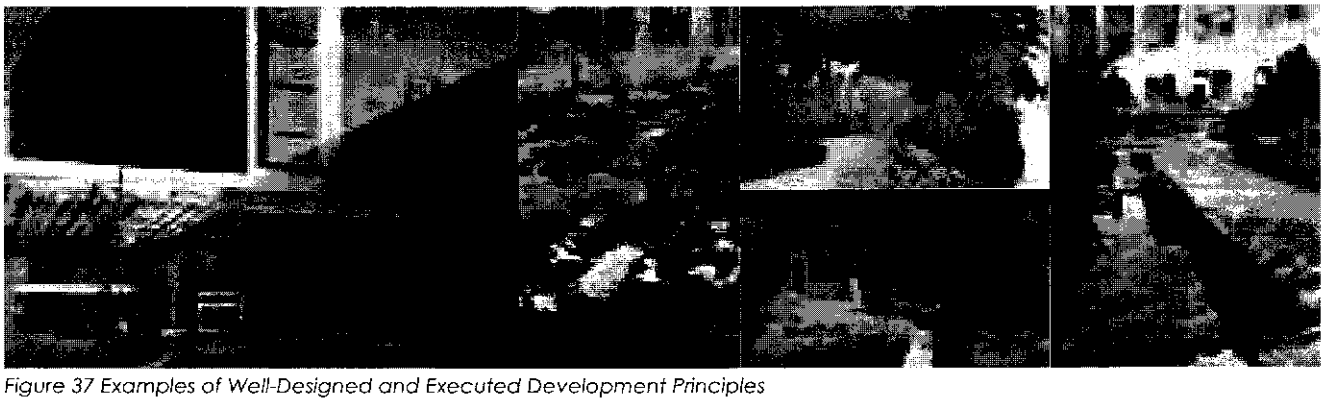


Figure 37 Examples of Well-Designed and Executed Development Principles

Through thoughtful, sustainable facility master planning, Children's future development will consider habitat, energy and water, which are essential to community design and reducing demand on the local infrastructure. These choices will contribute to a sustainable urban campus and, by extension, positively affect the community around it.

Children's is committed to following the principles and strategies in the Green Guide for Health Care™. This program describes the best-practice methods for hospital facility design, construction, facilities management and operations. Children's will use the Green Guide for Health Care™ during development of its Master Plan facilities. As a member of the Green Guide for Health Care's Executive Committee, Children's staff continues to review and help shape this national assessment tool. The U.S. Green Building Council's LEED for Health Care is currently under development and will build on and complement the Green Guide for Health Care™. Both provide a helpful framework for assessing success of ongoing greening efforts on Children's campus.

1. HOSPITAL CAMPUS GROUNDS AND FACILITIES

The existing campus has significant areas of impervious surfaces. To the extent feasible, future development of hospital grounds and facilities will be designed to protect existing tree canopy and landscaping; reduce impervious surfaces; and control, filter and reduce storm water runoff.

Large amounts of plantings shade some of the impervious areas and contribute to cooler areas on the campus. Vertical plantings on the perimeter of the campus are located to minimize views of the buildings and the light leaking off of the site into the surrounding neighborhood. This screen shields the hospital and, therefore, may minimize noise in the neighborhood associated with the hospital's operations.

Improvements to pedestrian pathways and linkages through and around the campus, as well as enhanced transportation management techniques, will support Children's Comprehensive Transportation Program to minimize trips to the site and reduce the carbon footprint, with improved access to transit and other modes of transportation.

To reduce the ecological footprint in the design of future hospital facilities, Children's will, at each phase of campus project development, consider specific sustainable design strategies and operational goals related to overall building performance, including energy use; greenhouse gas emissions; trip reduction and transportation choices; waste and recycling, potable water, impervious surface; and on-site storm water management.

2. SUSTAINABILITY GOALS FOR FACILITIES DESIGN, CONSTRUCTION AND OPERATIONS FOR NEW DEVELOPMENT

Children's will make meaningful performance efficiencies in the following areas as they relate to new development for facilities design, construction and operations:

- Adopt 2030 Challenge reduction in Green House Gas Emissions for new construction.
- Reduce BTU per square foot energy use of new building area over existing.
- Generate renewable energy on-site.
- Supply buildings' energy use purchased from off-site renewable green power sources.
- Use Green Roof Coverage.
- Purchase wood products used from certified sustainable forests.
- Increase the number of employees using alternatives to driving to work alone.
- Continue efforts to support visitors in their use of alternative transportation, e.g., transit, walking, shuttles, etc.
- Reduce construction waste; maintain high levels of demolition reuse and/or recycling.
- Employ operational recycling, solid waste diversion.
- Reduce potable water usage.
- Use locally sourced building materials.
- Purchase environmentally preferred, low V.O.C. products.

To monitor Children's projects, baseline measurements will be taken to allow for accurate comparison as the project progresses. These goals are aspirational and are not all presently achievable with today's technology. As the technology improves and becomes cost efficiently available, Children's will provide leadership in implementing its goals.

3. CHILDREN'S LEADS THE COMMUNITY IN CORPORATE ENVIRONMENTAL STEWARDSHIP

Children's is a member of the Mayor's Seattle Climate Partnership and will continue to advocate for reducing global greenhouse gas emissions with local and regional partners, as well as provide leadership in transportation alternatives and best management practices for lean-based sustainable measures consistent with heath care delivery and healthy environments.

C. UNDERLYING ZONING

The existing underlying zoning for Children's campus is Single Family 5000 (SF 5000) for the existing portion of the campus and Multi-Family Residential Lowrise 3 (L3) for Laurelon Terrace. In the 1994 Master Plan, MIOs of 37', 50', 70' and 90' were established on the existing campus. See Figure 33, Existing Zoning and Major Institution Overlay. The Master Plan revises the Major Institution Overlay for the entire campus and supersedes the requirements of the underlying zone development standards.

D. DEVELOPMENT STANDARDS

1. STRUCTURE SETBACKS

The above-ground structure setback standards will coincide with the depth of garden edges and street frontage edges. Above-ground development is expressly prohibited within the setback areas, as shown in Figure 38, except as otherwise allowed in the underlying zone.

The setbacks are measured from the existing property lines. A setback of 75 feet will start at the property line corner of 40th Avenue NE and NE 45th Street and extend east along NE 45th Street to 45th Avenue NE; then extending north along 45th Avenue NE to NE 47th Street; then west along NE 47th Street to 44th Avenue NE; at this corner, the existing 40-foot setback will be increased to 75 feet as it extends north along 44th Avenue NE to NE 50th Street; then it will extend west along NE 50th Street approximately 2/3 of the distance between 44th Avenue NE and Sand Point Way NE; at this point, the existing 20-foot setback will transition to a 40-foot setback as it extends west to Sand Point Way NE and then turns south along Sand Point Way NE to Penny Drive.

Along street frontage edges, structures will be located at a minimum setback of 10 feet along Sand Point Way NE from Penny Drive south to 40th Avenue NE. A minimum structure setback of 20 feet is proposed along 40th Avenue NE. The proposed setbacks will enable widened sidewalks with street trees and other pedestrian amenities.

Upper level setbacks 80 feet deep shall be applied to portions of buildings higher than 50 feet, along the western edge of the expanded campus on 40th Avenue NE from Sand Point Way NE south to NE 45th Street, and 30 feet deep on Sand Point Way NE from 40th Avenue NE to Penny Drive.

Below-grade structures will be allowed within setbacks in the garden edges and street frontage edges. Below-grade structure setbacks from the property lines will be zero.

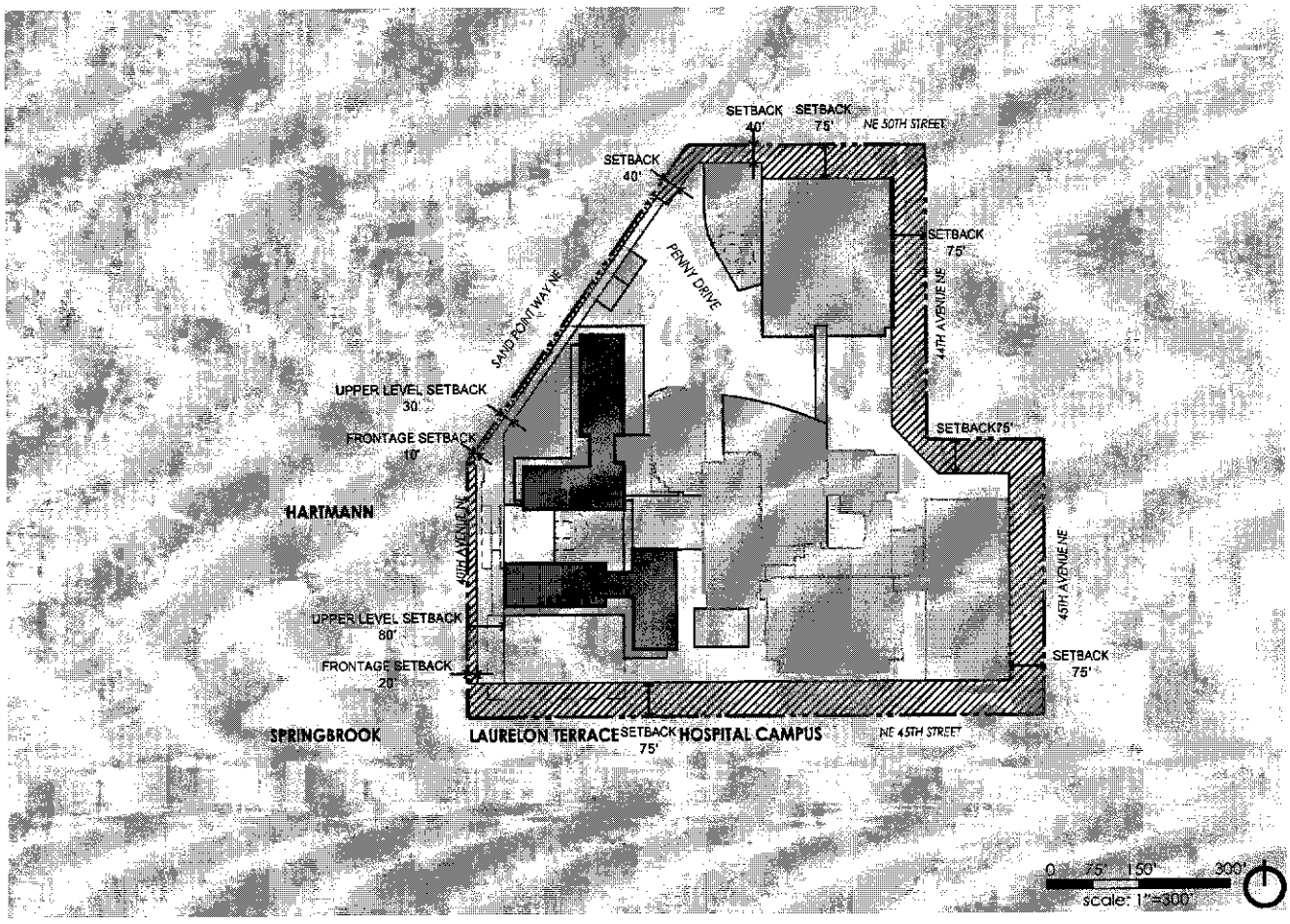
Any development standards for structure setbacks otherwise applicable in the SF or L3 zones are superseded by those in the Master Plan.

See Figure 38, Structure Setbacks.

2. MODIFICATIONS TO HEIGHT

Prior to the adoption of the new MIMP, the Children's campus included four height districts: MIO 37' around the periphery of the campus, MIO 50' along the south to form a transition to the MIO 70' and MIO 90' districts. The higher MIOs are centered at the core and southern parts of the campus and transition down to a lower height at the campus edges. The site generally slopes downward from east to west and from north to south. The existing buildings are approximately 20' from the northern property edge, 40' to 75' from the eastern property edge of the campus and also 40' on the west side of campus at the base of the slope. On the southern and southwestern edges, buildings are 75' from the property line. All of the setbacks are heavily landscaped to create a screen between the campus and surrounding neighborhood. Landscaping around the campus also provides open space and sidewalks as public amenities.

FIGURE 38:
STRUCTURE SETBACKS



In addition to the height limits shown in Figure 33, the Seattle City Council further conditioned the heights of two buildings on the campus in the 1994 Master Plan: the Janet Sinegal Patient Care Building and portions of the Melinda French Gates Ambulatory Care Building. The Janet Sinegal Patient Care Building is located in the MIO 90' area of the campus and was limited in height to 74', with an additional 15' allowed for mechanical equipment (a total of 89' with mechanical). The Melinda French Gates Ambulatory Care Building is located in an MIO 70' district. Portions of this building were limited in height to 54.5'.

The boundaries of the MIO districts have been expanded in the new Master Plan to include the Laurelon Terrace property. No more than 20% of the land area within the MIO, approximately 264,338 square feet, may include structures that exceed 90 feet in height. No more than 10% of the land area within the MIO, approximately 142,596 square feet, may include structures that exceed 125 feet in height. No structure in the MIO shall exceed 140 feet in height, excluding rooftop mechanical equipment. See Table 2 for a comparison of existing and future heights.

Any development standards for structure height otherwise applicable in the SF or L3 zones are superseded by those in the Master Plan.

Table 2. Modifications to the Underlying Zoning Heights

PROPERTY	PREVIOUS MASTER PLAN	NEW MASTER PLAN
Children's Campus – North of Penny Drive	SF 5000 with MIO of 37'	SF 5000 with MIO of 37' and 65'
Children's Campus – South of Penny Drive	SF 5000 with MIO of 37', 50', 70' and 90'	SF 5000 with MIO of 37', 50', 70' and 90' on the east, MIO of 37', 50', 70', 90' and 160'/140' and 160'/125' on the west
Laurelon Terrace	L3 Zoning	L3 with MIO of 37', 50' and 160'/140' and 160'/125'

3. LOT COVERAGE

The maximum lot coverage standard for the entire MIO district is 51%. The maximum lot coverage standard is calculated against the entire campus rather than against individual project sites. The existing campus-wide lot coverage is approximately 35%. See Table 3. Lot coverage is defined as that portion of a lot occupied by the principal structure and its accessory structures expressed as a percentage of the total lot area. Above-grade hand railings, sound- and view-blocking fences, surface parking, streets and sidewalks will not be considered structures for the purposes of lot coverage. Below-grade portions of buildings will not be counted as lot coverage. Any development standards for lot coverage otherwise applicable in the SF or L3 zones are superseded by those in the Master Plan.

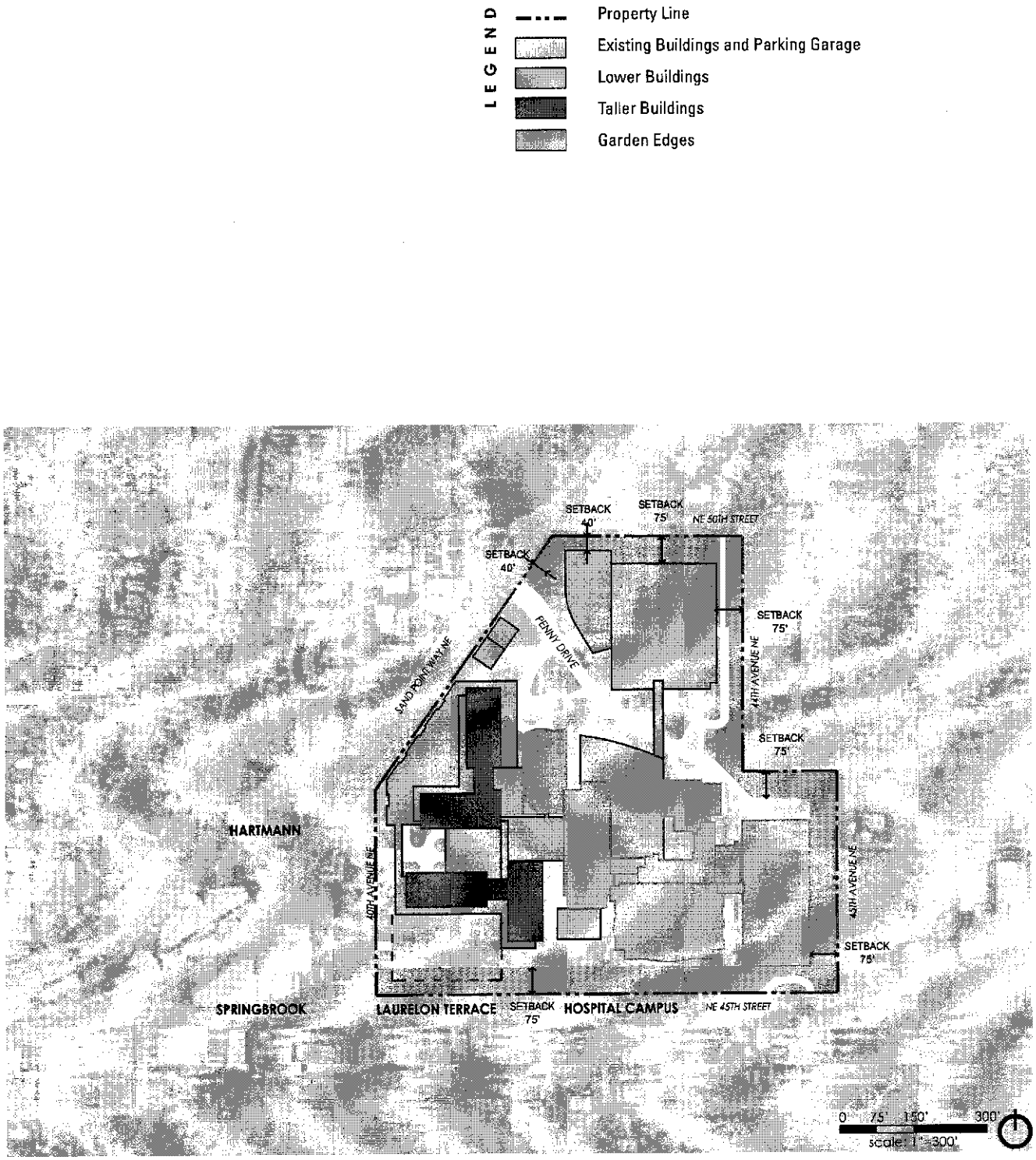
4. LANDSCAPING

Garden edges and street frontage edges will be landscaped and maintained to improve the visual quality of the streetscape, to buffer the visual impact of buildings and parking lots, to connect diverse architecture and land uses, and to promote attractive roadways and accommodate community activities around the campus. No above-grade buildings will be permitted in the setbacks; below-grade buildings, sidewalks, curb cuts and driveways, signs, fire hydrants, mailboxes, telephone poles, light poles and similar items may be permitted in the setbacks. Existing parking spaces within the garden edge may remain only until the new North Garage parking structure is available for occupancy. Existing paved roadways through and within the garden edge may remain in their present locations. Large, mature trees will be retained where possible.

The width of the garden edges and street frontage edges are described under "Structure Setbacks" in Part III D.1. On the north, the garden edge will increase from 20' to 40' and 75' in width. The east garden edge, now 40' and 75', will increase to 75' in width. The existing south garden edge of 75' will be retained on the existing campus, and a new garden edge of 75' will be added on the south side of Laurelon Terrace. See Figure 39, Future Landscaping, and Table 3.

Any development standards for landscaping otherwise applicable in the SF or L3 zones are superseded by the Master Plan.

FIGURE 39: FUTURE LANDSCAPING



5. PERCENTAGE OF MIO DISTRICT TO REMAIN IN OPEN SPACE

A minimum of 41% of the combined total area of the expanded campus shall be maintained as open space. In addition:

a. Open Space should be provided in locations at ground level or, where feasible, in other spaces that are accessible to the general public. No more than 20% of the designated 41% open space, shall be provided in rooftop open spaces;
b. Open Space areas shall include existing and proposed ground level setback areas identified in the Master Plan, to the extent that they meet the criteria in the approved Design Guidelines;
c. The location of open space, landscaping and screening as shown on Figure 39 of the Master Plan may be modified as long as the 41% figure is maintained;
d. To ensure that the 41% open space standard is implemented with the Master Plan, each planned or potential project should identify an area that qualifies as Open Space as defined in this Master Plan;
e. Open Space that is specifically designed for uses other than landscaped buffers or building setback areas, such as plazas, patios or other similar functions, should include improvements to ensure that the space contains Usable Open Space as defined under SMC 23.84A.028; and
f. Open space shall be designed to be barrier-free to the fullest extent possible.

The existing campus open space is 45% (see Table 3). Open space is defined as land and/or water area with its surface predominately open to the sky or predominately undeveloped, which is set aside to serve the purpose of providing park and recreation opportunities, conserving valuable natural resources and structuring urban development and form. Future open space will consist of plazas, gardens, courtyards and pathways to connect the campus with the surrounding public spaces and neighborhoods. Rooftop gardens and plazas that are accessible to the public will count as useable open space. Parking areas and driveways are not considered usable open spaces.

Any development standards for percentage of land to be retained as open space otherwise applicable in the SF or L3 zones are superseded.

6. HEIGHT AND SCALE TRANSITION

Transition in height and scale will be accomplished through the pattern of MIO district heights and other key design elements of the Master Plan. The greatest MIO heights will be located toward the center of the campus away from the single-family neighborhoods. On the north, east and south, the heights will transition down to the very generous setbacks that constitute the garden edges of the campus, where no above-grade buildings will be allowed. Along the active street frontage edges of Sand Point Way NE and 40th Avenue NE, the taller buildings will be terraced in order to reduce the visual bulk and height of the proposed buildings while maintaining low building frontage to allow transit-oriented hospital and neighborhood uses near the sidewalk. No structure in the MIO shall exceed 140 feet in height, excluding rooftop mechanical equipment.

Any development standards for height and scale transition otherwise applicable in the SF or L3 zones are superseded by the Master Plan.

See Figures 27 and 28 as well as Table 3.

7. WIDTH AND DEPTH LIMITS

The Master Plan allows for unlimited widths and depths of buildings. Along Sand Point Way NE and 40th Avenue NE, however, the effects of building bulk will be reduced by the following measures:

- Modulating the ground-level building façade
- Limiting the pedestal building height above grade to four stories
- Stepping back the building façade above four stories
- Applying upper level setbacks 80 feet deep to portions of buildings higher than 50 feet, along the western edge of the expanded campus on 40th Avenue NE from Sand Point Way NE south to NE 45th Street, and 30 feet deep on Sand Point Way NE from 40th Avenue NE to Penny Drive.

Any development standards for width and depth of buildings otherwise applicable in the SF or L3 zones are superseded by those in the Master Plan.

8. SETBACKS BETWEEN STRUCTURES

No setbacks between structures are required along interior campus property lines or along public right-of-ways or along the boundary of the MIO district for the campus. Instead of mandating specific setbacks and separation between structures, Children's Master Plan emphasizes perimeter setbacks. Children's is preserving and, in some cases, enhancing the width of the landscaped perimeter setbacks on the north, east and south of the campus. Setbacks between structures, however, remain an option and future project design will create building separation, open spaces, gardens and play areas. Any development standard for setbacks between structures otherwise applicable in the SF or L3 zones is superseded by those in the Master Plan.

9. PRESERVATION OF HISTORIC STRUCTURES

There are no structures designated on federal, state or local registers within the proposed MIO district.

10. VIEW CORRIDORS

The Master Plan contains no specific view corridors, but Children's has taken into consideration views from public spaces, rights-of-ways and adjacent properties, and has minimized the view impacts of its proposed development by a) moving the bulk of the facilities from the high ground on the existing campus to the lower-elevation Laurelon Terrace site, b) limiting building height exclusive of rooftop mechanical screening and equipment within MIO district boundaries, c) retaining generous buffers on the north, east and south edges of the existing campus and in some places increasing them, d) moving the tallest buildings to the west and away from the single-family neighborhood, e) committing to a fully designed streetscape on Sand Point Way NE and 40th Avenue NE, and f) committing to Phase 1 buildings on the Laurelon Terrace site that will be below the height limits allowed by the MIO 160'/140' and 160'/125' districts and by stepping back the faces of those buildings for each incremental increase in height. Any development standards for view corridors otherwise applicable in the SF or L3 zones (there are believed to be none) are superseded by the Master Plan.

11. PEDESTRIAN CIRCULATION

Streetscape and pedestrian amenity improvements will be provided around and across the campus. Improvements within the public right-of-way will conform to pedestrian and bike goals for residential areas around the garden edges of the campus and to goals for mixed-use commercial areas along the street frontage edges of the campus. Across the campus, pedestrian pathways will be a minimum of 4' wide and coordinate with the open spaces for the campus, with needed lighting and plantings, and conform to SMC 23.53.006, Pedestrian Access and Circulation. Any development standards for pedestrian circulation otherwise applicable in the SF or L3 zones (there are believed to be none) are superseded by the Master Plan.

12. DENSITY/FAR

The density allowed in the Master Plan, as defined by the total maximum developable gross floor area for the expanded MIO district, is 2.125 million square feet (excluding below-grade developable floor area, below-grade parking structures and rooftop mechanical equipment). This is the equivalent of a maximum floor area ratio (FAR) for the entire MIO district of 1.9. The existing campus FAR is approximately 0.9. The FAR is intended to be applied campus-wide and not to specific project sites. Any standards for density and FAR otherwise applicable in the SF or L3 zones are superseded by those in the Master Plan. See Table 3.

13. LIGHT AND GLARE

The previous Master Plan standards for light and glare will continue to be in effect in the new Master Plan. Those standards are as follows (see Table 3):

- Exterior lighting shall be shielded and directed away from adjacent properties.
- Interior lighting in parking garages shall be shielded to minimize nighttime glare on adjacent properties.
- Screening of vehicle lights from driveways to adjacent single-family properties and from parking areas to adjacent properties.

Any development standards for light and glare otherwise applicable in the SF or L3 zones are superseded by those in the Master Plan.

Table 3. Development Standards Comparison

	L3 ZONE	SF 5000	MASTER PLAN
STRUCTURE HEIGHT			
	Max 30'	Max 30', plus additional height of 1 foot for ea. 6% of slope on sloped lots	MIO'S 37', 50', 65', 70', 90', 160'/140' and 160'/125'
EXEMPTION FOR CAMPUS			
Mechanical Equipment	May extend 10' above max height; may cover 20% of roof if screened	May extend 10' above max height; may cover 20% of roof if screened	May extend 15' above max height; may cover 40% of roof if screened
LOT COVERAGE [1]			
	50% Max (town houses) 45% Max (all other structures)	35%	51%

	L3 ZONE	SF 5000	MASTER PLAN
STRUCTURE SETBACKS [2, 7]			
	5' to 15' (front) 15' to 25' (rear) 8' (side)	20' (front) 25' (rear) 10' (side)	10' along Sand Point Way NE from Penny Drive to 40th Ave NE, and 20' along 40th Ave NE to NE 45th St; 75' along NE 45th St, 45th Ave NE, NE 47th St, 44th Ave NE, and east 2/3 of NE 50th St; 40' along west 1/3 of NE 50th St and Sand Point Way NE to Penny Drive. Upper level setbacks 80 feet deep shall be applied to portions of buildings higher than 50 feet, along the western edge of the expanded campus on 40th Avenue NE from Sand Point Way NE south to NE 45th Street, and 30 feet deep on Sand Point Way NE from 40th Avenue NE to Penny Drive.
SETBACKS BETWEEN STRUCTURES			
	Average setback between facing facades 40' to 151' or more in length are 10' to 40'; minimum setback is 10'	NA	No setbacks between structures would be required along interior campus property lines, public right-of-ways, or along the boundary of the MIO district.
LANDSCAPING			
	Min area = 3' x length of all property lines = 7,869 SF	NA	75' along NE 45th St, 45th Ave NE, NE 47th St, 44th Ave NE, and east 2/3 of NE 50th St; 40' along west 1/3 of NE 50th St and Sand Point Way NE to Penny Drive. = 216, 755 SF
OPEN SPACE [3, 4, 5]			
	Min 25% of lot area; Max 1/3 of required open space can be roof gardens if required open space area increased to 30% of lot area	NA	12.27 acres or 41% of lot area
FAR (Floor Area Ratio) [6]			
	NA	NA	1.9
HEIGHT & SCALE TRANSITION			
	NA	NA	Transition in height and scale will be accomplished through tie pattern of MIO district heights, upper level setbacks along the western portion of campus and other key design elements of the Master Plan.

L3 ZONE		SF 5000	MASTER PLAN
WIDTH & DEPTH LIMITS			
	Maximum Building Width without Modulation: 30 feet; or 40 feet with a principal entrance facing a street; Max Building Width with Modulation: Apartments and ground-related housing (except townhouses), 75 feet; Max Building Depth: Apartments and ground-related housing including townhouses, 65% depth of lot.	NA	Unlimited dimensional limits, modulating the ground-level building façade, limiting the pedestal building height above grade to four stories, stepping back the building façade above four stories. Upper level setbacks 80 feet deep shall be applied to portions of buildings higher than 50 feet, along the western edge of the expanded campus on 40th Avenue NE from Sand Point Way NE south to NE 45th Street, and 30 feet deep on Sand Point Way NE from 40th Avenue NE to Penny Drive.
LIGHT & GLARE			
EXTERIOR			
	Exterior lighting shall be shielded and directed away from adjacent properties	Exterior lighting shall be shielded and directed away from adjacent properties	Exterior lighting shall be shielded and directed away from adjacent properties
INTERIOR			
	Interior lighting in parking garages shall be shielded to minimize nighttime glare on adjacent properties	Interior lighting in parking garages shall be shielded to minimize nighttime glare on adjacent properties	Interior lighting in parking garages shall be shielded to minimize nighttime glare on adjacent properties
Vehicle Lights			
	To prevent vehicle lights from affecting adjacent properties, driveways and parking areas for more than (2) vehicles shall be screened from adjacent properties by a fence or wall between five (5) feet and six (6) feet in height, or solid evergreen hedge or landscaped berm at least five (5) feet in height.	NA	Screening of vehicle lights from driveways to adjacent single-family and from parking areas to adjacent properties

Definitions:

1. "Lot coverage" means that portion of a lot occupied by the principal structure and its accessory structures are expressed as a percentage of the total lot area.
2. "Setbacks" means the required distances between every structure and the lot lines of the lot on which it is located. Also see "Upper level setbacks" below.
3. "Open space" means land and/or water area with its surface predominately open to the sky or predominantly undeveloped, which is set aside to serve the purposes of providing park and recreation opportunities, conserving valuable natural resources and structuring urban development and form. "Open space" includes "landscaped open space" and "usable open space."

4. "Open space, landscaped" means exterior space, at ground level, predominantly open to public view and used for the planting of trees, shrubs, ground cover and other vegetation.
5. "Open space, usable" means an open space that is of appropriate size, shape, location and topographic sitting so that it provides landscaping, pedestrian access or opportunity for outdoor recreational activity. Parking areas and driveways are not usable open spaces.
6. "FAR" means a ratio expressing the relationship between the amount of gross floor area permitted in a structure and the area of the lot on which the structure is located.
7. "Upper level setbacks" means the required distance between the lot line and the building façade applied only to portions of the building above a specified height.

E. APPLICABLE DEVELOPMENT STANDARDS

The development standards described in Parts III and IV of the Master Plan supersede the use and development standards currently found in the following portions of the Seattle Municipal Code (SMC): SMC Chapter 23.44 (Residential Single-Family), SMC Chapter 23.45 (Multi-family), SMC Chapter 23.55 (Signs); and, except as to the Sequoia tree grove on Hartmann, SMC Chapter 25.11 (Tree Protection).

F. DESIGN GUIDELINES

Children's Design Guidelines address issues of architectural concept, pedestrian scale, blank wall treatment, nighttime lighting, open space and landscaping, and other physical aspects of development. The Design Guidelines have been reviewed by the Seattle Design Commission and approved by DPD, and are included as Appendix E to this Compiled Final Master Plan. The guidelines will be used by the Standing Advisory Committee (SAC) during their review and evaluation of Children's development projects.

Future building designs are intended to enhance the experience of the hospital campus for both its users and neighbors. The Design Guidelines are intended to assist both Children's and the SAC achieve the desired character envisioned for the campus while harmonizing the hospital and surrounding neighborhood landscape and building forms.

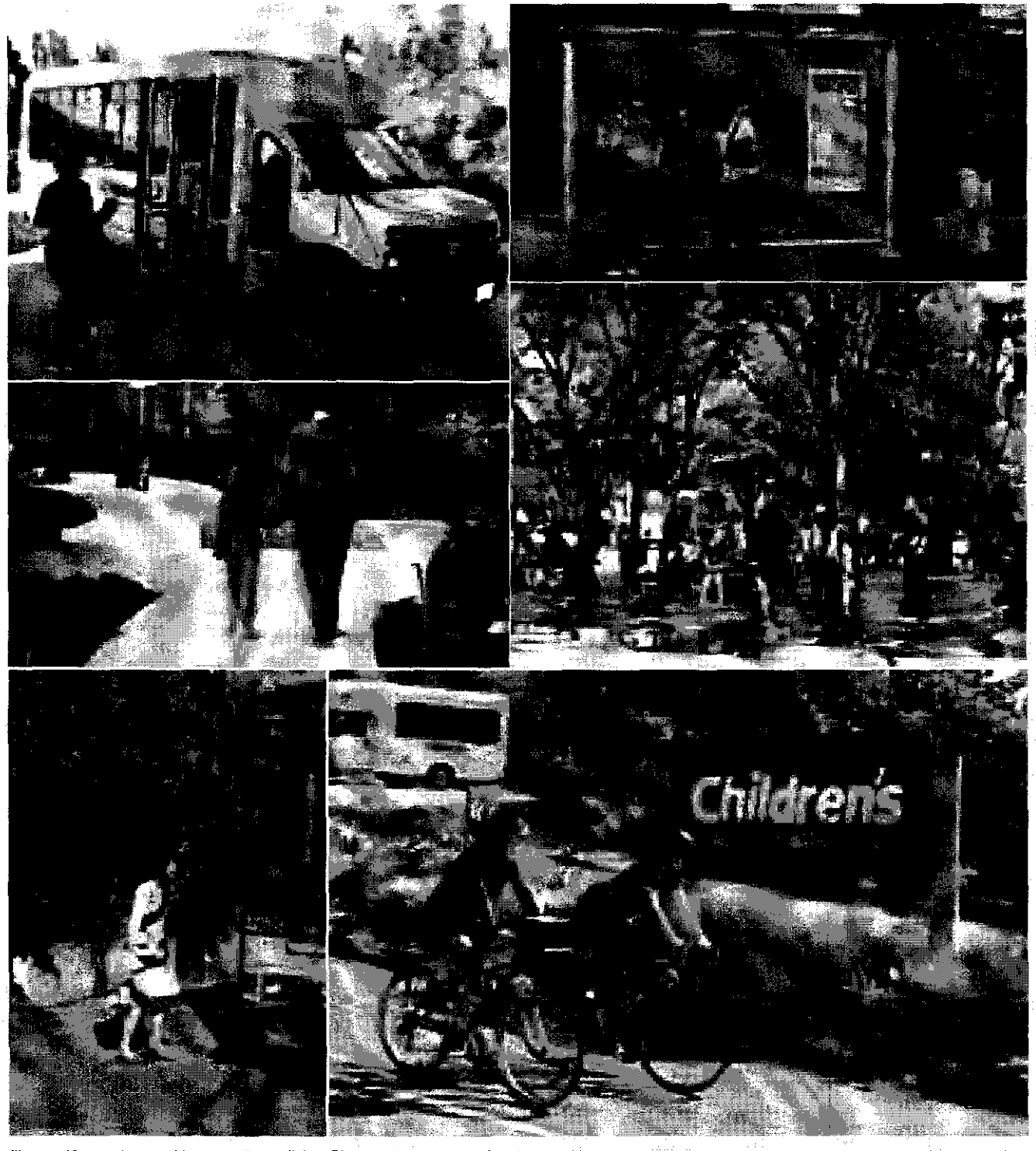


 Figure 40 Montage of Images Describing Planned Transportation Improvements

V. COMPREHENSIVE TRANSPORTATION MANAGEMENT PLAN

A. INTRODUCTION

Children's has long been recognized as a leader in Transportation Demand Management (TDM), receiving awards from the Governor's office, King County and the U.S. Environmental Protection Agency for its excellent commuter benefits and achievements in vehicle trip reduction. The hospital's programs to reduce drive-alone commuting and vehicle trips to the campus have resulted in a drive-alone rate of only 38% among daytime employees, down from 73% in 1995 as measured by a state-administered Commute Trip Reduction survey. This accomplishment is significant both for a hospital and for an employer located in a neighborhood with limited public transit service.

With the input of the Citizens Advisory Committee, SDOT and DPD, Children's developed a Comprehensive Transportation Plan (CTP) to focus on sustainable transportation programs. The CTP includes a Transportation Management Plan (per Code, Transportation Management Program) (TMP) to mitigate vehicle traffic related to MIMP expansion by shifting even more employees and visitors from single-occupancy vehicles (SOV) to bicycling, walking, shuttle and transit. In addition, the CTP goes above and beyond the traditional TMP elements by including a substantial investment in transportation infrastructure improvements outside the hospital campus.

The TMP enhancements described in this document, consisting of enhanced shuttle, bicycle and incentive programs, are expected to further reduce the percent of employees driving alone to work, leading to an SOV mode split of 30% or lower among daytime employees at MIMP build-out. For comparison, this meets or exceeds the 2020 goal of 70% non-SOV travel set for the University District Urban Village in the City of Seattle's Comprehensive Plan (see Appendix F for a complete discussion of the TMP enhancements and the methodology used to calculate the proposed TMP's SOV and vehicle trip reduction benefits).

See Figure 40, Montage of Images Describing Planned Transportation Improvements.

B. EXISTING AND PLANNED TRANSPORTATION SYSTEM

1. VEHICULAR ACCESS AND PARKING

EXISTING HOSPITAL CAMPUS ACCESS

Sand Point Way NE is the primary arterial serving Children's. The hospital campus entry is at the signalized intersection of Sand Point Way NE and Penny Drive. Most vehicle trips related to hospital operations use this access point to Penny Drive.

The second access point to the campus is a driveway from NE 45th Street near the southeast corner of the campus. This is a secured access point that is not available to the public. Service vehicles can enter the Whale Garage via a secured gate. In addition, an apron at this location allows Metro buses to lay over on Children's property. This entrance also provides access to a fire lane on the south side of the Melinda French Gates Ambulatory Care Building.

FUTURE HOSPITAL CAMPUS ACCESS

Two entrances will be located on 40th Avenue NE to serve the Emergency Department and the Southwest Garage. These two vehicle access and egress locations on campus will allow vehicles to be distributed more evenly on and around the campus, reducing congestion and vehicle conflicts with pedestrians, bikes and pedestrian access to transit service.

New signals or improvements to existing intersections will be made in cooperation with the City of Seattle's Department of Transportation to distribute peak demands from Children's while also enhancing safety and access for bicycles and pedestrians. The City of Seattle has a plan to install a traffic signal at Sand Point Way NE at 40th Avenue NE, Penny Drive. Limited emergency access, such as fire and rescue, will be provided for NE 50th Street.

EXISTING INTERNAL CIRCULATION

Penny Drive distributes vehicles to all parking areas, entry points and loading docks. The roadway has two through-lanes with a two-way center turn lane and 10-mph speed limit. At-grade crosswalks are located along Penny Drive, connecting the parking and campus facilities areas to the north with the primary hospital areas to the south.

FUTURE INTERNAL CIRCULATION

Penny Drive will continue to distribute vehicles to the north parking areas, entry points and loading docks. The roadway has two through-lanes with a two-way center turn lane and 10-mph speed limit. At-grade crosswalks are located along Penny Drive, connecting the parking and campus facilities areas to the north with the primary hospital areas to the south.

2. PARKING

EXISTING PARKING

Children's currently provides 1,462 parking spaces on campus.

The existing 728-space Giraffe Garage provides parking for patients, visitors, staff and physicians. The garage has four levels, which are not currently interconnected with ramps between floors; direct access to each level is via separate garage entrances off Penny Drive. The Giraffe Garage is located on Penny Drive across from the hospital. ADA-accessible parking is located at the Janet Sinegal Patient Care Building entry plaza.

The existing 608-space three-level Whale Garage serves the main entrance of the Melinda French Gates Ambulatory Care Building and provides direct access to ADA-accessible parking. Automobile access to the Whale Garage is primarily from Penny Drive, although a secured service access is located off NE 45th Street.

Parking for the Emergency Department is provided by 126 surface parking spaces, which also accommodate patient/family motor homes and other visitors. The number of surface parking spaces has been reduced due to interim modular office units and landscape maintenance operations.

See Figure 41, Existing Transportation and Parking.

FUTURE PARKING

Traffic generated by 600 pediatric beds at Children's would require 3,600 parking spaces. The Comprehensive Transportation Plan will reduce that demand by 500 spaces, leaving a parking need of 3,100 spaces. The Master Plan parking would provide up to 3,100 spaces on-campus at full campus buildout.

As necessary to mitigate future impacts, Children's may identify 100 to 200 out-of-area, off-site parking spaces as part of its Comprehensive Transportation Plan. This plan could further reduce the amount of parking needed on campus and result in significantly reduced impacts on the transportation system near campus. Every 100 parking spaces located off-site and out of the area would reduce impacts near campus by 5%. For more information on the off-site parking plan and its impacts, see Appendix F and the Environmental Impact Statement.

The full on-campus parking demand alternative calls for a new 1,392-space North Garage, which will be built on the northeast corner of the property. The parking levels of the proposed garage will align with floors of the current Giraffe Garage, which will be connected by an internal ramp and circulation system. Another 1,100 spaces will be located in a new Southwest Garage.

As discussed in the TMP, the forecasted parking supply, including the potential leasing of off-site spaces, exceeds the maximum allowed under the Land Use Code. Therefore, if Children's continues to meet its Transportation Master Plan goals, the Master Plan authorizes parking in excess of the Code maximum to minimize adverse parking impacts in the adjacent neighborhood.

See Figure 42, Planned Transportation and Parking.

3. LOADING AND SERVICE FACILITIES

EXISTING DELIVERIES AND SERVICE TRAFFIC

Most deliveries are handled at two separate loading docks, one for general receiving and one specifically for food deliveries. Neither loading dock is configured to allow larger trucks to turn around. Therefore, most delivery and service vehicles must back in from Penny Drive. See Figure 41, Existing Transportation and Parking.

FUTURE DELIVERIES AND SERVICE TRAFFIC

Deliveries on the main campus will be consolidated into one loading dock for general receiving and one for food deliveries. An additional, secondary loading dock is planned for the Laurelon Terrace site to provide service to buildings built on that portion of the campus. See Figure 42, Planned Transportation and Parking.

C. EXISTING AND PLANNED SHUTTLES AND TRANSIT

EXISTING SHUTTLES

Shuttles provide access to Children's off-campus parking as well as off-campus work locations, and operate from 5:30 a.m. to 9 p.m., Monday through Friday. During peak commuting hours, two shuttles serve each lot; during off-peak commuting hours, a single shuttle serves each lot. On campus, the Children's shuttle drops off shuttle riders at the Giraffe Entrance.

Frequent weekday shuttle service is provided to off-campus parking locations. Shuttles also serve inter-facility transportation needs between Children's main campus and other Children's facilities in Seattle. The service reduces traffic and parking congestion. A third shuttle runs every hour to Children's research facility in downtown Seattle. The Seattle Cancer Care Alliance (SCCA) shuttle runs every 40 minutes to the University of Washington, where it connects to service to the SCCA in South Lake Union. Guest Services transportation is provided to patients and families via a separate fleet of ADA-equipped vehicles.

See Figure 41, Existing Transportation and Parking.

EXISTING TRANSIT

The hospital campus is served by Metro Transit routes #25 and #75. In anticipation of Children's new Master Plan expansion, Children's partnered with Metro to have both routes enhanced in fall 2007 in an effort to reduce single-occupant vehicle use to the hospital. This $250,000-per-year investment provides service at least every 30 minutes on route #75 throughout the entire service time span, enhancing service greatly during shift-change times. The #75 serves the main entrance of the campus on Sand Point Way NE. Sheltered bus stops are located in both the northbound and southbound directions, and an ADA-accessible ramp system provides access from Sand Point Way NE to the Giraffe Entrance.

The #25 serves the secondary access point of the campus along NE 45th Street. A single, sheltered bus stop on Children's property serves both incoming and outgoing trips. A covered, ADA-accessible walkway through the Whale Garage provides access to the Whale Entrance.

See Figure 41, Existing Transportation and Parking.

FUTURE TRANSIT AND SHUTTLE BUSES

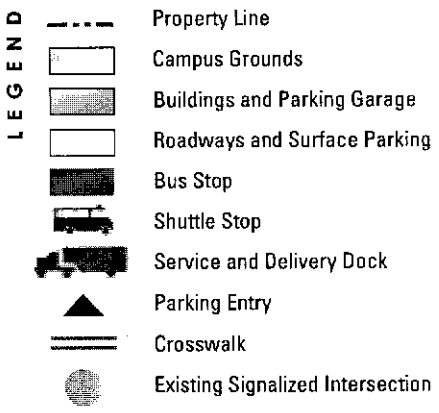
The Master Plan allows for the development of a high-quality transit center on both sides of Sand Point Way NE at 40th Avenue NE, in front of the hospital and the Hartmann property. Currently, there are no shelters at the transit stops in this location and the crossing is extremely dangerous, forcing some transit riders to dart across four lanes of traffic to reach their destination.

The transit center will bring benefit to the surrounding community as well as provide easy access for commuters and visitors to the hospital's "front door" on 40th Avenue NE and Sand Point Way NE. The transit center will be served by a safe and attractive covered waiting area for both public transit and shuttles.

Four to six bays, two to three on each side of Sand Point Way NE, will create a welcoming and dry location for neighborhood commuters and Children's staff to catch transit and shuttles. Coordination with Metro will occur to design the transit stops.

See Figure 42, Planned Transportation and Parking

FIGURE 41: EXISTING
TRANSPORTATION AND PARKING



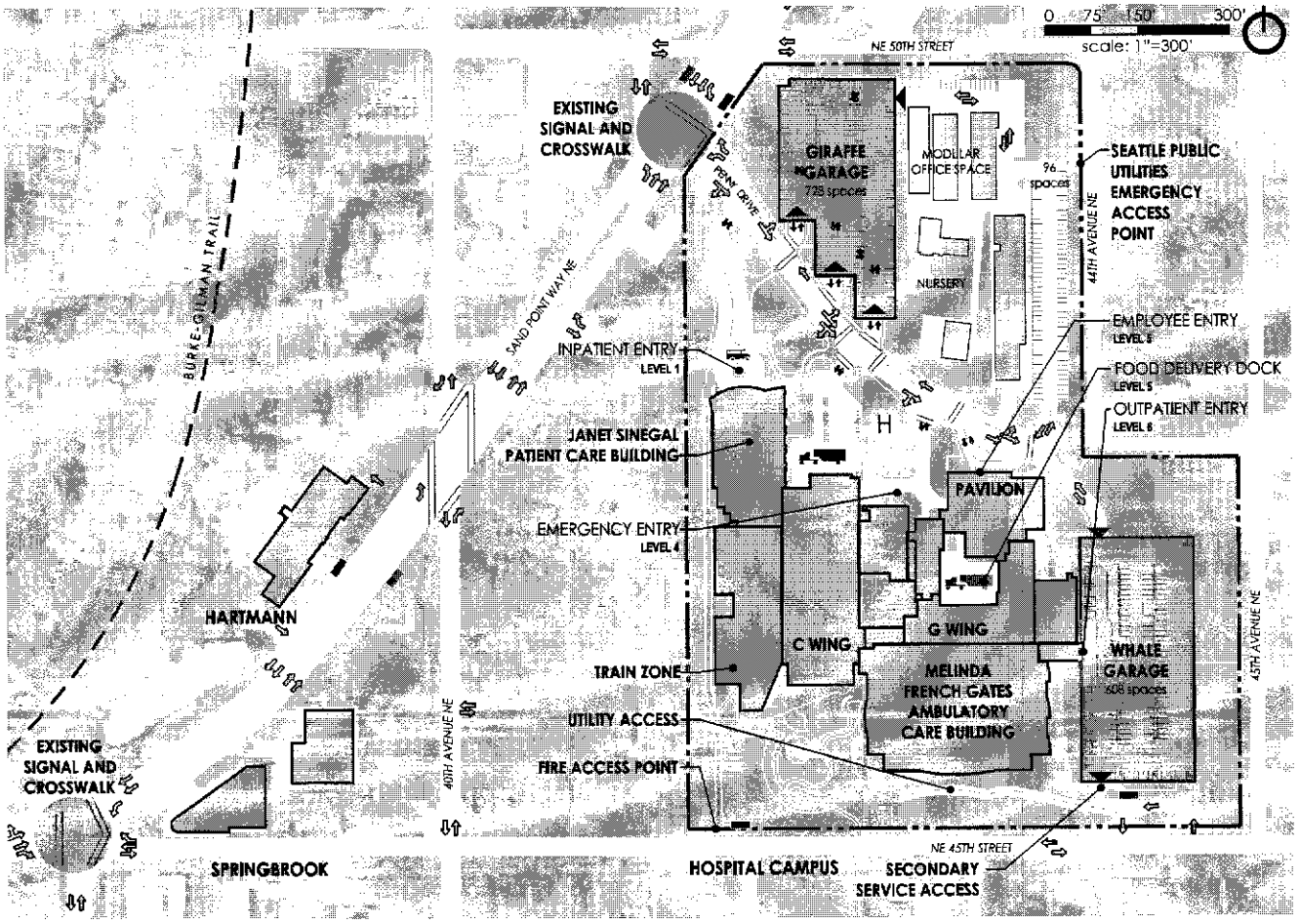
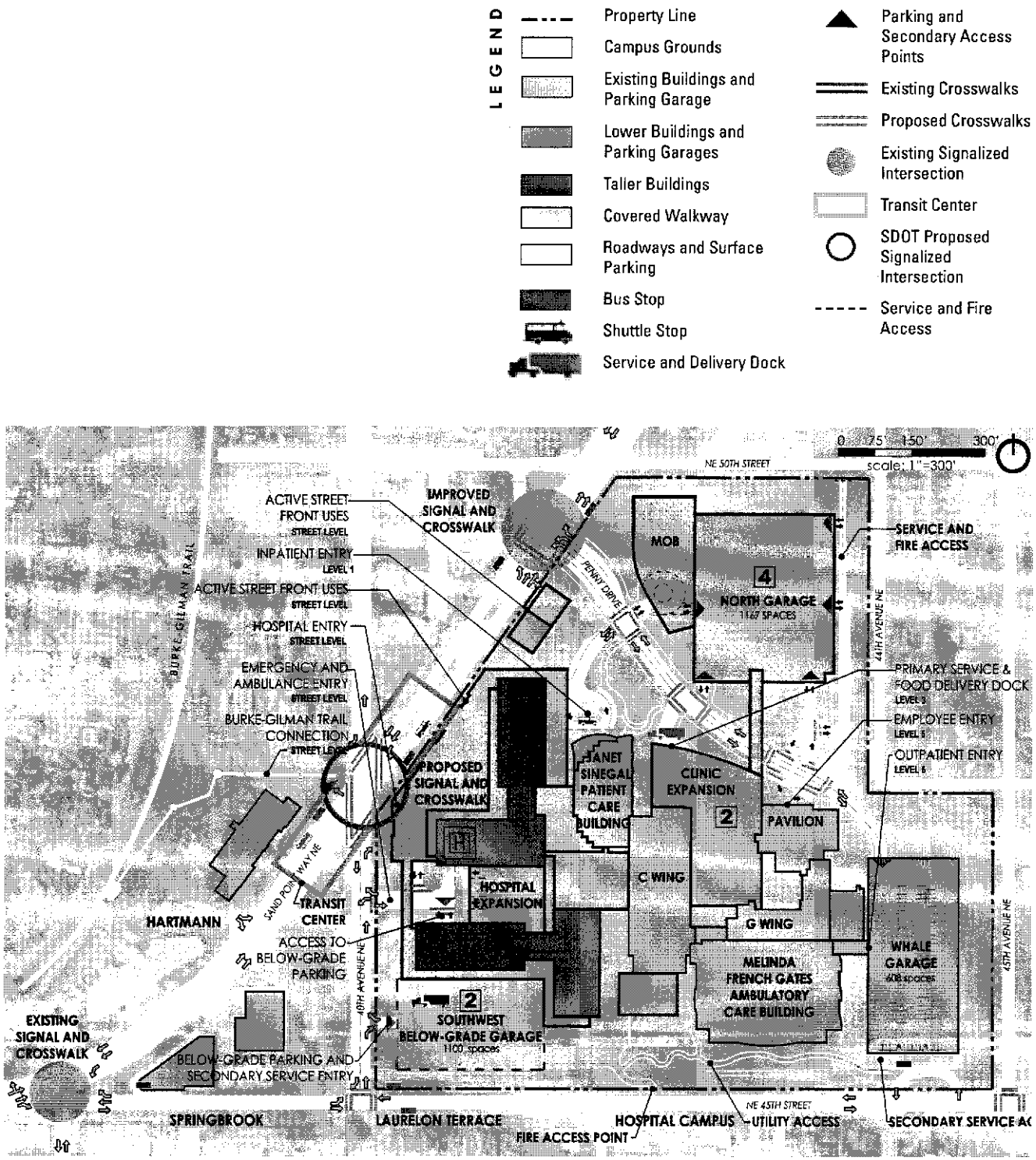


FIGURE 42: PLANNED
TRANSPORTATION AND PARKING



D. EXISTING AND PLANNED NONMOTORIZED CONNECTIONS

1. EXTERNAL PEDESTRIAN AND BICYCLE ACCESS

EXISTING PEDESTRIAN AND BICYCLE ACCESS

The primary pedestrian entrance is from Sand Point Way NE.

There are three pedestrian access points off NE 45th Street. The primary pedestrian access point is at the bus stop and layover area, which provides access to the Whale Entrance, sculpture garden and a courtyard. Another is via a secured gate into the outdoor play area. The third is the pathway described previously, which connects NE 45th Street with a stairwell to the Giraffe Entrance. None of these are ADA-compliant routes.

The primary bicycle entrance is from Sand Point Way NE via Penny Drive. Bicyclists can access covered, secured bicycle parking in each level of the Giraffe Garage, or open bicycle racks at nearly every entrance of the hospital. Bicycles also access the campus via a secured gate on NE 45th Street, behind which is a long-term bicycle storage area. Cyclists have access to showers and lockers in the Melinda French Gates Ambulatory Care Building as well as the modular buildings north of Penny Drive.

EXISTING OFF-CAMPUS PEDESTRIAN AND BICYCLE FACILITIES

There are no sidewalks on the east side of Sand Point Way NE between NE 50th Street and 47th Avenue NE. There are also no sidewalks in either direction along NE 50th Street between 41st Avenue NE and 40th Avenue NE. The Hartmann property frontage, including the bus zone for route #75, does not have sidewalks.

The Burke-Gilman Trail is located two blocks west of Children's campus. The trail access point closest to the hospital campus is a short trail spur that leads to a dead-end portion of NE 50th Street. There is no marked bicycle route between this access point and Sand Point Way NE. Due to the slope of 40th Avenue NE and parked cars in violation of the 30-foot restriction from the corner of NE 50th Street, cyclists crossing 40th Avenue NE have limited visibility to traffic in both directions. Cyclists must then cross two lanes of traffic on Sand Point Way NE to reach the left turn lane into Penny Drive. As an alternative, some cyclists ride down 41st Avenue NE and use the crosswalk to cross Sand Point Way NE.

See Figure 43, Existing Nonmotorized Connections.

FUTURE PEDESTRIAN AND BICYCLE ACCESS

Making nonmotorized transportation safe, attractive and time-competitive with SOV travel is a guiding principle of the Children's Transportation Plan. Nonmotorized solutions include clear, safe pedestrian routes from nearby neighborhoods, transit and shuttle stops, end-of-trip amenities such as bicycle racks and showers for cyclists and walkers, and safe and intuitive connections between buildings and parking garages.

The pedestrian focus of the expanded campus will be along Sand Point Way NE and 40th Avenue NE. The Master Plan will provide pedestrians and bicyclists with a "front door" on 40th Avenue NE and Sand Point Way NE and will eliminate the hill climb on Penny Drive.

The City's planned installation of a signalized intersection along Sandpoint Way NE at 40th Avenue NE, with a pedestrian-only phase, would add another pedestrian crossing, making Sand Point Way NE safer and more convenient to cross. This will provide a direct bicycle and pedestrian connection between the hospital campus, the Laurelhurst neighborhood and the Burke-Gilman Trail, as a new connection to the Burke-Gilman Trail will be made along the north boundary of the Hartmann property, within the applicable zoning constraints.

On the north side of the campus, a pedestrian path will connect Penny Drive through the Laurelon Terrace property to 40th Avenue NE, along Sand Point Way NE. A new entrance along Sand Point Way NE near 40th Avenue NE will provide convenient access to transit and shuttle users and those using the new parking structure. The proposed Emergency Department will have similar convenience along 40th Avenue NE.

The addition of bicycle route signs and pavement markings, such as bike lanes or sharrows, will enhance wayfinding between the hospital campus, the Laurelhurst neighborhood and the Burke-Gilman Trail will improve bicycle access.

See Figure 44, Planned Nonmotorized Connections.

2. INTERNAL PEDESTRIAN ACCESS

EXISTING INTERNAL PEDESTRIAN ACCESS

From the main pedestrian access point on Sand Point Way NE, a ramp provides an ADA-accessible route to the Giraffe Entrance for pedestrians. A pedestrian pathway crosses the campus from NE 45th Street to Sand Point Way NE. Other pedestrian access points along the eastern perimeter lead to parking lots and do not follow contiguous pathways to Penny Drive or to a main building entry.

The primary pedestrian access point along NE 45th Street from the bus stop provides access to the Whale Entrance, sculpture garden and a courtyard. Another is via a secured gate to the outdoor play area. The third is the pathway described previously, which connects NE 45th Street with a stairwell to the Giraffe Entrance. None of these are ADA-compliant routes.

There are four pedestrian crossings of Penny Drive between the parking areas on the north and the hospital buildings on the south. All are surface level crossings with some areas of limited line of sight from drivers rounding the curves of Penny Drive. These crossings direct patients, staff and visitors to the entries of the Giraffe building, Emergency Department and Pavilion building.

FUTURE INTERNAL PEDESTRIAN ACCESS

The Master Plan will provide enhanced crossings of the campus through a system of gardens, courtyards and plazas. The pedestrian pathways through the campus could connect other park and garden spaces in the community.

Access between the proposed North Garage and the hospital will be consolidated at two locations, where Helen Lane is realigned, and at the new clinical entry in front of the Pavilion. ADA-compliant crossings of Penny Drive will be made at these locations. The pedestrian movements at these crossings will be safer, as there will be fewer crossings and they will be better coordinated with planned vehicle movements. Elevated walkways and tunnels may also be developed.

On the west side of the existing hospital campus, a pedestrian path will be retained between the development on Laurelon Terrace and that on the hospital campus at a new elevation of EL. 92. This will provide access across the middle of the campus in the north-south direction. It will distribute visitors to the rooftop gardens built atop buildings on Laurelon Terrace.

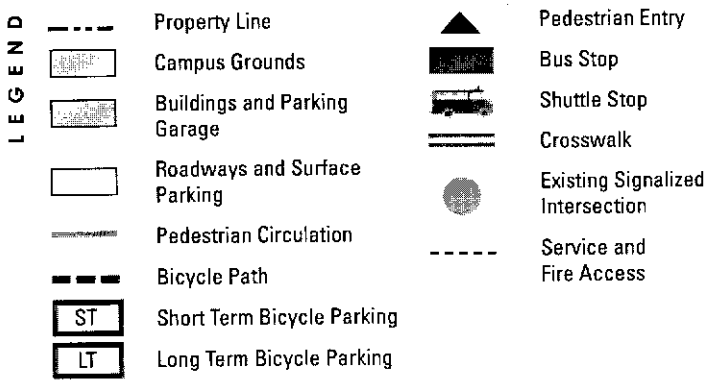
The pedestrian system could connect across the proposed signalized intersections along Sand Point Way NE, through the campus and up toward 45th Avenue NE, 47th Avenue NE and 50th Avenue NE.

Pedestrian pathways will be designed to make it easier for neighbors to access and, where appropriate, to cross the campus. The design of these facilities will include wayfinding signage. Design of pedestrian and green space areas on campus will include accepted national standards for public safety, such as Crime Prevention Through Environmental Design (CPTED).

Walking and ADA access between this lower campus and the upper campus to the east will be made through interior corridors, stairs and elevators as well as potentially exterior stairs and ramps. The rooftop gardens at the EL. 92 level may allow a pedestrian path around the perimeter of this area of the building. From here, access to public gardens and buildings will occur, connecting Helen Lane to 42nd Avenue NE to the south.

See Figure 44, Planned Nonmotorized Connections.

FIGURE 43: EXISTING
NONMOTORIZED CONNECTIONS



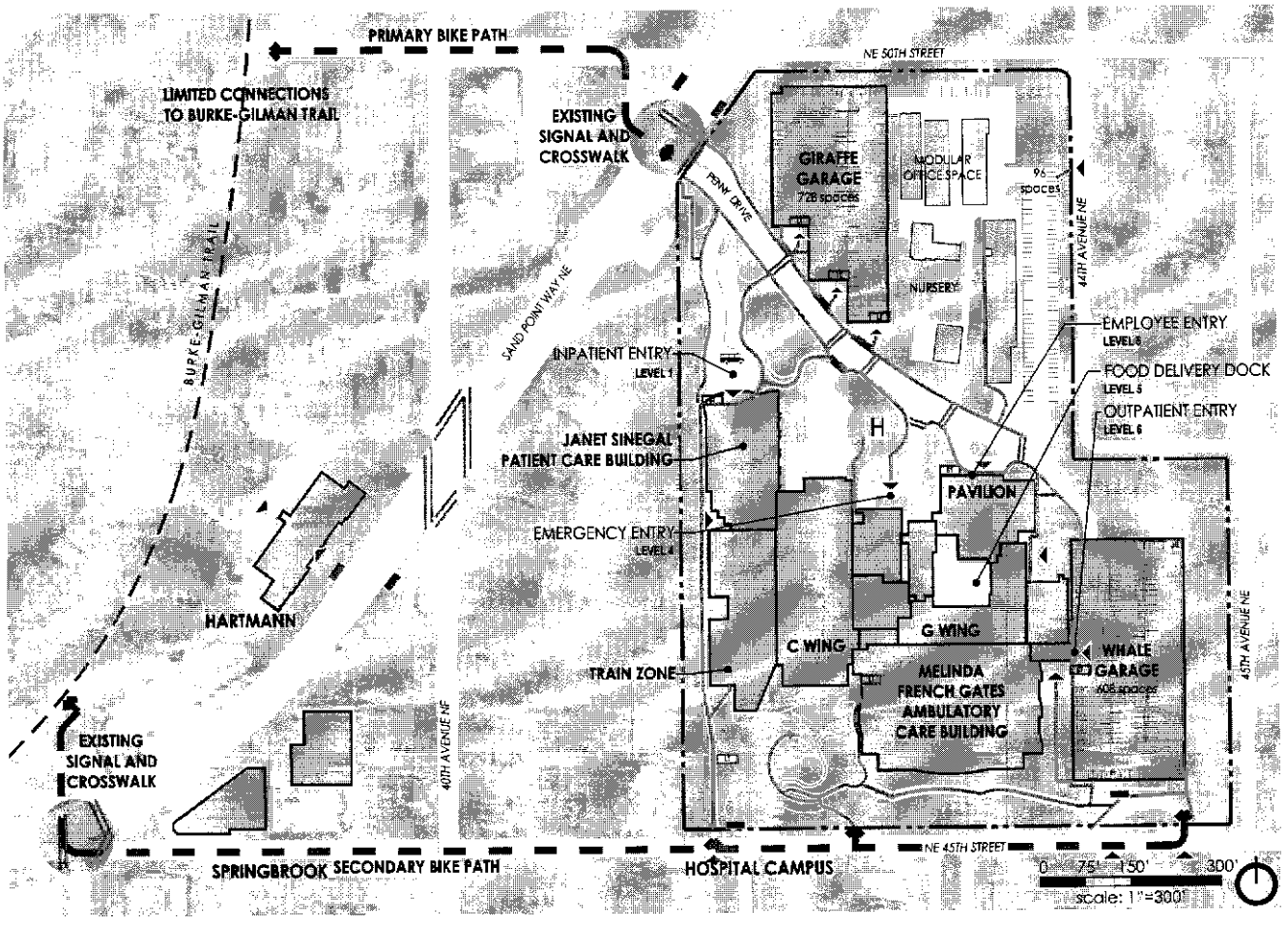
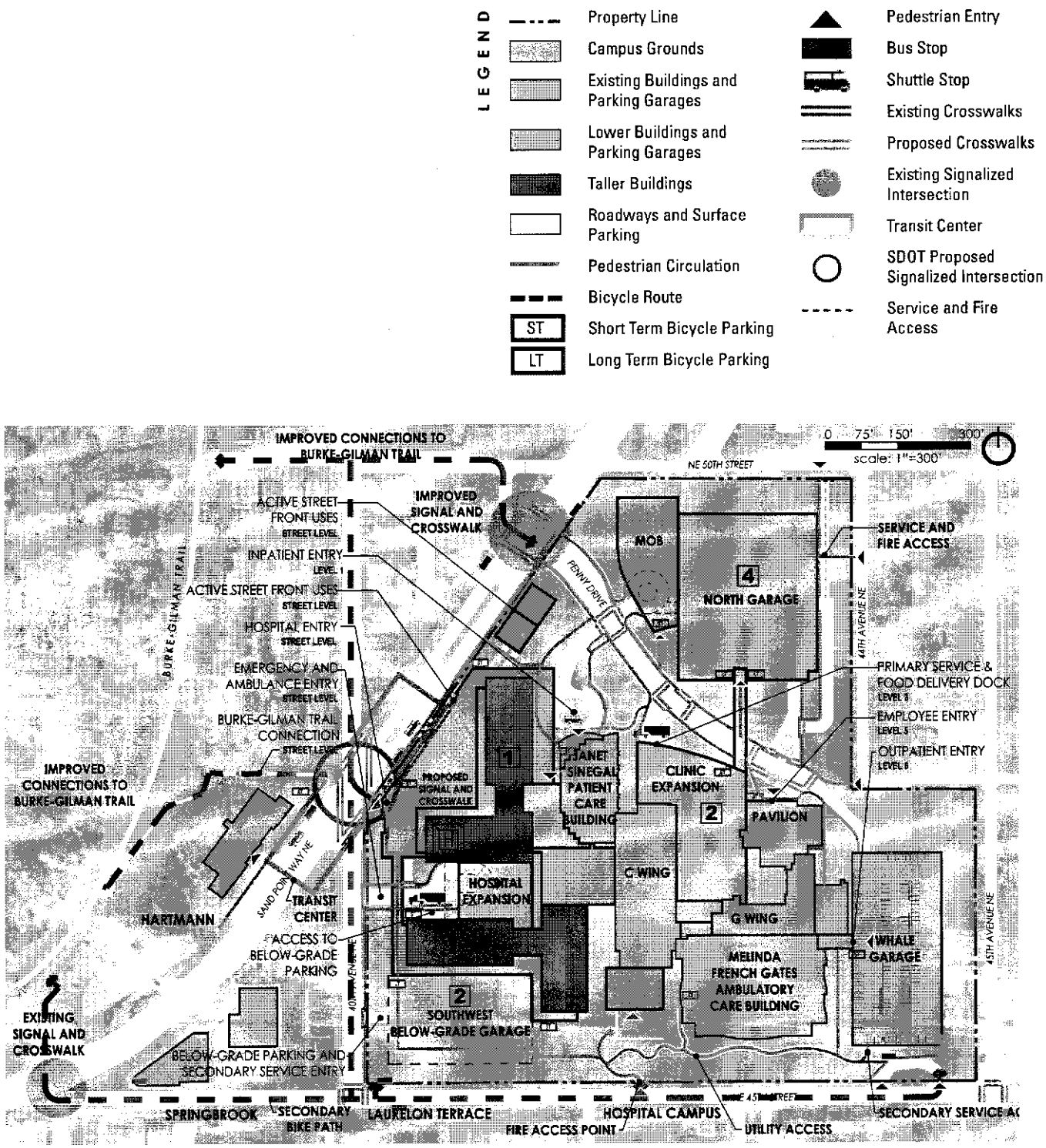


FIGURE 44 : PLANNED
NONMOTORIZED CONNECTIONS



E. PROGRAMS TO REDUCE TRAFFIC IMPACTS AND ENCOURAGE USE OF ALTERNATIVES TO SINGLE-OCCUPANT VEHICLES

Children's is committed being a leader in sustainable transportation programs. Through the CTP, the hospital will mitigate vehicle traffic related to MIMP expansion by shifting even more employees and visitors from single-occupant vehicles (SOV) to biking, walking, shuttle and transit. The CTP will allow Children's to:

- Achieve a 30% SOV rate, matching the 2020 mode share goal set by the City of Seattle comprehensive plan for the University District.
- Reduce the number of parking spaces needed on campus by 500.
- Reduce vehicle miles traveled, and thus reduce the resulting greenhouse gas emissions that would otherwise be generated with no further mitigation measures beyond Children's 2007 TMP.

For more detailed information on Children's Comprehensive Transportation Plan, please refer to Appendix F.

The first three elements of Children's CTP represent major enhancements to programs in the TMP. The balance of the CTP consists of five new elements that go beyond the measures usually associated with a TMP.

1. ELEMENTS 1-3: ENHANCED TRANSPORTATION MANAGEMENT PLAN

Children's proposed enhanced policies and programming for its TMP include expanding its Transportation Demand Management incentives and extending Children's shuttle system to offer new commute alternatives. These TMP enhancements will achieve a 30% SOV mode split or lower at full Master Plan buildout among existing and future employees, as measured under applicable TMP requirements. Modeling indicates that the enhanced TMP and its associated SOV mode split is expected to result in a 36% reduction in net new PM peak-hour vehicle trips, reducing what would otherwise be additional peak-hour vehicle traffic generated by the MIMP expansion. The level of additional investment in shuttles and other elements of the TMP is a significant commitment and represents additional costs on the order of several million dollars annually, in addition to capital expenditures.

The three enhanced Transportation Management Plan elements are listed below.

Tables 4, 5, 6 and 7 describe the enhancements proposed for Children's Transportation Management Plan. Plan elements will be monitored and adjusted, as necessary and appropriate, to optimize the outcome in the most cost-effective manner.

(1) ROBUST SHUTTLE-TO-TRANSIT SYSTEM LINKING CHILDREN'S TO REGIONAL TRANSIT HUBS
Children's expanded shuttle system is designed to increase the number of employees who use transit by providing frequent and convenient service between Children's and regional transit hubs, including the Downtown Transit Tunnel and 3rd Avenue corridor, Campus Parkway in the University District, the Montlake Flyover stop at SR-520, and park-and-ride locations in south Snohomish County during later phases of development.

Expected outcome: 19% reduction in net new PM peak-hour vehicle trips by 2028

Table 4. Shuttle Service and Future Enhancements

2007 Program	Enhancements
Seven routes connect Children's facilities and off-campus parking	Create shuttle routes to regional transit hubs
Shuttle fleet of 12 vehicles, equipped to carry bicycles	Green Line launched in June 2008: Route to Westlake Station
	Purple Line launched in January 2009
	Route to University District NE 45th Street and Campus Parkway hubs
	Proposed route to SR 520/Montlake Blvd Station
	Proposed route to Future UW light rail station at Husky Stadium
	Proposed route to south Snohomish County

(2) INNOVATIVE BICYCLE PROGRAMS
Children's is pioneering a number of creative programs to increase the use of bicycles for commute and mid-day trips, such as:

- Company Bikes, which offers free use of a bicycle to employees who commit to cycling at least two days per week
- Flexbikes, a shared-bicycle program that allows users to check out bicycles for one-way travel to the 70th / Sand Point Way administrative building or the Autism Clinic located off the Burke-Gilman trail near the University Village

Expected outcome: Increase in the percentage of employees who commute by bicycle from 6% (2007) to 10% by 2028

Table 5. Bicycle Programs and Future Enhancements

Element	2007 Program	Enhancement
Incentives for Bicycle Commutes	120 bicycle parking spaces	600 bicycle parking spaces
	Showers and lockers for cyclists and walkers	Expand number of showers and lockers
	Towel service	Same
	Subsidized tune-ups	Same
		Implement Flexbike program in cooperation with the University of Washington
		Assign a Children's-owned bicycle to employees who commit to cycling
		Institute a $100 per year gear bonus for bike commuters

(3) INCREASED FINANCIAL REWARDS FOR EMPLOYEES WHO COMMUTE WITHOUT DRIVING ALONE
Children's rewards employees who use alternative forms of transportation with monthly financial bonuses. Children's will continue to provide many other programs, such as free transit passes, fully subsidized vanpools, guaranteed taxi rides home in the case of emergency and others.

Expected outcome: 17% reduction in net new PM peak-hour vehicle trips in 2028

Table 6. TDM Programs and Future Enhancements

Element	2007 Program	Enhancement
Incentives for Alternate Commutes	Up to $50 per month in Commuter Bonus for not driving to work alone	Increase incentive to $65 per month
	Internal rideshare matching	Same
	Reserved parking for vanpools	Increase number of stalls for vanpools
	Vanpool bonus -Driver $250/quarter -Backup driver -Bookkeepers	Same
	Free FlexPass for employees	Same; expand to non-employee staff
	Showers and lockers for cyclists and walkers	Expand number of showers and lockers
	Towel service	Same
	Umbrellas, reflective lights provided annually	Same
	New walking incentives	$100 per year gear bonus for walking commuters
	Guaranteed Ride Home — up to eight emergency taxi trips per year; maximum 60 miles per trip	Same
	Zipcars — three cars on-site. Free membership and free miles for business use	Same

Table 7. Parking Management Policies and Future Enhancements

Element	2007 Program	Enhancement
Parking Cost	$50 per month paid parking on-campus and off-campus	Increase to pay-per-use with $100 per month maximum Review annually to establish rate that encourages non-SOV modes
	Patients, families, carpools and vanpools park on campus for free, as do medical residents, students, fellows, volunteers, community physicians, trustees, board members and vendors	Eliminate free parking with introduction of pay-per-use. Charge patients and families for parking, with the potential for validation or Medicaid vouchers for families.
Street Parking Enforcement	Parking on neighborhood street forbidden and enforced by Children's patrol. Disciplinary action for infraction.	Expand

Table 8 compares the standard Transportation Management Plan elements typically required of developers by the City of Seattle with the elements of Children's existing TMP and the future TMP included as part of this Master Plan.

Table 8. Required Elements of Transportation Management Plan in Existing and Future TMP

Program Element	Existing TMP	Future TMP
Transportation Coordinator	Required and provided	Same
Promotions	Required and provided	Same
Commuter Information Center	Required and provided	Same
Tenant Participation	Not included	Same
Ridematch Program	Required and provided	Same
Site and Access Improvements	Required and provided	Provides additional pedestrian and bicycle access
Height and Turning Clearances for Vanpools	Required and provided in limited areas	New garage to accommodate vanpool access to designated vanpool parking
Carpool/Vanpool Parking	Required and provided	Same
Bicycle Parking	Required and provided	Provides additional bike parking
Shower/Lockers	Required and provided	Provides more showers and lockers for bike riders
Pedestrian/Bicycle Links	Not included	Provides link to Burke-Gilman Trail and to near-site transit stops
Transportation Management Associations	Not included	Same
Parking Fees	Required and provided	Review annually to establish rate that encourages non-SOV modes
Non-SOV Subsidy	Required and provided	Review annually to establish rate that encourages non-SOV modes
Unbundling of Parking Charges	Not included	Same – not included
Flexible Work Schedule	Accommodates where applicable	Accommodates where applicable
Subscription Bus Service	Not included	Same – not included
Shuttle Service	Required and provided	Review annually to serve facilities and reduce SOVs
Telecommuting	Accommodates where applicable	Accommodates where applicable
Reduced SOV Parking	Parking supply is less than code allowable	Parking supply will be less than code allowable
Fleetpools	Not included	Same – not included
Car-Sharing Programs	Zipcar on site	Zipcar on site
Guaranteed Ride Home Program	Required and provided	Same
Multifamily Requirements	Not applicable	Same – not applicable
Off-Site Mitigation	Not included	Provides pedestrian and vehicular mobility improvements in key corridors
Residential Parking Zones	Not included	Same – not included
Annual Program Reports	Required and provided	Same
Biannual Surveys	Required and provided	Same

2. ELEMENTS 4-8: ABOVE AND BEYOND A TYPICAL TMP

The additional five elements of the Comprehensive Transportation Plan are above and beyond what is typically included in a TMP. These additional elements will provide community benefits, improve northeast Seattle's transportation network and provide even further reductions in transportation impacts related to the hospital's expansion. These elements are:

(4) CAMPUS DESIGN AND NEAR-SITE IMPROVEMENTS TO ENCOURAGE ALTERNATIVE TRANSPORTATION
Through careful arrangement of design elements such as pedestrian access, bicycle facilities, transit centers and the buildings themselves, Children's will create a campus that supports the convenience and attractiveness of alternative transportation modes. This campus design will blend with the surrounding neighborhood and include adjacent improvements on Sand Point Way NE and 40th Avenue NE to support vehicle and pedestrian movement near the campus, both for Children's transportation and for the benefit of the surrounding neighborhood.

Expected outcome: A more attractive, safe and pleasant development that encourages walking, bicycling and transit use

(5) INTELLIGENT TRANSPORTATION SYSTEMS (ITS) FOR NE 45TH STREET / MONTLAKE BOULEVARD / SAND POINT WAY NE
Children's will contribute up to $500,000 to directly fund Intelligent Transportation System (ITS) projects in the corridor most likely to be impacted by the hospital's expansion: Montlake Boulevard through Sand Point Way NE to the hospital. By applying smart signals that adapt to traffic conditions, ITS enhancements will optimize the performance of key intersections and produce substantial reductions in vehicle delay and travel time within the corridor. For example, when ITS improvements were installed at Greenwood Avenue N and Holman Road NW in Seattle, the result was a 30% reduction in vehicle delay and a 15% reduction in travel time.

Expected outcome: 5% to 10% reduction in delay and travel time

(6) CONTRIBUTIONS TO CAPITAL PROJECTS THAT WILL IMPROVE THE NORTHEAST SEATTLE TRANSPORTATION NETWORK
The City of Seattle has identified a comprehensive list of projects intended to improve the movement of people and goods as well as increase safety in the area impacted by Children's. These projects emerged from a number of planning efforts conducted by the City, including the University Area Transportation Study, the University Area Transportation Action Strategy, the Bicycle Master Plan and the Sand Point Way Pedestrian Plan. Children's will contribute a proportionate share of the cost of the projects on this list based upon the amount of traffic related to Children's, in an amount up to $1.4 million.

Expected outcome: Currently unfunded improvements in the Northeast Seattle transportation network will receive substantial financial support

(7) INVESTMENTS IN WALKABLE AND BIKEABLE NORTHEAST SEATTLE.
Children's will contribute up to $2 million to a Bicycle + Pedestrian Fund that will be used to build capital projects — in some cases above and beyond those found in existing plans — that improve pedestrian and cyclist access, mobility and safety for Children's employees, visitors and members of the surrounding community. Projects listed in the Bicycle Master Plan that have a connection to Children's and are currently unfunded will receive first priority. Children's will work with the City and communities surrounding the hospital to identify improvements that will create wide-ranging community benefits, particularly those that promise to increase the numbers of families and children who feel safe and comfortable bicycling and walking in northeast neighborhoods. These projects should also lead to even further increases in the numbers of Children's employees who arrive at work on foot or by bicycle.

Expected outcome: Significant reductions in vehicle/bicycle crashes, and greater numbers of cyclists and pedestrians in the area

(8) OUT-OF-AREA PARKING

Children's may identify out-of-area, off-site parking spaces per each phase of development as part of its CTP and as necessary to mitigate future transportation impacts. As a first step, Children's and Sound Transit have signed a Memorandum of Understanding committing both organizations to investigate options to create capacity for Children's employees at regional park-and-ride facilities.

Expected outcome: Every 100 cars parked in off-site, out-of-area facilities will result in a 5% reduction in traffic impacts surrounding the hospital

APPENDIX A: LEGAL DESCRIPTIONS

APPENDIX A

LEGAL DESCRIPTION OF CHILDREN'S MASTER PLAN PROPERTY

EXISTING CAMPUS

PARCEL A
THAT PORTION OF THE WEST HALF OF THE SOUTHEAST QUARTER OF THE SOUTHWEST QUARTER OF SECTION 10, TOWNSHIP 25 NORTH, RANGE 4 EAST, WILLAMETTE MERIDIAN, IN KING COUNTY, WASHINGTON, DESCRIBED AS FOLLOWS:

BEGINNING ON THE EASTERLY LINE OF SAID SUBDIVISION AT A POINT 658.20 FEET NORTHERLY OF THE SOUTHEAST CORNER THEREOF; THENCE WEST 271.44 FEET, MORE OR LESS TO THE WESTERLY LINE OF BLOCK 1, GWINN'S LAURELHURST MANOR ADDITION, ACCORDING TO THE PLAT THEREOF, RECORDED IN VOLUME 41 OF PLATS, PAGE 27, IN KING COUNTY, WASHINGTON; THENCE NORTH 0'26'19" EAST ALONG THE NORTHERLY PRODUCTION OF SAID WESTERLY LINE TO THE SOUTHEASTERLY LINE OF SAND POINT WAY; THENCE NORTHEASTERLY ALONG SAID SOUTHEASTERLY LINE TO THE SOUTHERLY LINE OF NORTHEAST 50TH STREET; THENCE EASTERLY ALONG SAID SOUTHERLY LINE TO THE EASTERLY LINE OF SAID SUBDIVISION; THENCE SOUTHERLY ALONG SAID EASTERLY LINE 630 FEET, MORE OR LESS, TO THE POINT OF BEGINNING.

PARCEL B:
THE WEST 5.00 FEET OF THE NORTHEAST QUARTER OF THE SOUTHEAST QUARTER OF THE SOUTHWEST QUARTER OF SECTION 10, TOWNSHIP 25 NORTH, RANGE 4 EAST, WILLAMETTE MERIDIAN, IN KING COUNTY, WASHINGTON; EXCEPT THE NORTH 30.00 FEET THEREOF; AND EXCEPT THE SOUTH 25 FEET THEREOF.

PARCEL C:
BLOCKS 1, 2, 3, 4, 5 AND 6, GWINN'S LAURELHURST MANOR ADDITION, ACCORDING TO THE PLAT THEREOF, RECORDED IN VOLUME 41 OF PLATS, PAGE 27, IN KING COUNTY, WASHINGTON.

PARCEL D:
THOSE PORTIONS OF 42ND AVENUE NORTHEAST, 43RD AVENUE NORTHEAST, 44TH AVENUE NORTHEAST AND NORTHEAST 47TH STREET, VACATED UNDER ORDINANCE NO. 76010 OF THE CITY OF SEATTLE.

LAURELON TERRACE

THAT PORTION OF THE WEST HALF OF THE SOUTHEAST QUARTER OF THE SOUTHWEST QUARTER OF SECTION 10, TOWNSHIP 25 NORTH, RANGE 4 EAST, W.M., IN KING COUNTY, WASHINGTON, DESCRIBED AS FOLLOWS:

BEGINNING AT THE SOUTHWEST CORNER OF SAID SUBDIVISION; THENCE NORTH ALONG WEST LINE THEREOF TO ITS INTERSECTION WITH THE SOUTHEASTERLY LINE OF SAND POINT WAY; THENCE NORTH 35°10'24" EAST ALONG SAID SOUTHEASTERLY LINE, TO ITS INTERSECTION WITH THE WEST LINE OF BLOCK 1 OF GWINN'S LAURELHURST MANOR ADDITION, ACCORDING TO THE PLAT RECORDED IN VOLUME 41 OF PLATS, PAGE 27, IN KING COUNTY, WASHINGTON, PRODUCED NORTH; THENCE SOUTH ALONG SAID PRODUCED WEST LINE OF BLOCK 1 AND THE WEST LINE OF SAID BLOCK 1 TO THE SOUTH LINE OF SAID SUBDIVISION; THENCE WEST ALONG SAID SOUTH

LINE TO THE POINT OF BEGINNING; EXCEPT THE SOUTH 30 FEET FOR EAST 45TH STREET; EXCEPT PORTION THEREOF LYING WITHIN 40TH AVENUE NORTHEAST; EXCEPT THAT PORTION THEREOF LYING WITHIN THE ALLEY ADJOINING TO THE WEST LINE OF SAID BLOCK 1, GWINN'S LAURELHURST MANOR ADDITION, ACCORDING TO THE PLAT RECORDED IN VOLUME 41 OF PLATS, PAGE 27, IN KING COUNTY, WASHINGTON. EXCEPT A STRIP OF PARCEL OF LAND 50 FEET IN WIDTH OVER AND ACROSS A PORTION OF THE SOUTHEAST QUARTER OF THAT SOUTHWEST QUARTER OF SECTION 10, TOWNSHIP 25 NORTH, RANGE 4 EAST, W.M., IN KING COUNTY, WASHINGTON, THE CENTERLINE OF WHICH SAID STRIP IS DESCRIBED AS FOLLOWS:

BEGINNING AT THE SOUTHWEST CORNER OF SAID SUBDIVISION; THENCE ON THE WEST LINE THEREOF NORTH 0°25'38" WEST 235.54 FEET; THENCE NORTH 89°34'22" EAST 30 FEET TO THE TRUE POINT OF BEGINNING; THENCE FROM SAID POINT NORTH 89°34'22" EAST 129 FEET TO A POINT OF CURVE TO THE LEFT; THENCE WITH A RADIUS OF 42.50 FEET FOLLOWING THE ARC OF SAID CURVE THROUGH A CENTRAL ANGLE OF 90° FOR A DISTANCE OF 66.76 FEET TO A POINT OF TANGENCY; THENCE ON SAID TANGENT NORTH 0°25'38" WEST 179.85 FEET TO A POINT OF CURVE TO THE RIGHT; THENCE WITH A RADIUS OF 204 FEET FOLLOWING THE ARC OF SAID CURVE IN A NORTHERLY DIRECTION THROUGH A CENTRAL ANGLE OF 27°32'09" FOR A DISTANCE OF 98.04 FEET TO A POINT OF TANGENCY; THENCE ON SAID TANGENT NORTH 27°06'31" EAST 111.02 FEET TO A POINT OF CURVE TO THE LEFT; THENCE WITH A RADIUS OF 330 FEET FOLLOWING THE ARC OF SAID CURVE IN A NORTHERLY DIRECTION THROUGH A CENTRAL ANGLE OF 13°08'00" FOR A DISTANCE OF 75.64 FEET TO A POINT OF COMPOUND CURVE; THENCE WITH A RADIUS OF 98.94 FEET FOLLOWING THE ARC OF SAID CURVE TO THE LEFT IN A NORTHERLY DIRECTION THROUGH A CENTRAL ANGLE OF 69°00'00" FOR A DISTANCE OF 119.15 FEET TO A POINT OF TANGENCY; THENCE ON SAID TANGENT NORTH 55°01'29" WEST 58.75 FEET TO A POINT ON THE SOUTHEASTERLY LINE OF SAND POINT WAY; AND EXCEPT THE WEST 30 FEET OF THE NORTH 368 FEET OF THE SOUTH 398 FEET OF THE SOUTHEAST QUARTER OF THE SOUTHWEST QUARTER OF SAID SECTION 10, TOWNSHIP 25 NORTH, RANGE 4 EAST, W.M., IN KING COUNTY, WASHINGTON.

APPENDIX B: CITIZENS ADVISORY COMMITTEE MEMBER LIST

APPENDIX B

CITIZENS ADVISORY COMMITTEE FOR SEATTLE CHILDREN'S MAJOR INSTITUTION MASTER PLAN (MIMP)

(Confirmed by Seattle City Council on July 30, 2007, by Resolution 31002)

Karen Wolf	Ravenna/Bryant Resident / Chair
Catherine Hennings	Laurelhurst Resident / Vice Chair
Kim O. Dales	Laurelhurst Resident
Theresa Doherty	Educational Institutional Representative
Doug Hanafin	Laurelhurst Resident
Shelley D. Hartnett	Hawthorne Hills Resident
Cheryl Kitchin	Laurelhurst Resident
Bob Lucas	View Ridge Resident
Yvette Moy	City-Wide Representative
Myriam Muller	Laurelhurst Resident
Michael S. Omura	Hawthorne Hills Resident / Architect
Wendy Paul	Seattle Children's Non-Management Representative
Dolores Prichard	Laurelhurst Resident
Robert Rosencrantz	Montlake Resident
Dr. Gina Trask	Laurelhurst Resident / Local Business Owner

Alternates:

Dr. Brice Semmens	Ravenna/Bryant Resident
Nicole Van Borkulo	Ravenna/Bryant Resident / Local Business Owner
Mike Wayte	Laurelhurst Resident

Ex-Officio Members:

Steve Sheppard	Department of Neighborhoods, City of Seattle
Scott Ringgold	Department of Planning and Development, City of Seattle
Ruth Benfield	Seattle Children's Hospital

APPENDIX C: COMMUNITY OUTREACH OVERVIEW

APPENDIX C

OVERVIEW OF COMMUNITY OUTREACH ACTIVITIES SINCE SPRING 2007

- Laurelhurst Community Club Board of Trustees (March 2007)
- Children's Standing Advisory Committee for Major Institution Master Plan (March 2007)
- Children's 70th and Sand Point Advisory Committee (April 2007)
- Community-wide meeting in Laurelhurst sponsored by Children's (May 2007)
- View Ridge Community Council Annual Meeting (May 2007)
- Laurelhurst Community Club Annual Meeting (June 2007)
- Community-wide meeting in Laurelhurst sponsored by Children's (June 2007)
- Laurelon Terrace Representatives (September 2007)
- Virginia Mason physicians based at the Hartmann Building (October 2007)
- Two model presentations in Laurelhurst (October 2007)
- Montlake Community Club Board Meeting (December 2007)
- Burke-Gilman Public Development Authority (January 2008)
- Laurelcrest Condo Association Board Meeting (April 2008)
- Odessa Brown Community Clinic Open House (April 2008)
- NE District Council Meeting (June 2008)
- Montlake Community Club (June 2008)
- Children's 70th and Sand Point Advisory Committee (June 2008)
- University District Farmer's Market Q and A (June 2008)
- West Seattle Farmer's Market Q and A (June 2008)
- View Ridge Community Council (June 2008)
- Ravenna/Bryant Community Club (June 2008)
- Four model presentations at Laurelhurst Community Center (June, July and two in October 2008)
- Ravenna/Bryant Focus Groups (August 2008)
- Hawthorne Hills Community Council (September 2008)
- View Ridge Community Council (September 2008)
- Ravenna/Bryant Community Council (September 2008)
- Laurelhurst Community Club Board of Trustees (October 2008)
- Model presentation at the NE branch of the Seattle Public Library, Ravenna/Bryant (November 2008)

APPENDIX D: ADOPTING ORDINANCE

Michael Jenkins/MJ
Seattle Children's Hospital MIMP CF 308884
March 17, 2010
Version 3

ORDINANCE 123263

AN ORDINANCE relating to land use and zoning; adopting a new Major Institution Master Plan for Seattle Children's Hospital; and amending Chapter 23.32 of the Seattle Municipal Code at Page 63 of the Official Land Use Map, to modify height limits and rezone property to and within the Major Institution Overlay, all generally located along Sand Point Way Northeast (Project Numbers 3007521 and 3007696, Clerk File 308884).

WHEREAS, Seattle Children's Hospital (Children's) had an existing Major Institution Master Plan (MIMP) which was adopted by the City Council in September 1994 by Ordinance 117319; and

WHEREAS, because the 900,000 total square feet of development authorized under that MIMP has been largely realized, Children's sought a new MIMP to allow additional development over a time period of at least 20 years; and

WHEREAS the preparation and review of the proposed new Children's MIMP included the following principal steps:

1. The application to the Department of Planning and Development (DPD) for a new MIMP in July 2007;
2. Council's approval of a new Citizen's Advisory Committee (CAC) by Resolution 31002 in July 2007;
3. Issuance of a Draft MIMP and Draft Environmental Impact Statement (EIS) on June 9, 2008;
4. Publication of the Final MIMP and Final EIS (FEIS) on November 10, 2008;
5. An appeal of the adequacy of the FEIS by the Laurelhurst Community Club (LCC) on December 15, 2008;
6. The publication of the DPD Director's recommendation to City Council on February 5, 2009;
7. A hearing on the LCC appeal starting March 2, 2009 and ending March 10, 2009;
8. The issuance of a remand by the Hearing Examiner on the adequacy of the FEIS related to the Land Use and Housing impacts analyzed in the FEIS, on April 20, 2009;
9. DPD's publication of a revised FEIS concerning the review of Land Use and Housing impacts on May 28, 2009;
10. An appeal by LCC on the adequacy of the Revised FEIS in June 2009;
11. The Hearing Examiner's hearing on the appeal of the Revised FEIS on July 14-15, 2009;
12. The issuance of a determination that the Revised FEIS was adequate on August 11, 2009;

Passed as Revised on December 17, 2009

13. The publication of a Recommendation by the Hearing Examiner to deny to requested MIMP on August 11, 2009, with conditions if the MIMP is approved;
14. 11 separate appeals filed on August 25, 2009 concerning the Hearing Examiner's recommendation;
15. Review of the proposed MIMP by the City Council's Planning, Land Use and Neighborhood Committee on November 18, 2009;
16. Continued review by the City Council's Committee on the Built Environment (COBE) January 13, 2010 and January 20, 2010;
17. Oral Argument concerning requirements for replacement housing required under Seattle Municipal Code (SMC) Section 23.34.124B7, along with the presentation of a Settlement Agreement between appellants, on February 3, 2010;
18. Further review by COBE on February 25, 2010;
19. Submission of supplemental briefings on March 5, 2010 by certain appellants on the issue of replacement housing requirements under SMC 23.34.124B7;
20. An Executive Session held by the City Council on March 8, 2010 concerning the issue of replacement housing requirements under SMC 23.34.124B7; and
21. Further review by COBE on March 11, 2010, culminating in a recommendation to approve the MIMP, with certain conditions, which was then forwarded to full Council for a vote; and

WHEREAS the City Council has considered the proposed MIMP, the record assembled by the Hearing Examiner, including the reports of the CAC, DPD and the Hearing Examiner, and the arguments of the appellants, **NOW THEREFORE,**

BE IT ORDAINED BY THE CITY OF SEATTLE AS FOLLOWS:

Section 1. Children's Final MIMP, dated November 10, 2008 and filed in Clerk's File (C.F.) 308884, is hereby adopted by the City Council subject to the conditions contained in Council's Findings, Conclusions and Decision in Attachment A. Upon DPD review and approval of a final compiled MIMP, including the conditions adopted by the City Council, pursuant to the provisions of Seattle Municipal Code Section 23.69.032K, DPD shall submit a copy of the final compiled Children's MIMP to the City Clerk, to be placed in C.F. 308884.

Section 2. This Ordinance affects the legally described properties ("the Property") held separately by Seattle Children's Hospital, currently known as 4800 Sand Point Way Northeast,

and the Laurelon Terrace Condominiums, currently known as 4644 – 41st Street Northeast, as described in Attachment B.

Section 3. The Official Land Use Map zone classification, established on page 63 of the Official Land Use Map, adopted by Ordinance 110381 and last modified by Ordinance 123129, is amended to rezone the Property through the adoption of a Major Institution Overlay (MIO) District, and mapped with height limits of 37 feet, 50 feet, 65 feet, 70 feet, 90 feet and 160 feet, conditioned to 125 feet and 140 feet, as shown in Attachment C. The underlying zoning of Single Family 5000 and Lowrise 3 is not changed as a result of this Ordinance.

Section 4. This Ordinance, effectuating a quasi-judicial decision of the City Council and not subject to mayoral approval or disapproval, shall take effect and be in force thirty (30) days from and after its passage and approval by the City Council.

Passed by the City Council the 5th day of April, 2010, and signed by me in open session in authentication of its passage this 5th day of April, 2010.

President of the City Council

Filed by me this 5th day of April, 2010.

City Clerk

(Seal)

Attachment A: Clerk's File 308884 – Findings Conclusion and Declation

Attachment B: Legal Description

Attachment C: Rezone Map

SEATTLE CITY COUNCIL

FINDINGS, CONCLUSION AND DECISION

SEATTLE CHILDREN'S HOSPITAL MAJOR INSTITUTION MASTER PLAN

APRIL 5, 2010

Introduction

This matter involves the petition of Seattle Children's Hospital (Children's) to establish a new Major Institution Master Plan ("MIMP") for its main campus located at 4800 Sand Point Way Northeast in Northeast Seattle (Clerk's File 308884). The proposed MIMP includes the approval of a twenty year physical development plan in four phases, a new Transportation Management Plan regulating commuting and parking, development standards governing new construction, an increase in the amount of allowed parking provided at the campus, and a rezone to expand the existing boundaries of the Major Institution Overlay (MIO) District and increase the permitted height of buildings within the MIO. Finally, the MIMP proposes the vacation of two streets – 41st Avenue Northeast and Northeast 46th Street – that would be considered by the City Council under a different process and potentially approved by the Council by another ordinance.

The rezone would extend the MIO boundaries from 21.7 acres to 28.4 acres as a result of the acquisition of Laurelon Terrace Condominiums (Laurelon), a 6.7 acre, 136 unit condominiums immediately to the west of the existing MIO. The MIO expansion would also change the zoning within Laurelon from Lowrise 3 (L3) to a combination of height limits that include MIO 37 feet, MIO 50 feet, MIO 90 feet and MIO 160 feet (conditioned to 125 feet and 140 feet, respectively). MIO Heights on the existing campus are 37, 50, 70 feet (with part conditioned to 54.5 feet), and 90 feet (with part conditioned to 74) feet. The MIMP as reflected in the Settlement Agreement[1] proposes heights of 37 feet, 50 feet, 65 feet, 70 feet, 90 feet, and 160 feet (conditioned to 125 feet and 140 feet, respectively).

Children's previous MIMP, adopted in September 1994 by the City Council through Ordinance 117319, authorized development of up to 900,000 square feet for the MIO. The MIMP indicates that the campus currently has approximately 846,000 square feet of development and, as such, a new MIMP is required for additional growth in the MIO.

In March 2007, Children's began the process of establishing a new MIMP. In August 2007 a Citizens Advisory Committee (CAC) began its review of the proposed MIMP. In January 2009, the Department of Planning and Development (DPD) issued its Analysis, Recommendation and Determination of the DPD Director, recommending that the MIMP be approved subject to conditions. In February 2009, the CAC issued its Final Report and Recommendation, recommending that the MIMP be approved subject to conditions.

[1] The "Settlement Agreement" refers to a proposal to revise the MIMP as it was originally proposed, to reflect an agreement between Children's Hospital and the Laurelhurst Community Club.

Report and Recommendation, recommending that the MIMP be approved subject to conditions. Appeals were filed to the Seattle Hearing Examiner of DPD's decision that the final Environmental Impact Statement (FEIS) was adequate.

In March 2009, the Hearing Examiner held a hearing on the appeal of the FEIS. On April 20, 2009, the Hearing Examiner issued a decision that the FEIS was inadequate because it failed to adequately discuss potential environmental impacts of the proposed development on housing and land use. A revised FEIS was published by DPD in May 2009, and the adequacy of the revised FEIS was also appealed to the Hearing Examiner. In July 2009, the Hearing Examiner held a hearing on the adequacy of the Revised FEIS. On August 11, 2009 the Hearing Examiner issued a decision ((decided)) that the Revised FEIS was adequate. On August 11, 2009 the ((The)) Hearing Examiner also published a recommendation ((also recommended)) that the Council deny the proposed MIMP or, if the Council were to approve the MIMP, to attach 43 conditions to its approval. Eleven ((11)) appeals of the Hearing Examiner's recommendation were filed with the Council. The names and addresses of all eleven appellants are listed on the last page of this document.

The City Council's Planning, Land Use and Neighborhood Committee ((Urban Development and Planning (UDP) Committee)) began consideration of the proposed MIMP at a meeting on November 18, 2009. The Council's Committee on the Built Environment (COBE), the successor to the UDP, considered the matter on January 13 and 20, 2010. Oral argument by appellants was presented to the COBE on February 10, 2010. On February 10, 2010 a Settlement Agreement was also submitted to the Council. The nine appellants who presented claims on the extent of physical development under the MIMP withdrew their appeals in support of the Settlement Agreement. A remaining appeal by the Seattle Displacement Coalition and Interfaith Taskforce on Homelessness (SDC/ITH) on the application of Seattle Municipal Code (SMC 23.34.124.B.7), the housing replacement ordinance, remained. Oral argument was presented on this issue. ((A)) S((s))ubsequent COBE meetings were ((was)) held on February 24, 2010, ((with the Council holding an executive session on the proposed MIMP on)) March 8, 2010 and then March 11, 2010. ((Supplemental briefings were also accepted by COBE on the housing replacement options. These were submitted by appellants on or before March 5, 2010.))

Findings of Fact

Background

1. Children's is an academic medical center that provides highly specialized pediatric and adolescent health care services to children throughout the Northwest through integrated diagnostic and therapeutic services provided by specialists in multiple disciplines.

2. Children's "bed mix" includes separate neonatal, pediatric, and cardiac intensive care units, an inpatient psychiatric unit, a rehabilitation and complex care unit, a Seattle Cancer Care Alliance unit, a surgical unit, and a medical unit.

Appeals were filed to the Seattle Hearing Examiner of DPD's decision that the final Environmental Impact Statement (FEIS) was adequate.

In March 2009, the Hearing Examiner held a hearing on the appeal of the FEIS. On April 20, 2009, the Hearing Examiner issued a decision that the FEIS was inadequate because it failed to adequately discuss potential environmental impacts of the proposed development on housing and land use. A revised FEIS was published by DPD in May 2009, and the adequacy of the revised FEIS was also appealed to the Hearing Examiner. In July 2009, the Hearing Examiner held a hearing on the adequacy of the Revised FEIS. On August 11, 2009 the Hearing Examiner issued a decision that the Revised FEIS was adequate. On August 11, 2009 the Hearing Examiner also published a recommendation that the Council deny the proposed MIMP or, if the Council were to approve the MIMP, to attach 43 conditions to its approval. Eleven appeals of the Hearing Examiner's recommendation were filed with the Council. The names and addresses of all eleven appellants are listed on the last page of this document.

The City Council's Planning, Land Use and Neighborhood Committee (PLUNC) began consideration of the proposed MIMP at a meeting on November 18, 2009. The Council's Committee on the Built Environment (COBE), the successor to the UDP, considered the matter on January 13 and 20, 2010. Oral argument by appellants was presented to the COBE on February 10, 2010. On February 10, 2010 a Settlement Agreement was also submitted to the Council. The nine appellants who presented claims on the extent of physical development under the MIMP withdrew their appeals in support of the Settlement Agreement. A remaining appeal by the Seattle Displacement Coalition and Interfaith Taskforce on Homelessness (SDC/IFH) on the application of Seattle Municipal Code (SMC 23.34.124.B.7), the housing replacement ordinance, remained. Oral argument was presented on this issue. Subsequent COBE meetings were held on February 24, 2010, March 8, 2010 and then March 11, 2010.

Findings of Fact

Background

1. Children's is an academic medical center that provides highly specialized pediatric and adolescent health care services to children throughout the Northwest through integrated diagnostic and therapeutic services provided by specialists in multiple disciplines.

2. Children's "bed mix" includes separate neonatal, pediatric, and cardiac intensive care units; an inpatient psychiatric unit; a rehabilitation and complex care unit; a Seattle Cancer Care Alliance unit; a surgical unit; and a medical unit.

3. Children's population includes patients (from premature newborns to 21 years of age); hospital employees; physicians, students and residents; and visitors.

Site and Vicinity

4. Children's Laurelhurst campus within the existing Major Institution Overlay (MIO) is located on approximately 21.7 acres at 4800 Sand Point Way Northeast in northeast Seattle. Neither the Laurelhurst neighborhood nor Children's campus are located in an "urban center" or "urban village", as designated in the City's Comprehensive Plan. The closest urban center or village is the Ravenna portion of the University Community Urban Center located approximately one-half mile away.

5. The existing Children's MIO includes downhill slopes from east to west and from north to south. The MIO is currently bounded on the northwest by Sand Point Way Northeast; on the north by Northeast 50th Street; on the east by 44th Avenue Northeast (from Northeast 50th Street to Northeast 47th Street) and by 45th Avenue Northeast (from Northeast 47th Street to Northeast 45th Street); on the south by Northeast 45th Street; and on the west by a shared property line with Laurelon.

6. The underlying zoning in the existing Children's MIO is Single-family 5000 (SF5000). The neighborhood outside of the existing MIO to the east and south is also zoned SF 5000, with a 30 foot height limit, and is developed with single-family residences. The area to north of the existing MIO is zoned Lowrise Duplex/Triplex, with a 25-foot height limit, and is developed with low density multifamily residences. The area to the northwest of the existing MIO is zoned Lowrise 3 (L3) with a 30-foot height limit and is also developed with low density multifamily residences. The area to the west of the existing MIO is also zoned L3, and is developed with the Laurelon Terrace Condominiums (Laurelon), a 6.7 -acre, two- and three-story garden-style community built in the 1940s. To the west and southwest of Laurelon is L3-zoned property developed with low density multifamily residences, and then a strip of property along Sand Point Way that is zoned Neighborhood Commercial 2 with a 30-foot height limit (NC2-30) and developed with the Springbrook professional buildings and a bank. L3 zoning and development continues to the north of the existing MIO across Sand Point Way and includes the nonconforming one-story medical office use in the Hartmann Building. To the southwest of the Hartmann site is Neighborhood Commercial 2 zoning with a 40 foot height limit (NC2-40) developed with a nonconforming 100-foot-high condominium building. Further to the west from that NC2-40 zone is the Burke-Gilman Trail, and then the Bryant neighborhood with SF5000 zoning and development. *See* Exhibit 4 (Final Master Plan) at 63, Figure 45[2].

7. Retail and commercial businesses, including University Village, QFC and Safeway, the Virginia Mason Pediatric Clinic, the Springbrook buildings, and smaller specialty businesses, are located primarily to the southwest of Children's. Several institutions are also located nearby, including Children's 70th and Sand Point Way facility, the Talaris Research and Conference Center at Northeast 41st Street, Laurelhurst Elementary School and Villa Academy to the east, and the University of Washington less than one mile to the southwest.

Current Major Institution Overlay

[2] Exhibits refer to exhibits in the Hearing Examiner's record.

8. Children's Laurelhurst campus is located within an existing MIO under a MIMP approved in 1994. Existing facilities include a hospital with 250 beds (230 of which are acute care) in 200 patient rooms, a clinic, and clinical research, office and laboratory space, for a total permitted building area within the MIO of 900,000 square feet. In addition, Children's maintains an existing clinic and office at the Hartmann Building on the west side of Sand Point Way Northeast. Children's owns the 1.7 acre Hartmann site and the 16,228 square foot Hartmann Building. Children's has a partnership interest in the Springbrook buildings at Northeast 45th Street and Sand Point Way Northeast and leases 6,700 square feet in those buildings. Both Hartmann and Springbrook are located outside, but within 2,500 feet of the existing MIO. Children's also owns nine single-family residences located across from its east and south boundaries that it purchased in 2007 and 2008. Exhibit 22, Attachment G.

9. Primary access to Children's is via the Northeast 45th Street corridor (Sand Point Way Northeast and Northeast 45th Street to Interstate 5), or via the Montlake Boulevard corridor (Sand Point Way Northeast and Montlake Boulevard Northeast to SR 520). Approximately 50% of Children's employees travel one of these corridors to reach Children's. The campus itself is accessed via Penny Drive from Sand Point Way Northeast. Three King County Metro bus stops are located on or adjacent to the campus.

10. Children's provides a total of 2,182 parking stalls, including 80 surface stalls at the Hartmann Building and 640 off-campus leased stalls.

11. Current MIO height districts are 37 feet north of Penny Drive, and 37, 50, 70 and 90 feet south of Penny Drive. Part of the 90-foot height district is conditioned to 74 feet plus mechanical, and part of the 70-foot height district is conditioned to 64 feet. Setbacks are approximately 20 feet on the north, 40 feet on the west and a portion of the east, and 75 feet on the south and a portion of the east. Many of the existing setbacks are heavily landscaped to screen the campus from the surrounding neighborhood.

12. As documented in the MIMP Children's has completed approximately 846,000 square feet of the development approved in its existing MIMP, with approximately 54,000 square feet remaining.

13. Children's has relocated its research facilities away from the hospital campus and established pediatric specialty care at regional clinics in Alaska, Montana and many cities within Washington. It is also working with community providers to increase the availability of pediatric specialty care services within the area.

Master Plan Process

14. The MIMP process began in the spring of 2007, when Children's submitted a notice of intent to prepare a new MIMP. The Citizens Advisory Committee (CAC) was formed and first met in July of 2007. The Draft MIMP was submitted and a draft EIS was issued on June 9, 2008. Exhibits 3 and 5. Public review during development of the draft MIMP and draft EIS included public meetings of the CAC, which included time for public comment; a public scoping meeting; two public comment periods; and a public hearing. The Final MIMP and FEIS were issued on November 10, 2008. Exhibits 4 and 6. The Director's Report and Recommendation was issued on January 20, 2009. Exhibit 9.

15. The CAC, staffed by the Department of Neighborhoods, held 26 public meetings over a period of 18 months. They received 248 public comments, and reviewed and commented on draft MIMP and SEPA documents. The CAC was instrumental in achieving many changes to the MIMP that would reduce the proposed MIMP's impact on the surrounding neighborhood. The CAC's Final Report and Recommendation, and six Minority Reports from 13 CAC members, were issued on February 3, 2009. Exhibit 8.

Public Comment

16. The Director received approximately 600 written comments on the MIMP and EIS, and heard from 66 people at the Director's 2008 public hearing. The Examiner received 153 public comments, and heard testimony from 65 members of the public at the Examiner's two public hearings.

Hearing Examiner Recommendation

17. On August 11, 2009 the Hearing Examiner recommended that the proposed MIMP be denied. Balancing the potential adverse impacts to the neighborhood against Children's asserted expansion needs, the Examiner concluded that without considering a less expansive development proposal, the potential impacts to the neighborhood outweighed Children's needs. The Examiner also concluded that the proposal was inconsistent with the "urban village strategy" contained in the City's Comprehensive Plan.

18. The Hearing Examiner recognized that the City Council could strike a different balance than that struck by the Examiner, and decide to approve the proposed MIMP. Accordingly she recommended that if the Council decided to approve the MIMP, the Council consider adopting a number of conditions for such approval.

Appeals and Settlement Agreement

19. Eleven parties appealed the Hearing Examiner's recommendation to the Council. Approximately half supported approval of the MIMP and half opposed approval.

20. On February 10, 2010, Children's and parties supporting approval of the MIMP, and the Laurelhurst Community Club (LCC) and parties opposing approval of the MIMP, with the exception of two housing advocacy appellants, told the Council that they had concluded a Settlement Agreement that would reduce the scope of Children's proposed development under the MIMP. Those parties agreed that the proposed MIMP, as amended and limited by the terms of the Settlement Agreement, achieved a proper balance "between the need for Children's to expand and the livability of the adjacent neighborhoods."

21. In light of the Settlement Agreement, the following descriptions of the proposed MIMP describe the proposed MIMP as revised, in part, by the Settlement Agreement.

Proposed Master Plan

22. Children's has applied for a new MIMP to establish development potential through the year 2030. The MIMP would remain in place until Children's constructs the allowed developable square footage. The objectives of Children's proposed MIMP are stated in the Final MIMP, Exhibit 4 at Pages 12-15, and are summarized in the Director's Report, Exhibit 9 at 9.

23. Children's Final MIMP includes the three required components under SMC 23.69.030: (1) a development program; (2) development standards; and (3) a transportation management program.

24. Details of Children's proposed development program are found at pages 17-73 of the proposed MIMP, Exhibit 4.

25. Children's explored seven alternatives that would have achieved its original objective of obtaining a total of 2,400,000 square feet of development area. The alternatives are described in detail in Exhibit 6 at 2-7 to 2-33, and in Exhibit 4 at 20-23. As a result of the Settlement Agreement, that amount has been reduced to 2,125,000 square feet.

26. Children's selected Alternative 7R as its preferred alternative. It originally sought to expand the MIO boundary to include both Laurelon and the existing Hartmann site across Sand Point Way Northeast. As a result of the Settlement Agreement, Children's has withdrawn its proposal to include Hartmann within the MIO. Children's has purchased 100 of the Laurelon units and holds an option to purchase the entire 136-unit complex.

27. Laurelon, along with portions of certain existing campus buildings would be demolished, and development under the proposed MIMP would occur in four phases. The timing for the phases remains an estimate. Phase 1 is designated "planned development." Phases 2, 3 and 4 are designated "potential development." See Exhibit 4 at 66-68; Exhibit 6 at 2-22 to 2-30.

28. Phase 1 would expand total building area up to approximately 1,492,000 square feet. Phase 1 is expected to occur between 2010 and 2012, and would include:

- Demolition and removal of Laurelon
- Construction of a new Emergency Department (93,527 square feet)
- Construction of Bed Units 1 and 2 (258,800 square feet)
- Construction of diagnostic and treatment facilities (176,343 square feet)
- Construction of mechanical facilities (49,400 square feet)
- Construction of a mechanical penthouse (14,000 square feet)

29. Phase 2 would expand total building area up to approximately 1,604,000 square feet, (including replacement of 65,000 square feet of existing space to be demolished) and is expected to occur from the fourth quarter of 2013 to the fourth quarter of 2016. It would include:

- Construction of a 1,100 stall, below grade garage for staff at the south end of the Laurelan (Southwest garage)
- Construction of additional diagnostic, treatment, and ancillary, mechanical and general plant facilities
- Demolition at existing portions of the campus at D and F wing

30. Phase 3 is expected to occur in two sub-phases and would expand total building area up to approximately 2,060,000 square feet (including replacement of 136,000 square feet to be demolished): Sub-phase 3A from the second quarter of 2017 to the fourth quarter of 2019; and Sub-phase 3B from the first quarter of 2022 to the fourth quarter of 2024. Phase 3 would include:

- Construction of Bed Units 3 and 4
- Construction of diagnostic, treatment, and ancillary, mechanical and general plant facilities
- Demolition of existing portions of the campus at Train 3B

31. Phase 4 would expand total building area up to approximately 2,125,000 square feet and is expected to occur from the fourth-quarter of 2025 to the fourth-quarter of 2027. It would include:

- Demolition of the Giraffe Garage on the northwest portion of the campus
- Construction of a new North Garage, offices, and ancillary, mechanical and general plant facilities on the north part of the property

32. The net increase in building area over the life of the MIMP would be 1,225,000 square feet, with a total building area for the completed campus of approximately 2,125,000 square feet, 136% larger than Children's existing facilities. The net increase in beds would range from 250 to 350, for a total bed count ranging from 500 to 600 beds.

33. Development under the proposed MIMP would require vacation of streets within Laurelon, specifically 41st Avenue Northeast and Northeast 46th Street between Sand Point Way Northeast and 40th Avenue Northeast. While the MIMP assumes the vacation of these streets, the review of the proposed street vacations requires a separate legislative action.

Major Areas of Concern

Need and Public Benefit

34. SMC 23.69.002 states that the purpose and intent of the Major Institution Code is to:

> A. Permit appropriate institutional growth within boundaries while minimizing the adverse impacts associated with development and geographic expansion;
>
> B. Balance the Major Institution's ability to change and the public benefit derived from change with the need to protect the livability and vitality of adjacent neighborhoods;
>
> C. Encourage the concentration of Major Institution development on existing campuses, or alternatively, the decentralization of such uses to locations more than two thousand five hundred (2,500) feet from campus boundaries;
>
> ...
>
> E. Discourage the expansion of established major institution boundaries;
>
> ...
>
> H. Accommodate the changing needs of major institutions, provide flexibility for development and encourage a high quality environment through modifications of use restrictions and parking requirements of the underlying zoning;
>
> I. Make the need for appropriate transition primary considerations in determining setbacks. Also setbacks may be appropriate to achieve proper scale, building modulation, or view corridor.
>
> ...

35. SMC 23.69.025 states that the intent of a MIMP is to "balance the needs of the Major Institutions to develop facilities for the provision of health care or educational services with the need to minimize the impact of Major Institution development on surrounding neighborhoods."

36. The Director of DPD concluded that Children's has shown a credible need for the requested expansion, and no appellants now dispute that conclusion.

37. Children's states its mission as preventing, treating and eliminating pediatric disease, and providing access to quality pediatric health care regardless of a family's ability to pay. Children's proposed MIMP is intended to allow Children's to fulfill its mission in a manner consistent with its 2006 strategic plan.

38. Children's cites a recent national study of freestanding pediatric hospitals that estimated an annual growth rate of 3.1 percent in inpatient demand for pediatric services through 2010 due to increased severity of pediatric illnesses; increases in prematurity and low birth weight; increased prevalence of chronic conditions; growing prevalence of obesity; more patients surviving childhood diseases and utilizing healthcare services longer; and a need for single bed rooms to control the potential spread of infection.

39. Children's states that a report on its own experience reflects the reported national trends. In 2007 and 2008, it experienced average "midnight occupancy levels" above the targets recommended by the Washington State Department of Health. It has identified a need to improve and expand its facilities to respond to increasingly complex patients who require additional staff, specialists, technology, and equipment and storage space that often varies by patient size, as well as space for additional visitors. See Exhibit 26, Slide 5. Children's reports that its current inpatient occupancy rates exceed the national standard of care for pediatric hospitals.

40. Children's has projected the following total unmet bed need, in single-bed rooms, for specialized pediatric care, including psychiatric care, within the State of Washington: 2012 - 336 beds; 2017 - 408 beds; 2019 - 460 beds; 2024 - 600 beds.

41. Children's indicates that it will decide how much of the projected need to accept when it applies for a Certificate of Need.

42. To calculate the total square footage required to accommodate total state need, Children's multiplied the maximum projected bed need by 4,000 square feet, which includes 300 square feet required for bed space plus the amount said to be required to support each pediatric bed (i.e., the "per bed share" of family space, operating rooms, diagnostic and therapeutic spaces, offices, central plant space, etc.). See Exhibit 26, slide 6. The total bed need of 600 times 4,000 square feet equals 2,400,000 square feet. These assumptions were not modified under the Settlement Agreement.

43. Children's growth projections show that under Phases 3 and 4 of the proposed MIMP, available space would somewhat exceed total projected need. Exhibit 26, slide 3.

44. Children's most recent Certificate of Need from the state was issued in 2001. The state's planning horizon for a hospital's request for a certificate of need is generally seven years. Thus, Children's anticipates that it would need to submit applications for at least three certificates of need during the lifetime of the proposed MIMP.

45. Public comment uniformly supported the mission of Children's and applauded its work in the region. However some members of the public questioned the need for Children's to nearly triple the square footage of its existing facilities within the MIO.

46. Children's originally did not evaluate any alternatives that included less than 2,400,000 square feet of development area. Instead, the alternatives considered different ways to configure the same amount of development space on the existing campus and Hartmann site, and later, on an expanded campus that included both Laurelon and Hartmann sites. Now, Children's proposes to exclude the Hartmann site from the MIO and to limit the development area to 2,125,000 square feet.

47. The CAC gave considerable attention to the issue of need. Comments to the CAC were provided by individuals and groups both in support and against Children's projections concerning the rationale for a certificate of need. *See* Exhibits 51-63, 65 and 66, and Exhibits 73-78 and 108. *See also*, Exhibit 22 at 2-8.

48. In response to the CAC's continuing concerns about the discrepancies between Children's and LCC's need projections, Children's offered assurance that it had no intention to build beyond its actual needs.

49. Aside from the impacts of a significantly expanded medical center, some neighbors expressed concern that facilities not be constructed for general research or other uses not directly supporting Children's pediatric medical care.

50. The CAC determined to accept Children's projections of need with the understanding that the issue would be thoroughly vetted during the state certificate of need process. However, the CAC recommended "in the strongest terms" that the decision on the MIMP include both conditions on phasing the project in relationship to need and conditions restricting use of the constructed facilities. Exhibit 8 at 17-19.

Boundary Expansions

51. Children's originally proposed to meet projected need primarily within existing MIO boundaries. This required raising heights limits up to 240 feet and expanding the boundary to include up to 105-foot heights on the Hartmann site. The community made it clear that such heights were unacceptable.

52. Children's revised its proposed MIMP to include early expansion onto Laurelon (Alternative 7R), thereby enabling it to construct new facilities without disrupting existing hospital operations. The change also allowed Children's to eliminate height increases on the existing campus, reduce the overall height of all new development to less than 160 feet, reduce the overall height of new facilities to an elevation similar to the highest building elevation on the existing campus, place increased height and bulk at a lower elevation where it is removed from most single-family neighborhoods to the east and south and multifamily development to the north, and provide vehicle access via 40th Avenue Northeast (a neighborhood access street), to Sand Point Way Northeast, an

arterial. This eliminated the need for entrances on Northeast 45th Street and Northeast 50th Street (also neighborhood access streets).

53. Both the CAC and the Director recommended that the MIO boundary be expanded to incorporate Laurelon.

Intensity

54. Lot coverage on the existing campus is 35%, and would increase to 51% under the proposed MIMP. However, institutions in the underlying Lowrise zone are not regulated by lot coverage but by structure width and depth limits.

55. The proposed MIMP, following the Settlement Agreement, requests 2,125,000 gross square feet. "Gross floor area" is "the number of square feet of total floor area bounded by the inside surface of the exterior wall of the structure as measured at the floorline." SMC 23.84A.014.

56. "Floor area ratio" (FAR) is "a ratio expressing the relationship between the amount of gross floor area or chargeable floor area permitted in one or more structures and the area of the lot on which the structure is, or structures are, located, as depicted in Exhibit 23.84A.012A." SMC 23.84A.012.

57. Children's received a DPD Director's interpretation on FAR which stated that since the Code does not prescribe the FAR, or any exclusion from it, for a MIMP, both may be defined by the decision on the MIMP.

58. The proposed MIMP originally requested an increase in intensity of development, expressed as FAR, from .9 on the main campus and .2 at Hartmann, to 1.9 across the entire MIO including Hartmann. While the Settlement Agreement removed Hartmann from the MIO, no adjustment was proposed to modify the 1.9 FAR.

59. The record documents review by DPD, the CAC and the Hearing Examiner concerning the amount of FAR being requested under the MIMP, including the methods by which FAR should be calculated and what features (parking structures, rooftop mechanical equipment, etc) should be included in the calculations.

60. The Settlement Agreement reflects that the FAR for the campus should be 1.9. FAR is defined in the settlement agreement as "the square footage of above-grade gross developable floor area plus the square footage of above-grade parking floor area, divided by the combined square footage of land in the New MIO Boundary (The current MIO campus plus Laurelon):

$$\frac{\text{Above-grade gross developable floor area (gsf)} + \text{Above grade parking floor area (gsf)}}{\text{SF of current MIO campus} + \text{SF of Laurelon}}$$

Rooftop mechanical equipment is not included in floor area ratio calculations".

Development Standards and Transitions

62. Details of the proposed development standards for the MIMP are found at pages 75-87 of the proposed MIMP, Exhibit 4, and are summarized at pages 88-91. The development standards would modify or supersede most underlying zoning standards.

Height

63. MIO Heights on the existing campus are 37, 50, 70 (with part conditioned to 64), and 90 (with part conditioned to 74) feet. The MIMP as modified by the Settlement Agreement proposes heights of 37 feet, 50 feet, 65 feet, 70 feet, 90 feet, and 160 feet (conditioned to 125 feet and 140 feet, respectively).

64. DPD, the CAC and the Hearing Examiner heard comments on the original proposed 160 foot height limit within the Laurelon expansion area. Concerns expressed by some individuals included a feeling of towers looming over the streetscapes and the multifamily development across 40th Avenue Northeast, and the opinion that a 160 foot height limit is too high for an area outside an urban village. There was some public comment, including by members of the CAC, calling for reducing the 160 foot MIO height to 105 feet, the current MIO height limit at some major institutions located outside an urban village. However, the record, including comments from the CAC, clearly states that the proposed 160 foot height limit should be conditioned to 140 feet and 125 feet, respectively.

65. The CAC recommended modifications to the heights shown in the proposed MIMP. These included adding a MIO 50 height district along the west side of the main hospital campus along 40th Avenue Northeast, reducing the MIO 160 district to MIO 140 and MIO 125, placing limits on the number of floors above the podiums for the bed towers, limiting and screening rooftop mechanical equipment, and establishing a MIO 65 for the Hartmann site. *See* Exhibit 93[1].

66. SMC 23.86.006 currently provides that heights are to be measured from existing or finished grade, whichever is lower.

Setbacks

67. Under the proposed MIMP, setbacks on the western one-third of the north boundary would increase from 20 feet to 40 feet and on the eastern two-thirds of the north boundary, from 20 feet to 75 feet. Setbacks on the south boundary of the existing campus would remain at 75 feet. On the south boundary of Laurelon, the setback would be 40 feet. On the east, the setback along 45th Avenue Northeast would increase from 40 feet to 75 feet; along 44th Avenue Northeast and Northeast 47th Street, they would remain at 75 feet. Setbacks on the west boundary along 40th Avenue Northeast would be 20 feet.

[1] The measurements for the MIO 160/140 and MIO 160/125 districts noted in CAC Recommendation 7, at pages 12 and 25 of Exhibit 8, are incorrect. The correct measurements are noted in the motion that adopted Recommendation 7, which is found at page 212 of Exhibit 8. These measurements are reflected in Exhibit 93.

On the west boundary along Sand Point Way Northeast setbacks would be 10 feet from 40th Avenue Northeast to Penny Drive, and 40 feet from Penny Drive to Northeast 50th Street. In their Settlement Agreement, Children's agreed to increase the setback along Northeast 45th Street to a minimum 75 foot setback along the entire Northeast 45th Street frontage.

Landscaping and Open Space

68. Children's existing campus includes extensively landscaped edges and open space. Children's proposes similar "garden-edge" landscaping within the proposed north, south and east setbacks. On the west, along 40th Avenue Northeast and Sand Point Way Northeast, Children's proposes to landscape the street frontage edges. Extensive landscaping is currently located within Laurelon.

69. Open space on the main campus is proposed to decrease from 45% to 41% of lot area. Some open spaces will continue to be available for community use, and Children's proposes streetscape and pedestrian amenity improvements around and across the campus, including pathways, lighting and plantings.

70. The CAC was concerned that open space is maintained and accessible. It recommended that designated open space be provided in locations at ground level or other spaces accessible to the general public, and that no more than 20% of the designated open space be provided in rooftop locations. Children's has agreed to the recommended condition.

71. Councilmembers expressed a desire that mature, existing vegetation at Laurelon be maintained and preserved, if feasible, following redevelopment within the Laurelon expansion area.

Design

72. A design review process would address the design of new buildings. Children's anticipates that building façades would be composed of materials that aesthetically blend with the existing campus buildings, such as a "precast/ceramic wall cladding system or glazed aluminum curtain wall system". FEIS at 3.9-3.

Transitions

73. Transitions in height, bulk and scale are proposed to be addressed through the pattern of MIO district heights, setbacks, upper-level setbacks, landscaping and design elements.

74. The FEIS stated that the proposed MIMP would have some height, bulk and scale impacts when viewed from Sand Point Way Northeast, and on existing residential areas to the south and west. For the no-build scenario, Alternative 1, and the preferred alternative, Alternative 7R, Viewpoint 13 shows these impacts using a wide angle perspective from a location south of the single-family residences across from the south boundary of Laurelon, and south and west of the multifamily residences across 40th Avenue Northeast from Laurelon. FEIS, Appendix C. Viewpoint 8 also shows these impacts from a location west of the multifamily residences on 40th Avenue Northeast.

75. The Director advised, with respect to the original proposed MIMP, that the combination of the approximately 55-foot wide Northeast 45th Street right-of-way, 40-foot landscaped setback, and MIO 50 height district in which a 4- to 5-story garage will be constructed would create a sufficient transition between the row of one- and two-story single-family residences south of Laurelon and the proposed 125- and 140-foot towers to be constructed on that site. As part of the Settlement Agreement, Children's has agreed to change the MIO height district along Northeast 45th Street to be a MIO 37 foot zone for a continuous 75 foot depth along Northeast 45th Street. This corresponds with Children's agreement to establish a 75 foot continuous setback along Northeast 45th Street.

76. With respect to transitions on the west, the Director recommended that the MIMP include upper level setbacks along the western edge of campus, requiring that above 50 feet in height, the buildings step back at least 40 feet from the western property line. The Director also recommended that any proposed structure higher than 37 feet and located adjacent to a street edge is reviewed by a standing advisory committee pursuant to design guidelines that will be established.

Transportation, Access and Parking

77. Transportation-related impacts are addressed in section 3.10 and Appendix D of the FEIS. They are also examined in the Director's Report at 70-73 and in the Examiner's decision in MUP-08-035(W).

Transportation

78. Children's has proposed a transportation management program (TMP) that includes the information required by SMC 23.69.030 and SMC 23.54.016. Details of the TMP are found at pages 93-108 of the proposed MIMP, Exhibit 4, as well as in Exhibit 6, the FEIS, at Appendix D, Attachment T-9.

79. Children's existing TMP has reduced single occupant vehicle (SOV) commute trips to 38% of daytime employees. The proposed TMP includes enhancements to reduce that number to 30%, in increments of approximately 2% with each phase of development.

80. Proposed enhancements to Children's TMP include an expanded shuttle service linking the Children's campus to regional transit hubs, an extensive bicycle commute program, financial rewards for employees who commute by means other than SOV, various improvements to encourage alternative transportation, and improvements to Children's off-site parking program.

81. The CAC supported the enhanced TMP and recommended an additional provision restricting vehicle entrances on Northeast 45th and 50th Streets to service and emergency access only for the life of the MIMP. In addition, Children's will work with the standing advisory committee to develop additional pedestrian and bicycle-only perimeter access points and designated pedestrian and bicycle routes through the campus to allow efficient connection to the Burke Gilman Trail.

82. The FEIS projects that the MIMP will result in 8,400 new daily vehicle trips without mitigation measures, and 6,800 daily trips with the TMP. That equates to 850 new AM peak hour trips and 690 new PM peak hour trips without the TMP, and 540 new AM peak hour trips and 440 new PM peak hour trips with the TMP.

83. Level of service (LOS) is a measure of average delay at intersections and ranges from LOS A (free-flowing, minimal delay) to LOS F (extreme congestion, long delays). As a general rule, the City considers LOS D (using a weighted average of delays for all approaches) or better acceptable at the signalized intersections.

84. Most intersections in the vicinity of Children's are operating at LOS D or better and are expected to continue to do so in the "No Build" scenario. Notable exceptions are the "Five Corners" intersection (Northeast 45th Street/Union Bay Place Northeast), which presently operates at LOS F and is expected to deteriorate to LOS F with or without Children's expansion (FEIS, Page 3.10-17), and the Montlake Boulevard Northeast/Eastbound SR-520 ramps, which presently operates at LOS E and is expected to continue at that level.

85. Traffic times were calculated across two main corridors – Sand Point Way Northeast to the Montlake Bridge and Northeast 45th Street to Interstate 5 (I-5). The changes in travel times from "no build" to full build out of the MIMP, with an enhanced TMP include:

- Children's to Roanoke Exit via Sand Point Way Northeast/Montlake Northbound – 0 minutes;
- Children's to Roanoke Exit via Sand Point Way Northeast/Montlake Southbound – 1 minute;
- Children's to I-5 via Sand Point Way Northeast/Northeast 45th Street Westbound – 1 minute; and
- Children's to I-5 via Sand Point Way Northeast /Northeast 45th Street Eastbound – 2 minutes.

Exhibit 6 at 3.10-14 to 3.10-23

86. Some residents of the area expressed concern about congested traffic conditions in the area and questioned whether the traffic models used to predict intersection LOS at build out of the MIMP accounted for "pipeline projects" in the projection for background traffic. In addition to anticipated development at Children's, master use permit applications have been submitted for expansion of the Talaris Research and Conference Center at Northeast 41st Street and expansion of University Village shopping center. Other potential projects, such as redevelopment of the University Village QFC, are anticipated.

87. The FEIS shows that background traffic growth totaling 710 PM peak hour trips is projected at the Five Corners intersection and 450 trips at the intersection of Montlake Boulevard and Northeast 45th Street. At the hearing on the FEIS, the Director testified that together, the Talaris and University Village expansions are expected to generate 186 PM peak hour trips at Five Corners, and 193 PM peak trips at Montlake Boulevard/Northeast 45th Street of this growth.

88. The Director did not consider the transportation impacts of the state's project to improve SR 520 because funding for the project had not been approved when the FEIS and Director's Report were prepared. It is now known that the state's schedule for construction on the west side of the SR 520 project will coincide with the projected timeline for build out of the first two phases of Children's proposed MIMP. Exhibit R-10.

89. Approximately 10 percent of Children's employees commute by transit, and 12 percent drive or carpool to one of three off-site parking lots and commute via the shuttle service Children's provides between campus and the lots. Children's proposes under the preferred alternative to relocate shuttle and transit stops to Sand Point Way Northeast at 40th Avenue Northeast to provide more direct access to Children's.

90. Approximately 11% of Children's employees either walk or bike to work. To encourage increased utilization of non-motorized modes of travel, Children's proposes to construct new sidewalks along portions of Sand Point Way Northeast, develop new pedestrian and bicycle facilities for the MIO, and contribute to funds for improvements to pedestrian and bicycle facilities.

Access

91. Access to Children's under the preferred alternative will continue from Penny Drive via Sand Point Way Northeast. In addition, Children's proposes to add both an emergency entrance and a general parking entrance from 40th Avenue Northeast, a residential access street. 40th Avenue Northeast would also serve as a secondary service access. A traffic signal and crosswalk, with emergency vehicle preemption, will be added at the intersection of 40th Avenue Northeast and Sand Point Way Northeast.

92. Some Laurelhurst residents have expressed concern about potential congestion at the 40th Avenue Northeast access points. The street provides the major connection between the Laurelhurst community and northbound Sand Point Way Northeast, and emergency vehicles access Laurelhurst via 40th Avenue Northeast to Northeast 45th Street.

93. The transportation analysis determined that the two 40th Avenue Northeast access points would operate at LOS C or better at build out.

94. The FEIS recommends that a left turn lane be constructed on eastbound Northeast 45th Street at 40th Avenue Northeast to facilitate access to the proposed southwest garage from Northeast 45th Street.

95. The CAC recommended that Children's limit access from 40th Avenue Northeast to one point for either parking or emergency access, but not both, and instead, construct a second new access from Sand Point Way Northeast. The CAC also recommended that if the 40th Avenue Northeast entrance is used for parking, it should be designed so that vehicles entering and exiting the garage avoid travel on Northeast 45th Street east of Sand Point Way Northeast by traveling only on the portion of 40th Avenue Northeast between the access point and Sand Point Way Northeast.

96. DPD's consulting transportation engineer evaluated the possibility of adding a second access on Sand Point Way between the traffic signals at 40th Avenue Northeast and Penny Drive, but determined that it would degrade traffic operations on that roadway segment. Consequently, Children's did not agree to the CAC's recommendations.

Parking

97. The FEIS shows that peak parking demand under the MIMP at build out would be approximately 3,400 vehicles, but reduced to 3,190 vehicles with proposed TDM programs and 2,940 with both TDM programs and Transit Shuttles. SMC 23.54.016 requires Children's to supply 2,300 to 3,100 parking spaces, either on site or within off-site parking lots. Under this code section, additional spaces may be provided if the major institution is meeting its TMP goal. Children's originally proposed to supply 3,100 parking spaces on site, including Hartmann, and 500 leased off-site spaces as needed to mitigate future transportation impacts. This would be an increase of 1,418 spaces over existing provided parking. No specific provisions were provided in Children's Settlement Agreement concerning the potential location of the 225 parking spaces that were planned for Hartmann.

Mitigation Strategy and Unmitigated Impacts

98. Children's proposed transportation mitigation strategy, including phasing, is discussed at pages 3.10-56 to 3.10-67 of the FEIS and in Appendix D, and is summarized by the Director as follows:

(1) Children's design and facilities, including campus design, near-site improvements, and off-site parking. Campus improvements include development of a shuttle hub (perhaps combined with transit), additional bicycle parking and shower and locker facilities, a relocated "front door" for the hospital at 40th Ave Northeast, clear pedestrian flow paths from adjacent neighborhoods and through campus, and a redesign of Penny Drive to provide designed spaces for pedestrians and bicycles, as well as automobiles. Near-site improvements would consist of reconfiguring the Sand Point Way Northeast/40th Avenue Northeast intersection in conjunction with Seattle Department of Transportation (SDOT) to enhance pedestrian crossings, modifying the Sand Point Way Northeast/Penny Drive intersection, and restriping Northeast 45th St to accommodate a left-turn lane for eastbound-to-northbound turns. Wayfinding and design of near-site pedestrian and bicycle facilities would be improved, and connectivity between the hospital and the Burke-Gilman Trail would be enhanced through improved wayfinding and intersection enhancements. Children's also will continue to pursue new off-site and out-of-area remote parking facilities, which Children's would connect to the hospital campus with shuttle service.

(2) Children's Enhanced Transportation Management Program. To achieve a maximum 30% single-occupant vehicle goal, Children's would expand its existing transit shuttle program, to identify effective shuttle connections from downtown, the University District, and future light rail stations; add new trip reduction services and programs; and modify its parking management policies, including raising the cost of both on-campus single-occupant vehicle parking and commuter bonus awards.

(3) Contributions to area transportation facilities. This encompasses three general strategies:

(a) a contribution of $500,000 to construct Intelligent Transportation System improvements from Montlake Boulevard/Northeast 45th Street and Sand Point Way Northeast/Northeast 50th Street;

(b) a proportional share of Northeast Seattle transportation improvements identified in certain City documents (the University Area Transportation Action Strategy, the Sand Point Way Northeast Pedestrian Study, and the City of Seattle Bicycle Master Plan), amounting to approximately $1,400,000;

(c) a $2,000,000 contribution to cover unfunded pedestrian and bicycle improvements in Northeast Seattle, including priority projects from the Bicycle Master Plan, connections from Children's to the broader bicycle/pedestrian network, and possibly bicycle boulevards.

(4) Proportional share of installation of traffic signals at 40th Avenue Northeast/Northeast 55th Street and 40th Avenue Northeast/Northeast 65th Street. These intersections will be monitored by Seattle Department of Transportation over the life of the Master Plan to determine the timing of the mitigation implementation.

99. The FEIS shows that traffic generated by Children's will contribute to congestion and the deterioration of traffic conditions in the area. The proposed mitigation package would likely reduce impacts to traffic operations across the Montlake Boulevard and Northeast 45th Street corridors. The FEIS stated that "it is anticipated that a 40 to 60 percent improvement could be achieved as a result of this mitigation". Exhibit 6 at 3.10-67 to 3.10-68.

Construction

100. The Director has recommended several conditions to mitigate construction impacts of the proposed MIMP. The CAC has recommended an additional condition to mitigate impacts specific to construction on the Hartmann site, and Children's has agreed to the CAC's recommended condition. *See* Exhibit 26, Slide 28. However, potential conditions related to Hartmann are no longer applicable because this MIMP does not regulate development at the Hartmann site because it is outside of the MIO boundary.

Housing demolition and replacement

101. Major Institutions may not expand their boundaries if the expansion would result in demolition of housing "unless comparable replacement is proposed to maintain the housing stock of the city." SMC 23.34.124.B.7.

102. Children's proposes to expand its existing MIO boundaries into Laurelon and to demolish the 136 condominium housing units on that site.

103. Children's has agreed to purchase the Laurelon property for 2.55 times its fair market value, approximately $93,000,000, if Children's MIMP and boundary expansion are approved.

104. Rather than constructing replacement housing, Children's proposes to pay the City $5,000,000 in fulfillment of the housing replacement requirement. The City's Office of Housing believes that such a payment would satisfy the requirements of SMC 23.34.124.B.7, and entered into a Memorandum of Agreement (MOA) to that effect, subject to approval by the City Council. Exhibit R-6. Children's agreed that its proposed payment could be used to construct replacement housing that would be subject to City rent controls.

105. Under the terms of the proposed MOA, Children's payment would be combined with other funding sources to construct replacement housing, and Children's would receive full credit for fulfillment of the housing replacement requirement even though much of the replacement cost would be paid by other private or public fund sources.

106. The cost to construct 136 replacement housing units comparable to those to be demolished by Children's is estimated to be $31,218,136 based upon July, 2009 construction costs. Exhibit R-12.

Height District Rezone

107. The Director's Report addresses the required rezone in detail relative to the requirements of SMC 23.34.124 on designation of MIO's and SMC 23.34.008, the general rezone criteria. Exhibit 9 at 45-62.

108. Rezones are required for the areas identified in MIMP Figure 1 (Exhibit 4 at 12) as Laurelon, and for increased height districts on portions of the existing campus.

109. Laurelon is presently zoned L3 for low-density residential development. Laurelon was developed as a one-and two-story, garden-style apartment complex in the 1940s. Laurelon was converted to Condominiums in 1979.

110. The most recent Children's master plan and rezones were approved in 1994, and added 262,630 square feet, for a total allowed development area of 900,000 square feet. The FAR was increased from .5 to .9.

111. Children's existing height districts are shown in Exhibit 4, Figure 45 at 63. MIO heights are MIO 37 on the north, increasing to MIO 70 (conditioned to 69) and MIO 90 (conditioned to 74) toward the center of the campus, and decreasing to MIO 50 and MIO 37 on the south. Children's MIMP included proposed height districts, as modified by accepted CAC recommendations, and are shown in Exhibit 93. The proposed MIMP increases heights to MIO 65 on the northeast and MIO 90, MIO 160/140 and MIO 160/125 on approximately the west one-third of the center of the expanded campus, and adds MIO 50 and MIO 37 on the south part of the expanded campus. The extent of the proposed MIO 37 foot and MIO 50 foot height limits were modified in the Settlement Agreement. The MIO 37 foot height limit would be a continuous depth of 75 feet from Northeast 45th Avenue, to correspond to the continuous 75 foot setback from Northeast 45th. As a result of the proposal in the Settlement Agreement to eliminate Hutchinson from the MIO, no change in zoning at Hutchinson is required.

112. The Director advises that the MIO rezones as originally proposed are consistent with the zoning principle that requires minimization of the impact of more intensive zones on less intensive zones through use of transitions or buffers, if possible. (SMC 23.34.008.E.1); that with recommended conditioning, the height limits of the district boundaries are compatible with heights in adjacent areas (SMC 23.34.124.C.2); and that transitional height limits have been provided where the maximum permitted height within the MIO is significantly higher than permitted heights in adjoining areas (SMC 23.34.124.C.3).

113. The Director also advises that the rezone is consistent with the zoning principle which provides that, in general, height limits greater than 40 feet should be limited to urban villages, and that height limits greater than 40 feet may be considered outside urban villages if the limits would be consistent with an adopted neighborhood plan, a major institution's adopted master plan, or the existing built character of the area (SMC 23.34.008.E.4).

Conclusions

Need and Public Benefit

1. There is no question raised concerning the public benefits that Children's provides and will provide in the future. The record includes a substantial amount of information about Children's exceptional work.

2. Although SEPA allows an applicant broad latitude in defining its own development objectives, SMC 25.05.440.D, of the Major Institution Code requires more when it comes to "need". To assure that the Master Plan balances the projected needs of the Major Institution with the need to minimize impacts on surrounding neighborhoods, as required by SMC 23.69.025, it is necessary to know with some degree of accuracy what the Major Institution's needs actually are.

3. Testimony by Children's and LCC's healthcare planning experts was provided during the appeal hearing. However, because of illness, LCC's expert on healthcare planning was not subject to cross examination. There is evidence in the record showing that, in calculating bed need, LCC's expert incorrectly excluded patients ages 15 and over from the first step of the state methodology used for calculating need, and used a "midnight occupancy level" for Children's that assumed any available bed could be used for any patient. In fact, Children's 230 acute-care beds are located in several discrete specialty units and are generally not interchangeable. These errors resulted in a report from LCC's expert that understated total bed need. The report is also inconsistent with Children's current experience.

4. The evidence in the record shows that the Certificate of Need process requires, among other things, that an applicant demonstrate that it has control of a site proposed for expansion; document that the proposed site may be used for the intended project and is properly zoned; provide a project timeline; and begin the project within two years of receiving a Certificate of Need. Consequently, it appears that an approved MIMP is necessary before Children's can successfully apply for a Certificate of Need.

5. Children's has shown a projected statewide need for specialized pediatric care over the next 20 years sufficient to support the development area being requested in the proposed MIMP.

6. The CAC's recommended condition, that approval of Master Use Permits for the various phases of development be contingent on a demonstration of need by Children's, and restricting use of space within the MIO primarily to those providing pediatric medical care or directly related services, is appropriate and should be included as a condition if the MIMP is approved.

Boundary Expansion

7. The Code strongly discourages expansion of MIO boundaries, and calls for MIOs to include contiguous areas that are as compact as possible within the constraints of existing development and property ownership. However, the Code also stresses the need to protect the livability and vitality of adjacent neighborhoods. As suggested in the Director's Report, the likely intent of Code provisions discouraging boundary expansion is to protect established residential neighborhoods from unrestrained major institution expansion. In this case, nearby residential neighborhoods are better protected by expansion of the MIO boundary to include the Laurelon site than they would be by requiring Children's to accommodate the entire projected need within existing boundaries.

8. Children's enhanced TMP, including connections to the Burke Gilman Trail on the Hartmann site, and transit and shuttle improvements on both sides of Sand Point Way, was developed to provide partial mitigation for the significant adverse transportation impacts associated with each of the alternatives studied, including the non-Hartmann Alternative 8

9. The CAC's recommended conditions to reduce the bulk and scale and other impacts on neighboring properties are appropriate and should be included as a condition of approval. The mitigation of these impacts is achieved through additional property line, and upper level structure setbacks and the approval by DPD of site specific design guidelines.

Intensity

10. The increase in lot coverage from the 35% coverage allowed in the underlying single-family zone to 51%, an amount similar to the 45%-50% coverage allowed in the underlying L3 zone at Laurelon, will increase the intensity of development on the Children's campus but not to an unreasonable extent. No change in lot coverage was included in the Settlement Agreement.

11. The Settlement Agreement proposes a reduction from 2.4 million square feet to 2.125 million gross square feet of development area, or a reduction of 275,000 square feet. The reduced square feet are associated with the exclusion of the 150,000 square feet of development proposed for Hartmann as well as an additional 125,000 square feet deducted from the remaining area of MIO. Rooftop mechanical equipment and all above and below ground parking areas are excluded from the calculation of gross square feet of development.

12. Exclusions from FAR calculations under the Code depend upon the zone in which a proposal is located. Since FAR does not apply to single-family or Lowrise zones, which is the underlying zoning within the MIO, there are currently no prescribed FAR limits or exclusions governing this application, as stated in the Director's interpretation

13. Children's has agreed that a FAR of 1.9 is sufficient to meet its development needs. No change in FAR was included in the Settlement Agreement. As no provisions were made concerning the method of calculation of FAR, SMC 23.86.007 as now or hereafter amended shall be used when determining FAR.

Development Standards and Transitions

14. The Examiner recommended that MIO heights be measured from existing or finished grade, whichever is lower, in accordance with SMC 23.86.006, as now or amended.

15. All property line setbacks proposed in the MIMP meet or exceed the setbacks required in the underlying zones. In addition, the proposed upper level setbacks are designed to mitigate the impacts of additional height bulk and scale resulting from the MIMP. These measures, along with the proposed landscaping, height restrictions and open space plan, provide adequate mitigation of height bulk and scale impacts on surrounding properties.

16. The setback on the east boundaries, together with moving the greatest mass of development to the west side of the campus and stepping it down the hillside, will provide a sufficient buffer for the single-family neighborhood to the east.

Transportation, Access and Parking

17. The issue of whether the forecast for PM peak hour background trips included in the traffic model was sufficient to cover traffic generated by known "pipeline projects" is a SEPA issue and was addressed briefly in the decision on MUP-08-035(W). To summarize, the record shows that the background traffic forecast was sufficient to cover known "pipeline projects". Further, Master Use Permit applications and additional environmental review would be required for each project within Children's proposed MIMP. Additional mitigation could be required if it were shown that a shortfall in forecast traffic growth will likely lead to unanticipated transportation impacts.

18. Although approval of the MIMP is expected to result in significant adverse impacts on traffic, the FEIS shows that a 40 percent and 60 percent improvement in travel time could be achieved as a result of the proposed mitigation package, relative to impacts without such mitigation.

19. Although there is significant concern by some neighborhood groups about congestion on 40th Avenue Northeast, the evidence in the record shows that the two access points proposed for this street will operate at LOS C or better, and that moving one of the access points to Sand Point Way Northeast would degrade traffic operations on that arterial. The CAC's suggestion to limit access from 40th Avenue Northeast to one entrance should not be included as a condition of approval.

20. The transportation impacts of the overlap between the state's schedule for construction on the west side of the SR 520 project and build out of the first two phases

of Children's proposed MIMP must be considered and appropriate mitigation imposed. However, the analysis would be more accurate, and the mitigation more effective, if current information available during the Master Use Permit process for each development project were used.

Housing

21. SMC 23.24.127 (B) (7) contemplates that a major institution may satisfy the housing replacement obligation by financing and constructing the replacement housing itself, and therefore Children's is entitled to do that if it chooses to do so. However as a matter of policy the Council will allow Children's to pay the City to facilitate the provision of replacement housing, as further described in Conclusions 22-24.

22. If Children's elects to pay the City to facilitate the provision of the replacement housing, then Children's shall pay the City 35% of the estimated cost of the replacement housing. Based upon a 2009 estimated replacement cost of $31.2 million (Exhibit R-12), Children's payment to the City would be $10,920,000.

23. If Children's prefers to have the 35% figure determined on the basis of the estimated replacement cost at the time it proceeds with development, then it may ask DPD and the Office of Housing to determine that cost at that time. To assist DPD and the Office of Housing to make that determination, Children's must submit at least two development pro formas that describe the estimated replacement cost. The determination by DPD and the Office of Housing of the estimated replacement cost is final and not subject to appeal.

24. If Children's elects to pay the City to facilitate the provision of replacement housing, the City may use Children's payment to construct housing that is affordable. If Children's elects to build the housing itself, it may build affordable housing, but is not required to do so.

Height District Rezone

25. The Laurelon expansion area is across the street from a well-established single-family zone to the south and a limited area of multifamily residences in an L3 zone across 40th Ave Northeast. The impact of rezoning Laurelon to MIO-160, conditioned to heights of 140 feet and 125 feet (MIO-160/140 and MIO-160/125), and the anticipated corresponding development allowed under the MIMP, can be minimized by the use of proposed transitions in height, upper level setbacks, the proposed property line setbacks and the use of design guidelines that have been included in the MIMP and recommended to be further amended by DPD. With these measures, in light of the overall approach in this MIMP and the limited number of properties directly affected by the proposed expansion, the mitigation of the rezone impacts is appropriate. However, the mitigating measures required here are based on a review of the proposed impacts outlined in this MIMP and the related final EIS. It should not be concluded that this solution is appropriate in any other circumstance where a MIO seeks an expansion and the expansion area is across a right of way from a residential zone.

Balancing

26. SMC 23.69.025 states that "the intent of the Major Institution Master Plan shall be to balance the needs of the Major Institutions to develop facilities for the provision of health care or educational services with the need to minimize the impact of Major Institution development on surrounding neighborhoods.

27. Council reviewed the proposed MIMP, revised MIMP, Final EIS and revised Final EIS, the Hearing Examiner's record, and considered oral argument and submittals from appellants, including the Settlement Agreement. It is Council's conclusion that the MIMP embodies an appropriate balance between Children's need for long-term growth and the need to lessen the impact of that growth on the surrounding community, and should therefore be approved. Mitigation measures are found in Children's significant commitments that include **1)** reducing and managing the transportation impacts by employees and patients while improving the transportation infrastructure at or near its campus; **2)** creating a development plan that lessens the impacts of new buildings through significant setbacks, the siting of new buildings and limitations on lot coverage; **3)** limiting the massing and location of new buildings to lessen their visual impacts on surrounding properties; **4)** providing a comprehensive open space network to provide relief from bulk and scale of development while providing passive recreation opportunities for the campus; and **5)** a commitment to landscaping that enhances the campus while shielding it from neighboring properties.

28. The City's Land Use Code (SMC Title 23) and substantive SEPA policies (SMC 25.05) authorize reference to the City's Comprehensive Plan as a basis for review of a proposed MIMP only with respect to specific Comprehensive Plan policies identified in those ordinances, neither of which include policies related to the "urban village" strategy described in that Plan. Therefore the Council lacks authority to consider those policies as a basis for its decision whether to approve the proposed MIMP.

29. The Council has reviewed the record of public participation that includes the role of the Citizen's Advisory Committee and the process that allowed the general public to comment from the plan's initial inception up through and including the Hearing Examiner's hearings on the final MIMP and final EIS. Council concludes that this process was fair, thorough, thoughtful, deliberative and designed to provide a balance between the stated plans detailed by Children's in their MIMP and the concerns expressed by members of the community.

30. The Council takes notice of the February 3, 2010 Settlement Agreement that was provided to the Council as part of the oral argument heard by Council on February 10, 2010. The Council appreciates that Children's and the LCC have concluded an agreement concerning the scope of physical development in keeping with the intent of the balancing section in SMC 23.69.025.

DECISION

The Council hereby **approves** the MIMP for Seattle Children's Hospital, Clerk's File 308884, subject to the following MIMP and SEPA conditions.

MIMP CONDITIONS

As a requirement for approval of the Children's MIMP, Children's shall comply with the following conditions:

1. Total development on the existing and expanded campus shall not exceed 2,125,000 gross square feet, excluding above and below grade parking and rooftop mechanical equipment.

2. The Floor Area Ratio (FAR) for the expanded campus shall not exceed 1.9, excluding below grade developable floor area, below-grade parking structures and rooftop mechanical equipment.

3. No more than 20% of the land area within the MIO, approximately 264,338 square feet, may include structures that exceed 90 feet in height. No more than 10% of the land area within the MIO, approximately 142,596 square feet, may include structures that exceed 125 feet in height. No structure in the MIO shall exceed 140 feet in height, excluding rooftop mechanical equipment.

4. MIO heights shall be measured in accordance with SMC 23.86.006 as now or hereafter amended.

5. Children's shall amend Section IV.D.1 of the Master Plan to add upper level setbacks 80 feet deep, applied to portions of buildings higher than 50 feet, along the western edge of the expanded campus on 40th Avenue Northeast from Sand Point Way Northeast south to Northeast 45th Street, and 30 feet deep on Sand Point Way from 40th Avenue Northeast to Penny Drive.

6. Children's shall amend Section IV.D.1 and Master Plan Figure 50, "Proposed Structure Setbacks," to increase the south setback to 75 feet along the entire Northeast 45th Street boundary.

7. Children's shall amend Section IV.C.1 of the Master Plan to expressly prohibit above-ground development within the setback areas, as shown on revised Figure 50, except as otherwise allowed in the underlying zone.

8. The Hartmann site as originally proposed in the MIMP is not included within the MIO boundary and is not subject to this MIMP.

9. A minimum of 41% (being 507,000 square feet) of the combined total area of the expanded campus shall be maintained as open space. In addition:

a. Open Space should be provided in locations at ground level or, where feasible, in other spaces that are accessible to the general public. No more than 20% (being 101,000 square feet) of the designated 41% open space, shall be provided in roof top open spaces;
b. Open Space areas shall include existing and proposed ground level setback areas identified in the Master Plan, to the extent that they meet the criteria in the proposed Design Guidelines;
c. The location of open space, landscaping and screening as shown on Figure 42 of the Master Plan may be modified as long as the 41% figure is maintained;
d. To ensure that the 41% open space standard is implemented with the Master Plan, each planned or potential project should identify an area that qualifies as Open Space as defined in this Master Plan;
e. Open Space that is specifically designed for uses other than landscaped buffers or building setback areas, such as plazas, patios or other similar functions, should include improvements to ensure that the space contains Usable Open Space as defined under SMC 23.84A.028; and
f. Open space shall be designed to be barrier-free to the fullest extent possible.

10. For the life of the Master Plan, Children's should maintain open space connections as shown on Figure 56 of the Final Master Plan, or similar connections constituting approximately the number and location of access points as shown in the Master Plan. During the review of all future buildings, Children's should evaluate that building's effect upon maintaining these connections. If Children's proposes to change the open space connections from surrounding streets from that shown on Figure 56, it shall first provide notice to DPD and DON, and formally review the proposed changes with the SAC.

11. The City's tree protection ordinance, SMC 25.11, applies to development authorized by this MIMP. In addition, to the extent feasible, any trees that exceed 6 caliper inches in width measured three feet above the ground and that are located within the Laurelon expansion area shall be used on Children's campus.

12. Children's shall amend Section V.D, "Parking" on page 104 of the Final Master Plan to add the following at the end of that subsection: "As discussed in the TMP, the forecasted parking supply including the potential leasing of off-site spaces, exceeds the maximum allowed under the Land Use Code. Therefore, if Children's continues to meet its Transportation Master Plan goals, the Master Plan authorizes parking in excess of the Code maximum to minimize adverse parking impacts in the adjacent neighborhood."

13. Children's shall amend Table 3 "Development Standard Comparisons" in the Master Plan to be consistent with all modifications to development standards made by this decision.

14. Prior to the submittal of the first Master Use Permit application for Phase 1, Children's must draft a more comprehensive set of Design Guidelines for planned and potential structures, to be reviewed by the Seattle Design Commission and approved by DPD. The Design Guidelines are not a part of this approved MIMP, but shall be an appendix to the Master Plan, and shall address issues of architectural concept, pedestrian scale, blank wall treatment, tower sculpting, nighttime lighting, and open space and landscaping, among others.

15. Children's shall create and maintain a Standing Advisory Committee (SAC) to review and comment on all proposed and potential projects prior to submission of their respective Master Use Permit applications. The SAC shall use the Design Guidelines for their evaluation.

16. Prior to issuance of any MUP for any project under Phases 2, 3 and 4 of the Master Plan, Children's shall provide documentation to the Director and the SAC clearly demonstrating that the additional construction requested is needed for patient care and directly related supporting uses by Children's, including administrative support.

17. The TMP will be governed consistent with Director's Rule 19-2008, or any successor rules. In addition, Children's shall achieve a 30% SOV goal at full build out of the MIMP. The 30% SOV goal shall be achieved in increments, as Children's moves from its current 38% SOV mode split to the 30% goal at build out of the MIMP.

18. No portion of any building on Children's extended campus shall be rented or leased to third parties except those who are providing pediatric medical care, or directly related supporting uses, within the entire rented or leased space. Exceptions may be allowed by the Director for commercial uses that are located at the pedestrian street level along Sand Point Way Northeast, or within campus buildings where commercial/retail services that serve the broader public are warranted.

19. Before Children's may receive a temporary or permanent Certificate of Occupancy for any structure that is included in any phase of proposed development described on page 66 of the MIMP, DPD must find that Children's has performed either of the following options:

a. That Children's has submitted an application for a MUP for the construction of comparable housing, as defined below, in replacement of the housing demolished at Laurelon Terrace. In the event that Children's will construct more than one housing project to fulfill the housing replacement requirement, then Children's must have applied for a MUP for the first housing replacement project, which shall include no fewer than 68 housing units. A MUP application must be submitted for all of the remaining replacement units before a temporary or permanent certificate of occupancy may be issued for any project authorized in Phases 2-4 of the MIMP. The MUP application(s) for the replacement housing project(s) may not include projects that were the subject of a MUP application submitted to DPD before Council approval of the MIMP. Children's may seek City funds to help finance the replacement housing required by this condition, but may not receive credit in fulfillment of the housing replacement requirement for that portion of the housing replacement cost that is financed by City funds. City funds include housing levy funds, general funds or funds received under any housing bonus provision.

b. That Children's has either 1) paid the City of Seattle $10,920,000 to help fund the construction of comparable replacement housing or 2) paid the City of Seattle 35% of the estimated cost of constructing the comparable replacement housing, as determined by DPD and the Office of Housing. In determining the estimated cost, DPD and the Office of Housing shall consider at least two development pro-forma, prepared by individual(s) with demonstrated expertise in real estate financing or development, and submitted by Children's. DPD and the Office of Housing's determination of the estimated cost is final and not subject to appeal. Money paid to the City under this option b shall be used to finance the construction of comparable replacement housing, as defined below, and subject to the provisions of the City's Consolidated Plan for Housing and Community Development and the City's Housing Levy Administrative and Financial Plan in existence at the time the City helps finance the replacement housing.

For purposes of this condition 19, the comparable replacement housing must meet the following requirements:

1) Provide a minimum of 136 housing units;
2) Provide no fewer than the number of 2 and 3 bedroom units as those in the Laurelon Terrace development;
3) Contain no less than 106,538 gross square feet;
4) The general quality of construction shall be of equal or greater quality than the units in the Laurelon Terrace development; and
5) The replacement housing will be located within Northeast Seattle. Northeast Seattle is bounded by Interstate 5 to the west, State Highway 520 to the south, Lake Washington to the east, and the City boundary to the north.

20. Children's shall develop a Construction Management Plan (CMP) for review and comment by the SAC prior to the approval of any planned or potential project discussed in the Master Plan. The CMP must be updated at the time of site-specific SEPA review for each planned or potential project identified in the MIMP. The CMP shall be designed to mitigate impacts of all planned and potential projects and shall include mitigating measures to address the following:

a. Construction impacts due to noise
b. Mitigation of traffic, transportation and parking impacts on arterials and surrounding neighborhoods
c. Mitigation of impacts on the pedestrian network
d. Mitigation of impacts if more than one of the projects outlined in the Master Plan are under concurrent construction

21. Prior to the issuance of a Certificate of Occupancy for any project associated with development of Phase 1 of the MIMP, the proposed traffic signal at 40th Avenue Northeast and Sand Point Way NE shall be installed and functioning.

SEPA CONDITIONS

Geology

22. To minimize the possibility of tracking soil from the site, Children's shall ensure that its contractors wash the wheels and undercarriage of trucks and other vehicles leaving the site and control the sediment-laden wash water using erosion control methods prescribed as City of Seattle and King County best management practices for construction projects. Such practices include the use of sediment traps, check dams, stabilized entrances to the construction site, erosion control fabric fences and barriers, and other strategies to control and contain sediment.

23. Children's shall ensure that its contractors cover the soils loaded into the trucks with tarps or other materials to prevent spillage onto the streets and transport by wind.

24. Children's shall ensure that its contractors use tarps to cover temporary on-site storage piles.

Air Quality

25. Prior to demolition of the existing housing units at Laurelon Terrace, Children's shall perform an asbestos and lead survey and develop an abatement plan to prevent the releases into the atmosphere and to protect worker safety.

26. During construction, Children's shall ensure that its contractors spray exposed soils and debris with water or other dust suppressants to reduce dust. Children's shall monitor truck loads and routes to minimize impacts.

27. Children's shall stabilize all off-road traffic, parking areas, and haul routes, and it shall direct construction traffic over established haul routes.

28. Children's shall schedule delivery of materials transported by truck to and from the project area to minimize congestion during peak travel times on adjacent City streets. This will minimize secondary air quality impacts otherwise caused by traffic having to travel at reduced speeds.

29. Children's shall ensure that its contractors cover any exposed slopes/dirt with sheets of plastic.

30. Around relevant construction areas, Children's shall install perimeter railings with mesh partitioning to prevent movement of debris during helicopter landings.

Noise

31. Construction will occur primarily during non-holiday weekdays between 7:00 am and 6:00 pm, or as modified by a Construction Noise Management Plan, approved by DPD as part of a project-specific environmental review.

32. Children's will inform nearby residents of upcoming construction activities that could be potentially loud. Children's shall schedule particularly noisy construction activities to avoid neighborhood conflicts whenever possible.

33. Impact pile driving shall be avoided. Drilled piles or the use of a sonic vibratory pile driver are quieter alternatives.

34. Buildings on the extended campus are to be designed in such a way that noise received in the surrounding community is no greater than existing noise based on a pre-test of ambient noise levels and subsequent annual noise monitoring to be conducted by Children's.

Transportation

35. Consistent with the Transportation Management Plan (TMP), onsite improvements shall include: a shuttle hub; an enhanced campus pathway to connect to transit along Sand Point Way Northeast and/or 40th Ave Northeast; and bicycle parking.

36. Consistent with the TMP, near-site improvements will include: working with Seattle Department of Transportation and Washington State Department of Transportation (WSDOT) to improve intersections such as Penny Drive/Sand Point Way Northeast and 40th Ave Northeast/Sand Point Way Northeast; improve connectivity between the Burke-Gilman Trail and Children's; enhance the Sand Point Way Northeast street frontage.

37. Consistent with the TMP, and as necessary to reduce future transportation impacts, Children's may provide off-site parking that reduces the level of required parking on site and reduces traffic on Northeast 45th St, Sand Point Way Northeast and Montlake Blvd/SR 520 interchange area.

38. Children's shall enhance its TMP to achieve a 50% single occupancy vehicle (SOV) mode split goal or lower.

39. Prior to the issuance of any construction permits for any project outlined in Phase 1 of the MIMP, Children's shall pay the City of Seattle its fair share to the future installation of traffic signals at 40th Ave Northeast/Northeast 55th St. Prior to the issuance of any construction permits for any project outlined in Phase 2 of the MIMP, Children's shall pay the City of Seattle its fair share, based on the to the future installation of traffic signals at 40th Ave Northeast/Northeast 65th St. These intersections shall be monitored by the Seattle Department of Transportation over the life of the Master Plan to determine the timing of the mitigation implementation.

40. Prior to the issuance of any construction permits for any project outlined in Phase 1 of the MIMP, Children's shall pay the City of Seattle $500,000 to build Intelligent Transportation System improvements through the corridor from Montlake Blvd/Northeast 45th St to Sand Point Way Northeast/Northeast 50th St. The contribution shall be used to fund all or part of the following projects:

a. Install a detection system that measures congestion along southbound Montlake Boulevard, linked to smart traffic control devices that adapt to traffic conditions;
b. Install variable message signs to give real-time traffic information for drivers, including travel time estimates, updates of collisions and other traffic conditions, and to implement variable speed limits throughout the day to keep traffic flowing as smoothly as possible;
c. Optimize signal coordination and timing to move vehicles most efficiently and optimize signal performance;
d. Upgrade signal controllers as needed to allow signals to be interconnected; and/or
e. Install traffic cameras as identified by the City of Seattle

41. Children's shall pay the Seattle Department of Transportation (SDOT) a pro rata share of the Northeast Seattle Transportation improvement projects identified from the University Area Transportation Action Strategy, the Sand Point Way Northeast Pedestrian Study, and the City of Seattle Bicycle Master Plan. This amount is estimated at approximately $1,400,000 or approximately $3,955 per bed, over the life of the MIMP (adjusted for inflation as beds come online). Each pro-rata share payment shall be made prior to the issuance of any construction permits for the first project constructed under each phase of the MIMP. The total payment of $1,400,000 shall be completed by the issuance of any construction permit for a project outlined in Phase 4 of the MIMP.

42. Children's shall pay the Seattle Department of Transportation (SDOT) a total of $2,000,000 for pedestrian and bicycle improvements in Northeast Seattle over the timeframe of the Master Plan development. A pro-rata share payment shall be made prior to the issuance of any construction permits for the first project constructed under each phase of the MIMP. The total payment of $2,000,000 shall be completed by the issuance of any construction permit for a project outlined in Phase 4 of the MIMP.

Dated this 5th day of April, 2010.

City Council President

PARTIES OF RECORD – CHILDREN'S HOSPITAL MIMP APPEALS

1. **Seattle Displacement Coalition/Interfaith Taskforce on Homelessness**
   John V Fox, Seattle Displacement Coalition, 4554 – 12th Ave NE, Seattle, WA 98105
   Bill Kirlin-Hackett, Interfaith Task Force on Homelessness, 3030 Bellevue Way NE, Bellevue, WA 98004

2. **Coalition of Major Institutions**
   Thomas Walsh and Judy Runstad, Foster Pepper Law Firm, 1111 Third Ave, Suite 3400, Seattle, WA 98101

3. **Catherine Hennings – Member of Children's Hospital Citizen Advisory Committee and resident of Laurelhurst Neighborhood**
   Catherine J Hennings, 3638 – 49th Ave NE, Seattle, WA 98105

4. **Steve Ross – Chair, Friends of Children's Hospital and resident of Laurelhurst Neighborhood**
   Steve Ross, 3625 – 47th Ave NE, Seattle, WA 98105

5. **Hawthorne Hills Community Council**
   Bonnie Miller, Chair of Land Use Committee, 6057 Ann Arbor Ave NE, Seattle, WA 98115-7618

6. **Seattle Community Council Federation**
   Rick Barrett, Vice President, 1711 N 122nd Street, Seattle, WA 98133

7. **Seattle Children's Hospital**
   John F. Keegan, Davis Wright Tremaine, 1201 Third Avenue, Suite 2200, Seattle, WA 98101

8. **City of Seattle, Department of Planning and Development**
   Judith Barbour, Assistant City Attorney, Seattle City Attorney's Office, 600 Fourth Avenue, 4th Floor, P.O. Box 94769, Seattle, WA 98124-4769

9. **Laurelhurst Community Club**
   Peter J. Eglick and Jane S. Kiker, Eglick Kiker Whited, 1000 Second Avenue, Suite 3130, Seattle, WA 98104

10. **Dixie and Steve Wilson**
    Peter Buck, The Buck Law Group, 2030 First Avenue, Suite 201, Seattle, WA 98121

11. **Laurelon Terrace**
    Peter Buck, The Buck Law Group, 2030 First Avenue, Suite 201, Seattle, WA 98121

ATTACHMENT B

LEGAL DESCRIPTION OF CHILDREN'S MASTER PLAN PROPERTY

EXISTING CAMPUS

PARCEL A
THAT PORTION OF THE WEST HALF OF THE SOUTHEAST QUARTER OF THE SOUTHWEST QUARTER OF SECTION 10, TOWNSHIP 25 NORTH, RANGE 4 EAST, WILLAMETTE MERIDIAN, IN KING COUNTY, WASHINGTON, DESCRIBED AS FOLLOWS:

BEGINNING ON THE EASTERLY LINE OF SAID SUBDIVISION AT A POINT 658.20 FEET NORTHERLY OF THE SOUTHEAST CORNER THEREOF; THENCE WEST 271.44 FEET, MORE OR LESS TO THE WESTERLY LINE OF BLOCK 1, GWINN'S LAURELHURST MANOR ADDITION, ACCORDING OT THE PLAT THEREOF, RECORDED IN VOLUME 41 OF PLATS, PAGE 27, IN KING COUNTY WASHINGTON; THENCE NORTH 0°26'19" EAST ALONG THE NORTHRLY PRODUCTION OF SAID WESTERLY LINE TO THE SOUTHEASTERLY LINE OF SAND POINT WAY; THENCE NORTHEARTLY ALONG SAID SOUTHEASTERLY LINE TO THE SOUTHERLY LINE OF NORTHEAST 50TH STREET; THENCE EASTERLY ALONG SAID SOUTHERLY LINE TO THE EASTERLY LINE OF SAID SUBDIVISION; THENCE SOUTHERLY ALONG SAID EASTERLY LINE 630 FEET, MORE OR LESS, TO THE OF BEGINNING.

PARCEL B:
THE WEST 5.00 FEET OF THE NORTHEAST QUARTER OF THE SOUTHEAST QUARTER OF THE SOUTHWEST QUARTER OF SECTION 10, TOWNSHIP 25 NORTH, RANGE 4 EAST, WILLAMETTE MERIDIAN, IN KING COUNTY, WASHINGTON; EXCEPT THE NORTH 30.00 FEET THEREOF; AND EXCEPT THE SOUTH 25 FEET THEREOF.

PARCEL C:
BLOCKS 1, 2, 3, 4, 5 AND 6, GWINN;S LAURELHURST MANOR ADDITION, ACCORDING TO THE PLAT THEREOF, RECORDED IN VOLUME 41 OF PLATS, PAGE 27, IN KING COUNTY, WASHINGTON.

PARCEL D:
THOSE PORTIONS OF 42ND AVENUE NORTHEAST, 43RD AVENUE NORTHEAST, 44TH AVENUE NORTHEAST AND NORTHEAST 47TH STREET, VACATED UNDER ORDINANCE NO. 76010 OF THE CITY OF SEATTLE.

LAURELON TERRACE

THAT PORTION OF THE WEST HALF OF THE SOUTHEAST QUARTER OF THE SOUTHWEST QUARTER OF SECTION 10, TOWNSHIP 25 NORTH, RANGE 4 EAST, W.M., IN KING COUNTY, WASHINGTON, DESCRIBED AS FOLLOWS:

BEGINNING AT THE SOUTHWEST CORNER OF SAID SUBDIVISION; THENCE NORTH ALONG WEST LINE THEREOF TO ITS INTERSECTION WITH THE SOUTHEASTERLY LINE OF SAND POINT WAY; THENCE NORTH 35°10'24" EAST ALONG SAID SOUTHEASTERLY LINE, TO ITS INTERSECTION WITH THE WEST LINE OF BLOCK 1 OF GWINN'S LAURELHURST MANOR ADDITION, ACCORDING TO THE PLAT RECORDED IN VOLUME 41 OF PLATS, PAGE 27, IN KING COUNTY, WASHINGTON, PRODUCED NORTH; THENCE SOUTH ALONG SAID PRODUCED WEST LINE OF BLOCK 1 AND THE WEST LINE OF SAID BLOCK 1 TO THE SOUTH LINE OF SAID SUBDIVISION; THENCE WEST ALONG SAID SOUTH LINE TO THE POINT OF BEGINNING; EXCEPT THE SOUTH 30 FEET FOR EAST 45TH STREET; EXCEPT PORTION THEREOF LYING WITHIN 40TH AVENUE NORTHEAST; EXCEPT THAT PORTION THEREOF LYING WITHIN THE ALLEY ADJOINING TO THE WEST LINE OF SAID BLOCK 1, GWINN'S LAURELHURST MANOR ADITION, ACCORDING TO THE PLAT RECORDED IN VOLUME 41 OF PLATS, PAGE 27, IN KING COUNTY, WASHINGTON. EXCEPT A STRIP OF PARCEL OF LAND 50 FEET IN WIDTH OVER AND ACROSS A PORTION OF THE SOUTHEAST QUARTER OF THAT SOUTHWEST QUARTER OF SECTION 10, TOWNSHIP 25 NORTH, RANGE 4 EAST, W.M., IN KING COUNTY, WASHINGTON, THE CENTERLINE OF WHICH SAID STRIP IS DESCRIBED AS FOLLOWS:

BEGINNING AT THE SOUTHWEST CORNER OF SAID SUBDIVISION; THENCE OF THE WEST LINE THEREOF NORTH 0°25'38" WEST 235.54 FEET; THENCE NORTH 89°34'22" EAST 30 FEET TO THE TRUE POINT OF BEGINNING; THENCE FROM SAID POINT NORTH 89°34'22" EAST 129 FEET TO A POINT OF CURVE TO THE LEFT; THENCE WITH A RADIUS OF 42.50 FEET FOLLOWING THE ARC OF SAID CURVE THROUGH A CENTRAL ANGLE OF 90° FOR A DISTANCE OF 66.76 FEET TO A POINT OF TANGENCY; THENCE ON SAID TANGENT NORTH 0°25'38" WEST 179.85 FEET TO A POINT OF CURVE TO THE RIGHT; THENCE WITH A RADIUS OF 204 FEET FOLLOWING THE ARC OF SAID CURVE IN A NORTHERLY DIRECTION THROUGH A CENTRAL ANGLE OF 27°32'09" FOR A DISTANCE OF 98.04 FEET TO A POINT OF TANGENCY; THENCE ON SAID TANGENT NORTH 27°06'31" EAST 111.02 FEET TO A POINT OF CURVE TO THE LEFT; THENCE WITH A RADIUS OF 330 FEET FOLLOWING THE ARC OF SAID CURVE IN A NORTHERLY DIRECTION THROUGH A CENTRAL ANGLE OF 13°08'00" FOR A DISTANCE OF 75.64 FEET TO A POINT OF COMPOUND CURVE; THENCE WITH A RADIUS OF 98.94 FEET FOLLOWING THE ARC OF SAID CURVE TO THE LEFT IN A NORTHERLY DIRECTION THROUGH A CENTRAL ANGLE OF 69°00'00" FOR A DISTANCE OF 119.15 FEET TO A POINT OF TANGENCY; THENCE OF SAID TANGENT NORTH 55°01'29" WEST 58.75 FEET TO A POINT ON THE SOUTHEASTERLY LINE OF SAND POINT WAY; AND EXCEPT THE WEST 30 FEET OF THE NORTH 368 FEET OF THE SOUTH 298 FEET OF THE SOUTHEAST QUARTER OF THE SOUTHWEST QUARTER OF SAID SECTION 10, TOWNSHIP 25 NORTH, RANGE 4 EAST, W.M. IN KING COUNTY, WASHINGTON.

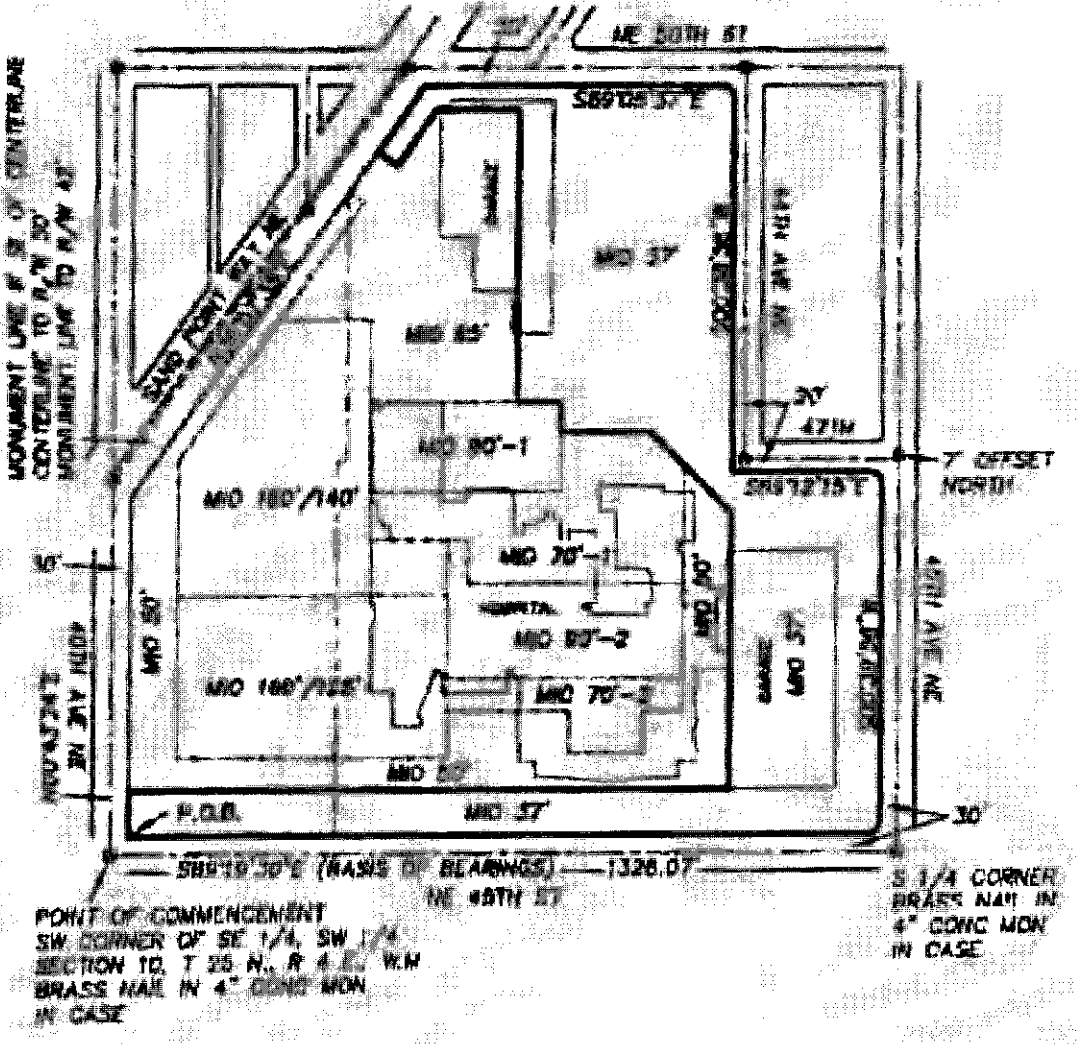
Children's Hospital and Regional Medical Center
Seattle Washington
March 12, 2010

MIO 37' Zone

That portion of the southeast quarter of the southwest quarter of Section 10, Township 25 North, Range 4 East, W.M., in the City of Seattle, King County, Washington described as follows:

COMMENCING at the southwest corner of said subdivision, being the intersection of 40th Ave NE and NE 45th St, and being marked by a brass nail in a 4" concrete monument in case, from whence the south quarter corner of said section, being a brass nail in a 4" concrete monument in case at the intersection of 45th Ave NE and NE 45th St., bears S89°19'30"E a distance of 1326.07 feet, thence S89°19'30"E a distance of 30.00 feet;
Thence N00°43'24"E a distance of 30.00 feet to the intersection of the north margin of NE 45th St. with the east margin of 40th Ave NE and the **POINT OF BEGINNING**;
Thence from said **POINT OF BEGINNING**, continuing N00°43'24"E, along said east margin, a distance of 75.00 feet;
Thence, leaving said margin, S89°19'30"E a distance of 1010.96 feet;
Thence N00°39'56"E a distance of 464.64 feet;
Thence N44°19'30"W a distance of 191.43 feet;
Thence N89°19'30"W a distance of 151.00 feet;
Thence N00°38'56"E a distance of 50.00 feet;
Thence N89°19'30"W a distance of 72.00 feet;
Thence N00°38'56"E a distance of 499.28 feet;
Thence N89°05'37"W a distance of 139.45 feet;
Thence S46°07'38"W a distance of 115.41 feet;
Thence N53°52'22"W a distance of 40.00 feet to the southeast margin of Sand Point Way NE;
Thence N36°07'38"E along said southeast margin a distance of 136.14 feet to the south margin of NE 50th St.;
Thence S89°05'37"E along said south margin a distance of 499.43 feet;
Thence tangent to the preceding course along the arc of a curve to the right, having a radius of 20.00 feet and a central angle of 89°44'38", an arc length of 31.33 feet to the west margin of 44th Ave NE;
Thence tangent to the preceding curve S00°38'56"W, along said west margin, a distance of 828.48 feet to the south margin of NE 47th St.;
Thence S89°12'15"E along said south margin a distance of 234.09 feet;
Thence tangent to the preceding course along the arc of a curve to the right having a radius of 20.00 feet and a central angle of 89°52'11", an arc length of 31.37 feet to the west margin of 45th Ave NE;
Thence tangent to the preceding curve S00°39'56"W, along said west margin, a distance of 567.94 feet;
Thence tangent to the preceding course along the arc of a curve to the right having a radius of 20.00 feet and a central angle of 90°00'34", an arc length of 31.42 feet to the north margin of NE 45th St.;
Thence tangent to the preceding curve N89°19'30"W along said north margin a distance of 1246.04 feet to the **POINT OF BEGINNING.**

Contains 456,631 sq. ft. +/- (10.48 acres)



MIO 37' ZONE

CHILDREN'S HOSPITAL AND REGIONAL MEDICAL CENTER
MIO HEIGHT LIMIT ZONES (MAJOR INSTITUTION OVERLAY)

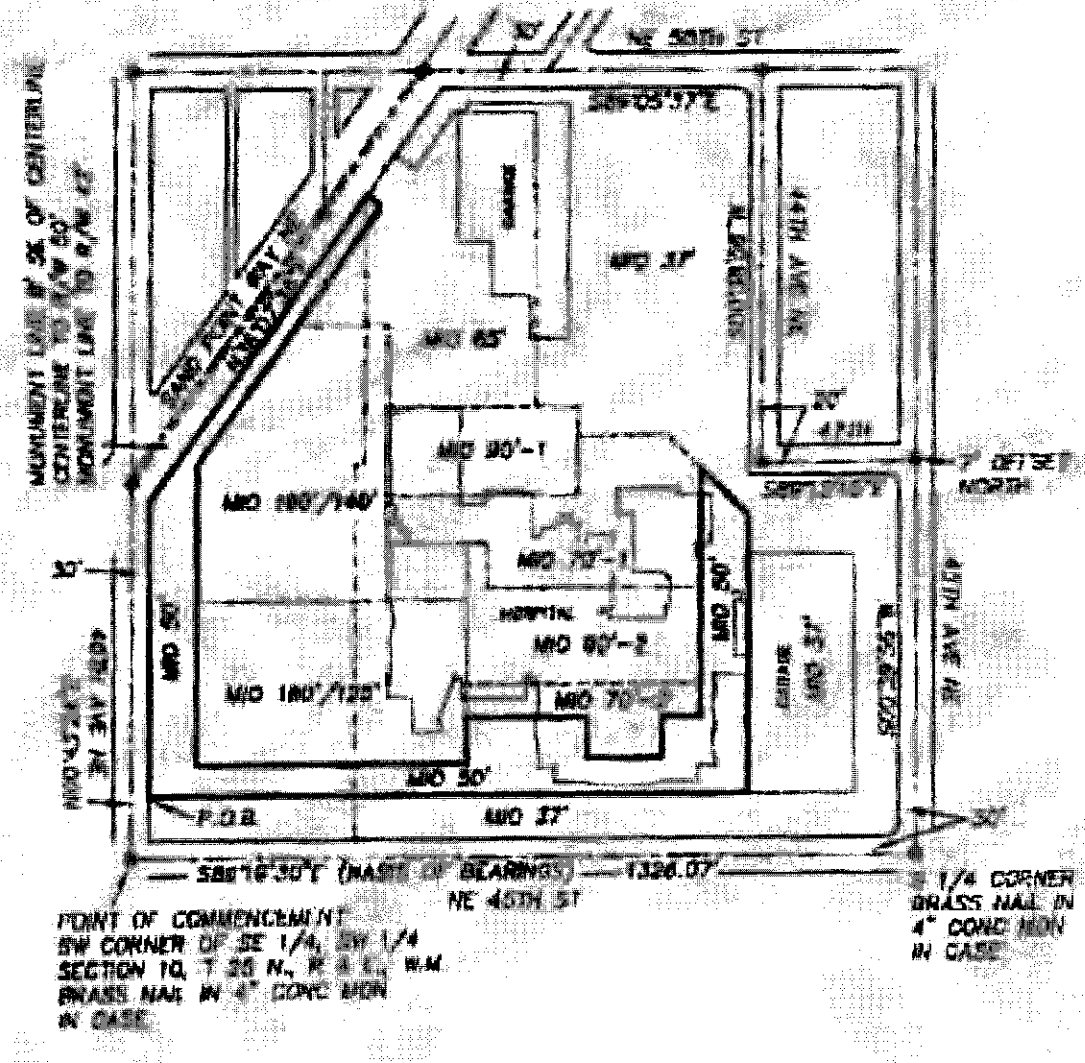
Children's Hospital and Regional Medical Center
Seattle Washington
March 16, 2010

MIO 50' Zone

That portion of the southeast quarter of the southwest quarter of Section 10, Township 25 North, Range 4 East, W.M., in the City of Seattle, King County, Washington described as follows:

COMMENCING at the southwest corner of said subdivision, being the intersection of 40th Ave NE and NE 45th St. and being marked by a brass nail in a 4" concrete monument in case, from whence the south quarter corner of said section, being a brass nail in a 4" concrete monument in case at the intersection of 45th Ave NE and NE 45th St., bears S89°19'30"E a distance of 1326.07 feet, thence S89°19'30"E a distance of 30.00 feet;
Thence N00°43'24"E a distance of 30.00 feet to the intersection of the north margin of NE 45th St. with the east margin of 40th Ave NE;
Thence continuing N00°43'24"E, along said east margin, a distance of 75.00 feet to the **POINT OF BEGINNING;**
Thence from said **POINT OF BEGINNING,** continuing N00°43'24"E, along said east margin, a distance of 493.17 feet to the southeast margin of Sand Point Way NE;
Thence N36°07'38"E along said southeast margin a distance of 628.44 feet;
Thence, leaving said margin, S53°52'22"E a distance of 30.00 feet;
Thence S36°07'38"W a distance of 533.55 feet;
Thence S00°43'24"W a distance of 501.87 feet;
Thence S89°19'30"E a distance of 455.91 feet;
Thence N00°39'56"E a distance of 78.00 feet;
Thence S89°19'30"E a distance of 205.00 feet;
Thence S00°39'56"W a distance of 70.00 feet;
Thence S89°19'30"E a distance of 125.00 feet;
Thence N00°39'56"E a distance of 70.00 feet;
Thence S89°19'30"E a distance of 65.00 feet;
Thence N00°39'56"E a distance of 414.65 feet;
Thence S44°19'30"E a distance of 113.16 feet;
Thence S00°39'56"W a distance of 464.64 feet;
Thence N89°19'30"W a distance of 1010.96 feet to the **POINT OF BEGINNING.**

Contains 166,007 sq. ft. +/- (3.81 acres)



MID 50' ZONE

CHILDREN'S HOSPITAL AND REGIONAL MEDICAL CENTER
MID HEIGHT LIMIT ZONES (MAJOR INSTITUTION OVERLAY)

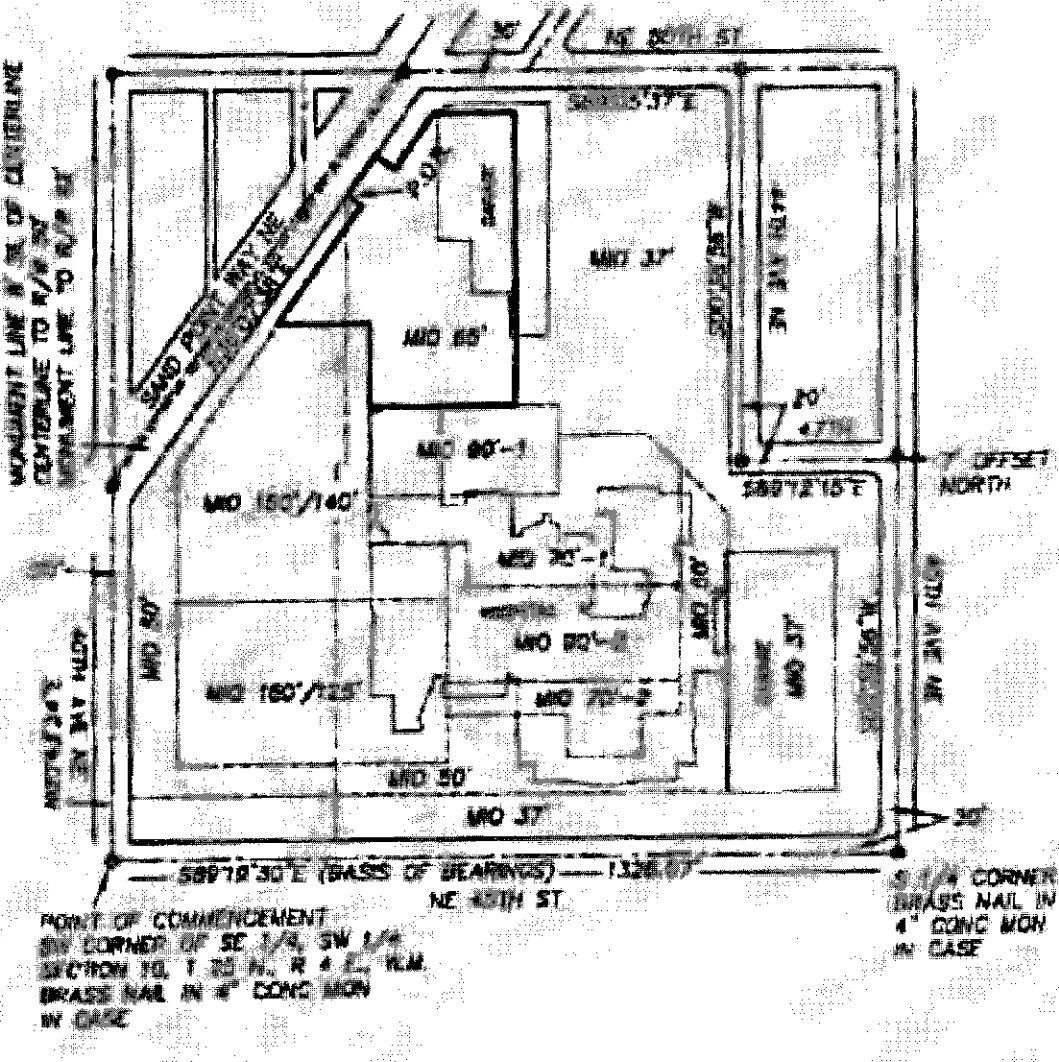
Children's Hospital and Regional Medical Center
Seattle Washington
April 1, 2010

MIO 65' Zone

That portion of the southeast quarter of the southwest quarter of Section 10, Township 25 North, Range 4 East, W.M., in the City of Seattle, King County, Washington described as follows:

COMMENCING at the southwest corner of said subdivision, being the intersection of 40th Ave NE and NE 45th St, and being marked by a brass nail in a 4" concrete monument in case, from whence the south quarter corner of said section, being a brass nail in a 4" concrete monument in case at the intersection of 45th Ave NE and NE 45th St., bears S89°19'30"E a distance of 1326.07 feet, thence S89°19'30"E a distance of 30.00 feet;
Thence N00°43'24"E a distance of 30.00 feet to the intersection of the north margin of NE 45th St. with the east margin of 40th Ave NE;
Thence continuing N00°43'24"E, along said east margin, a distance of 568.17 feet to the southeast margin of Sand Point Way NE;
Thence N36°07'38"E along said southeast margin a distance of 629.44 feet to the **POINT OF BEGINNING;**
Thence from said **POINT OF BEGINNING**, continuing N36°07'38"E, along said southeast margin, a distance of 82.40 feet;
Thence, leaving said margin, S53°52'22"E a distance of 40.00 feet;
Thence N36°07'38"E a distance of 115.41 feet;
Thence S89°05'37"E a distance of 139.45 feet;
Thence S00°38'56"W a distance of 493.28 feet;
Thence N89°19'30"W a distance of 249.63 feet;
Thence N00°42'32"E a distance of 139.00 feet;
Thence N89°19'30"W a distance of 155.07 feet;
Thence N36°07'38"E a distance of 244.91 feet;
Thence N53°52'22"W a distance of 30.00 feet to the **POINT OF BEGINNING.**

Contains 134,000 sq. ft. +/- (3.08 acres)



MID 65' ZONE

CHILDREN'S HOSPITAL AND REGIONAL MEDICAL CENTER
MID HEIGHT LIMIT ZONES (MAJOR INSTITUTION OVERLAY)

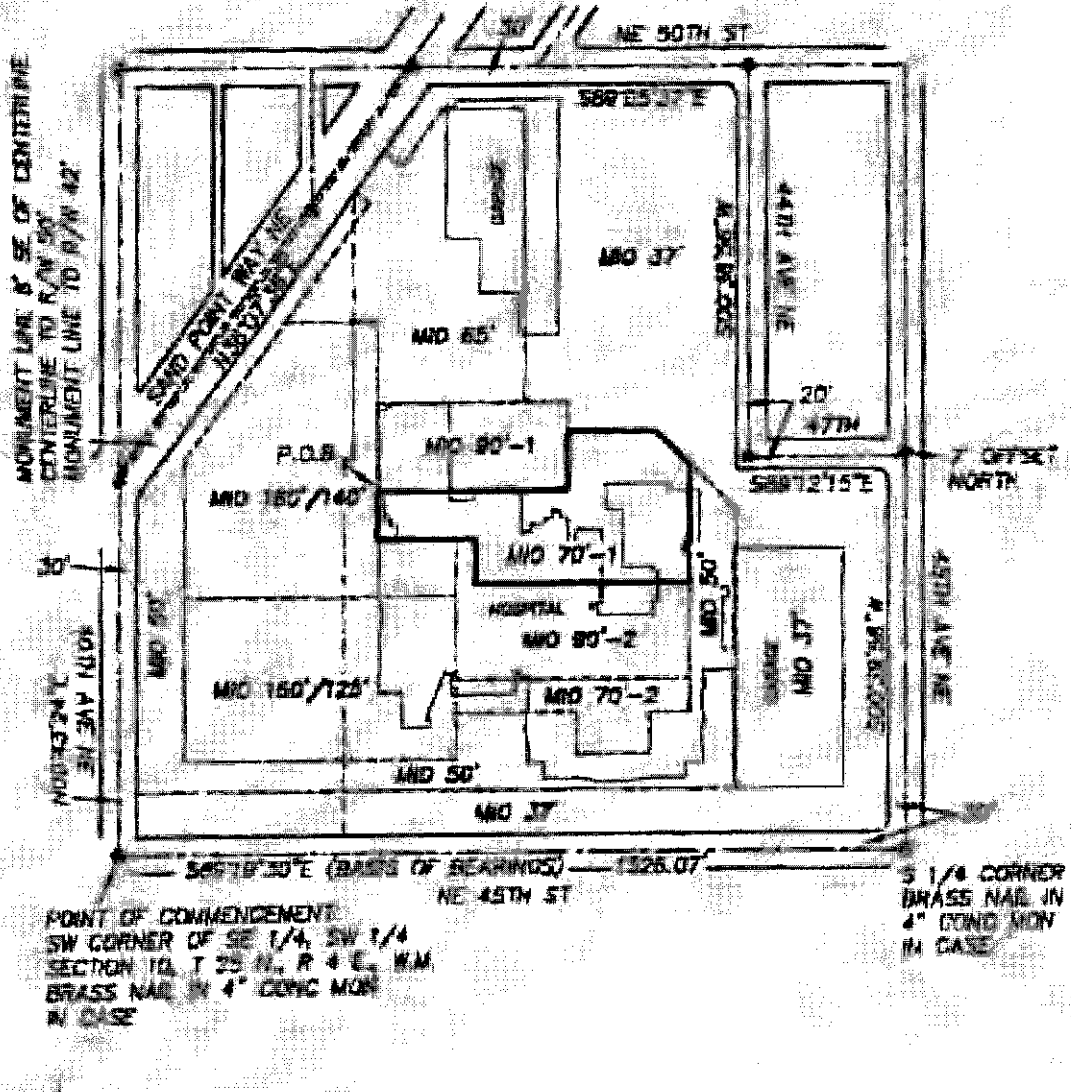
Children's Hospital and Regional Medical Center
Seattle Washington
April 1, 2010

MIO 70'-1 Zone

That portion of the southeast quarter of the southwest quarter of Section 10, Township 25 North, Range 4 East, W.M., in the City of Seattle, King County, Washington described as follows:

COMMENCING at the southwest corner of said subdivision, being the intersection of 40th Ave NE and NE 45th St. and being marked by a brass nail in a 4" concrete monument in case, from whence the south quarter corner of said section, being a brass nail in a 4" concrete monument in case at the intersection of 45th Ave NE and NE 45th St., bears S89°19'30"E a distance of 1326.07 feet, thence S89°19'30"E a distance of 30.00 feet;
Thence N00°43'24"E a distance of 30.00 feet to the intersection of the north margin of NE 45th St. with the east margin of 40th Ave NE;
Thence continuing N00°43'24"E, along said east margin, a distance of 568.17 feet to the southeast margin of Sand Point Way NE;
Thence N36°07'38"E along said southeast margin a distance of 629.44 feet;
Thence, leaving said margin, S53°52'22"E a distance of 30.00 feet;
Thence S36°07'38"W a distance of 244.91 feet;
Thence S89°19'30"E a distance of 155.07 feet;
Thence S00°42'32"W a distance of 289.00 feet to the **POINT OF BEGINNING;**
Thence from said **POINT OF BEGINNING**, S89°19'30"E a distance of 321.79 feet;
Thence N00°38'56"E a distance of 100.00 feet;
Thence S89°19'30"E a distance of 151.00 feet;
Thence S44°19'30"E a distance of 78.27 feet;
Thence S00°39'56"W a distance of 199.65 feet;
Thence N89°19'30"W a distance of 361.00 feet;
Thence N00°39'56"E a distance of 75.00 feet;
Thence N89°19'30"W a distance of 167.16 feet;
Thence N00°42'32"E a distance of 80.00 feet to the **POINT OF BEGINNING.**

Contains 88,426 sq. ft. +/- (2.03 acres)



MIO 70'-1 ZONE

CHILDREN'S HOSPITAL AND REGIONAL MEDICAL CENTER
MIO HEIGHT LIMIT ZONES (MAJOR INSTITUTION OVERLAY)

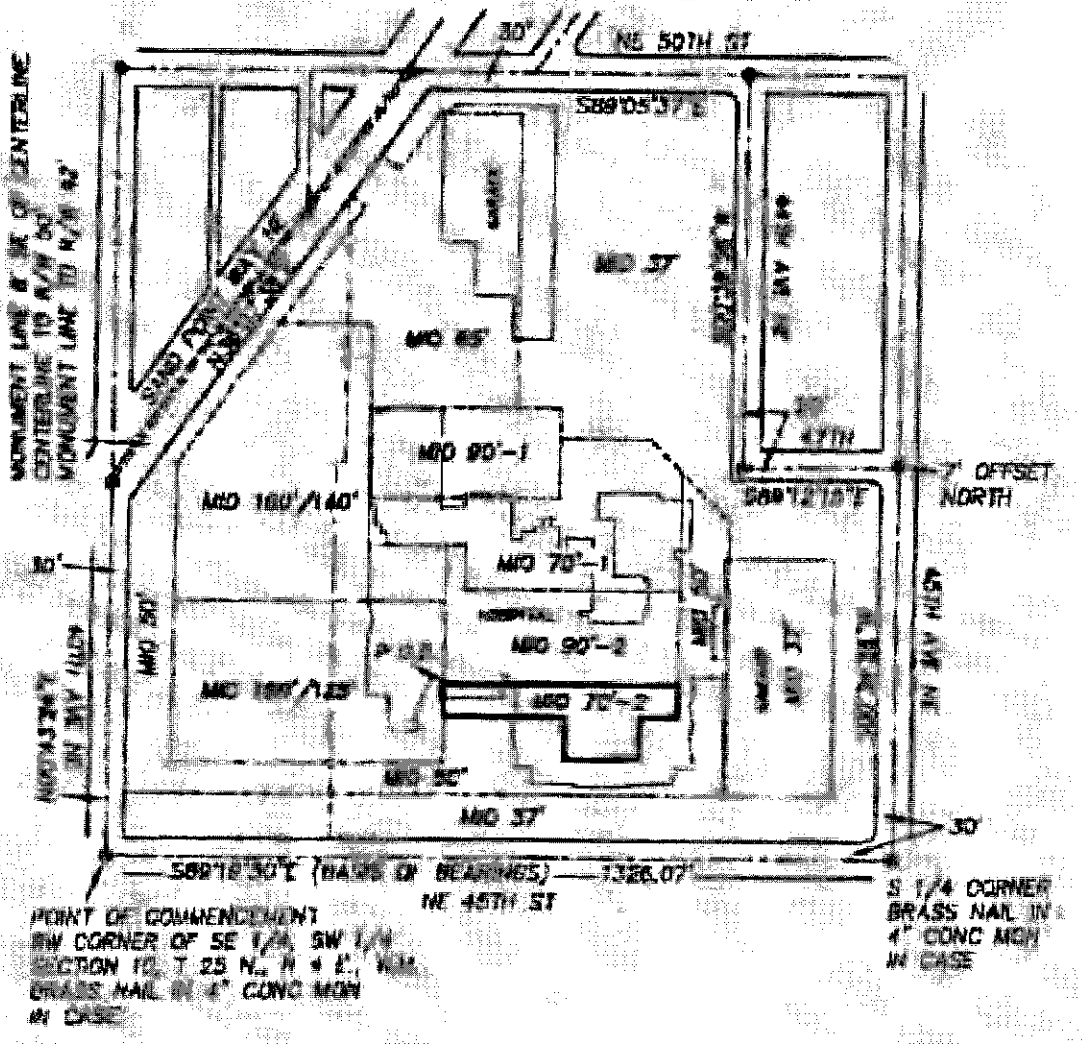
Children's Hospital and Regional Medical Center
Seattle Washington
April 1, 2010

MIO 70'-2 Zone

That portion of the southeast quarter of the southwest quarter of Section 10, Township 25 North, Range 4 East, W.M., in the City of Seattle, King County, Washington described as follows:

COMMENCING at the southwest corner of said subdivision, being the intersection of 40th Ave NE and NE 45th St. and being marked by a brass nail in a 4" concrete monument in case, from whence the south quarter corner of said section, being a brass nail in a 4" concrete monument in case at the intersection of 45th Ave NE and NE 45th St., bears S89°19'30"E a distance of 1326.07 feet, thence S89°19'30"E a distance of 30.00 feet;
Thence N00°43'24"E a distance of 30.00 feet to the intersection of the north margin of NE 45th St. with the east margin of 40th Ave NE;
Thence continuing N00°43'24"E, along said east margin, a distance of 568.17 feet to the southeast margin of Sand Point Way NE;
Thence N36°07'38"E along said southeast margin a distance of 629.44 feet;
Thence, leaving said margin, S53°52'22"E a distance of 30.00 feet;
Thence S36°07'38"W a distance of 244.91 feet;
Thence S89°19'30"E a distance of 155.07 feet;
Thence S00°42'32"W a distance of 369.00 feet;
Thence S89°19'30"E a distance of 133.16 feet;
Thence S00°39'56"W a distance of 235.00 feet to the **POINT OF BEGINNING;**
Thence from said **POINT OF BEGINNING,** S89°19'30"E a distance of 395.00 feet;
Thence S00°39'56"W a distance of 55.00 feet;
Thence N89°19'30"W a distance of 65.00 feet;
Thence S00°39'56"W a distance of 70.00 feet;
Thence N89°19'30"W a distance of 125.00 feet;
Thence N00°39'56"E a distance of 70.00 feet;
Thence N89°19'30"W a distance of 205.00 feet;
Thence N00°39'56"E a distance of 55.00 feet to the **POINT OF BEGINNING.**

Contains 30,475 sq. ft. +/- (0.70 acres)



N

SCALE 1"=200'

MIO 70'-2 ZONE

CHILDREN'S HOSPITAL AND REGIONAL MEDICAL CENTER
MIO HEIGHT LIMIT ZONES (MAJOR INSTITUTION OVERLAY)

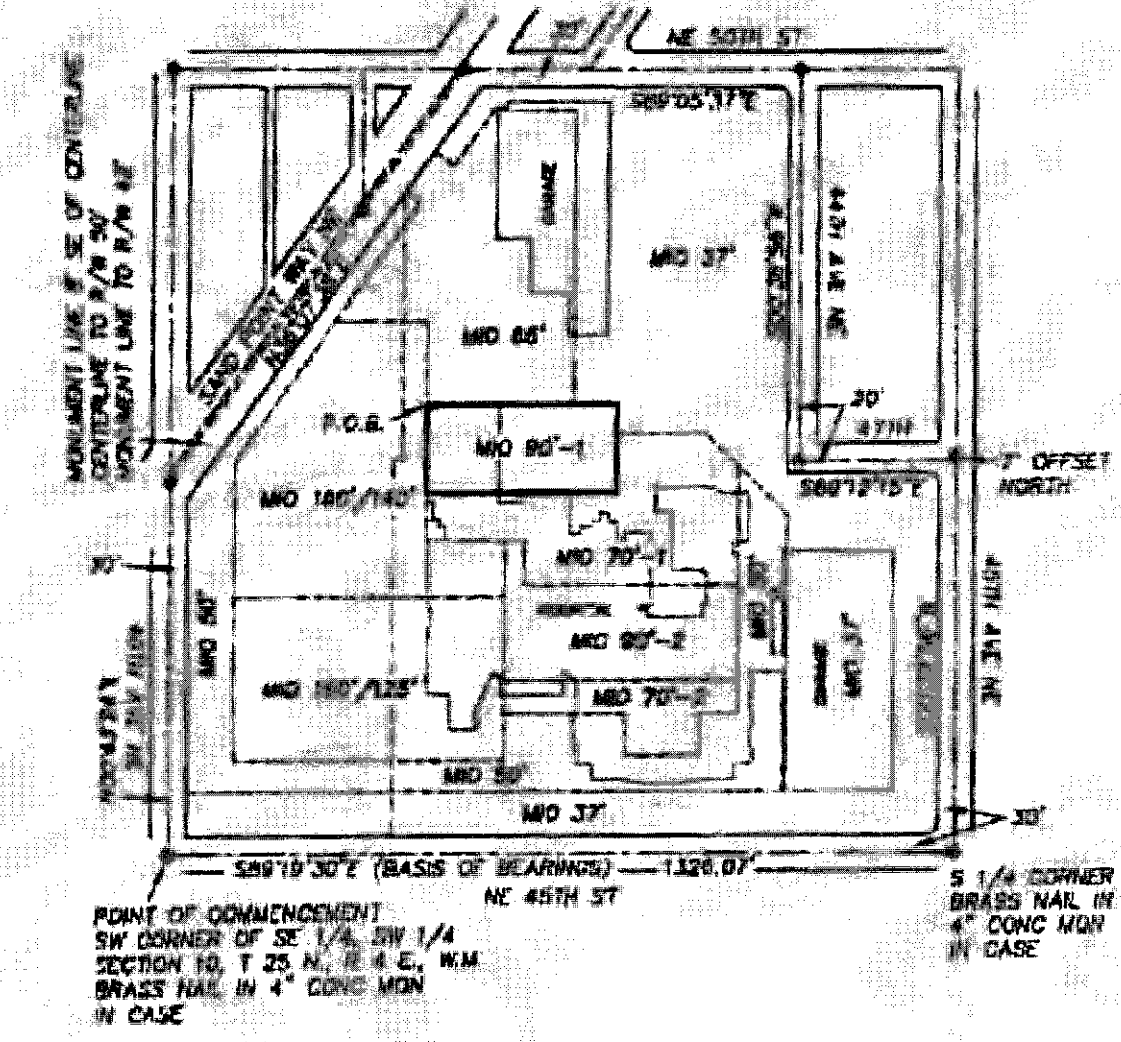
Children's Hospital and Regional Medical Center
Seattle Washington
April 1, 2010

MIO 90'-1 Zone

That portion of the southeast quarter of the southwest quarter of Section 10, Township 25 North, Range 4 East, W.M., in the City of Seattle, King County, Washington described as follows:

COMMENCING at the southwest corner of said subdivision, being the intersection of 40th Ave NE and NE 45th St. and being marked by a brass nail in a 4" concrete monument in case, from whence the south quarter corner of said section, being a brass nail in a 4" concrete monument in case at the intersection of 45th Ave NE and NE 45th St., bears S89°19'30"E a distance of 1326.07 feet, thence S89°19'30"E a distance of 30.00 feet;
Thence N00°43'24"E a distance of 30.00 feet to the intersection of the north margin of NE 45th St. with the east margin of 40th Ave NE;
Thence continuing N00°43'24"E, along said east margin, a distance of 568.17 feet to the southeast margin of Sand Point Way NE;
Thence N36°07'38"E along said southeast margin a distance of 629.44 feet;
Thence, leaving said margin, S53°52'22"E a distance of 30.00 feet;
Thence S36°07'38"W a distance of 244.91 feet;
Thence S89°19'30"E a distance of 155.07 feet;
Thence S00°42'32"W a distance of 139.00 feet to the **POINT OF BEGINNING;**
Thence from said **POINT OF BEGINNING,** S89°19'30"E a distance of 321.63 feet;
Thence S00°38'58"W a distance of 150.00 feet;
Thence N89°19'30"W a distance of 321.79 feet;
Thence N00°42'32"E a distance of 150.00 feet to the **POINT OF BEGINNING.**

Contains 48,256 sq. ft. +/- (1.11 acres)



N

SCALE 1"=300'

MID 90'-1 ZONE

CHILDREN'S HOSPITAL AND REGIONAL MEDICAL CENTER
MID HEIGHT LIMIT ZONES (MAJOR INSTITUTION OVERLAY)

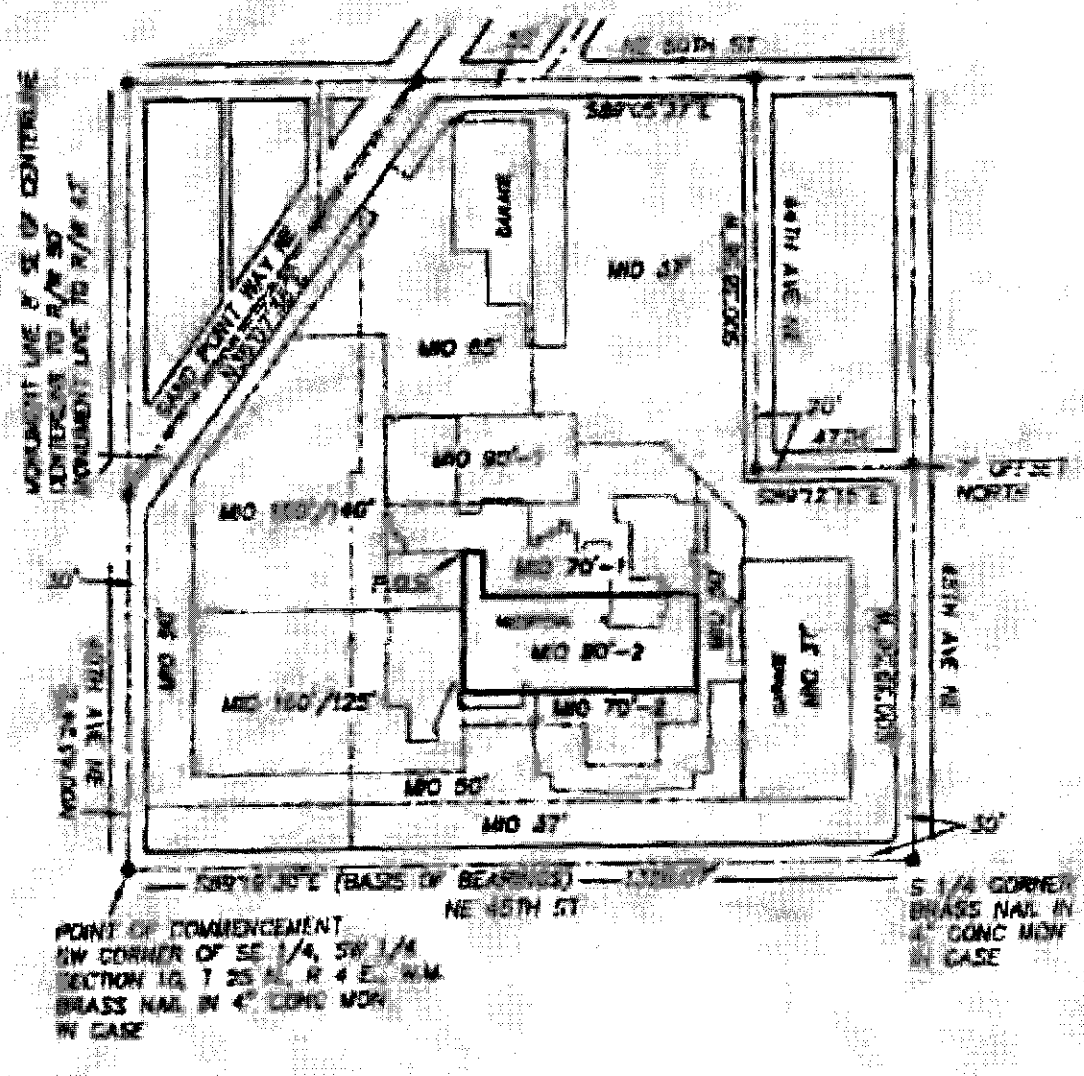
Children's Hospital and Regional Medical Center
Seattle Washington
April 1, 2010

MIO 90'-2 Zone

That portion of the southeast quarter of the southwest quarter of Section 10, Township 25 North, Range 4 East, W.M., in the City of Seattle, King County, Washington described as follows:

COMMENCING at the southwest corner of said subdivision, being the intersection of 40th Ave NE and NE 45th St. and being marked by a brass nail in a 4" concrete monument in case, from whence the south quarter corner of said section, being a brass nail in a 4" concrete monument in case at the intersection of 45th Ave NE and NE 45th St., bears S89°19'30"E a distance of 1326.07 feet, thence S89°19'30"E a distance of 30.00 feet;
Thence N00°43'24"E a distance of 30.00 feet to the intersection of the north margin of NE 45th St. with the east margin of 40th Ave NE;
Thence continuing N00°43'24"E, along said east margin, a distance of 568.17 feet to the southeast margin of Sand Point Way NE;
Thence N36°07'38"E along said southeast margin a distance of 629.44 feet;
Thence, leaving said margin, S53°52'22"E a distance of 30.00 feet;
Thence S36°07'38"W a distance of 244.91 feet;
Thence S89°19'30"E a distance of 155.07 feet;
Thence S00°42'32"W a distance of 369.00 feet;
Thence S89°19'30"E a distance of 133.16 feet to the **POINT OF BEGINNING;**
Thence from said **POINT OF BEGINNING,** continuing S89°19'30"E, a distance of 34.00 feet;
Thence S00°39'56"W a distance of 75.00 feet;
Thence S89°19'30"E a distance of 361.00 feet;
Thence S00°39'56"W a distance of 160.00 feet;
Thence N89°19'30"W a distance of 395.00 feet;
Thence N00°39'56"E a distance of 235.00 feet to the **POINT OF BEGINNING.**

Contains 65,750 sq. ft. +/- (1.51 acres)



N

SCALE 1"=200'

MIO 90'-2 ZONE

CHILDREN'S HOSPITAL AND REGIONAL MEDICAL CENTER
MIO HEIGHT LIMIT ZONES (MAJOR INSTITUTION OVERLAY)

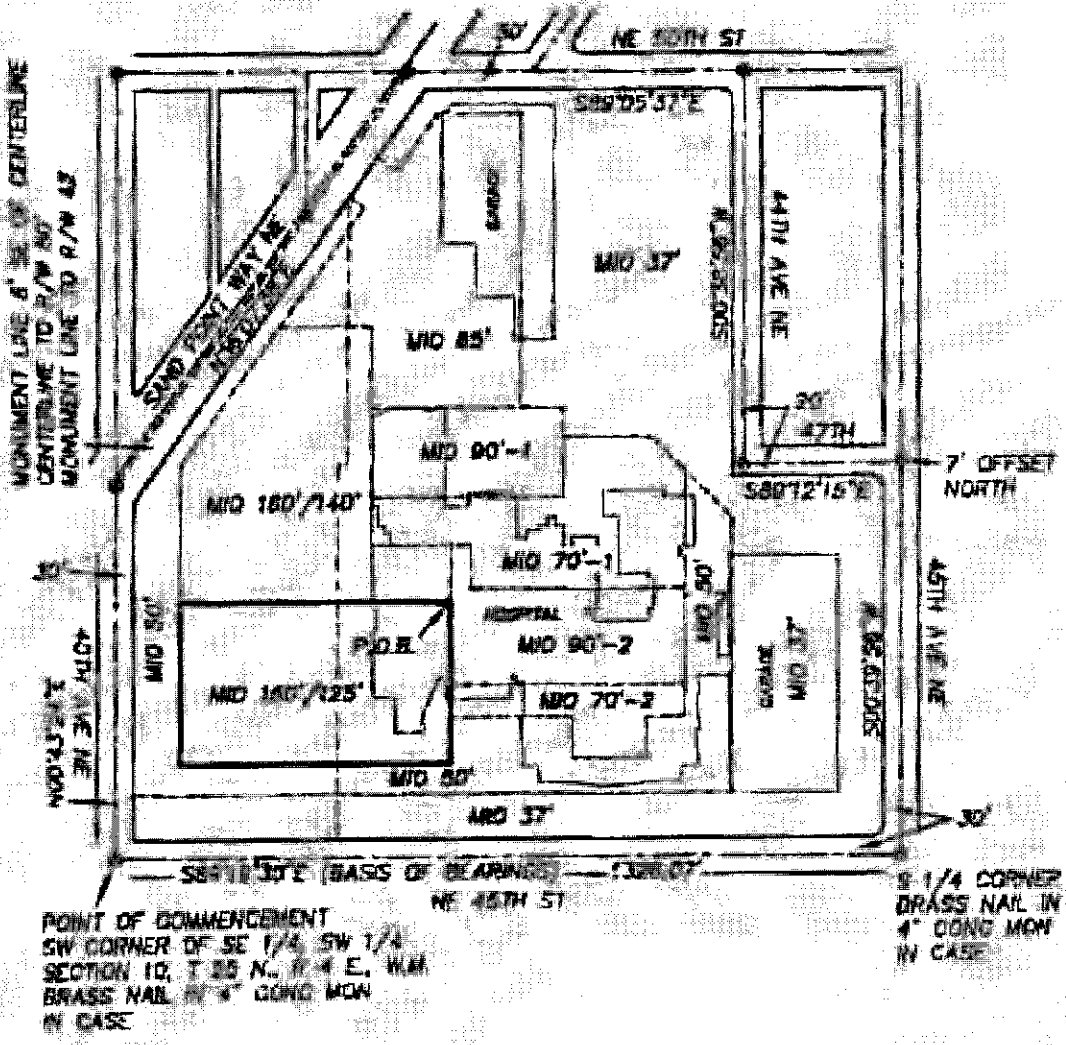
Children's Hospital and Regional Medical Center
Seattle Washington
April 1, 2010

MIO 160'/125' Zone

That portion of the southeast quarter of the southwest quarter of Section 10, Township 25 North, Range 4 East, W.M., in the City of Seattle, King County, Washington described as follows:

COMMENCING at the southwest corner of said subdivision, being the intersection of 40th Ave NE and NE 45th St. and being marked by a brass nail in a 4" concrete monument in case, from whence the south quarter corner of said section, being a brass nail in a 4" concrete monument in case at the intersection of 45th Ave NE and NE 45th St., bears S89°19'30"E a distance of 1326.07 feet, thence S89°19'30"E a distance of 30.00 feet;
Thence N00°43'24"E a distance of 30.00 feet to the intersection of the north margin of NE 45th St. with the east margin of 40th Ave NE;
Thence continuing N00°43'24"E, along said east margin, a distance of 568.17 feet to the southeast margin of Sand Point Way NE;
Thence N36°07'38"E along said southeast margin a distance of 629.44 feet;
Thence, leaving said margin, S53°52'22"E a distance of 30.00 feet;
Thence S36°07'38"W a distance of 244.91 feet;
Thence S89°19'30"E a distance of 155.07 feet;
Thence S00°42'32"W a distance of 369.00 feet;
Thence S89°19'30"E a distance of 133.16 feet;
Thence S00°39'56"W a distance of 95.00 feet to the **POINT OF BEGINNING;**
Thence from said **POINT OF BEGINNING**, continuing S00°39'56"W, a distance of 273.00 feet;
Thence N89°19'30"W a distance of 455.91 feet;
Thence N00°43'24"E a distance of 273.00 feet;
Thence S89°19'30"E a distance of 455.64 feet to the **POINT OF BEGINNING.**

Contains 124,426 sq. ft. +/- (2.86 acres)



N

SCALE 1"=200'

MID 160'/125' ZONE

CHILDREN'S HOSPITAL AND REGIONAL MEDICAL CENTER
MID HEIGHT LIMIT ZONES (MAJOR INSTITUTION OVERLAY)

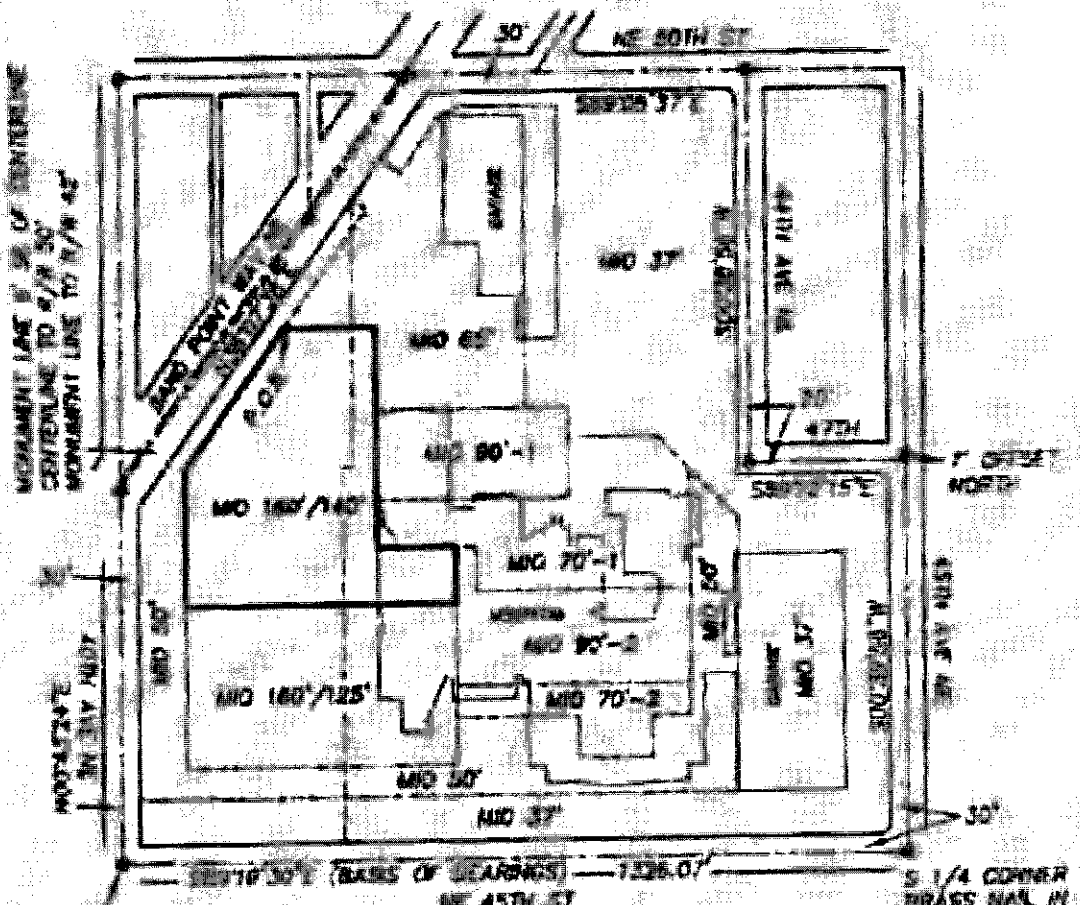
Children's Hospital and Regional Medical Center
Seattle Washington
April 1, 2010

MIO 160'/140' Zone

That portion of the southeast quarter of the southwest quarter of Section 10, Township 25 North, Range 4 East, W.M., in the City of Seattle, King County, Washington described as follows:

COMMENCING at the southwest corner of said subdivision, being the intersection of 40th Ave NE and NE 45th St. and being marked by a brass nail in a 4" concrete monument in case, from whence the south quarter corner of said section, being a brass nail in a 4" concrete monument in case at the intersection of 45th Ave NE and NE 45th St., bears S89°19'30"E a distance of 1326.07 feet, thence S89°19'30"E a distance of 30.00 feet;
Thence N00°43'24"E a distance of 30.00 feet to the intersection of the north margin of NE 45th St. with the east margin of 40th Ave NE;
Thence continuing N00°43'24"E, along said east margin, a distance of 568.17 feet to the southeast margin of Sand Point Way NE;
Thence N36°07'38"E along said southeast margin a distance of 529.44 feet;
Thence, leaving said margin, S53°52'22"E a distance of 30.00 feet;
Thence S36°07'38"W a distance of 244.91 feet to the **POINT OF BEGINNING;**
Thence from said **POINT OF BEGINNING**, S89°19'30"E a distance of 155.07 feet;
Thence S00°42'32"W a distance of 369.00 feet;
Thence S89°19'30"E a distance of 133.16 feet;
Thence S00°39'56"W a distance of 95.00 feet;
Thence N89°19'30"W a distance of 455.64 feet;
Thence N00°43'24"E a distance of 228.47 feet;
Thence N36°07'38"E a distance of 288.64 feet to the **POINT OF BEGINNING.**

Contains 142,565 sq. ft. +/- (3.27 acres)



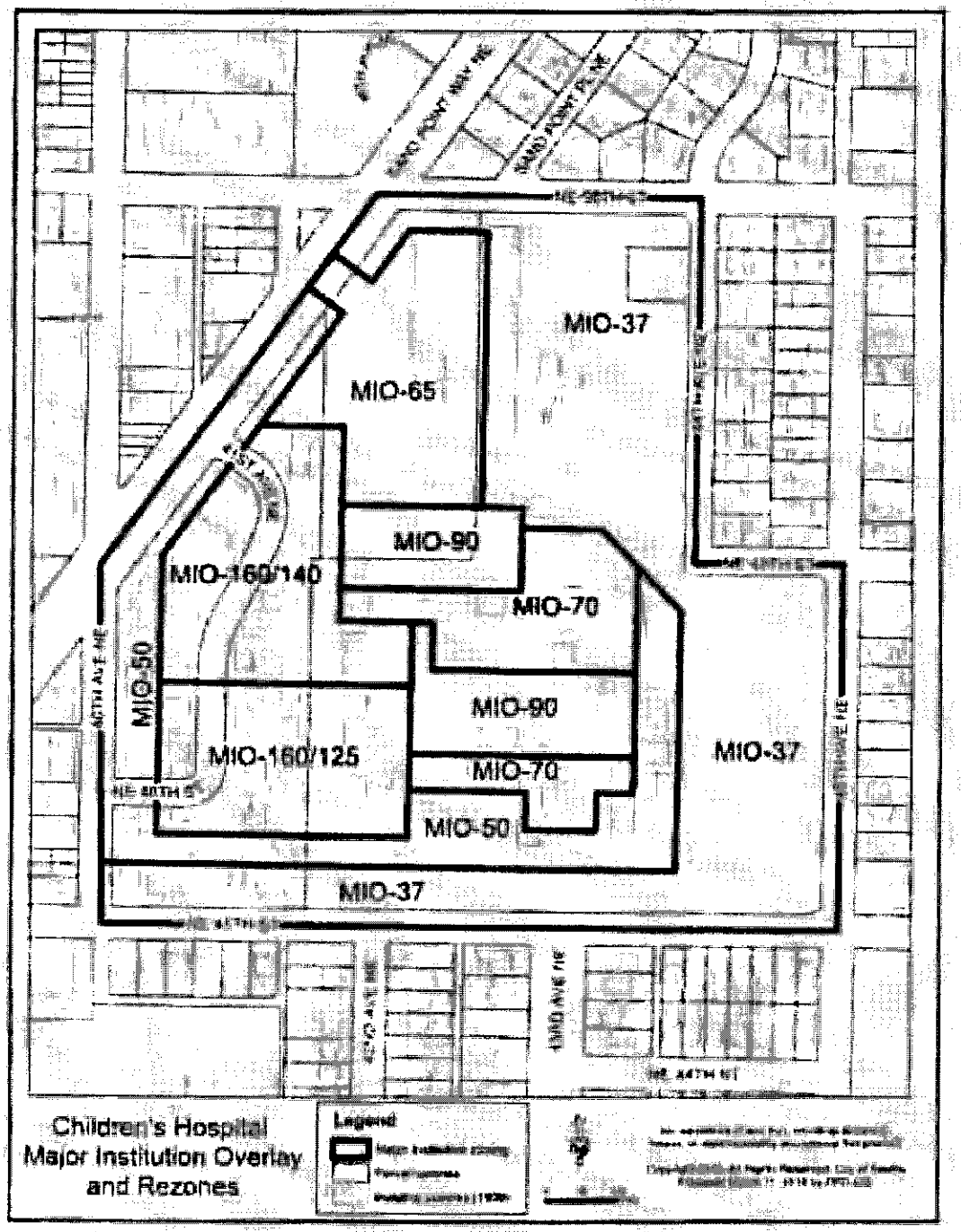
N

SCALE 1"=300'

MID 160'/140' ZONE

CHILDREN'S HOSPITAL AND REGIONAL MEDICAL CENTER
MID HEIGHT LIMIT ZONES (MAJOR INSTITUTION OVERLAY)

ATTACHMENT C



FISCAL NOTE FOR NON-CAPITAL PROJECTS

Department:	Contact Person/Phone:	DOF Analyst/Phone:
Legislative	Michael Jenkins, 615-1674	NA

Legislation Title:

AN ORDINANCE relating to land use and zoning; adopting a new Major Institution Master Plan for Seattle Children's Hospital; and amending Chapter 23.32 of the Seattle Municipal Code at Page 63 of the Official Land Use Map, to modify height limits and rezone property to and within the Major Institution Overlay, all generally located along Sand Point Way Northeast (Project Numbers 3007521 and 3007696, Clerk File 308884).

Summary of the Legislation:

This is legislation adopting a new Major Institution Master Plan (MIMP) for Seattle Children's Hospital and approving an expansion of the Major Institution Overlay boundary and approving height rezones.

Background:

This legislation and Council review has been undertaken in accordance with the requirements and process set out for the adoption of Major Institution Master Plans in Seattle Municipal Code (SMC) Section 23.69. Related legislation includes Clerks File 308884

- *Please check one of the following:*

__X__ **This legislation does not have any financial implications.** *(Stop here and delete the remainder of this document prior to saving and printing.)*

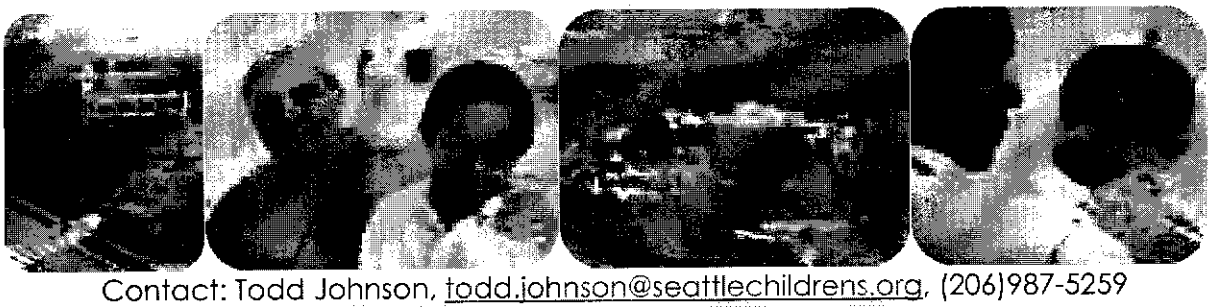
____ **This legislation has financial implications.** *(Please complete all relevant sections that follow.)*

APPENDIX E: APPROVED DESIGN GUIDELINES

Seattle Children's Major Institution Master Plan

DESIGN GUIDELINES

Approved May 7, 2010



Contact: Todd Johnson, todd.johnson@seattlechildrens.org, (206)987-5259

Seattle Children's

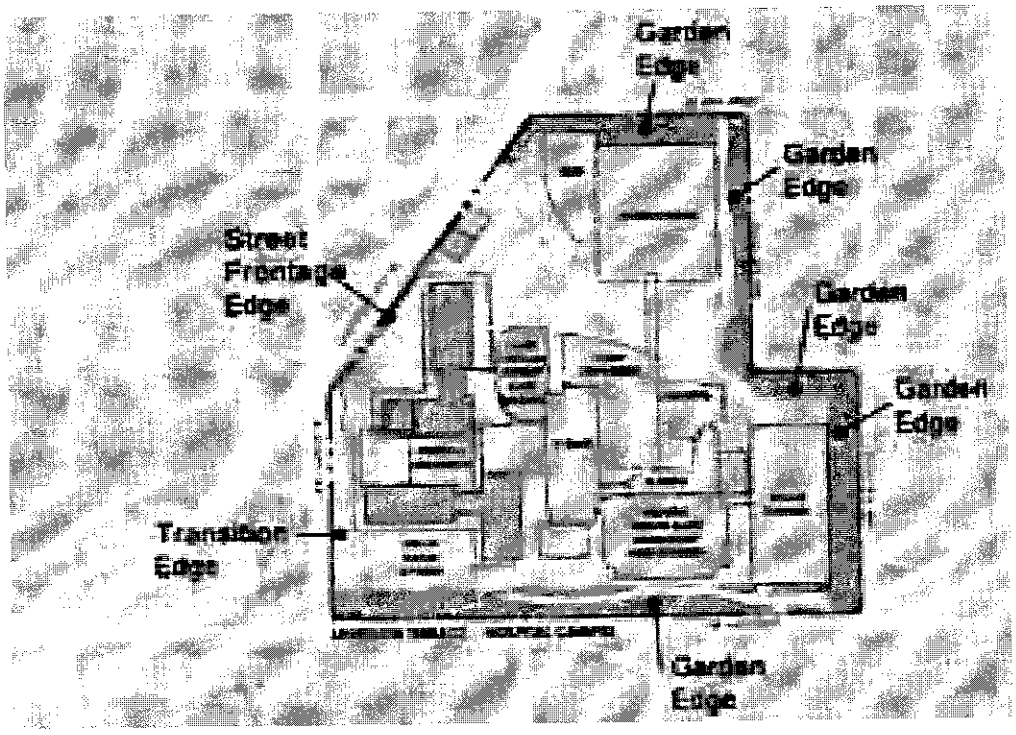


Figure 1 Seattle Children's Major Institution Master Plan Area

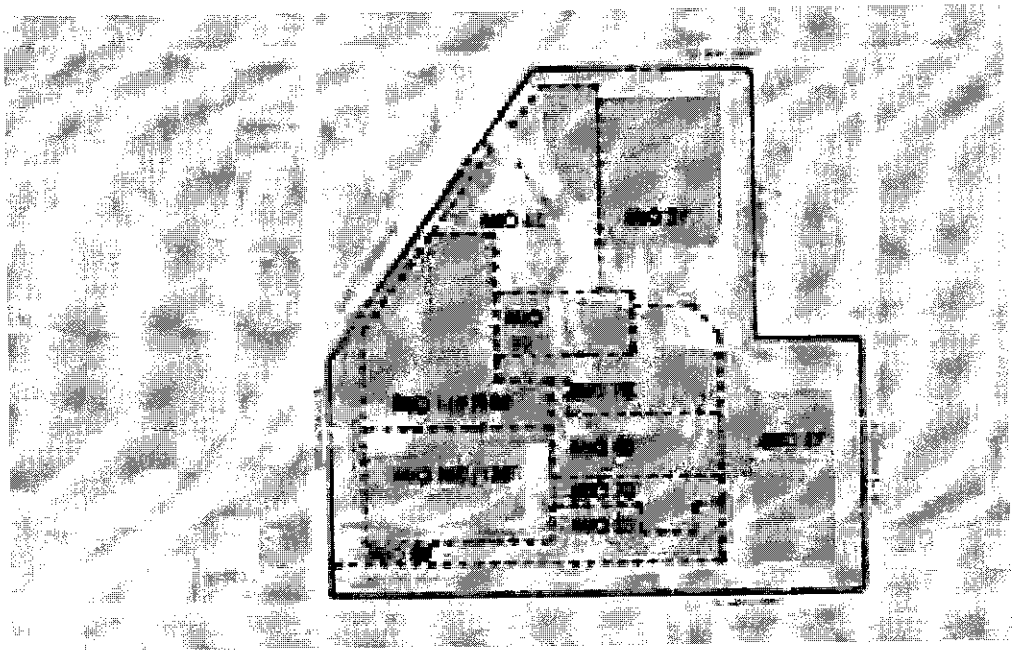


Figure 2 Seattle Children's Major Institution Overlay Map

A. MASTER PLAN DESIGN GUIDELINES

A1.0 Context

Seattle Children's Master Plan, approved by the Seattle City Council in accordance with the conditions in the Major Institutions Code (Seattle Municipal Code Chapter 23.69), is the governing development plan for future expansion of Children's facilities at its Laurelhurst campus. The Master Plan has three major components:

- The development standards component (the height, setback, open space and other regulatory standards that supersede the development standards in the underlying zone);
- The development program component (proposals for physical development of the campus, including total maximum developable gross floor area allowed, overall Floor Area Ratio, number of parking spaces, phasing and other features);
- The transportation management component (the internal and external pedestrian and traffic circulation systems that serve the development and programs to reduce the use of single-occupant vehicles).

These Master Plan components are mandated by the City's Major Institutions Code and, in the event of conflict, the provisions of the Master Plan supersede these Design Guidelines.

The development standards in the Master Plan and these Design Guidelines serve different, yet complementary purposes.

- The development standards are prescriptive regulations that define the allowable development envelope within Children's Major Institution Overlay ("MIO") boundaries (see Figure 2).
- The Design Guidelines address hospital campus character and provide a qualitative basis for assessing conformance with the Master Plan.

A1.1 Purpose of Design Guidelines

In its review of Children's Master Plan, the City's Department of Planning and Development (DPD) recommended that Seattle Children's create a comprehensive set of Design Guidelines that are customized to Children's Master Plan. DPD explained how these Design Guidelines would be used: "To frame future Standing Advisory Committee (SAC) review [of projects to implement the Master Plan] ... SAC members would then apply the guidelines as they evaluate how specific proposals address shared concerns about how hospital development is to address its nearby neighbors and the public realm." [See DPD Director's Report, pg. 39] Seattle Children's accepted DPD's recommendation, prepared these Design Guidelines for its Master Plan that go beyond the examples mentioned by DPD, and submitted them to the Seattle Design Commission for review and recommendation. DPD approved, adopted and will administer these Design Guidelines.

The objective of the Design Guidelines is to balance the impacts from hospital development on the surrounding, non-institutional community, and to enhance the transition between, and the compatibility of, the hospital and the surrounding community. Such impacts include those related to the height, bulk and scale of structures, character of development, transportation (such as increased vehicle and other traffic, and circulation), and operational noise and lighting.

Each section of the Design Guidelines contains an intent statement followed by specific guidelines and suggested strategies to meet those guidelines.

A1.2 Design Guidelines

The Design Guidelines are to assist in achieving the desired character envisioned for the hospital campus. Future facilities should strive to blend old with new while harmonizing with the surrounding neighborhood landscape and building forms. Materials and plantings should be durable, attractive and high quality; using green building practices wherever feasible.

The Design Guidelines provide for compatibility in the use of materials, design of public spaces and overall character of the hospital campus for the life of the Master Plan. The SAC is to prioritize key guidelines, recognizing that all guidelines do not necessarily apply to all projects.

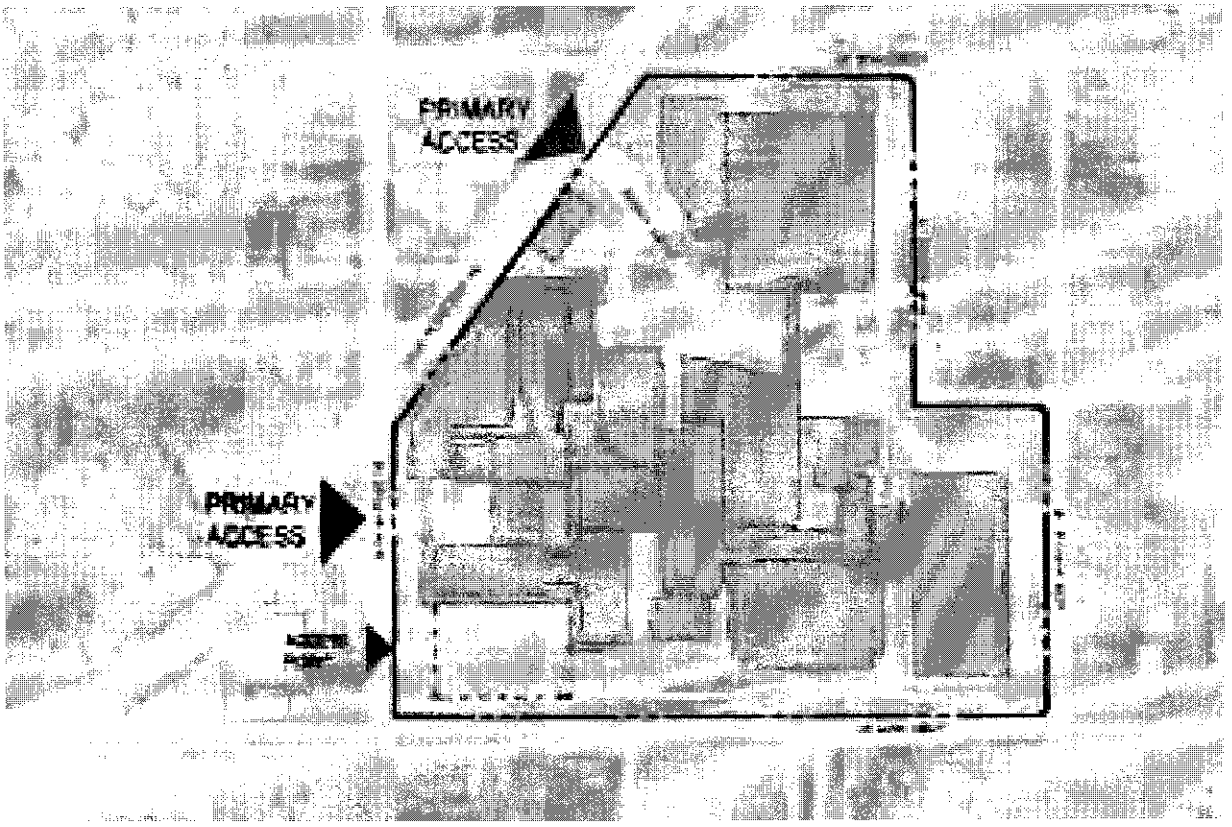


Figure 3 Seattle Children's Access Locations

B. DESIGN GUIDELINES

B1.0 Site Design

B1.1 Hospital Campus Character

Street Frontage Edge Examples *Stephanie Bower, Architectural Illustration*

B1.1.1 Statement of Intent:

The hospital campus shall be both a healing environment and complement aesthetic goals of the neighborhood.

B1.1.2 General Guidelines:

- Acknowledge the character of surrounding single-family residential, multi-family and mixed use areas at each edge.
- Use a compatible palette, texture, and color of building materials to unify the hospital campus.
- Use landscaping to soften and enhance outdoor spaces and screen utilities, blank walls and other more functional elements.

B1.1.3 Street Frontage Edge:

- Design open spaces adjacent to Street Frontage Edges to be inviting, open and complementary to adjacent street frontage uses.
- Use a combination of the following architectural treatments to enhance "front door" Street Frontage Edges: architectural features and detailing such as railings and balustrades, awnings or canopies, decorative pavement, decorative lighting, seats, planter boxes, trellises, artwork, signs.

B1.1.3.1 Public Entrances and Access Points

Stephanie Bower, Architectural Illustration

Create a hierarchy of public entrances and access points to emphasize their appearance at Street Frontage Edge locations, and diminish them at Garden Edge locations where visible from single family residences.

Landscaping, artwork and detailing can define primary entrances and access points to create a sense of arrival and place. Primary access points are transition locations that identify entry or departure points for pedestrians and vehicles. They may also identify public building entrances or the beginning of public pathways that cross the hospital campus. These locations are place-making opportunities.

Consider use of:

- Distinctive architectural elements, landscaping and signage at primary public entrances and access points to provide visual emphasis and ease of identification.
- Wayfinding that clearly identifies building entries, pathways, and public gardens and pedestrian-scaled signage.
- Identifiable hospital campus access points to connect neighborhood areas to hospital buildings and gardens throughout hospital campus.
- Location, number and design of access points to balance goals for landscape screening with needs for pedestrian access.

B1.1.3.2 Streetscape and Pedestrian Pathways

Stephanie Bower, Architectural Illustration

Design streets and pathways to accommodate all travel modes.

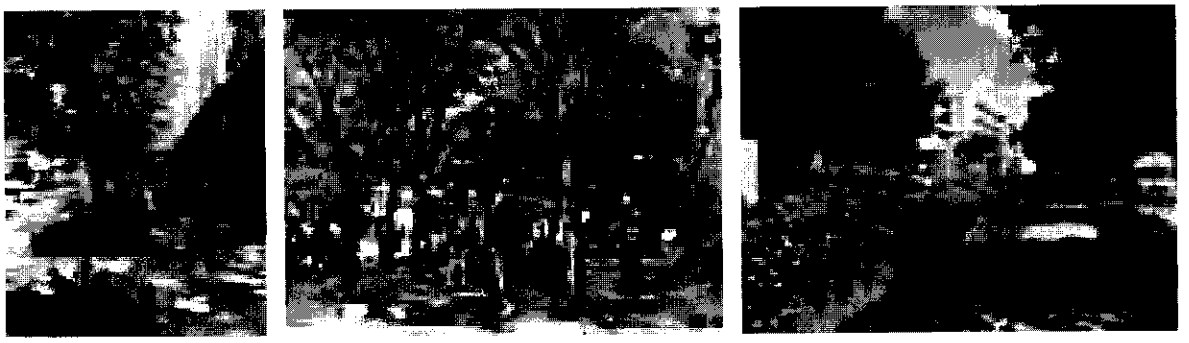
Streets, sidewalks and hospital campus pathways should be welcoming, open to the general public, as well as barrier-free and ADA-accessible.

The vision for street level use is to encourage bicyclist and pedestrian activity, improve public surveillance, and capacity for all travel modes. Pathways and streets around the hospital campus shall provide opportunities to complete street-to-street connections. Each should encourage travel by transit, bike or walking with a streetscape that is attractive and safe.

Consider use of:

- Nighttime lighting designed for safety and good surveillance with minimal spillover/light pollution.
- Enhanced sidewalk and pathway system with wayfinding program and signage.
- Sidewalks that meet the anticipated pedestrian peak load through zone areas without impediments.
- Street front awnings and weather protection along primary pedestrian pathways.
- Pedestrian amenities in prominent, active areas that are complementary to the adjacent building use or programmed open space, such as:
    - Benches
    - Drinking Fountain
    - Kiosk
    - Lighting, both street and pedestrian
    - Short Term Bicycle Parking
    - Stormwater Facilities
    - Trees
    - Tree grates

B1.1.3.3 Sidewalks



Relate the sidewalk and its amenities to the adjacent uses, the organization of pedestrian movements, and the experience along its length.

Sidewalks provide pedestrian connections throughout the campus. To enhance the function of the sidewalk, organize furnishings in a furnishings zone, between the curb and the through zone. Areas flanking the through zone at the property line would allow pedestrians to stand out of the way of through pedestrian movements. Here, the building zone could be expanded to larger plaza areas, developed with the building.

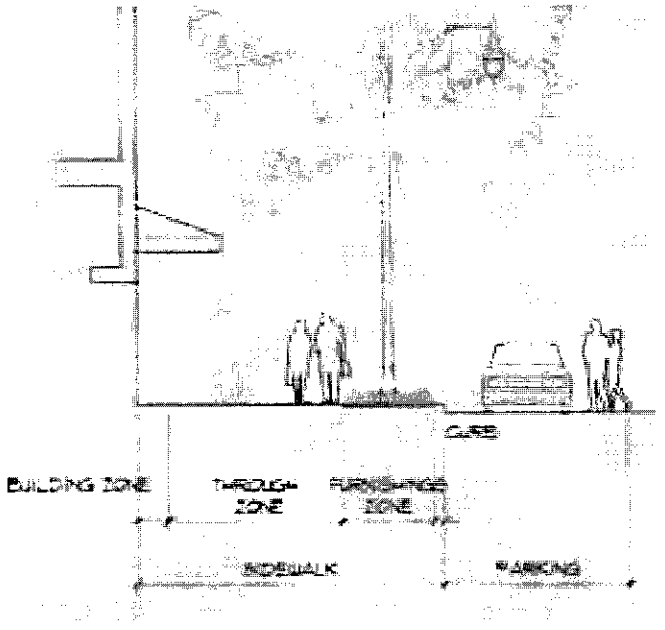


Figure 4 Typical Sidewalk Section

B1.1.3.4 Parking and Vehicle Access

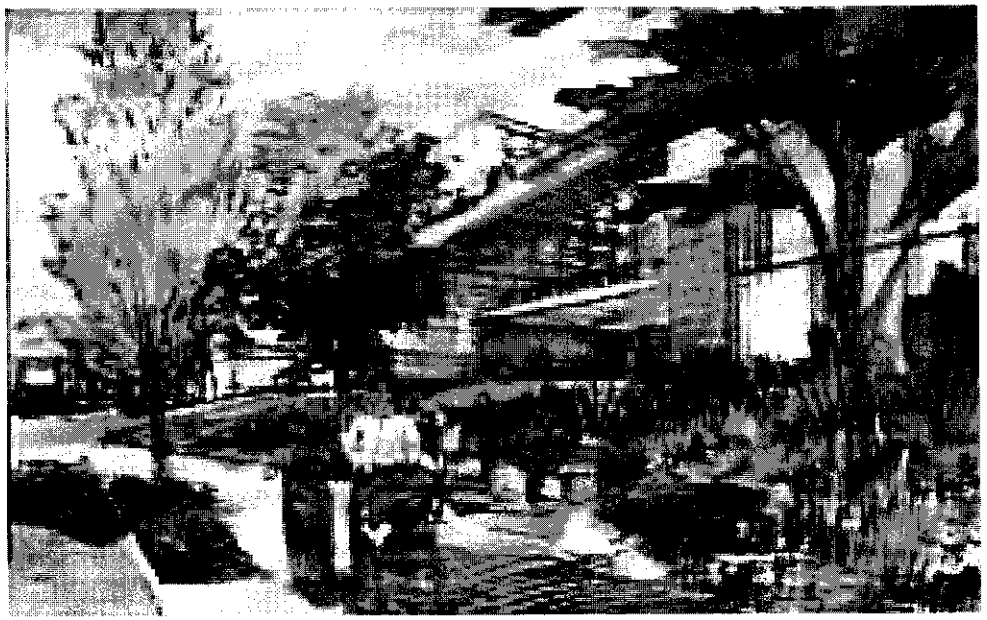
Stephanie Bower, Architectural Illustration

Minimize vehicle movement and storage and design facilities to complement the envisioned calming character of the campus.

Design of vehicular access and parking facilities provide opportunities to optimize operational functionality and contribute to desired hospital character. Design Street Frontage Edges to direct vehicle movements, mark access points to the campus, and promote safety for bike, pedestrian and transit users. Design Garden Edges to help screen views of parking and access points.

Consider use of:

- Vehicle wayfinding using signage and directions to facilitate orderly movements to and from the hospital campus.
- Vines, hanging plants and other plantings on vertical surfaces of elevated structures to conceal parking.
- Shielded lighting to limit light effects on adjacent properties along driveways, surface parking and garage areas.
- Landscaping to provide tree canopy shading of driving surfaces as well as shrubs to screen views of driveways, surface parking lots and parking garage rooftops.
- Consolidated wayfinding signage to reduce visual clutter.
- Bollards and other appropriate traffic management elements to minimize use of service access point.



Transition Edge *Stephanie Bower, Architectural Illustration*

B1.1.4 Transition Edge:

- Transition Edge is a hybrid of the Street Frontage Edge and the Garden Edge.
- This edge occurs along 40th Ave NE, where the street transitions from the urban Street Frontage Edge to the denser landscaping of the residential Garden Edge.

Evaluate the Transition Edge against the same for Street Frontage Edge and Garden Edge guidelines and considerations.

Garden Edge Examples

B1.1.5 Garden Edge:

- The objective of the Garden Edge is to screen hospital structures and light that emanates from vehicles, buildings and site fixtures, while providing an aesthetically pleasing and diversely vegetated viewscape and safe walking environment for pedestrians.
- Architectural features, landscape improvements, and the transition zone between hospital buildings and the public right of way around Garden Edges shall be designed to be compatible with adjacent single family character.
- Use a combination of the following treatments to ensure compatibility with adjacent uses: planted screens, gardens, plaza areas, decorative pavement, non-glare lighting, seating, planter boxes, trellises, artwork, and signage.

B 1.2 Exterior Spaces

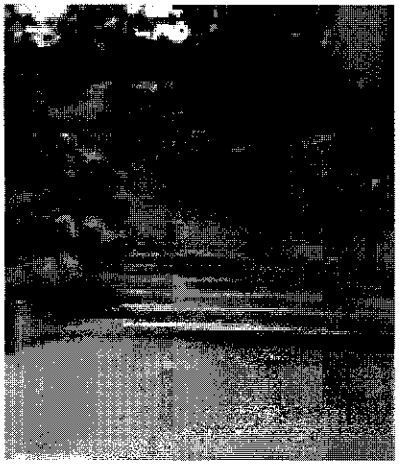
B1.2.1 Statement of Intent:

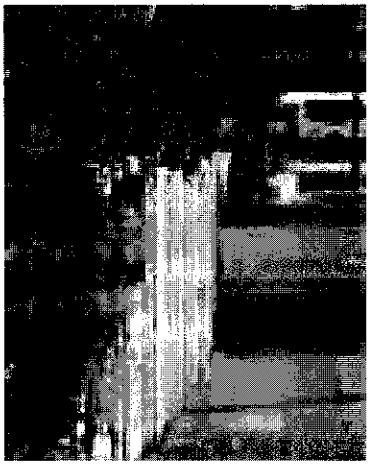
The hospital campus should relate to and feel integrated with the surrounding residential areas while maintaining clarity of its identity, character and use.

B1.2.2 General Guidelines:

- Exterior spaces should extend the color, texture, pattern and quality of the surrounding residential areas.
- Exterior spaces shall provide a visually and otherwise calming experience.
- The hospital campus shall be designed to include and provide access to restorative and therapeutic gardens with seasonal sun and shade to provide outdoor comfort for families, patients, caregivers and neighbors.
- Similar materials in plantings, paving, stairs and walls to provide a unifying context for the site development which matches or complements existing campus and surrounding areas.
- Artwork integrated into publicly accessible areas of buildings and landscaping that evokes a sense of place related to the use of the area.
- Focal point features such as building entries, fountains, botanical gardens, therapy gardens or pools that relate to wayfinding or honors and memorials.

B1.2.3 Retaining Wall Guidelines:





- Retaining walls near a public sidewalk that extend higher than eye level should be avoided where possible.
- Where high retaining walls are unavoidable, they should be designed to reduce their visual impact and increase the interest for the pedestrian along the streetscape.

Consider use of:

- Masonry, stone or other textured material for retaining walls where visible.
- Terracing and landscaping to reduce the visual impact of high retaining walls, especially on sloped sites.
- Hanging plant material at the top and base of walls to soften appearance and blend with surrounding landscaping.

B1.2.4 Screening Guidelines:



- Where necessary, use screening sensitively to soften noise and visual impacts to adjacent properties.
- Design screening to minimize impact of noise producing equipment to adjacent residential neighborhoods.

Landscaping, fencing and walls can serve as screens to block views of the hospital campus buildings, of loading and utility areas, lighting, parking and functional hospital components. Control sound with screen walls. Soften the appearance of walls with plantings.

Consider use of:

- Planted visual screens.
- Barrier walls to reduce noise impacts on adjacent residential neighbors.
- Plantings to screen areas of greater noise activity.
- Semi-transparent wall systems to minimize screen wall mass, in combination with plantings.

B1.2.5 Lighting, Safety and Security Guidelines:

The design and locations of physical features such as site furnishings, landscaping, pathways and lighting should maximize pedestrian visibility and safety while fostering positive social interaction among patients, visitors, caregivers and neighbors.

The design of the hospital campus shall place high importance on public safety and security. The location of entrances and exits, fencing, lighting and landscape will be used to limit or encourage access or control use. The design of the landscape can help define public, semi-public and private spaces that can be visually monitored effectively by users.

Consider use of:

- Publicly accessible spaces designed with clear sight lines and visible from the street or primary bike or pedestrian pathways.
- Low shrubs and pruned trees for high visibility in landscaped areas. Design structures to eliminate hiding places for predators by locating building windows or security cameras overlooking pathways, plazas and parking.
- Evenly distributed, glare-free lighting to increase security and reduce impacts on adjacent property.
- Lighting placed along pathways and other pedestrian-use areas at proper heights for lighting the faces of the people in the space for ease of identification.
- Landscape designs that promote surveillance needs, especially in proximity to designated points of entry and at points where unauthorized individuals may gain entry.

B1.2.6 Artwork Guidelines:

Include opportunities for art in the design process as early as possible to allow integration into the design.

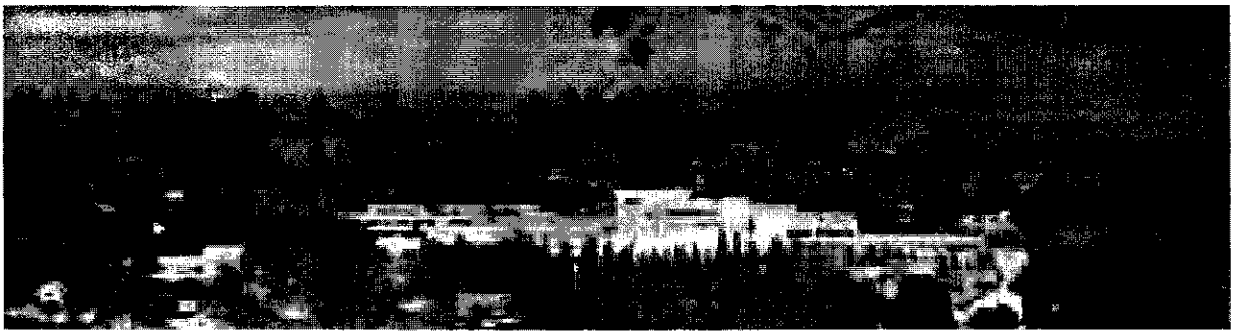
Evaluate the suitability of artwork, whether commissioned or acquired, for its specific site. Consider the artwork's size, materials, concept, etc.

Artwork for the Seattle Children's campus is an integral element to enliven spaces, to create interest and focal points, and to instill layers of meaning and craft to the variety of spaces created by development of the campus.

Consider use of:

- Ephemeral, seasonal forms and artwork employing new technologies that are in keeping with the mission and users of the campus.

B1.3 Landscape



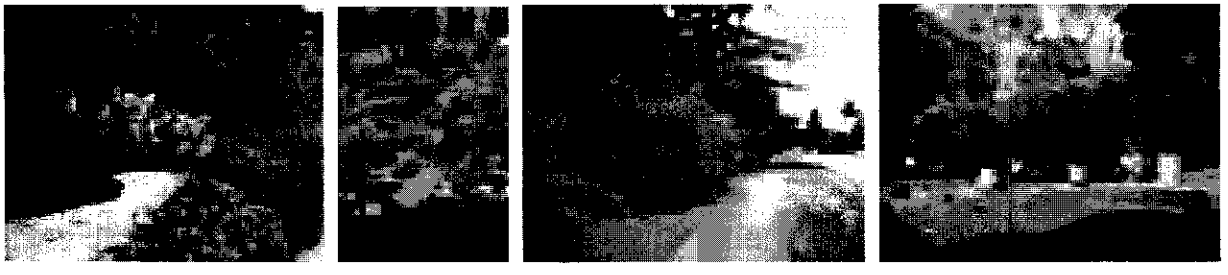
B1.3.1 Statement of Intent:

The hospital campus should be composed of a rich and varied landscape and plant palette providing the character and sense of an arboretum.

B1.3.2 General Guidelines:

- The landscape plan shall respond to special on-site conditions such as steep slopes, existing significant trees - such as mature, rare or ornamental trees - as well as extend or improve off-site conditions, such as greenbelts, natural areas and streets.
- Coordinate plant locations with adjacent building functions.
- The landscape should extend the color, texture and pattern of the surrounding residential areas while maintaining the visually calming experience unique to the hospital campus.
- Focal point features such as building entries, fountains, botanical gardens, therapy gardens or pools that relate to wayfinding or honors and memorials.

B1.3.3 Planting Guidelines:



- Plantings shall include mix of groundcovers and perennials, shrubs, understory and canopy trees to provide multi-layered interest.
- Plantings shall include deciduous and evergreen plants to provide multi-seasonal interest.
- Plantings shall include some portion of hybridized or native plants which are drought tolerant and beneficial to native insects and birds.
- Avoid dense, dark vegetated "walls" along sidewalks by instead planting year-round screens that are softened by diverse and deciduous plantings and open spaces.
- Avoid planting low-branching shrubs and other potentially unsafe, view-obscuring plants close to sidewalks.
- To minimize need for irrigation beyond the establishment period, consider drought and urban tolerant plants.

- Supplemental planting types and densities to connect greenways and wildlife corridors.
- Existing plant materials mixed with new plant material to maximize longevity of both campus and right-of-way plant communities.

B1.3.4 Stormwater Guideline:

- Stormwater treatment and control integrated with the natural rain water cycle, grading and plant communities of the site.

B1.3.5 Irrigation Guideline:

- Mix of drought tolerant landscape plantings, reused stormwater, and drip irrigation to conserve potable water.

B1.3.6 Steep Slope Guideline:

- Plantings and other erosion control measures to prevent site destabilization on steep topography.

B2.0 Architectural Character

B2.1 Height, Bulk and Scale

Stephanie Bower, Architectural Illustration

Design buildings with materials that help visually reduce the scale and form of the buildings into smaller scaled elements and that complement neighboring structures within the same visual field.

Use landscaping to reduce the visible building area, and change finish materials to reduce large fields of like materials on building surfaces.

Consider use of:

- A palette of compatible materials to divide areas of large forms into smaller shapes that are in scale with surrounding structures; including but not limited to windows, curtain walls, metal panels, retail frontages, glass and brick.
- Articulated building volume by setting wall planes back or forward to create shadows or break up long expanses of building walls.
- Terraced retaining walls to lift landscaping, screen buildings and break up large areas of inclined or retained landscape.
- Trellises, climbing vines or wall mounted planters to soften vertical walls.

B2.2 Architectural Elements and Features



Integrate new buildings with the existing architecture to establish a new cohesive whole for the campus.

Overall, the architecture would use materials that create a backdrop for building entries and public spaces on the Street Frontage Edges as well as less obtrusive forms along Garden Edges. Architectural design should be visually integrated with existing campus while mitigating visual impacts to surrounding residential neighborhood.

Consider use of:

- Compatible palette of materials which is visually harmonious and applied across the entire campus.
- Materials such as glass, metal and wood to celebrate building entries or public spaces which complement their function and use.
- Building forms and treatment of building edges that are scaled in proportion to surrounding buildings.
- Accent lighting, landscaping and other features to highlight and give definition to the architecture.

B2.3 Rooftops

Stephanie Bower, Architectural Illustration

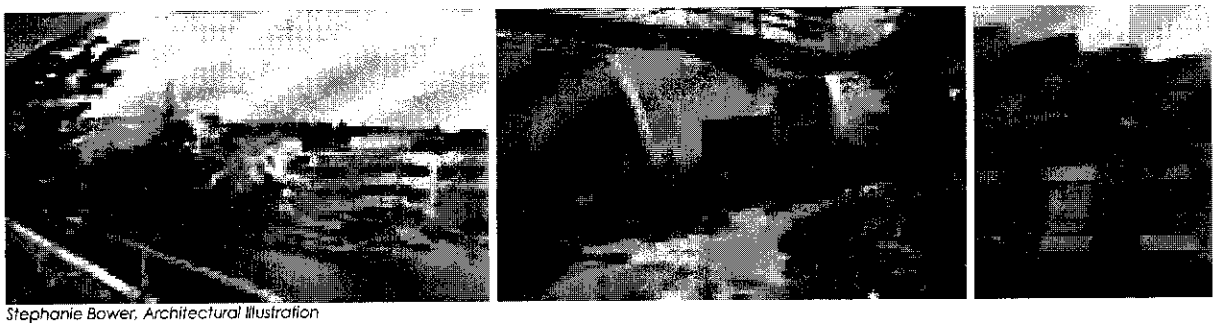
Where rooftops are visible from locations beyond the hospital campus, rooftops are a design element.

Designs should show attention to public views of rooftops from the adjacent neighborhoods.

Consider use of:

- Rooftop elements and surface finishes organized to minimize appearance from higher elevations overlooking the campus.
- Screens to hide roof mounted equipment, and to minimize visual clutter on the roof.
- Rooftop gardens, but be mindful of the visual impacts or the noise impacts of rooftop gathering places.

B2.4 Finish Materials



Stephanie Bower, Architectural Illustration

Design and build new buildings with high-quality, attractive, durable materials aesthetically appropriate to the hospital and the neighborhood.

The selection and use of exterior materials is a key factor in determining how a building will look. Some materials have an intrinsic sense of permanence or can provide texture or scale that helps new buildings fit better in their surroundings.

Consider use of:

- Color palette selected according to relationships to other nearby buildings.
- Reusable and sustainable building materials where feasible, incorporated into the design and acquired from regional producers and manufacturers.
- Low reflective or glare-reducing materials to minimize visual impact on adjacent properties.
- Nighttime light transmission reducing elements.

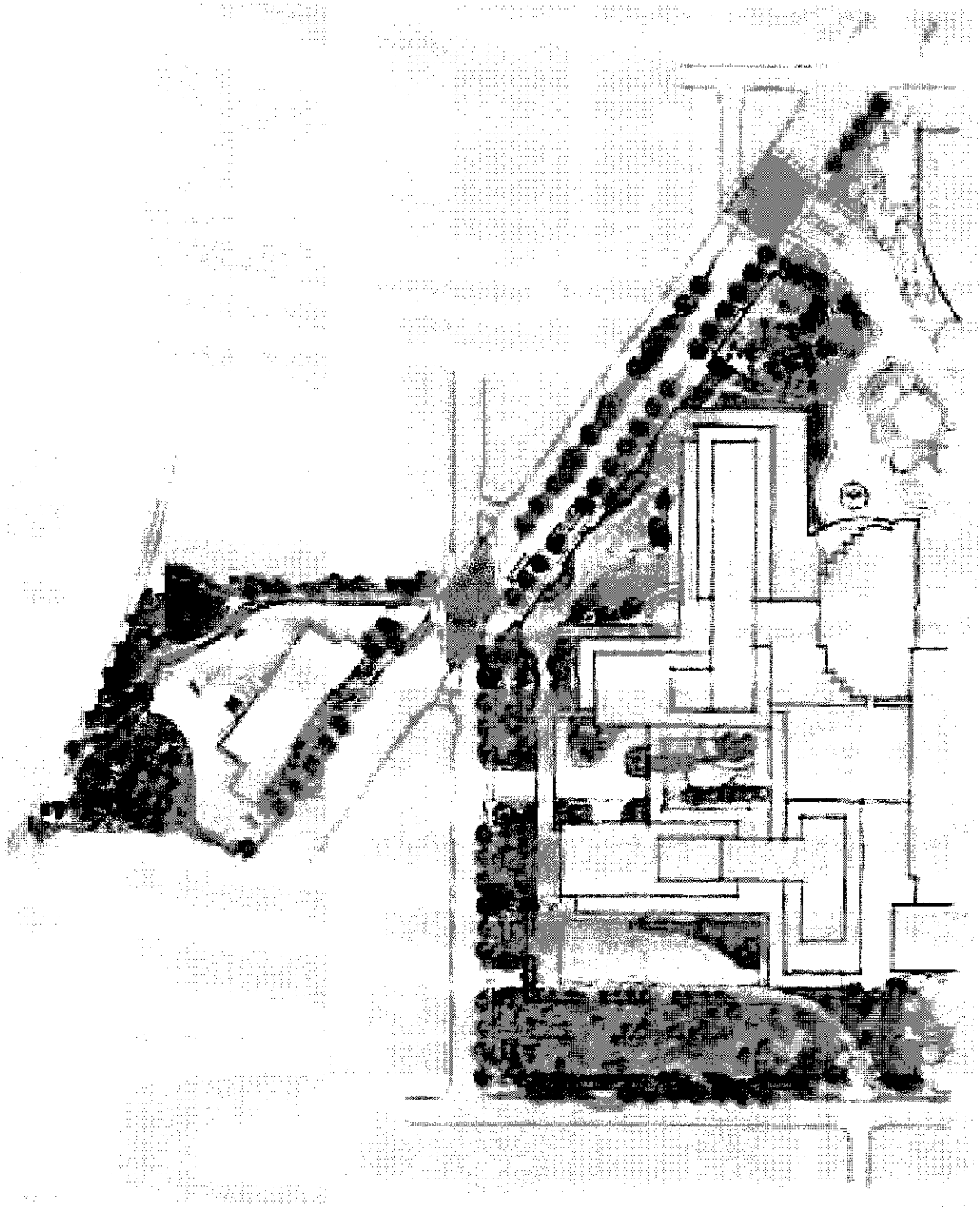


Figure 5 Campus Expansion Landscape Plan Concept (Hartmann shown but not part of expanded Campus)

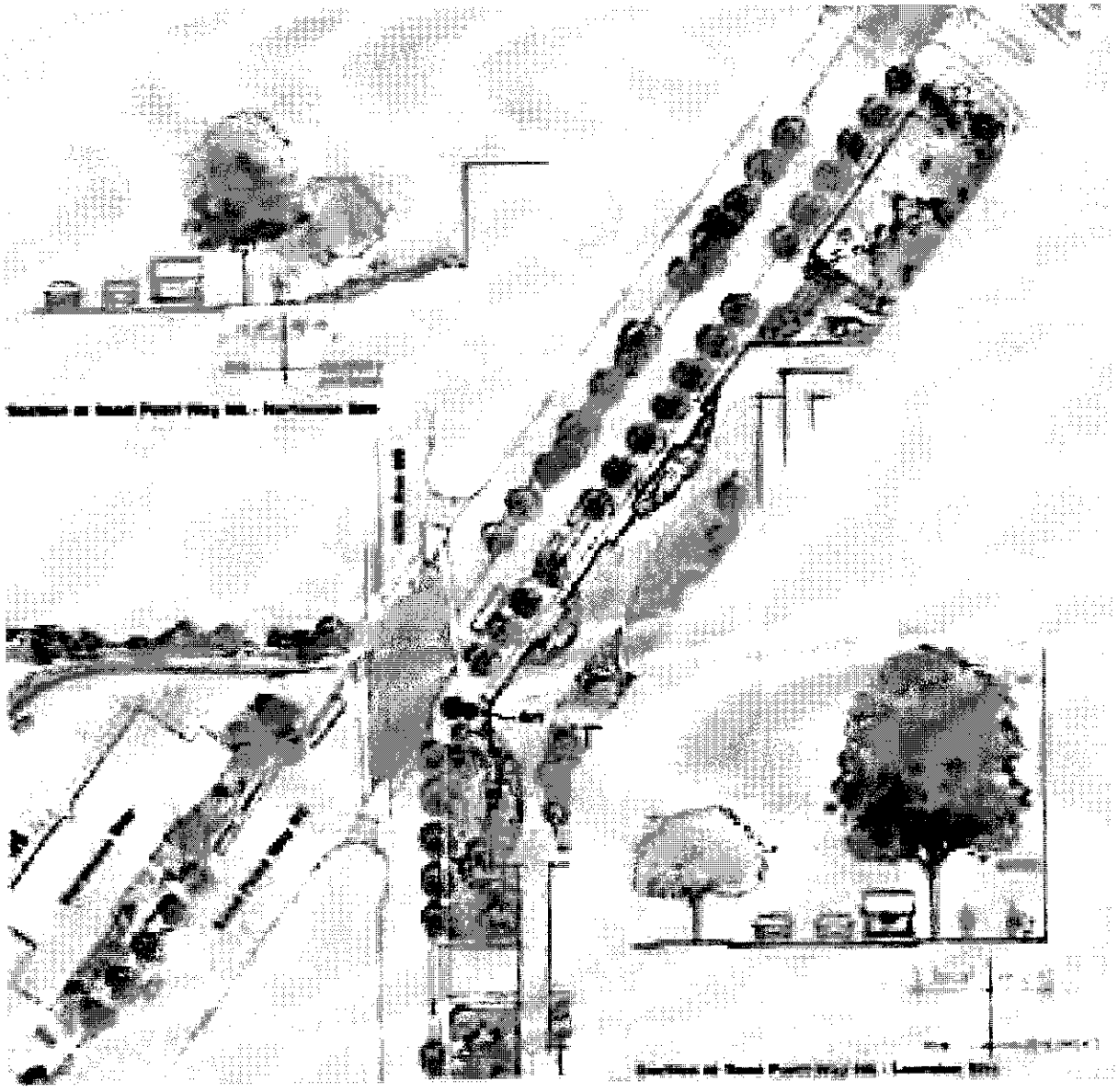


Figure 6 Sand Point Way NE

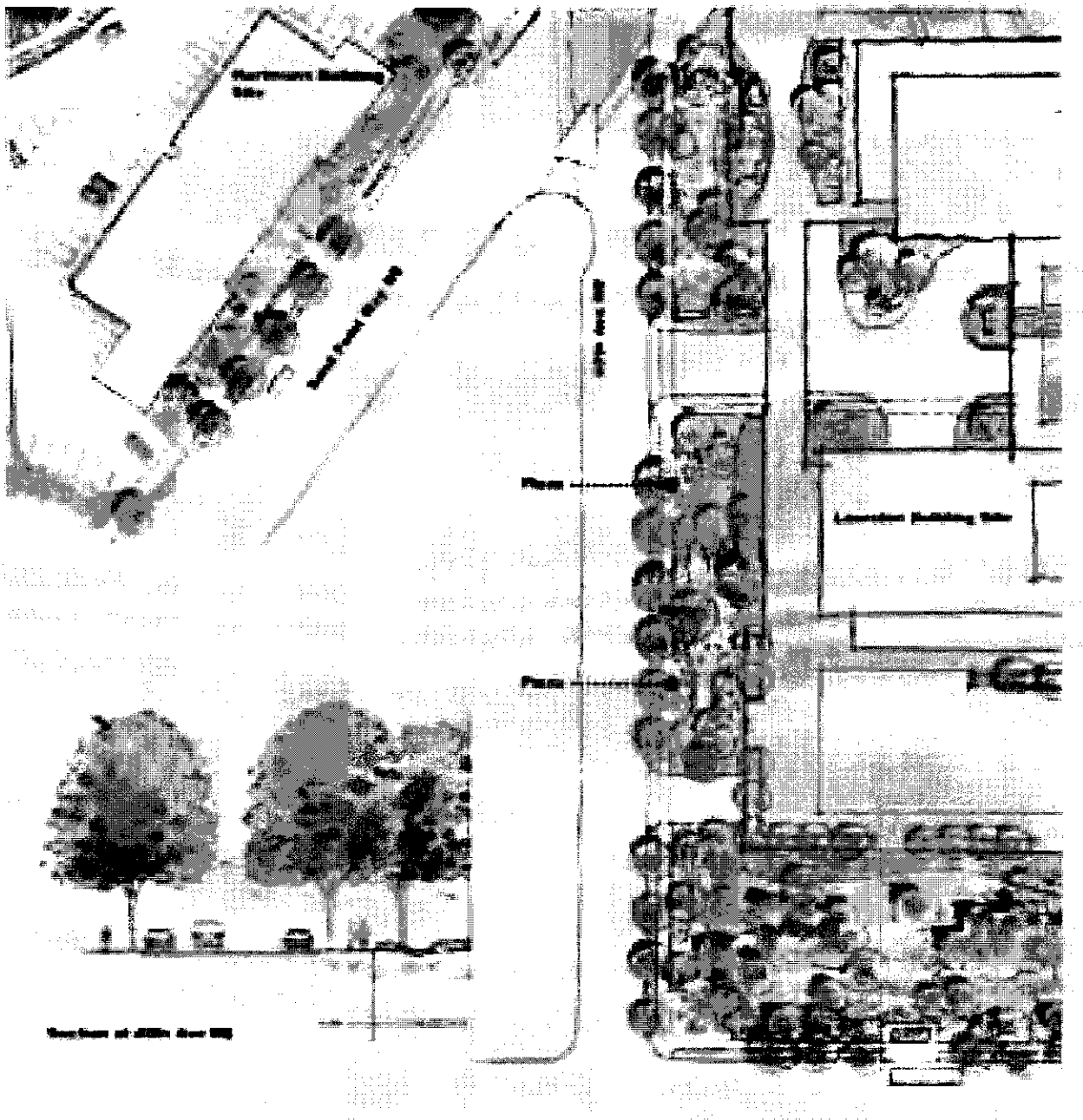


Figure 7 40th Avenue NE

Appendix: Design Guidelines Checklist

	Priority?	*Comments/ Notes*

B1.0 Site Design

B1.1 Hospital Campus Character

B1.1.2 General Guidelines

- Acknowledge the character of surrounding single-family residential, multi-family and mixed use areas at each edge. ☐
- Use a compatible palette, texture, and color of building materials to unify the hospital campus. ☐
- Use landscaping to soften and enhance outdoor spaces and screen utilities, blank walls and other more functional elements. ☐

B1.1.3 Street Frontage Edge

- Open spaces adjacent to Street Frontage Edges to be inviting, open and complementary to adjacent street frontage uses. ☐
- Use a combination of the following architectural treatments to enhance "front door" Street Frontage Edges: architectural features and detailing such as railings and balustrades, awnings or canopies, decorative pavement, decorative lighting, seats, planter boxes, trellises, artwork, signs. ☐

B1.1.3.1 Public Entrances and Access Points

- Create a hierarchy of public entrances and access points to emphasize their appearance at Street Frontage Edge locations, and diminish them at Garden Edge locations where visible from single family residences. ☐

B1.1.3.2 Streetscape and Pedestrian Pathways

- Design streets and pathways to accommodate all travel modes. ☐
- Streets, sidewalks and hospital campus pathways should be welcoming, open to the general public, as well as barrier-free and ADA-accessible. ☐

	Priority?	*Comments/ Notes*
B1.1.3.3 Sidewalks		
• Relate the sidewalk and its amenities to the adjacent uses, the organization of pedestrian movements, and the experience along its length.	☐	
B1.1.3.4 Parking and Vehicle Access		
• Minimize vehicle movement and storage and design facilities to complement the envisioned calming character of the campus.	☐	
B1.1.4 Transition Edge		
• Evaluate the Transition Edge against the same for Street Frontage Edge and Garden Edge guidelines and considerations.	☐	
B1.1.5 Garden Edge		
• The objective of the Garden Edge is to screen hospital structures and light that emanates from vehicles, buildings and site fixtures, while providing an aesthetically pleasing and diversely vegetated viewscape and safe walking environment for pedestrians.	☐	
• Architectural features, landscape improvements, and the transition zone between hospital buildings and the public right of way around Garden Edges shall be designed to be compatible with adjacent single family character.	☐	
• Use a combination of the following treatments to ensure compatibility with adjacent uses: planted screens, gardens, plaza areas, decorative pavement, non-glare lighting, seating, planter boxes, trellises, artwork, and signage.	☐	
B1.2 Exterior Spaces		
B1.2.2 General Guidelines		
• Exterior spaces should extend the color, texture, pattern and quality of the surrounding residential areas.	☐	

	Priority?	*Comments/ Notes*
• Exterior spaces shall provide a visually and otherwise calming experience.	☐	
• The hospital campus shall be designed to include and provide access to restorative and therapeutic gardens with seasonal sun and shade to provide outdoor comfort for families, patients, caregivers and neighbors.	☐	
• Similar materials in plantings, paving, stairs and walls to provide a unifying context for the site development which matches or complements existing campus and surrounding areas.	☐	
• Artwork integrated into publicly accessible areas of buildings and landscaping that evokes a sense of place related to the use of the area.	☐	
• Focal point features such as building entries, fountains, botanical gardens, therapy gardens or pools that relate to wayfinding or honors and memorials.	☐	
B1.2.3 Retaining Wall Guidelines		
• Retaining walls near a public sidewalk that extend higher than eye level should be avoided where possible.	☐	
• Where high retaining walls are unavoidable, they should be designed to reduce their visual impact and increase the interest for the pedestrian along the streetscape.	☐	
B1.2.4 Screening Guidelines		
• Where necessary, use screening sensitively to soften noise and visual impacts to adjacent properties.	☐	
• Design screening to minimize impact of noise producing equipment to adjacent residential neighborhoods.	☐	
B1.2.5 Lighting, Safety and Security Guidelines		
• The design and locations of physical features such as site furnishings, landscaping, pathways and lighting should maximize pedestrian visibility and safety while fostering positive social interaction among patients, visitors, caregivers and neighbors.	☐	

	Priority?	*Comments/ Notes*

B1.2.6 Artwork Guidelines

- Include opportunities for art in the design process as early as possible to allow integration into the design. ☐
- Evaluate the suitability of artwork, whether commissioned or acquired, for its specific site. Consider the artwork's size, materials, concept, etc. ☐

B1.3 Landscape

B1.3.2 General Guidelines

- The landscape plan shall respond to special on-site conditions such as steep slopes, existing significant trees - such as mature, rare or ornamental trees - as well as extend or improve off-site conditions, such as greenbelts, natural areas and streets. ☐
- Coordinate plant locations with adjacent building functions. ☐
- The landscape should extend the color, texture and pattern of the surrounding residential areas while maintaining the visually calming experience unique to the hospital campus. ☐
- Focal point features such as building entries, fountains, botanical gardens, therapy gardens or pools that relate to wayfinding or honors and memorials ☐

B1.3.3 Planting Guidelines

- Plantings shall include mix of groundcovers and perennials, shrubs, understory and canopy trees to provide multi-layered interest. ☐
- Plantings shall include deciduous and evergreen plants to provide multi-seasonal interest. ☐
- Plantings shall include some portion of hybridized or native plants which are drought tolerant and beneficial to native insects and birds. ☐

	Priority?	*Comments/ Notes*
• Avoid dense, dark vegetated "walls" along sidewalks by instead planting year-round screens that are softened by diverse and deciduous plantings and open spaces.	☐	
• Avoid planting low-branching shrubs and other potentially unsafe, view-obscuring plants close to sidewalks.	☐	
• To minimize need for irrigation beyond the establishment period, consider drought and urban tolerant plants.	☐	
• Supplemental planting types and densities to connect greenways and wildlife corridors.	☐	
• Existing plant materials mixed with new plant material to maximize longevity of both campus and right-of-way plant communities.	☐	
B1.3.4 Stormwater Guideline		
• Stormwater treatment and control integrated with the natural rain water cycle, grading and plant communities of the site.	☐	
B1.3.5 Irrigation Guideline		
• Mix of drought tolerant landscape plantings, reused stormwater, and drip irrigation to conserve potable water.	☐	
B1.3.6 Steep Slope Guideline		
• Plantings and other erosion control measures to prevent site destabilization on steep topography.	☐	

B2.0 Architectural Character

B2.1 Height, Bulk and Scale

• Design buildings with materials that help visually reduce the scale and form of the buildings into smaller scaled elements and that complement neighboring structures within the same visual field.	☐	

	Priority?	*Comments/ Notes*
B2.2 Architectural Elements and Features		
• Integrate new buildings with the existing architecture to establish a new cohesive whole for the campus.	☐	
B2.3 Rooftops		
• Where rooftops are visible from locations beyond the hospital campus, rooftops are a design element.	☐	
B2.4 Finish Materials		
• Design and build new buildings with high-quality, attractive, durable materials aesthetically appropriate to the hospital and the neighborhood.	☐	

APPENDIX F: COMPREHENSIVE TRANSPORTATION PLAN

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MEMORANDUM

To: Paulo Nunes-Ueno, Seattle Children's (Children's)

From: Tom Brennan, Andrea Broaddus, Maggie McGehee, and Manuel Soto: Nelson\Nygaard
Peter Valk, TMS

Date: October 20, 2008

Subject: Proposed Comprehensive Transportation Plan in Support of the 2008 MIMP

Introduction

This memorandum expands upon and amends the memorandum dated March 28, 2008 as presented in Appendix T-9 to the Children's Hospital and Regional Medical Center (now Seattle Children's) Draft Environmental Impact Statement (DEIS) for its Major Institution Master Plan (MIMP). The following document outlines the revised Comprehensive Transportation Plan (CTP) that Children's proposes as part of its anticipated MIMP. Children's would implement the proposed CTP upon MIMP approval.

This CTP is based on Nelson\Nygaard's recommendations and analysis, which are documented in Appendix A to this memorandum. Improvements and refinements to the plan as recommended in the March 28, 2008 memo were made in consultation with the Citizen's Advisory Committee, the City of Seattle Departments of Planning and Development (DPD) and Transportation (SDOT), and in response to comments made by the general public during the review period of the Major Institution Master Plan.

This proposed CTP supports Children's transportation goals, which focus institutional planning and investments to minimize Children's impacts on the transportation network and the environment, while at the same time making the most of precious healthcare dollars by limiting construction of expensive, new parking facilities. Children's transportation goals are to:

- Further reduce the percent of commute trips made by single-occupant vehicle (SOV)
- Further reduce AM and PM peak hour vehicle travel
- Reduce the need to build parking on campus or in nearby facilities within the area that would be affected by MIMP-related vehicle trips, and
- Support Children's continued leadership in delivering innovative transportation solutions in the context of climate change.

This CTP would represent a substantial investment in sustainable transportation programs and infrastructure beyond the hospital campus. The CTP is comprised of eight additive elements that reduce congestion and other negative transportation impacts related to the hospital's growth by making transit, walking, and biking not simply convenient choices, but rather the preferred way to travel to Children's.

Comprehensive Transportation Plan elements

Children's has long been recognized as a leader in Transportation Demand Management (TDM), receiving awards from the Governor's office, King County, and the U.S. Environmental Protection Agency for its excellent commuter benefits and achievements in vehicle trip reduction. The hospital's programs to reduce drive-alone commuting and vehicle trips to the campus have resulted in a drive-alone rate of only 38% among daytime employees in 2006, down from 73% in 1995. This accomplishment is significant both for a hospital and for an employer located in a neighborhood with limited public transit service.

With the input of the Citizens Advisory Committee, SDOT, and DPD, Children's has developed a Comprehensive Transportation Plan (CTP) to focus on sustainable transportation programs. The first three elements of the proposed CTP represent major enhancements in programs that are operated within Children's as part of its highly successful Transportation Management Plan (TMP). This enhanced TMP would mitigate vehicle traffic related to MIMP expansion by shifting even more employees and visitors from single-occupancy vehicles (SOV) to bicycling, walking, shuttle, and transit. In addition, the proposed CTP goes above and beyond the traditional TMP components by including five new elements that go well beyond the measures usually associated with a transportation management plan, including a substantial investment in transportation infrastructure improvements outside the hospital campus.

This enhanced TMP would lead to an **SOV mode split of 30% or lower among daytime employees** at MIMP build out.[1] For comparison, this would meet or exceed the 2020 goal of 70% non-SOV travel set for the University District Urban Village in the City of Seattle's Comprehensive Plan (*see Appendix A to this memorandum for a complete discussion of the TMP enhancements and the methodology used to calculate the proposed TMP's SOV and vehicle trip reduction benefits).*

Elements 1-3: Enhanced Transportation Management Plan[2]

Children's proposed enhanced policies and programming for its TMP include expanding its Transportation Demand Management incentives and extending Children's shuttle system to offer new commute alternatives. These TMP enhancements would achieve a 30% SOV mode split or lower among existing and future employees, as measured under applicable TMP requirements. Modeling indicates that the enhanced TMP and its associated SOV mode split is expected to result in a 36% reduction in net new PM peak hour vehicle trips, reducing what would otherwise be additional peak hour vehicle traffic generated by the MIMP expansion. The level of additional investment in shuttles and other elements of the TMP is a significant commitment, and would represent additional costs on the order of several million dollars annually, in addition to capital expenditures. The three enhanced Transportation Management Plan elements are:

1) A robust shuttle-to-transit system linking Children's to regional transit hubs. Children's expanded shuttle system is designed to increase the number of employees who use transit by providing frequent and convenient service between Children's and regional transit hubs. Children's has already initiated a shuttle route to the Downtown Transit Tunnel and 3rd Avenue corridor, and plans a new route to Campus Parkway in the University District in 2009. If the MIMP is approved, Children's would additionally run shuttle routes to the Montlake Flyover stop at SR-520, the future LINK light rail station at Husky Stadium, and park and ride locations in south Snohomish County during later phases of development.

Expected outcome: 19 percent reduction in net new PM peak hour vehicle trips by 2028.

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[1] As measured by Washington State Commute Trip Reduction (CTR) law reporting requirements.
[2] For a complete description of the proposed Enhanced TMP, see Appendix A to this memo.

2) Innovative bicycle programs. Children's is pioneering a number of creative programs to increase the use of bicycles for commute and mid-day trips, such as:

> *Company Bikes,* which offers free use of a bicycle to employees who commit to cycling at least two days per week, and
>
> *Flexbikes,* a shared-bicycle program which allows users to check out electric-assist bicycles for one-way travel to the 70th / Sand Point Way administrative building on the University of Washington Medical Center (UWMC).

Expected outcome: Increase in the percentage of employees who commute by bicycle from 6% (2007) to 10% by 2028

3) Increased financial rewards for employees who commute without driving alone. Children's rewards employees who use alternative forms of transportation with monthly financial bonuses. The amounts of these incentives would be increased, parking fees would rise, and Children's would also continue to provide many other programs such as free transit passes, fully subsidized vanpools, guaranteed taxi rides home in the case of emergency, and others.

Expected outcome: 17 percent reduction in net new PM peak hour vehicle trips in 2028, for a total 30-40% reduction in net new PM peak hour vehicle trips combined with Element 1.

Elements 4-8: Above and beyond a typical TMP

The additional five elements of the Comprehensive Transportation Plan would go above and beyond what is typically included in a Transportation Management Plan. These additional elements would provide community benefits, improve Northeast Seattle's transportation network, and provide even further reductions in transportation impacts related to the hospital's expansion. These elements are:

4) Campus design and near-site improvements to encourage alternative transportation. Through careful arrangement of design elements such as pedestrian access, bicycle facilities, transit centers, and the buildings themselves, Children's would create a campus that supports the convenience and attractiveness of alternative transportation modes. This campus design would blend with the surrounding neighborhood and include adjacent improvements on Sand Point Way NE and 40th Avenue NE, to support vehicle and pedestrian movement near the campus both for Children's transportation and for the benefit of the surrounding neighborhood.

Expected outcome: A more attractive, safe, and pleasant development that encourages walking, bicycling, and transit use.

5) Intelligent Transportation Systems (ITS) for NE 45th Street / Montlake Boulevard / Sand Point Way NE. Children's would contribute up to $500,000 to directly fund Intelligent Transportation System (ITS) projects in the corridor most likely to be impacted by the hospital's expansion: Montlake Boulevard through Sand Point Way NE to the hospital. By applying smart signals that adapt to traffic conditions, ITS enhancements would optimize the performance of key intersections and produce substantial reductions in vehicle delay and travel time within the corridor. For example, when ITS improvements were installed at Greenwood Avenue N and Holman Road NW in Seattle, the result was a 30 percent reduction in vehicle delay and a 15 percent reduction in travel time.

Expected outcome: 5-10 percent reduction in delay and travel time.

6) Contributions to capital projects that would improve the Northeast Seattle transportation network. The City of Seattle has identified a comprehensive list of projects intended to improve the movement of people and goods as well as increase safety in the area impacted by Children's traffic. These projects emerged from a number of planning efforts conducted by the City, including the University Area Transportation Study, the University Area Transportation Action Strategy, the Bicycle Master Plan and the Sand Point Way Pedestrian Plan. Children's would contribute a proportionate share of the cost of the projects on this list based upon the amount of traffic related to Children's, in an amount up to $1.4 Million.

> ***Expected outcome:*** Currently unfunded improvements in the Northeast Seattle transportation network would receive substantial financial support.

7) Investments in Walkable + Bikeable Northeast Seattle. Children's would contribute up to $2 Million to a Bicycle + Pedestrian Fund that would be used to build capital projects – in some cases above and beyond those found in existing plans – that improve pedestrian and cyclist access, mobility, and safety for Children's employees, visitors, and members of the surrounding community. Projects listed in the Bicycle Master Plan that have a connection to Children's and are currently unfunded would receive first priority. Children's would work with the City and communities surrounding the hospital to identify improvements that would create wide-ranging community benefits, particularly those that promise to increase the numbers of families and children who feel safe and comfortable bicycling and walking in northeast neighborhoods. These projects should also lead to even further increases in the numbers of Children's employees who arrive at work on foot or by bicycle.

> ***Expected outcome:*** Significant reductions in vehicle/bicycle crashes, and greater numbers of cyclists and pedestrians in the area.

8) Out-of-area parking. If the MIMP is approved, Children's intends to identify 100 to 200 out of area, off-site parking spaces per each phase of development as part of its CTP and as necessary to mitigate future transportation impacts. As a first step, Children's and Sound Transit have signed a Memorandum of Understanding committing both organizations to investigate options to create capacity for Children's employees at regional park and ride facilities.

> ***Expected outcome:*** Every 100 cars parked in off-site, out-of-area facilities would result in a 5% reduction in traffic impacts surrounding the hospital.

Children's is committed to develop sustainable transportation programs in conjunction with its MIMP construction. Through the CTP, the hospital would mitigate vehicle traffic related to expansion by shifting even more employees and visitors from single occupant vehicle (SOV) to biking, walking, shuttle and transit. The CTP would allow Children's to:

- Achieve a 30% SOV rate, matching the 2020 mode share goal set by the City of Seattle comprehensive plan for the University District
- Reduce the number of parking spaces needed on campus by 500, and
- Reduce vehicle miles traveled, and thus reduce the resulting green house gas emissions that would otherwise be generated with no further mitigation measures beyond Children's 2007 TMP.

Element I. Robust shuttle-to-transit system

Significant investment would be made in the operation of new shuttles from major transit hubs that connect riders directly to the campus. Shuttle routes would meet regional transit service at Westlake Station and 3rd Avenue downtown (*launched in April 2008*), the University District (*scheduled to launch in 2009*), the Montlake/SR 520 flyover stop, and the future light rail station at Husky Stadium. Another route would provide connections from south Snohomish County during peak commute times.

Table 1 summarizes Children's shuttle program as of 2007, and presents the enhancements that Children's would implement in conjunction with the MIMP. This enhanced Shuttle service, along with Elements 2 and 3 of the CTP, would together meet Children's TMP goals referenced above (i.e., pioneering innovative climate change solutions and further reducing SOV rates, vehicle trips, and parking demand). Expanding Children's existing shuttle routes to connect with regional transit services effectively extends the reach and convenience of the public transit system and allows more employees and other visitors to choose alternate modes to reach campus. (*See Appendix A to this memorandum for a detailed description of the Shuttle program, strategy development for the entire TMP, and expected effectiveness.*)

Table 1. 2007 Shuttle Service and Proposed Enhancements

2007 Program	Proposed Enhancements
• 6 routes offer free rides between the main campus and parking lots, other Children's facilities, and affiliated institutions, Mon-Fri • Shuttle fleet of 12 vehicles, equipped to carry bicycles • 2 routes connect the hospital campus with nearby off-campus parking lots: every 7-10 minutes, runs 5:30AM-9PM • 1 route between the 70th/Sand Point Way administrative building and main campus: every 15 minutes, 6AM-6:30PM • 1 route connecting the Magnuson Park lot and 70th/Sand Point Way building: every 10 minutes, 6AM-10AM, 3PM-7PM • 1 route between Children's main campus and Metropolitan Park West offices in downtown Seattle: every 30 minutes during peak, 20 minutes off-peak, 6AM-8PM • 1 route between Children's Hospital Research Institute Building 1 University of Washington Medical Center (UWMC), and Children's main campus: every hour, 8AM-5PM • Fred Hutchinson provides one route from the Seattle Cancer Care Alliance to UWMC and Children's: every 40 minutes, 7AM-7PM	• Initiate additional Transit Shuttle routes to public transit hubs • Increase shuttle fleet as needed to support service enhancements • Launched in June 2008: Route to 3rd Avenue/Westlake Station every 15 minutes (absorbing Metropolitan Park West route and 70th/Sand Point Way to hospital route) • Planned for launch in 2009: Route to University District NE 45th St and Campus Parkway hubs, every 10 minutes during peaks, every 15 minutes off-peak • Route to SR 520/Montlake Blvd. Station every 10 minutes during peaks, every 15 minutes off-peak • Route to Future UW light rail station at Husky Stadium, every 10 minutes during peaks, every 15 minutes off-peak • Route to south Snohomish County every 30 minutes, only during peaks

Element II. Innovative bicycle programs

Building on its history as an innovator in transportation management, Children's is piloting novel bicycle programs to bolster the number and proportion of its employees who commute by this physically active, non-polluting transportation mode. Children's campus provides the free use of showers, lockers, secure bicycle parking, and subsidized tune-ups for all employees. Lockers are currently available on a first-come, first-served basis to those who bike or walk to work or who exercise mid-day and utilize the shower and changing facilities.

On July 17, 2008, Children's launched its **Company Bikes** program. Under Company Bikes, Children's invites employees to pledge to bicycle to work at least two days every week, year-round. After completing two bike commuting courses offered by Children's Commuter Services staff, these pledged employees are provided with a bicycle free of charge from the hospital, for their use as long as they continue bike commuting twice a week. The Company Bikes program enjoyed an enormously positive start, assigning 30 bicycles within the first two days of its launch and committing all 100 bicycles for the 2008 program by September. Commuter Services has 27 bicycle commuting courses scheduled through November 2008. 100 more Company Bikes bicycles are planned for purchase and distribution in 2009.

Scheduled to launch in the first quarter of 2009, the **Flexbikes** bike-sharing program would house 20 bicycles on the hospital campus that employees can rent during the day, with the first half hour free. The bicycles would have an electric-assist motor that can be turned on to help climb hills. Children's program would link with a system of 40 Flexbikes to be housed on the University of Washington campus. Flexbikes would reduce the number of midday vehicle trips between the Hospital and nearby facilities such as the 70th and Sand Point administrative offices and the University of Washington Medical Center. In addition, the provision of bikes for mid-day trips would help employees who may not be ready or able to bicycle to campus to try biking for errands and meetings, reducing motorized vehicle trips during the day.

In order to support the projected 10% of employees cycling to work by 2028, Children's is planning for showers, lockers, and bike parking to accommodate 600 cyclists. The hospital is considering a locker-assignment system to ensure consistency and predictability for locker users.

Element III. Increased financial rewards for employees who commute without driving alone

Children's employees receive substantial financial and convenience incentives to choose non-drive alone commute modes. In conjunction with the MIMP, as part of the Comprehensive Transportation Plan, Children's proposes to greatly enhance its 2007 incentives programs to provide substantial economic motivation, supportive benefits, and ample information and guidance to encourage employees to get to work by transit or shuttle, carpool or vanpool, or by bicycle or on foot.

Children's would make the following enhancements to employee incentives:

Table 2. 2007 Incentive Programs and Proposed Enhancements

Element	2007 Program	Proposed Enhancement
Financial Incentives for Alternate Commutes	Children's employees and CUMG physicians can earn up to $50 per month in Commuter Bonus	Medical residents, fellows, and students also eligible for the monthly bonus; maximum incentive increased to $65 per month, matching parking fees
	Additional quarterly bonuses for vanpool drivers, backup drivers, and bookkeepers	Same
	FlexPass for all Children's and CUMG employees; PugetPass for others upon request	FlexPass for medical residents & fellows; UPASS subsidized for students (out of pocket portion)
	Free bicycle tune-ups, umbrellas, and reflective lights provided annually.	Institute a $100 per year gear bonus for commuters who walk or bike to work
Parking costs	Children's employees, CUMG Physicians, Pace temps, travelers, UW employees, and contractors who drive alone to work charged $50 per month for parking. Children's tracks University of Washington parking fee increases and raises hospital parking fees concurrently.	Raise on-campus SOV parking charge to $65 per month, with ongoing increases still made in step with University of Washington parking fee changes. Add medical residents, students and fellows to employees charged for monthly parking, similar to UW policies.
	Patients, families, carpools and vanpools park on campus for free, as do: medical residents, students, fellows, volunteers, community physicians, trustees, board members and vendors	Eliminate free parking with introduction of pay-per-use. Charge patients and families for parking, with the potential for validation or Medicaid vouchers for families. Institute parking charges for carpoolers to create a market incentive for carpoolers to increase the occupancy of their cars and the frequency with which they share the ride to work.
Carpool and Vanpool	Carpool groups managed internally by Children's Transportation staff. No incentives for formation, but $65/month bonus for full time carpooling and free parking. Therefore, carpoolers get enhanced utility from sharing the ride.	Children's would invest in technology that facilitates carpool matching by commuters themselves, including real-time matching. Children's would transition to a single carpool formation bonus and institute parking charges for carpoolers. These changes would create market incentives for carpoolers to maximize the number of rides they share and to increase the occupancy of their cars.
Supportive programs	Guaranteed Ride Home and carsharing memberships provided to employees. Shuttles are equipped to carry bicycles.	Continue proportional investment in GRH and Zipcar as employee populations grow.

Element IV. Campus design and near-site improvements to encourage alternate transportation

Research shows that the choice to drive, take transit or use human powered modes is influenced as much by the quality of the built environment along the way as by the availability transportation choices. For example, a well-designed campus portal located near transit, or deliberate placement of bicycle facilities near entrances, help to reduce any real or perceived penalty associated with the use of transit or non-motorized travel modes.

Making non-motorized transportation safe, attractive, and time-competitive with SOV travel is a guiding principle of the CTP. Children's has integrated pedestrian- and cyclist-supportive infrastructure into every design decision during the MIMP planning process, both within the campus and at access points, crossings, and pedestrian environments along the hospital's perimeter. Such detailed design efforts would support the effectiveness of all other Children's transportation programs, and make non-drive-alone travel modes feasible and appealing for all groups of people who come to campus, including clinical and administrative staff, medical students and community physicians, and volunteers and visitors.

On-Campus Capital Improvements

Children's is working with its architect to ensure that the campus would be designed to make walking, biking, and transit the best ways to commute to work. New on-site facilities would serve increasing numbers of shuttle and transit passengers, bike commuters, and pedestrians. Careful attention is being paid to walking and cycling connections between shuttle and bus stops, campus access points, and main buildings. Regardless of initial travel mode, visitors would navigate the campus by foot or using a mobility aid such as a wheelchair or walker when traveling from the parking garages, transit stops, bicycle cages, or between different buildings; safe, convenient, and clearly-marked on-site pedestrian facilities are necessary for all hospital visitors. Tables 3 and 4 describe facilities on Children's existing site and proposed enhancements that would be included in the MIMP design:

Table 3. 2007 On-Campus Shuttle/Transit Facilities and Proposed Enhancements

Travel Mode	2007 Facilities	Proposed Enhancements
Shuttle	Shuttles drop passengers off at the turn-around platform in front of the Giraffe Building	Enhanced shuttle service would require 4-6 bus bays for efficient drop off/pick up and vehicle turn around. Build a high-quality hub to serve Children's shuttles and public transit (see "Proposed combined enhancement" below)
	Passengers dropped off adjacent to hospital building	Support pedestrian circulation with clear, separated infrastructure between shuttle bays and hospital buildings
	Shuttles stored overnight at National Archives on Sand Point Way NE	Dedicate 18,000 sf. (on or off campus) for fleet storage, maintenance and operator facilities
King County Metro Transit riders	Route 75: Arriving passengers must walk up a steep hill on Penny Drive from the bus stops on Sand Point Way NE to buildings. Bus stops are covered adjacent to the hospital campus. However, stops near the Hartmann facility are unsheltered, and there is no signalized crossing to help passengers safely navigate the four lanes of traffic.	Create a pedestrian-oriented building entrance directly adjacent to the Route 75 stops (see "Proposed combined enhancement" below)

	Route 25: Passengers arrive in a protected turn-around but must walk through the Whale parking garage, or find a hidden stairway leading through a garden plaza, to reach the hospital	Enhance signage directing passengers to the path through the garden plaza. If possible after negotiations with King County Metro, co-locate the stops for routes 25 and 75.

Proposed combined enhancement: Transit/Shuttle Hub

Depending on which MIMP alternative is chosen, Children's would work with King County Metro and SDOT to create a shared location where routes 75, 25, and Children's shuttles all stop. Under Alternative 7R, this hub would be located on both sides of Sand Point Way NE at 40th Avenue NE, in front of the hospital and the Hartmann property. The Transit/Shuttle Hub would be designed as a true gateway arrival point for the campus, with attractive and comfortable amenities such as seating, lighting, and weather protection. This would enable passengers to walk to and wait at a single stop and have the option of using any of these transportation services. As the hospital site exists today, passengers must choose a single option ahead of time – either one of the two Metro routes or a shuttle – because stops for each are located at different places around campus. Co-locating a Transit/Shuttle Hub would encourage more people to choose these modes to travel to and from the hospital by creating more travel options and greater arrival frequencies at one dedicated, safe, and appealing waiting area.

Table 4. 2007 On-Campus Pedestrian/Bike Facilities and Proposed Enhancements

Travel Mode	2007 Facilities	Proposed Enhancements
Bicycle	Secure bicycle parking for 120 bicycles provided inside bike cages in parking garages, at building entrances, and uncovered locations.	Add enough bicycle parking to accommodate 600 cyclists. Focus bike parking in locations that create easy access to the desired destinations in the campus. Create dedicated central location for Flexbikes (see Element II "Innovative bicycle programs" and Appendix A for details)
	End-of-trip amenities, such as shower and locker facilities, provided free of charge.	Add shower/locker facilities to accommodate the demand generated by 600 cyclists per day as well as those traveling to campus on foot.
Pedestrian	Main campus access point at Penny and Sand Point Way NE is oriented to vehicles. Building entrances are located uphill and far from this main access point as well as all other bike/pedestrian access points.	Build a "front door" to the hospital campus and directly into the main hospital building on 40th Avenue NE and Sand Point Way NE, eliminating the hill climb on Penny Drive. Build ADA-compliant crossings on Penny between garages and buildings.
	Paved paths lead through campus, but it is difficult to discern where you are and where you should head while on foot outside of the hospital buildings.	Incorporate consideration of pedestrian flow as a fundamental element of all MIMP design work. Build clear, safe, and intuitive pedestrian circulation routes from nearby neighborhoods, transit and shuttle stops, and between buildings and parking garages. Use a system of gardens, courtyards, and plazas to create a beautiful pedestrian space. Utilize accepted national standards for public safety, such as Crime Prevention Through Environmental Design (CPTED). Develop a comprehensive wayfinding system for on foot circulation both to and within the campus, in support of all other elements of the CTP.
	Pedestrian crossings on Penny Drive are marked with crosswalks, signage, and flashing signal lights.	Carefully design all campus vehicle routes to safely serve people on foot as primary users

Proposed combined enhancement: Redesign Penny Drive

Existing Penny Drive has narrow sidewalks, two lanes and center turn lane that pedestrians must cross, and no designated bike space. In addition to building a comprehensive system of dedicated pedestrian and cyclist circulation routes through campus, Children's would revamp Penny Drive and any new campus streets to create obvious places for pedestrians and cyclists, so that drivers are naturally aware of and yield to these travelers.

Near-site improvements

This same attention is being applied to non-motorized safety and mobility treatments at existing and newly created major street crossings, where vehicles, pedestrians, transit riders, and cyclists meet. Children's will participate in improving intersections such as at Sand Point Way NE and Penny Drive and at Sand Point Way NE and NE 40th Street. Proposed near-site treatments are outlined in Table 5:

Table 5. 2007 Near-site Facilities and Proposed Enhancements

Travel Mode	2007 Facilities	Proposed Enhancements
King County Metro Transit riders	Route 75: In order to move between stops and the hospital buildings or Hartmann building, riders must cross five lanes of traffic on Sand Point Way NE.	Work with SDOT and WSDOT to suggest intersection designs at Sand Point Way NE at 40th Avenue NE that create priority for safe pedestrian crossings while balancing vehicle circulation requirements.
	Route 25: The dedicated turn-around on NE 45th Street allows for protected loading/off-loading westbound. Passengers cross NE 45th Street at unmarked crosswalks for eastbound stops.	From the turn-around, enhance signage directing passengers to the path through the garden plaza or Whale Garage. Consider marking crosswalks across NE 45th Street to the hospital.
Intersections on Sand Point Way NE	The intersection with Penny Drive is controlled by a traffic signal but requires pedestrians to push a button to request a "walk" phase. Crossing Sand Point Way NE here or at NE 50th Street requires navigating 4 lanes of traffic plus a center turn lane.	Improve the Penny Drive intersection to enhance safety and access for bicycles and pedestrians. If an alternative were chosen that includes a campus access point at NE 50th St, a signal and intersection improvements would be needed at NE 50th St.
	The 40th Ave NE intersection is uncontrolled. People run across Sand Point Way NE at this location, darting across five lanes of traffic between bus stops, Hartmann, and commercial destinations on the south side of Sand Point Way NE	It is currently in City plans to install a traffic signal at this intersection. It would be desirable to work with SDOT and WSDOT to encourage a design that integrates with the planned campus entrance and enhances pedestrian crossing safety.
Near-site pedestrian and cycling environment	Perimeter pedestrian entrances to the campus exist on 44th Avenue NE and on NE 45th Street close to 40th Ave NE, but are obscured by wooded areas.	Make the perimeter entrances off of 44th Avenue NE and NE 45th Street (including the bus pull-out) more obvious and inviting through wayfinding or design elements. Create additional pedestrian/ bicycle-only perimeter access points.
	The Burke-Gilman Trail runs north of the campus but does not extend to Sand Point Way NE. Connections between the trail and the hospital and Hartmann Building are unclear.	Create clear connection to the hospital from the trail using intersection enhancements and wayfinding. At Hartmann, build a trail connection that flows into the new crossing at 40th Ave NE to be implemented by SDOT. The crosswalk and level access to campus would greatly increase the convenience to pedestrians and cyclists as well as provide an ADA entrance near the transit drop-off.
	Main campus buildings are set far back from the roadway. The Hartmann Building is surrounded by a parking lot, discontinuous sidewalks, and a blank wall fronting Sand Point Way NE.	Create "Great Streets" along hospital-fronted roads, including Sand Point Way NE and 40th Ave NE Bring hospital buildings to the street, provide wide sidewalks and landscaped buffers, and install human-scale amenities such as lighting, seating, and weather protection. Consider adding retail on the first floor. If Hartmann is developed, enliven the street frontage on Sand Point so that pedestrians have a welcoming human-scale environment.

Element V. Intelligent Transportation Systems (ITS) for Sand Point Way and Montlake Boulevard

Above and beyond the trip reduction Children's would achieve through its enhanced TMP, the hospital is pledging capital dollars toward projects that would improve operations for all traffic on one of the most congested corridors impacted by the hospital's expansion. Children's would make a direct contribution of up to $500,000 to build Intelligent Transportation Systems (ITS) improvements through the corridor from Montlake Boulevard / NE 45th Street to Sand Point Way NE / NE 50th Street. These ITS projects will benefit all road users (not just Children's-generated traffic) by dynamically improving vehicle flow and travel times in response to changing traffic conditions. This contribution would implement and extend the ITS improvements identified by the City of Seattle in the University Area Transportation Action Strategy (UATAS).

ITS projects employ technology to optimize signal coordination and signal timing utilizing traffic cameras and variable message signs. ITS projects can be built quickly and do not require significant construction, so implementing such projects would result in minimal traffic disruption on affected corridors and is expected to provide the best results per dollar spent in terms of improving traffic flow. Beyond improving peak hour traffic conditions, ITS projects improve corridor travel at all times of the day and on weekends. Children's would fund these ITS projects from Montlake Boulevard through Sand Point Way NE to the hospital, up to $500,000. The contribution would be used to:

- Install a detection system that measures congestion along southbound Montlake Boulevard, linked to smart traffic control devices that adapt to traffic conditions,
- Install variable message signs to give real-time traffic information to drivers, including travel time estimates, updates on collisions and other traffic conditions, and even to implement variable speed limits throughout the day in order to keep traffic flowing as smoothly as possible,
- Optimize signal coordination and timing to move vehicles most efficiently and optimize intersection performance,
- Upgrade signal controllers as needed to allow signals to be interconnected, and/or
- Install traffic cameras as identified by the City of Seattle.

Practice-based research indicates that ITS enhancements achieve between 10-45% improvement in functional street capacity. For example, at Greenwood Avenue N and Holman Road NW in Seattle, an ITS implementation has led to a measured 30% reduction in vehicle delay and a 15% reduction in travel time. While it is inappropriate to model such improvements when dealing with long range forecasts, **achieving functional street capacity improvements even on the low end of the 10-45% range would represent a level of improvement that meets or exceeds the identified impact of Children's added traffic in those areas where ITS projects were implemented.**

Element VI. Contributions to capital projects that would improve the Northeast Seattle transportation network

Children's would contribute funds toward a pro rata share of projects designed to improve person- and vehicle-movement capacity, travel time, and safety through the area impacted by Children's traffic. The contribution amount is based on Children's pro rata share of its potential impact on the transportation system as applied to the cost of a comprehensive list of City projects in these corridors, and is proportionate to the amount of traffic related to Children's that would impact each project. The pro rata methodology used to calculate Children's contribution is consistent with the methods employed by the City of Seattle to calculate pro rata contributions toward transportation infrastructure improvements in other neighborhoods, including South Lake Union and Northgate. In conjunction with Children's MIMP, this methodology was applied to known impacts and project costs, and Children's contribution should be considered as an impact fee, agreed upon as part of project approval and later used by the City to fund projects as appropriate. Based on current estimates, Children's pro rata contribution would total up to $1.4 Million, or approximately $3,955 per new bed added over the course of MIMP construction.

Identifying a Comprehensive List of Projects

Children's worked with the Seattle Department of Transportation (SDOT) to identify a comprehensive list of potential capital improvement projects that would improve operations on corridors most impacted by Children's development: NE 45th Street, Montlake Boulevard, and Sand Point Way NE. Sources for the comprehensive list of projects include:

- **University Area Transportation Action Strategy (UATAS)**. HOV, bike and pedestrian, and capacity and flow projects that would improve the targeted corridors
- **Sand Point Way Pedestrian Study (SPW Ped Study)**. Projects within a one mile radius not otherwise funded or included in the Bicycle + Pedestrian Fund project list (*see Element VII "Investments in Walkable + Bikeable Northeast Seattle"*).
- **Draft Environmental Impact Statement for the Children's MIMP (DEIS)**. Projects identified from the UATAS, by Children's, and by the City that were included in the DEIS, excluding those projects that the City requested be removed from consideration due to project cancellation, and including new projects requested by SDOT.
- **Bicycle Master Plan (BMP)**. Projects on the prioritized BMP project list falling within Children's impacted corridors, or creating connections to other identified bike/pedestrian projects or to broader bike/pedestrian networks, as per the goals cited in Element VII "Investments in Walkable + Bikeable Northeast Seattle." Projects included on the comprehensive list were specifically requested for consideration by SDOT Bicycle Program staff.

Projects included on the comprehensive list meet one or more of the following selection criteria:

- Tailored to achieving greater vehicle or person travel capacity, safety, and improved travel time through the corridors
- Have a direct nexus to mitigating the impact of Children's MIMP on traffic
- Support City of Seattle and sub-area transportation goals, including the Mayor's initiative to make Seattle the most walkable and bikeable city in the country
- Support HOV and non-motorized modes promoted through Children's TMP

- Deemed a feasible and cost effective solution, but not already funded and scheduled for construction
- Provide benefit to the widest range of people within the community, including Children's employees, patients, and visitors.

Table 6 presents a potential comprehensive list of projects. Most of these appear in existing plans approved by the public. The list is not definitive, and no projects are guaranteed implementation.

Table 6. Comprehensive List of Projects for Pro Rata Consideration

UATAS projects	
NE 45th St corridor	Add westbound Business Access and Transit-only (BAT) lane
15th Ave / NE 45th St	Extend left-turn lane pocket, modify signal to move more buses
Ravenna Ave NE / NE 55th St corridor	Reconfigure to provide curbs, gutters, sidewalks; delineate corners for safety
NE 45th and Burke-Gilman Trail (BGT)	Construct a ped/bike connection between BGT and NE 45th St
Montlake, NE Pacific Place to 25th Ave NE *	Extend HOV lane from NE Pacific Place to 25th Ave NE
36th Ave NE / BGT	Connect BGT with ramp from 36th Ave NE at NE 45th St
NE 47th St / BGT at University Village	Create new pedestrian connections on 47th, realign 25th Ave intersections
Montlake Blvd E / E Hamlin St	Extend northbound left/U-turn lane to reduce congestion
NE 45th St, 18th-22nd Ave NE	Widen sidewalks, install landscaped pedestrian refuge islands
Montlake Blvd NE / NE Shelby St *	Narrow intersection, add bike lanes, widen sidewalk
NE 50th St / 30th Ave to 35th Ave NE	Complete sidewalk south of roadway; install traffic calming devices
Montlake Blvd / NE 45th St corridors	Install variable message signs for real-time traffic information
Montlake Blvd E / E Shelby St	Modify traffic island, add a bike lane
Projects identified in the DEIS process	
Montlake Blvd / NE 45th St to Sand Point Way NE / NE 50th St (ITS to Children's door)	Provide signal coordination and ITS improvements, including cameras, interconnect, signal timing improvements, etc. (see element V "ITS")
Montlake Blvd (ITS extended to SR 520)	Additional ITS along Montlake (Roanoke to NE 45th)
NE 45th St (ITS extended to I-5)	Additional ITS along NE 45th Street (I-5 to Montlake)
40th Ave NE / NE 55th St	Install traffic signal
40th Ave NE / NE 65th St	Install traffic signal
Sand Point Way NE / NE 50th St	Install traffic signal
NE 45th St / 40th Ave NE left-turn lane	Install left-turn lane within existing ROW on eastbound NE 45th Street
Extend Montlake HOV *	Extend SB HOV land from 25th Ave NE to the Five Corners intersection
"Sand Point Way Pedestrian Study" projects	
Sand Point Way NE / 40th Ave NE	Install new signal and crosswalks
Sand Point Way NE, NE 50th St – 47th Ave NE	Install pedestrian-only signal when warranted
Sand Point Way NE, Princeton – 50th Ave	Construct sidewalk or walkway on north side
Sand Point Way NE, NE 58th or NE 60th St	Monitor for potential crosswalk in the future
Sand Point Way NE, NE 65th – NE 70th St	Construct sidewalk or walkway on west side
Bicycle Master Plan projects	
20th Ave NE, NE 45th St to Ravenna Blvd	Sharrows, two sides
Ravenna Pl NE, NE 55th St to 25th Ave NE	Sharrows, two sides
20th Ave NE, NE 65th St to NE 86th St	Sharrows, two sides
35th Ave NE, NE Blakely St to NE 65th St	Sharrows, two sides
NE 65th St, Ravenna to Magnuson Park	Bike lane one side, Sharrow other (partial), Sharrows two sides (partial)
NE 77th St and Sand Point Way NE	Signalize as part of east-west route

* Note: Projects marked with an asterisk are included for pro rata calculation purposes here, though the specific projects are in question and subject to change as a result of SR 520 planning outcomes.

Due to uncertainty surrounding SR 520, it is impossible to accurately determine Children's future impacts on the Montlake corridor or appropriate mitigation. However, information from the UATAS, the

Sand Point Way Pedestrian Study, and the DEIS provide the best available understanding of future conditions and what future capital projects might include. This provides a basis for Montlake corridor projects included in the universe of projects to which Children's would contribute a pro rata share.

Calculating Children's Contribution

Children's and the City agreed upon using the City's established methodology for calculating a pro rata share of the overall cost of this comprehensive list of projects. This calculation is based on MIMP-generated traffic's estimated contribution to total traffic at MIMP build out, assuming all programs in the proposed TMP are implemented. The methodology is based on:

- Existing total PM peak hour vehicle trips from all sources, as measured in 2007 through each corridor,
- Estimated total PM peak hour vehicle trips from all sources, at MIMP build out through each corridor, and
- Children's net new PM peak hour vehicle trips expected in 2030 compared to 2007 through each corridor if the MIMP is built out. This is the net new trips expected with the proposed TMP mitigation in place.

Pro Rata contribution rate for each project based on Total Traffic:

Children's net new PM peak hour vehicle trips in 2030, divided by
the 2030 total PM peak hour vehicle trips expected from all sources.

For projects that would improve conditions for transit, bicycling, or walking, the pro rata contribution rate is further multiplied by a percentage based on the ratio of net new PM peak hour Children's trips expected to be made by those modes compared to in vehicles.

These pro rata contribution rates were then applied to the total cost of each project in the comprehensive list of projects, to achieve a pro rata contribution amount for each. The sum of each of these individual pro rata contribution amounts equates to Children's total pro rata contribution toward Northeast Seattle transportation network enhancements. Based on current estimates, Children's pro rata contribution would total up to $1.4 Million.

Project Prioritization and Implementation

Children's contribution was calculated by determining partial shares of many projects. It is anticipated that actual implementation would be determined by SDOT, and would be directed at funding high priority projects in the affected sub areas. The City should not be restricted to projects appearing on the comprehensive list if other higher-priority, as-yet-unplanned improvements are identified; however, there should be a relationship between any project funded and the identified transportation impacts of Children's development. Again, Children's pro rata contribution should be viewed as a one time fee for its impacts and is intended to also satisfy the institution's obligation for its share of any projects identified at a future date. Any amount of monies from Children's contribution could be applied to any individual project up to and including full funding, but Children's would not be required to make additional contributions once the hospital's pro rata contribution has been spent. Children's contribution may be phased to match the pace of MIMP development.

Element VII. Investments in Walkable + Bikeable Northeast Seattle

Children's TMP is centered on the premise of promoting transportation options that support environmental, community, and public health. Walking and biking are the most healthful forms of transportation, and Children's seeks to aggressively increase its numbers of walking and bicycling commuters through innovative on-campus programming (*as described under Elements II and III "Innovative bicycle programs" and "Increased financial rewards"*) as well as innovative off-site infrastructure improvements.

Although Children's is expected to achieve its reduction goals for vehicle trips, employee SOV rates, and parking demand entirely through the enhanced Transportation Management Plan detailed in Elements I – III, Children's proposes to also pay $2 Million for bicycle and pedestrian projects in Northeast Seattle. Children's would invest these Bicycle + Pedestrian fund monies over the timeframe of the MIMP. This Fund would implement key capital projects for pedestrian and cyclist connectivity and safety in neighborhoods and corridors leading to campus. The Bicycle + Pedestrian Fund would be applied to projects that:

- Improve safety for pedestrian and bicyclist access to campus for employees, visitors, and neighbors, particularly for people walking to and from transit stops and regional trails
- Create safe and pleasant routes in the neighborhoods where 24% of Children's employees live, within approximately three miles of campus
- Improve connections between residential streets and the Burke-Gilman Trail, particularly the safety of people crossing at intersections, and
- Add additional value by funding projects above and beyond those fully funded through existing City plans.

This fund would directly support the hospital's goal of enabling the most healthful, least impactful transportation modes while protecting the safety of all travelers. This investment would be intended to improve facilities and public health for both Children's visitors and the broader Northeast Seattle community.

Children's would work with the City, neighborhood residents, and pedestrian and bicycle advocates to identify potential improvements. The following represent potential categories of improvements that would guide the investment in bicycle/pedestrian infrastructure projects that Children's would consider funding:

- **Bicycle Master Plan priority projects.** A portion of the Bicycle + Pedestrian Fund would be allocated to projects listed in the Bicycle Master Plan that are currently unfunded and create a direct connection within Children's impact area. Examples of this category of projects include adding sharrows or bike lanes along significant sections of 20th Avenue NE, Ravenna Place, 20th Avenue NE, 35th Avenue NE, and NE 65th Street.
- **Connections between the hospital campus and larger bicycle/pedestrian networks.** A portion of the Bicycle + Pedestrian Fund would be dedicated to projects that improve safety, wayfinding, and connectivity between Children's and regional non-motorized transportation facilities such as the Burke-Gilman Trail.
- **Bicycle Boulevards.** Children's proposes that some of its funding would be devoted to the development of bicycle boulevards in Northeast Seattle, which would create wide-

ranging community benefits, particularly in increasing the numbers of families and children who feel safe and comfortable walking and bicycling in Northeast Seattle. Investing in bicycle boulevards is consistent with the core mission of the hospital, to enhance children's safety and welfare. In addition, it is consistent with the goal of enhancing travel options for cycling and walking to and from Children's, as well as from and within surrounding neighborhoods. Specific routes would be planned in collaboration with City staff, community members and bicycle advocacy organizations such as Cascade Bicycle Club.

These projects would be further screened based on general feasibility, cost effectiveness, and overall community benefit and approval. Children's would dedicate approximately 30% of the financial investments to project design, planning and public consultation costs.

Bicycle Master Plan Priority Projects

Children's would commit a portion of the Bicycle + Pedestrian Fund toward Bicycle Master Plan (BMP) projects that:

- Appear on SDOT's BMP project prioritization list
- Contribute to creating bicycle connections to Children's campus
- Were requested by SDOT Bicycle staff for inclusion in the pro rata list
- Are not already funded and scheduled for construction, and
- Fall within Children's impact area as studied in the DEIS (roughly bounded by I-5, NE 75th Street, and Roanoke St and Lake Washington)

Examples of candidate projects include:

Table 7. Prioritized Bicycle Master Plan Projects for Bicycle + Pedestrian Fund

Bicycle Master Plan projects	
20th Ave NE, NE 45th St to Ravenna Blvd	Sharrows, two sides
Ravenna Pl NE, NE 55th St to 25th Ave NE	Sharrows, two sides
20th Ave NE, NE 65th St to NE 86th St	Sharrows, two sides
35th Ave NE, NE Blakely St to NE 65th St	Sharrows, two sides
NE 65th St, Ravenna to Magnuson Park	Bike lane one side, Sharrow other (partial), Sharrows two sides (partial)

Connections from Campus to Larger Bike/Ped Networks

Examples of potential projects that would create connections from Children's campus to the regional Burke-Gilman Trail or to existing pedestrian networks appear in Table 8. These projects would improve conditions both for those walking, biking, and taking transit to Children's, as well as improving walking and cycling conditions for all neighborhood residents and visitors to the Northeast Seattle community. .

Table 8. Potential Projects Linking Children's to Bicycle/Pedestrian Networks

From Campus entrance at Penny Drive to Burke-Gilman Trail and sidewalks
Install clear wayfinding signs to and from campus and Sand Point Way NE to the Burke-Gilman Trail
Build sidewalk, west side on 41st Ave NE from Sand Point Way NE to NE 50th St (175')
Build sidewalk, both sides on NE 50th St from 40th Ave NE to Sand Point Way NE (connect to existing sidewalk on north side of the street extending from Sand Point Way NE to just west of 41st Ave NE) (475')
Build sidewalk, south side on Sand Point Way NE from NE 50th St to 47th Ave NE (1,800')

Bicycle Boulevards

Children's proposes to devote some of the Bicycle + Pedestrian Fund to create bicycle boulevards in Northeast Seattle. Wide-ranging community benefits have been associated with bicycle boulevards, including significant reductions in vehicle/bicycle accidents, increased property values, traffic calming, and greater numbers of women and children bicycling. There is a clear nexus between creating safer routes for bicyclists and working toward the principal mission of the hospital: to improve the health and safety of children.

In addition, twenty-four percent of Children's employees live within three miles of campus. This represents a great opportunity for bike commute mode shift even for novice cyclists. All Northeast Seattle community members, their children, and visitors would benefit from bicycle boulevards that improve safety and confidence for cyclists and calm traffic speeds on residential streets. Bicycle boulevard routes would be planned in collaboration with SDOT staff.

Further, Children's would be interested in seeking foundation support for a public health research project to test the efficacy of bicycle boulevards as a strategy for improving public health, by supporting increased physical activity and reducing crashes and injuries. This research would be valuable to other Seattle neighborhoods as well as communities nationwide in determining when, where, and how to most effectively implement bicycle boulevards.

Element VIII. Out-of-area parking

Children's existing parking policies are designed to manage demand for available parking supply and ensure no spill-over parking into surrounding neighborhoods. Children's proposed enhanced parking policies as part of the CTP are designed to go even further in removing vehicle trips from the most congested corridors.

Table 9. 2007 Parking Management Policies and Proposed Enhancements

Element	2007 Program	Enhancement
Parking management	Children's employees who drive alone to work assigned to on-campus or off-campus parking lots based on seniority and position. Medical residents and fellows park on campus. On-site employee parking lots are regulated by gates and accessed only by employee ID cards.	Parking assignments made on the basis of home address (begun in March 2008). Day-shift medical residents and fellows would be added to those who can be assigned off-campus. The hospital would pursue additional opportunities for off-site and out-of-area parking.
	Children's monitors speed limits, directs traffic, and enforces parking policies through a parking officer and security staff. Parking on neighborhood streets is forbidden, as strictly enforced by regular patrols who check license plates and issue warnings and tickets. Children's takes disciplinary actions for any employee found parking in the neighborhood, up to and including termination.	Children's would invest in technology to allow pay-per-use charges, control access to visitor lots, and more tightly manage on-campus parking supply. This would allow Children's to refocus FTE currently assigned to on-campus monitoring to patrol neighborhood streets for parking violations.

In addition to these policies detailed above, Children's would explore new off-site and out-of-area remote parking lots as a further method to bolster trip reduction. Requiring employees to park in off-site parking encourages the use of alternate modes to get to work (including Children's shuttles). Leasing or even constructing off-site parking may also be cheaper than constructing on-site structures, saving money and land that can be devoted to Children's primary mission of providing critical healthcare services.

Transpo's analyses indicate that for every 100 spaces reduced on-site (and located out-of-area), an approximately five to ten percent reduction in locally-generated traffic could occur.

Currently, 29% of the hospital's parking supply is leased at off-site lots, at the Church/Archives shared lot, Magnuson Park, and the E1 lot at Husky Stadium. In March 2008, Children's began assigning employees to off-campus lots on the basis of home address. This geographic parking assignment will be key to ongoing parking management strategies at Children's. For example, employees who live south of campus and would have to drive past the Husky Stadium E1 lot from their homes in order to reach the hospital will be assigned to park in the E1 lot. Employees then ride a dedicated shuttle route to complete their commute trip to the hospital. This program helps reduce the net number of vehicles proceeding further on Montlake and NE 45th Street and through Five Corners to reach Children's.

As detailed in Appendix A to this memorandum, Children's is forecasted to have a maximum parking demand for 3,100 spots at MIMP build-out if all proposed TMP enhancements are put in place. By ordinance, Children's is required to prove within its master plan that it will be able to accommodate all future parking demand. To demonstrate due diligence, Children's developed plans that show how the entire demand for 3,100 stalls can be accommodated on campus, if needed. At a minimum, Children's will be required to build at least 2,200 on-site parking spaces in order to meet ordinance requirements.

Securing off-site parking clearly supports the goal to reduce on-site parking, and it is Children's intent to pursue off-site parking wherever possible. Children's would:

- Identify 100 to 200 out of area, off-site parking spaces per each phase of development as part of its Comprehensive Transportation Plan and as necessary to mitigate future transportation impacts. It is expected that every 100 cars parked at out of area facilities would result in a five to ten percent reduction in traffic impacts surrounding the hospital. As a first step, Children's and Sound Transit have signed at Memorandum of Understanding committing both organizations to investigate options to create capacity for Children's employees at regional park and ride facilities. Children's would continue to pursue similar collaboration opportunities with Community and Pierce Transit.
- Pursue parking opportunities off-site both within and outside of the study area, including additional small-lot partnerships within Northeast Seattle (i.e., church parking lots). Children's would build on its positive relationships and parking agreements with the University of Washington and the City of Seattle to find further off-site locations and new partners.
- Expand shuttle service as needed in conjunction with new off-site parking locations, to bring employees between the lots and the hospital.

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APPENDIX A. Proposed Enhancements to Children's Transportation Management Plan in Support of the 2008 MIMP

Appendix A. Contents

TMP Purpose[3]

Seattle Children's (Children's) has long been recognized as a leader in Transportation Demand Management (TDM), receiving awards from the Governor's office, King County, and the U.S. Environmental Protection Agency for its excellent commuter benefits and achievements in reducing vehicle trips. The hospital's programs and incentives are targeted to reduce single-occupant vehicle commuting to the campus, and have successfully resulted in a drive-alone rate of only 38% among daytime employees in 2006. This accomplishment is significant both for a hospital and for an employer located in a neighborhood with limited public transit service.

Children's achieves significant commute trip reduction through its current Transportation Management Plan (TMP). This Appendix describes Children's proposed enhancements to its existing TMP that would allow the hospital to achieve the following goals:

- Further reduce the percent of commute trips made by single-occupant vehicle (SOV)
- Further reduce PM peak hour vehicle travel
- Reduce the need to build parking on campus or in nearby facilities within the area that would be affected by MIMP-related vehicle trips
- Support Children's continued leadership in delivering innovative transportation solutions in the context of climate change.

This TMP was developed as part of the Major Institution Master Plan (MIMP) process, through which Children's is proposing to expand its main campus in northeast Seattle. With the input of the Citizens Advisory Committee, SDOT, and DPD, Children's has developed a Comprehensive Transportation Plan (CTP) to focus on sustainable transportation programs. The enhanced TMP described in this appendix forms the basis of the CTP, designed to mitigate vehicle traffic related to MIMP expansion by shifting even more employees and visitors from single-occupancy vehicles (SOV) to bicycling, walking, shuttle, and transit.

The planned expansion would better serve the growing, complex healthcare needs of children in the four-state service region. The Preliminary Draft MIMP alternatives included 1.5 million additional square footage, growth to 500-600 beds, up to 3,600 parking stalls (with 3,000 on-site), and two or three new access points to the main campus.

Children's is responding to City and neighborhood concerns regarding additional traffic to the campus in conjunction with MIMP approval. The major transportation issues, as identified in the DEIS, comments to the DEIS, and by the Citizens' Advisory Committee (CAC), focused on increased congestion and delay at intersections in the surrounding transportation network, such as NE 45th Street and the Montlake corridor. Neighbors have also expressed concerns for pedestrian safety stemming from increased vehicle volumes and additional egress and ingress points from the campus.

Expanding Children's existing successful TMP would demonstrate a commitment to reduce potential traffic impacts generated by increasing populations of employees and patients through MIMP build out in 2028. This memorandum Appendix describes Children's proposed enhancements to its existing TMP and outlines how these mitigation strategies would reduce new vehicle trips to the main campus. In preparing this TMP with Children's, the consultant team: a) relied on the EPA COMMUTER Model (v2.0), a widely accepted model developed for the United States Environmental Protection Agency for

[3] *Also see Introduction to this memorandum*

assessing TDM strategy impacts, and b) prepared shuttle routes that connect with regional transit hubs and effectively extend the reach and convenience of the public transit system. Full analysis of the elements presented in the section "TMP Components" using the COMMUTER Model is presented in the final section of this appendix, "Effectiveness: SOV Rates, Vehicle Trips, and Parking Demand."

Measurement

The consultant team identified the above four TMP goals against which to evaluate different strategy packages. Pursuing these goals also contributes to ameliorating the major traffic impacts described in the DEIS. In conjunction with MIMP build out, Children's would commit to continuing its historically effective TMP and adopt additional programs to reduce its future contribution to area traffic.

The Transpo Group (i.e., Transpo), the firm that is analyzing the proposed MIMP's effects on the transportation system as part of the Environmental Impact Statement (EIS) process, previously forecasted Children's contribution to daily vehicle trips at MIMP build out if no additional mitigation measures were put in place. Transpo identified 720 PM peak hour vehicle trips today, and that 1,410 PM peak hour vehicle trips could be expected in 2028 with development associated with the proposed MIMP if no additional TMP measures were taken. The unmitigated forecast is 690 net new PM peak hour vehicle trips at MIMP build out.

Transpo's Trip Generation Model for unmitigated conditions assumes that the proportion of people arriving by SOV and by other transportation modes would remain constant while the total number of people grows. Children's proposed enhanced TMP mitigation strategies seek to shift the mode split so that greater proportions of people would arrive by shuttle and transit, carpool and vanpool, and bicycle and on foot rather than by driving alone, in order to reduce vehicle trips even while person trips increase.

Children's is legally obliged to monitor its TMP plan under state, county, and city Commute Trip Reduction (CTR) requirements. This monitoring is conducted via employee travel behavior surveys. By law, Children's must administer the CTR survey bi-annually in order to gauge SOV rates and TMP effectiveness. These surveys have shown a remarkable reduction in Children's daytime employee SOV travel from 73% in 1993, to 54% in 2001, and to 38% in 2006.

Children's would commit to achieving a **30% SOV mode split goal among these daytime employees at MIMP build out**. For comparison, this would meet the 30% SOV goal set for the University District Urban Village in the City of Seattle's Comprehensive Plan.

Children's ongoing commitment to implementing the enhanced TMP and achieving desired transportation results would include:

- Continued bi-annual employee State CTR surveys, administered by King County
- Continued measurements as required in the signed TMP agreement with the City, and
- Monitoring according to the standard procedures based on the Department of Planning and Development Director Rule 9-99, which applies to major institutions and requires an annual report that includes an update on Children's mode splits.

TMP Components

Children's delivers a TMP that has achieved considerable success in reducing SOV travel to its campus. Children's Shuttle routes and array of incentives and benefits for alternate commuters are models of innovative transportation solutions both for reducing a worksite's contribution to local and regional traffic, and in the context of global climate change. Children's would work to shift an even greater percentage of drive-alone trips to carpools, vanpools, transit, bicycle, and walking in order to reduce the transportation impacts of MIMP build out.

This section describes each component of Children's existing TMP (as of 2007) along with enhancements proposed as part of the modeled strategy package. Under no element would Children's reduce its current programming. Instead, the Transit Shuttle service and enhanced TDM elements proposed below would build on Children's already notable successes.

1. Children's Shuttle

Children's Shuttle programs cannot be modeled by the EPA COMMUTER Model, but the enhanced services are part of Children's proposed and analyzed vehicle trip and SOV rate reduction goals. In 2007, Children's operated six shuttle routes to provide access to off-site employee parking lots and connections between the hospital, administrative buildings, research facilities, and affiliated institutions. Shuttle counts conducted in October 2007 found approximately 500 riders per day. Riding the shuttle is free, and all routes operate Monday through Friday. Children's 2007 shuttle program consisted of:

- Shuttle fleet of 12 vehicles, equipped to carry bicycles
- 2 routes connect the hospital campus with nearby off-campus parking lots: every 7-10 minutes, runs 5:30AM-9PM
- Added in 2008: 1 route between the Husky Stadium E1 lot and Children's main campus
- 1 route between the 70th/Sand Point Way administrative building and main campus: every 15 minutes, 6AM-6:30PM
- 1 route connecting the Magnuson Park lot and 70th/Sand Point Way building: every 10 minutes, 6AM-10AM, 3PM-7PM
- 1 route between Children's main campus and Metropolitan Park West offices in downtown Seattle: every 30 minutes during peak commute periods, every 20 minutes off-peak, 6AM-8PM
- 1 route between Children's Building 1, University of Washington Medical Center (UWMC), and Children's main campus: every hour, 8AM-5PM
- Fred Hutchinson provides one route from the Seattle Cancer Care Alliance to UWMC and Children's: every 40 minutes, 7AM-7PM

Proposed Shuttle enhancements:

Children's would expand its existing shuttle service to extend the reach and convenience of the regional public transit system. Children's would do this by introducing a "last mile" Transit Shuttle program, a collection of routes that connect the campus to major transit hubs. Public transit riders can take regional buses and eventually light rail to one of these hubs, and then transfer onto a shuttle to continue directly to the Children's campus. New Transit Shuttle routes would meet riders at the following hubs:

Table 10. Transit Shuttle Routes and Frequencies

Transit hub connections	Service Description
University District hub (planned for launch 2009)	Every 10 minutes during peaks; every 15 minutes off-peak
SR 520/Montlake Blvd. Station	Every 10 minutes during peaks; every 15 minutes off-peak
Future UW light rail station at Husky Stadium	Every 10 minutes during peaks; every 15 minutes off-peak
Westlake Center / 3rd Avenue and Downtown Transit Tunnel (launched June 2008)[1]	Every 15 minutes, all day
South Snohomish County	Every 30 minutes, only during commute peaks

1. Westlake Center / 3rd Avenue shuttle (the Green Line) combines the 2007 Metropolitan Park West and Children's to 70th/Sand Point Way shuttle routes, adding a stop at Building 1 and a brand new stop downtown at the Westlake Center Transit Tunnel entrance and proximate to the 3rd Avenue transit corridor.

This enhanced shuttle strategy package does not include any further investments in regional public transit beyond the current Transit Now improvements to King County Metro routes 25 and 75. Under this Transit Now partnership, Children's funds 63 additional weekly trips on these two routes that serve the hospital, especially concentrated during shift changes.

Children's would plan its Transit Shuttles as a dynamic system, responding to changes in the transportation network, transit service, and employee housing patterns. Children's is building on its existing partnership with King County Metro as the hospital goes forward with shuttle planning and Metro considers service changes to the area. In addition, Children's has secured a letter of intent with Sound Transit to identify long-term partnerships designed to encourage the use of alternate transportation. These partnerships may include:

- Identifying future service enhancements, such as Sound Transit buses and facilities, that link to Children's expanded shuttle services
- Identifying potential private-public partnerships which would allow Children's to access current or future park and ride lots owned and operated by Sound Transit (*see Element VIII of the CTP regarding "Out-of-area parking"*), or
- Participate in regional forums or workshops where Children's would help to advance regional transportation alternatives.

Children's is continuing to pursue similar collaboration opportunities with Community Transit and Pierce Transit, as appropriate based on concentrations of employee home addresses.

2. Commuter Services

Children's funds a full-time staff in Commuter Services to support its TMP. Commuter Services offers the following programs:

- Meets with new employees on their first day of work to provide personalized commuting assistance, including transit route plans and potential car and vanpool partners

- Follows up with support and advice year-round to help staff and visitors identify transportation options
- Distributes information and marketing materials and plans events that promote and reward transportation alternatives to driving alone.
- Materials are distributed via brochures, transportation bulletin boards, a weekly in-house newsletter, email broadcasts, and an annual transportation fair. Commuter Services also maintains a comprehensive internal website and up-to-date print resources.

Children's Commuter Services staff develop innovative social marketing programs to promote the use and benefits of alternate transportation modes, including environmental, social, and public health benefits. For example, Children's is piloting a social marketing program in partnership with King County Metro in Fall 2008. This program, called "In Motion," reaches out to 4,000 hospital staff and 8,000 households in Northeast Seattle, encouraging participants to drive less and use alternative transportation. The program features proven social marketing elements, including incentives, a pledge to drive two fewer days each week, and supporting information regarding alternative travel modes.

Proposed Commuter Services staffing enhancements:

Children's added three new hires in Spring 2008, including Leads for Vanpool Programs, Bicycle Programs, and Transit Programs. One of these Leads filled a previously temporary position. In Summer 2008, Children's also added a Shuttle and Parking Manager. In total:

- Children's would increase Commuter Services staff between 50% and 80% to administer, promote, and monitor this level of commitment to expanded TDM and shuttle programs.
- Children's would continue to pursue innovative social marketing elements and programs to promote walking, biking, carpooling, and taking transit.

3. Parking Pricing

As of 2007, Children's assigned employees to on-campus or off-campus lots according to seniority, shift, and position. Children's Shuttles connect employees from the off-campus Magnuson Park and Church and Archives Lots, as well as the Husky Stadium E1 lot. Parking management and cost policies as of 2007 include:

- Children's employees, Children's University Medical Group (CUMG) physicians, travelers, Pace temps, UW employees, and contractors who drive alone to campus paid $50 per month to park (through 2007).
- Children's monitors parking fees at the University of Washington to gauge increases in market rates for parking, and the hospital raises its rates concurrently with UW rate increases.
- Patients and their visitors park free of charge, as do volunteers, community physicians, board members and trustees, vendors, medical residents, students, and fellows.
- On-campus employee parking lots are regulated by gates and accessed by ID cards.
- Carpools and vanpools park on campus in reserved spots at no charge.
- Students are required to park at an off-site lot.
- Children's monitors speed limits, directs traffic, and enforces parking policies through a parking officer and security staff.

- Employees are prohibited from parking on local neighborhood streets.
- Children's offers valet patient parking between 7:00 AM and 3:30 PM and between 5:00 PM and 11:00 PM on weekdays in order to use the existing parking supply as efficiently as possible and reduce the number of on-site spaces required.

Parking pricing enhancements proposed by Children's:

- Charging no less than $65 per month for on-campus SOV parking (implemented in May 2008, a 30% increase from 2007). These fees would be adjusted to what is appropriate for the market, as suggested by UW parking rate increases. However, the EPA COMMUTER Model results suggest that a rate of $65 would be sufficient to achieve the targeted SOV rates and vehicle trip reduction (*see the section "Effectiveness: SOV Rates, Vehicle Trips, and Parking Demand" in this Appendix for details on the modeling process*).
- Investing in technology (for example, enhancing the gates currently used to regulate on-campus employee parking lots) to control access to visitor lots, allow pay-per-use charges as well as monthly fees, enforce carpool and vanpool occupancy, and more tightly manage on-campus parking supply. This technology would allow Children's to refocus FTE currently assigned to enforce and monitor on campus parking lots, to instead increase the number of parking enforcement personnel assigned to patrol neighborhood streets for parking violations.
- Similar to UW policies, students, medical residents, and fellows who currently park for free would be required to pay the monthly parking fee as paid by Children's and CUMG employees. Day-shift medical residents and fellows would be added to those who can be assigned to off-campus lots.
- Free parking would be eliminated. This would be supported by per-use-charges enabled through the new parking management technology. Children's may consider offering parking validation, reduced fees, or Medicaid parking vouchers to patients' families.

The above parking management measures were the only measures modeled using the EPA COMMUTER Model. The COMMUTER Model can only analyze parking policies that relate to pricing. **The Model results indicate that the above parking management policies, in combination with the other modeled TMP elements, would achieve Children's targeted trip reduction and SOV rate reduction goals with no further parking changes.**

For further parking management programs proposed by Children's beyond those modeled by the COMMUTER Model, see sub-section 6 below "Additional Above-and-Beyond Trip Reduction Strategies."

4. Incentives for Not Driving Alone

In 2007, Children's employees and CUMG physicians could earn up to $50 per month in Commuter Bonus incentives, depending on how many days per week they don't drive to the campus by themselves. Other 2007 incentives for those who choose non-drive alone commutes included:

Carpool:

- Free, reserved parking on campus (204 spaces for carpools and vanpools)

Vanpool:

- 100% subsidized vanpool fare

- $250 additional bonus per quarter for vanpool drivers, $75 for backup drivers, and $50 for bookkeepers
- Free, reserved parking on campus
- Internal rideshare matching

Transit:

- FlexPass - annual, unlimited transit pass purchased for all Children's permanent employees and CUMG physicians
- PugetPass - monthly transit pass provided upon request to contractors, consultants, Pace temps, and University of Washington staff
- Partnership with King County Metro "Transit Now" to fund 63 additional roundtrips per week on Routes 25 and 75, to provide for higher frequency during shift changes

Bicycle:

- Showers and lockers free of charge
- Approximately 120 total covered and secured bicycle parking spaces, located in each parking garage and at employee entrances
- Subsidized annual bicycle tune-up, on-site

Walk:

- Umbrellas and reflective safety lights provided on an annual basis

Motorcycle:

- Free, covered parking for this more efficient, less-polluting mode

Proposed Incentives enhancements:

In addition to continuing the above programs:

- Children's would invest in technology that facilitates carpool matching by commuters themselves, including real-time matching. Children's would transition to a single carpool formation bonus and institute parking charges for carpoolers. These changes would create market incentives for carpoolers to maximize the number of rides they share and to increase the occupancy of their cars.
- Children's would increase the Commuter Bonus award up to an amount equal to the cost of parking (at least $65 per month). This bonus would be extended to students, medical residents, and fellows in addition to the Children's employees and CUMG physicians who are already eligible.
- Medical residents and fellows would also begin receiving FlexPass, and Children's would purchase each student's portion of a University of Washington UPASS (currently $45 per quarter).
- 24% of Children's employees live within a three mile walking and biking distance of the main campus. Children's would offer cyclists and pedestrians an additional $100 award once a year for equipment, such as bikes, shoes, or clothing, to further reward non-motorized commutes.

5. Alternative Work Schedules

Approximately 2% of Children's staff whose work schedules begin between 6:00 AM and 9:00 AM telecommute. Though the consultant team has not modeled expansion of this program, telework and compressed work weeks represent the quickest, least expensive way to remove a commuter from the road. Employees need not telecommute every day; even one day a week at home provides a trip reduction benefit. Compressed work weeks, such as working 10 hours a day, 4 days per week, 9 hours a day for 9 days over two workweeks, or even the common Children's work schedules consisting of 12 hours a day, 3 days per week, are also potential options for reducing commute trips. The consultant team will work with Children's to further explore employee categories, work tasks, and accountability systems that could allow the hospital to expand these scheduling options.

Proposed Alternative Work Schedule enhancements:

No new alternative work schedule or telework programs are included in the modeled package.

6. Additional Above-and-beyond Trip Reduction Strategies

Children's offers several trip reduction programs – and is evaluating further strategies for the future – that are not included in the modeled TMP package described in sub-sections 1 through 5 above. The strategies described below cannot be modeled using the EPA Commuter Model, and therefore weren't included in the consultant team's analyses of Children's ability to reach targeted trip and SOV rate reductions. The programs described here in sub-section 6 are therefore not necessary to meet the mitigation goals modeled as a result of the other TMP enhancements outlined in Appendix A. Rather, if implemented, these strategies would result in *greater* trip reduction than is modeled in this study.

Parking Management

Above and beyond the modeled parking pricing policies outlined in sub-section 3., and to pursue trip reduction greater than that analyzed in this memorandum and the DEIS, Children's is also proposing the following parking management measures:

- Instituting parking charges for carpools in order to create market incentives for carpoolers to maximize the number of rides they share and increase the occupancy of their cars.
- Partnering with the University of Washington on an agreement that allows Children's staff as employees of an affiliated institution to use the University of Washington's E1 parking lot (implemented in March 2008).
- Reassigning employees to off-campus parking lots based on the direction from which they travel to campus, in order to reduce distances traveled and potentially remove vehicles from the most congested corridors impacted by Children's (implemented in March 2008).
- Identifying between 100 to 200 off-site and out-of-area parking spaces per phase of development as necessary to mitigate future transportation impacts.

Children's has begun assigning employees to off-campus leased parking space on the basis of their home address. For example, employees who live south of campus and would have to drive past the E1 lot from their homes in order to reach the hospital are assigned to park in that lot. Employees ride a dedicated shuttle route to complete their commute trip to the hospital. This program reduces the net number of vehicles proceeding further on Montlake and through Five Corners to reach Children's.

This geographic parking assignment will be a key part of future ongoing parking strategies at Children's. The hospital intends to identify 100-200 off-site and new out-of-area parking spaces per phase of development, as necessary to mitigate future transportation impacts. It is expected that every 100 cars parked at out of area facilities would result in a five to ten percent reduction in traffic impacts surrounding the hospital. This out-of-area parking approach comprises element VIII of the Comprehensive Transportation Plan.

AGAIN: This program was not modeled as part of the TMP package analyzed using the COMMUTER Model, and could further decrease SOV mode split beyond what is predicted by the consultant team.

Innovative Bicycle Programs

The innovative bicycle programs comprising Element II of Children's Comprehensive Transportation Plan were not modeled using the COMMUTER Model, but will serve to bolster and support those employees shifting to bicycling for their commute.

Building on its history as an innovator in transportation management, Children's is piloting novel bicycle programs to bolster the number and proportion of its employees who commute by this physically active, non-polluting transportation mode.

On July 17, 2008, Children's launched its **Company Bikes** program. Under Company Bikes, Children's invites employees to pledge to bicycle to work at least two days every week, year-round. After completing two bike commuting courses offered by Children's Commuter Services staff, these pledged employees are provided with a bicycle free of charge from the hospital, for their use as long as they continue bike commuting twice a week. The Company Bikes program enjoyed an enormously positive start, assigning 30 bicycles within the first two days of the program and committing all 100 bicycles for 2008 by September. Commuter Services has 27 bicycle commuting courses scheduled through November 2008. 100 more Company Bikes bicycles are planned for purchase and distribution in 2009.

Scheduled to launch in the first quarter of 2009, the **Flexbikes** bike-sharing program will house 20 bicycles on the hospital campus that employees can rent during the day, with the first half hour free. The bicycles will have an electric-assist motor that can be turned on to help climb hills. The provision of bikes for mid-day trips will help employees who may not be ready or able to bicycle to campus to try biking for errands and meetings, reducing motorized vehicle trips during the day. Children's program will link with a system of 40 Flexbikes to be housed on the University of Washington campus.

In order to support the projected 10% of employees cycling to work by 2028, Children's is planning for showers, lockers, and bike parking to accommodate 600 cyclists. The hospital is considering a locker-assignment system to ensure consistency and predictability for locker users.

AGAIN: These programs were not modeled as part of the TMP package analyzed using the COMMUTER Model, and could further increase non-SOV mode split beyond what is predicted by the consultant team.

Supportive Transportation Benefits

Children's will continue to fund on-site Zipcars, employee Zipcar membership, and the Guaranteed Ride Home program that subsidizes emergency taxi rides home for alternative commuters in the event of personal or family illness or unscheduled overtime. Children's will also continue to equip its shuttles to carry bicycles, so employees have more options for traveling, including combining bicycling with

shuttles to complete trips. The COMMUTER Model used to evaluate proposed TDM program impacts does not assume any mode shift resulting directly from these benefits, as they are too integrated and dependent on other programs being in place. Nevertheless, these benefits bolster the opportunity for campus visitors to leave personal cars at home.

No new supportive transportation benefits are included in the modeled package.

Neighborhood Transportation Programs

Children's offers various transportation programs and benefits to the neighborhood at large. The hospital sponsors annual Bike to Work Day commuter stations, serving over 700 bicycle commuters in 2007 and over 1,000 in 2008. The Zipcars that Children's funds add to the fleet of cars available for the entire community of Zipcar members. The addition of 63 new daily roundtrips on King County Metro routes 25 and 75 provide enhanced mobility to all riders along those routes. Near the research campus in South Lake Union, Children's participated in a streetscape pedestrian safety audit, sponsored by Feet First, King County Metro, and Vulcan. These and other potential neighborhood programs benefit the entire community and expose more people to transportation alternatives, though it is difficult to predict with certainty what effect these activities have on trip reduction and traffic.

Children's will continue working with King County Metro to pursue the opportunity to offer neighborhood residents free access to use the Children's shuttle system. Bringing passengers onto the shuttles who are not affiliated with Children's will require detailed analysis and approval from Metro to extend the shuttle service to the general public. If Children's acquires this approval, the hospital will publish the shuttle schedules and routes for distribution to neighborhood residents.

In addition, Children's agrees to fund the formation of a Residential Parking Zone (RPZ), should the neighborhood(s) determine that one is desirable. However, Children's has been successful in effectively limiting the impact of employee parking through its employee parking policies and follow-up enforcement. Children's has continued to express a high priority intention to provide a high quality experience for its patients and their families and visitors, and will continue to manage on-site parking to assure that patients and visitors always have a space to park upon arrival.

Patient Transportation

Children's TMP efforts primarily focus on employee groups who make up about 65 percent of the total population traveling to the hospital. As detailed in the following "Evaluation" section, Children's expects to achieve all of its proposed vehicle trip and SOV rate reduction within those employee groups, even if all other populations' trips remain unmitigated. By comparison, patients and families comprise only 17 percent of all traveling to campus, and their trips do not concentrate during the most congested peak-period commute times of day. Even with this comparatively small portion of trips, Children's works to communicate about and enable patient transportation alternatives through its Guest Services department.

In February 2007, Children's initiated a shuttle service for patient families with one vehicle and driver. The fleet has grown to four vehicles and drivers making 200 trips per month. The patient and family shuttle is offered free of charge and is available to all families who come to Children's. 92% of all trips occur on weekdays, with 93% between the hours of 6:00 AM and 8:00 PM. Between October 2007 through July 2008, the patient and family shuttle made 2,431 runs. 41% of these runs connected the hospital to Sea-Tac Airport, 31% to the Ronald McDonald House, and 8% to hotels. The initial philosophy behind the patient and family shuttle was to make the experience of arriving to Children's less overwhelming for families coming from out of town, offering connecting shuttle trips from the airport, train and bus stations, and ferry terminals.

The patient shuttle service decreases the number of vehicles entering Children's campus by enabling families to leave their cars at home. The average length of a hospital stay at Children's is five days. When a family arrives on campus without bringing a car, it has a cumulative effect, ensuring that they will take alternative modes of transportation the entire time they are at the hospital. Key features of patient and family transportation services include:

- When possible, Children's groups patient family shuttle runs in order for multiple families to ride together.
- Children's also encourages families to stay at hotels that offer shuttles, and is currently working on a walking map of the area with Feet First, a organization that promotes walking. This map will include the health benefits of walking as well as how to use walking as a form of meditation.
- In the month of April 2007, Hopelink, a transportation broker for DSHS, provided over 900 individual trips to Children's for families on DSHS. Hopelink currently does not group multiple families into single trips. Children's is working to house a Hopelink transportation coordinator on site at the hospital, partnering in order to group multiple DSHS families into single trips. This partnership will improve the Hopelink service, decrease the number of single family trips, and increase the number of families utilizing the bus system.
- In June 2007, Children's began transporting children to the Hutch School Monday-Friday. The Hutch School is located on the SCCA campus and is for siblings of patients who are here for long term care. At the end of the 2007-2008 school year, the bus was at capacity.
- In January 2008, Children's changed the shuttle run to the Ronald McDonald House from a scheduled bi-hourly service to one that is by reservation only. Fliers encourage families to walk between the two facilities. This change resulted in a decrease of runs from 200 per month to an average of 68 per month.
- Children's surveyed patient families and found that they prefer having all of their clinic appointments scheduled on the same day. Children's has purchased a new integrated scheduling software system to help achieve that goal (when medically appropriate). This new software will impact every clinical area of the hospital, and will enhance interdepartmental communication and the ability to collaborate. This in turn will decrease the number of trips families will need to make in order to receive care at Children's.
- Children's also provides valet patient parking between 7:00 AM and 3:30 PM, and between 5:00 PM and 11:00 PM on weekdays, in order to use the existing parking supply as efficiently as possible and reduce the number of on-site spaces required.

Proposed Patient Transportation enhancements:

Children's would implement pay-per-use parking fees (as outlined in sub- 3 above regarding "Parking Pricing"), with the option for providing parking validation or Medicaid vouchers for patients. Children's would also expand the distribution of information to patients about non-SOV travel options to the hospital, including the shuttle to transit system and public transportation.

Resource Impact

As of 2007, Children's spent millions of dollars annually to plan, implement, and monitor its excellent TDM and shuttle programs. The proposed TMP would require substantial increased financial investment in program operations, staffing, and enhanced monitoring and enforcement of parking policies, as well as capital funding for facilities as described in Element IV of the CTP (*see main body of the memorandum, above).* The consultant team estimates that the hospital would need to substantially increase its annual financial commitment in order to implement these programs.

Effectiveness: SOV Rates, Vehicle Trips, and Parking Demand

The consultant team evaluated TMP strategy packages for expected reductions in SOV rates as measured under CTR requirements. In order to analyze associated reductions in vehicle trips and parking demand, the consultant team focused its attention on those trips made during the PM peak hour. Trips made in the middle of the afternoon or the night, when there are few cars on the road, have less potential for adding to overall delay than trips made during the morning and evening peak commute times. In its Trip Generation Model, Transpo forecasted Children's unmitigated vehicle trips at MIMP build out during the most congested hour of both the AM and PM peak. In order to achieve a substantive reduction of the otherwise unmitigated impacts described in the Preliminary DEIS, Children's should seek to reduce net new vehicle trips in peak periods, when traffic volumes are highest and intersection performance on Sand Point Way NE and in other impacted corridors is poorest. For analysis purposes, the consultant team chose the PM peak hour in addition to SOV rates as the standard of measurement for the TMP's effects, also because there are more patient trips during this period than in the AM, making it more challenging to mitigate vehicle travel.

EPA COMMUTER Model

The consultant team used the U.S. Environmental Protection Agency COMMUTER Model (v2.0) to predict future SOV rate and trip reduction achievements of the above-described TMP enhancements. The COMMUTER Model was created for use by government agencies and individual employers to model the effectiveness of various Transportation Demand Management and Transportation Control Measure strategies. TDM programs targeted with the COMMUTER Model include financial incentives (Commuter Bonus, transit fare), parking charges, and employer support programs (ridematching, Commuter Services staff time, etc). The COMMUTER Model analyzes financial and time savings as the core primary motivators of transportation choice, while supporting elements are offered primarily to meet increased demands on the employer's TDM programs.

The COMMUTER Model uses inputs of current and future population figures, existing mode splits and TDM incentives, and packages of TMP strategy and policy changes to forecast the mode split effects of the proposed programs. This is a logit mode-choice "pivot point" model, and environmental background characteristics that influence travel behavior – such as transit availability and land use patterns – are reflected in the starting mode splits. COMMUTER Model mode choice models have been developed for cities and regions nationwide, including the Puget Sound region. These mode choice coefficients reflect the willingness of people in the area to change travel modes in response to changing incentives or travel conditions. The values of these mode choice coefficients are based on travel models currently used by regional transportation planning agencies. The COMMUTER Model's forecasted future mode splits can be used to calculate future travel behavior and trip reduction, including daily trips, vehicle trips in the PM peak hour, and peak period parking demand.

The consultant team modeled the TDM enhancements outlined in sub-sections 2-5 under "TMP Components" above, assuming that full TDM offerings continue to apply to Children's employees and CUMG physicians, and that full benefits (including transit fare, parking management policies, and Commuter Bonus payments) are extended to medical residents, fellows, and students. These are the only groups included in the model. Other opportunities for trip reduction may exist in patient and non-employee populations, but non-employee travel cannot be modeled by the COMMUTER Model, and such reductions are not estimated here.

The COMMUTER Model results plus forecasted Transit Shuttle ridership combine to create an expected 36% reduction in predicted net new PM peak hour vehicle trips. The full reduction is expected to be achieved within the four populations evaluated using the COMMUTER Model:

- Children's daytime employees
- Children's non-daytime employees (including exempt & call, and evening and night shifts);
- CUMG physicians, and
- Medical residents, students, and fellows

For analyses of COMMUTER Model groups that combine several Trip Generation Model groups (i.e., Children's non-day and Residents/Students/Fellows), weighted averages were calculated for baseline modesplits and number traveling during PM peak hour, based on sub-group modesplits and numbers of people from the Trip Generation Model.

Among the total PM peak hour vehicle trips generated by these four groups in 2007, Children's daytime employees make the majority of the trips (74%, compared to 21% from non-day Children's employees, and 2% and 3% from CUMG physicians and students/residents/fellows, respectively). Correspondingly, the most absolute trip reduction is expected to be achieved among those daytime employees. Fortuitously, daytime employees tend to have the most regular work hours and set commuting schedules that make it more likely for them to travel during daylight (attractive to people on foot and on bicycle) and at times of peak public transit and Children's shuttle service, supporting a full range of commute alternatives.

The COMMUTER Model is set up to predict mode shift as a result of parking pricing, fiscal incentives for using an alternate mode, or TDM programs, but not changes in travel behavior that would occur as the result of new shuttle or transit service except with respect to reduced waiting or in-vehicle travel times. Expected Transit Shuttle ridership had to be calculated off model, and accounted for in the final analysis combined with COMMUTER Model outputs (*see "Transit Shuttle Calculations," below*).

Methodology

Base numbers were input into the COMMUTER Model, drawn from Transpo's Trip Generation Model data for current (2007) mode splits, current population, and expected 2028 population. The COMMUTER Model forecasts the following changes in mode splits from the unmitigated (2007) conditions solely as a result of the TDM strategies outlined above under "TMP Components":

Table 11. Percent mode splits with enhanced TDM strategies (not including Shuttle)

Modesplits (in percent %)	Children's Day-shift		Children's Non-day shift		CUMG Physicians		Students, Medical residents, & Fellows	
	Unmitigated	w/TDM	Unmitigated	w/TDM	Unmitigated	w/TDM	Unmitigated	w/TDM
SOV	38	30	63	58	66	60	73	53
Carpool	21	20	11	12	3	4	8	14
Vanpool	9	9	0	0	0	0	0	0
Transit	10	17	10	13	10	13	6	13
Bike	6	8	5	6	6	8	4	9
Walk	5	6	4	5	5	6	2	4
Other	11	10	7	6	10	9	7	7

The new mode splits achieved by TDM programs alone predict an SOV rate of 30% among Children's daytime employees in 2028. When the mode splits for each modeled group are input into the Trip Generation Model for future population, the calculations generate the following PM peak hour vehicle trips on motorized modes in 2028:

Table 12. PM peak hour vehicle trips expected in 2028 as a result of enhanced TDM strategies (not including Transit Shuttles)

	Number of PM peak hour vehicle trips by mode			Total (rounded)
	SOV	Carpool	Vanpool	
Children's Day-shift	389	113	19	520
Children's Non-day	212	19	-	230
CUMG	24	1	-	25
Students/ Residents/ Fellows	32	4	-	35
Total PM peak hour vehicle trips from all groups (rounded):				810

Without this TDM mitigation, the Trip Generation Model predicted 930 PM peak hour vehicle trips among these four modeled groups in 2028, representing 690 net new PM peak hour vehicle trips compared to today. The COMMUTER Model mode shift predicted based on TDM programs alone thus reduce 120 PM peak hour vehicle trips (930 – 810 = 120), representing a 17% reduction in net new vehicle trips in the PM peak hour at MIMP build out (120/690 = 17%).

Transit Shuttle Calculations

Shuttle ridership estimates then had to be accounted for in order to forecast the total reduction in SOV rates and in net new PM peak hour vehicle trips expected in 2028. Before running the model, the consultant team calculated the vehicle trip reduction that could be expected as a result of the enhanced Transit Shuttle service plan by calculating ridership and converting these person trips to vehicle trips. Shuttle patronage was based on projections of employee home locations, presence and quality of connecting public transit services, and the level of programmed shuttle service (headways). These estimates predict a peak hour Transit Shuttle ridership of 225 persons.

To calculate the Transit Shuttles' effect on mode split, the consultant team assumed that these 225 riders shift proportionally from each of the modeling groups, and, within each group, from among SOV, carpool, vanpool, and transit riders. We exclude bike and walk commuters from this shift, assuming that no one who lives close enough to the hospital to bicycle or walk to work will switch to taking transit to an out-of-area hub and transferring to a shuttle.

As with PM peak hour vehicle trips, the population of daytime Children's employees comprises the vast majority of all modeled persons; as a result, proportionally, most Transit Shuttle riders are expected to come from this group. Also among the four modeled populations, there is a higher proportion of individuals commuting today via SOV than by any other motorized mode. The 225 peak hour shuttle riders were not removed evenly from the groups (i.e., 225 / 4 = 56 riders taken from each of the four modeling groups, and then within the modeling groups 14 riders taken from each of the motorized modes). Rather, assuming that new shuttle passengers shift to shuttle proportionally from each motorized mode results in a greater reduction in SOV trips compared to trips by other modes.

These sub-proportions were calculated based on the baseline (2007) mode splits and relative numbers of PM peak hour person trips within each group, drawn from the Trip Generation Model. Existing mode split numbers were used to calculate the number of persons and vehicle trips shifted to Transit Shuttle from each mode to make up 225 peak hour riders. This allowed us to adjust the COMMUTER Model's mode split outputs to account for person and then vehicle trips shifted to shuttle, which results in the following PM peak hour vehicle trips including both the TDM effects combined with Transit Shuttle:

Table 13. PM peak hour vehicle trips expected in 2028 as a result of enhanced TDM strategies (COMMUTER model) and Transit Shuttles (forecasted ridership)

	Number of PM peak hour vehicle trips by mode			Total (rounded to nearest 10)
	SOV	Carpool	Vanpool	
Children's Day-shift	308	93	16	420
Children's Non-day	178	16	-	190
CUMG	20	1	-	20
Students/ Residents/ Fellows	26	3	-	30
			Total from all groups:	660

The Table below summarizes the net new PM peak hour vehicle trips expected from each model group, using the proposed TDM strategy and Transit Shuttle ridership to account for the effects of the complete TMP. These estimates include new PM peak hour vehicle trips generated by 2028 carpools, vanpools, and SOV vehicles, and net new trips from Transit Shuttle vehicles are added at the end.

Table 14. PM peak hour vehicle trips from modeled and non-modeled population groups, under full TMP mitigation (TDM strategies + Transit Shuttles)

PM Peak hour vehicle trips in 2028	Modeled mitigated populations				All non-modeled groups* (unmitigated)	Overall Total (rounded to nearest 10)
	CHRMC Day-shift	CHRMC Non-day	CUMG	Students, Residents, & Fellows		
Without mitigation (Trip Generation Model: unmitigated)	631	220	27	49	476	1,410
With TDM programs	521	231	25	36	476	1,290
Subtotal Reduced	110	-11	2	13	0	120
With TDM and Transit Shuttle	417	194	20	29	476	1,140
Total Reduced	214	26	7	20	0	270
					Net new PM peak hour vehicle trips created by Transit Shuttles:	20
					Overall net new PM peak hour vehicle trips including Transit Shuttles:	1,160
					Overall net new PM peak hour vehicle trips reduced:	**250**

*** Note**: Again, the COMMUTER Model cannot model non-employee travel. In order to ensure conservative estimates, no trip reduction is predicted from any Trip Generation Model group not modeled with the COMMUTER Model. This includes patient and family trips, volunteers, and consultants. Therefore, in the above table, the full 476 net new PM peak hour vehicle trips predicted from these groups in the Trip Generation Model for 2028 with no mitigation are assumed to hold steady with both TDM and Transit Shuttle mitigation. Programs targeted to patient or other non-employee trips could result in further reductions. The new Transit Shuttles will make 36 in and out trips during the PM peak hour; because the Green Line absorbs the former 6 trips during the PM peak hour from Met Park West, and 12 trips between Children's and 70th/Sand Point Way, net new shuttle trips is only 18 (rounded to 20 above).

20 net new PM peak hour vehicle trips are to be expected from the new Transit Shuttles, accounting for the existing shuttle routes absorbed by the new Transit Shuttle to downtown Seattle's Westlake Center / 3rd Avenue hub (*launched June 2008*). This results in a **net reduction of 250 net new PM**

peak hour vehicle trips (270–20 = ~250). The Trip Generation Model predicts 690 net new PM peak hour vehicle trips from all groups in 2028 if there is no mitigation and no mode shifts from baseline (2007) behaviors. Thus, the COMMUTER Model and Transit Shuttle ridership forecasts predict that the proposed TMP (TDM + shuttles) would achieve at least **30% reduction in net new PM peak hour vehicle trips** (250/690 = ~36%).

The proposed enhanced TMP programs are targeted only at the populations modeled using COMMUTER Model: Children's day- and non-day shift employees, CUMG physicians, and medical residents, students, and fellows. In the above calculations, all of the predicted mode shift and reduced PM peak hour vehicle trips are expected to occur among these groups only. This reduction, then, would be achieved even if vehicle trips from all other groups in the Trip Generation Model – including patients, consultants, and volunteers – increased as predicted under unmitigated conditions.

Results: Summary of SOV and Vehicle Trip Reduction

As shown in Table 11 above, the COMMUTER Model mode splits forecasted based on TDM programs alone would deliver a 30% SOV mode split among daytime Children's employees. Additional mode shift away from SOV should be expected due to use of the Transit Shuttles.

Final net new PM peak hour vehicle trips in 2028 calculated using these mode splits suggest that ***Implementing the proposed TMP could be expected to result in a 36% reduction in net new PM peak hour vehicle trips in 2028.*** Table 15 outlines the net new PM peak hour vehicle trips expected with and without enhanced TMP programs. All of these vehicle trip and SOV mode split estimates include expected net new vehicle trips generated by shuttle, carpool, vanpool, and SOV vehicles in 2028, from all population groups. These calculated reductions are achieved entirely within Children's day- and non-daytime employees, CUMG physicians, and medical residents, students, and fellows. Other opportunities for additional trip reduction may exist in other population groups, such as patients, contract and temporary employees, and volunteers.

Table 15. Net new PM peak hour vehicle trips in 2028 with and without enhanced TMP mitigation

Without additional mitigation	690
With expanded TDM programs	570
Subtotal Reduced	120
Percent Reduced	17%
With TDM and Transit Shuttle	420
Total Reduced	270
Net reduced with 20 net new Shuttle vehicle trips added back in	250
Percent Reduced	36%

Results: Parking Demand

SOV mode split reductions and vehicle trip reductions resulting from Children's proposed TMP package would also reduce the amount of parking needed. Rather than the 3,600 stalls that Transpo forecasted would be necessary at MIMP build out without further mitigation, Children's would need only 3,100, a reduction of 500 parking spaces. Parking may be accommodated on campus, or in leased stalls in off-campus parking lots. Under this mitigation package, Children's would need a total supply of 3,100 total stalls on and/or off campus.

Table 16. Future Peak Parking Demand at MIMP Buildout

Peak Parking Demand in 2028	Without mitigation	With TDM programs	With TDM and Transit Shuttle
Children's Employees - Day Shift	830	690	510
Children's Employees - Non-day	635	610	550
CUMG Physicians	270	250	240
Students, Medical residents, & Fellows	290	200	190
Other employees[1]	555	550	560
Patients (in- and out-)	890	890	890
Total:	3,470	3,190	2,940
Effective demand (+ 5% for circulation):	3,600	3,350	3,100

1. "Other employees" include EE Off-site Children's Employees, Pace temps, construction, consultants, community physicians, vendors, and volunteers. All numbers are rounded to the nearest 5.

Children's intends to pursue off-site parking opportunities when possible, and will continue to utilize geographic parking assignment plus shuttles to intercept vehicle trips that would otherwise enter the most congested impact area (*see Element VIII of the CTP*). Regardless, the enhanced TMP with expanded TDM + Transit Shuttle services alone would achieve the targeted 500 parking space demand reduction, as well as the 30% SOV rate and 30% reduction in net new PM peak hour vehicle trips as described in this memorandum.

APPENDIX G: SOUND TRANSIT LETTER OF INTENT

Children's

Letter of Intent
between
Children's Hospital and Regional Medical Center
and the Central Puget Sound Regional Transit Authority

Children's Hospital and Regional Medical Center is a nonprofit corporation in Washington State from federal income tax under Section 501(c)(3) of the Code, and fulfills its charitable health care mission in part through the operation of an acute care children's hospital and other children's health services in Seattle, Washington.

The Central Puget Sound Regional Transit Authority (Sound Transit) is a duly organized regional transit authority and has all the powers necessary to implement a high capacity transportation system. Sound Transit has implemented a regional transit system consisting of ST Express bus, Sounder commuter rail, Tacoma Link light rail and the capital infrastructure that supports these services. In mid 2009, Central Link light rail will offer service from downtown Seattle to Tukwila, followed by service to SeaTac Airport in December 2009.

Purpose
The purpose of this Letter of Intent is to document our mutual respect in discussing and identifying short term and long-term partnerships designed to encourage alternative transportation uses.

General Approach
Sound Transit and Children's Hospital and Regional Medical Center will work together to:

(a) Identify future service enhancements such as Sound Transit buses or facilities that link to Children's expanded campus service.

(b) Identify potential private-public partnerships which will allow Children's to access current or future park and ride lots owned and operated by Sound Transit.

(c) Participate in regional forums or workshops where we advance regional transportation alternatives.

Both parties also recognize the need to hold one-on-one discussions with other local and regional transit services related to service enhancements and other transit related arrangements.

Agency Representatives
Sound Transit and Children's Hospital and Regional Medical Center will each identify a single point of contact for carrying out this Letter of Intent.

Understandings
Sound Transit and Children's Hospital and Regional Medical Center recognize the importance of our collaboration in ensuring effective transportation options that enhance regional mobility. We recognize that potential service or capital project partnerships will be subject to approval by the Sound Transit Board and the Children's Hospital and Regional Medical Center Board of Trustees.

Children's Hospital and Regional Medical Center
Norman W. Hansen, MD, Chief Executive Officer

Date

Sound Transit
Joni Earl, Chief Executive Officer

Date

APPENDIX H: COMMUNITY TRANSIT LETTER OF INTENT

communitytransit
smile & ride

7100 Hardeson Road
Everett, WA 98203-5834

www.communitytransit.org
425/348-7100 ph
425/348-2319 fax

Joyce Eleanor
Chief Executive Officer

Letter of Intent Between
Seattle Children's Hospital and Community Transit

Seattle Children's Hospital is a nonprofit corporation in Washington exempt from federal income tax under Section 501(c) (3) of the Code, and fulfills its charitable health care mission in part through operation of an acute care children's hospital and other children's health services in Seattle, Washington.

Community Transit is a Public Transportation Benefit Area incorporated in 1976 under RCW 36.57 A. It operates 33 local bus routes, 31 commuter routes and DART paratransit service throughout Snohomish County. Community Transit also offers carpool matching, one of the nation's largest vanpool programs and offers travel training to disabled and senior citizens

Purpose

The purpose of this Letter of Intent is to document our mutual interest in exploring short-term and long-term partnerships designed to encourage alternative transportation and a "think transit first" lifestyle.

General Approach

Community Transit and Seattle Children's Hospital will work together to:

1. Where possible, coordinate connections between Seattle Children's shuttle service and Community Transit's bus service.
2. Explore potential private-public partnerships
3. Research transit efficient locations for future Seattle Children's facilities within Snohomish County
4. Explore targeted TDM programs to help employees access Community Transit services without driving

Both parties also recognize the need to participate in regional forums and hold coordinated discussions with other local and regional transit agencies and jurisdictions related to service enhancements and other transit related arrangements.

Conclusion

Community Transit and Seattle Children's Hospital recognize the importance of our collaboration in ensuring effective transportation options that enhance regional mobility. We recognize that potential service or capital project partnerships will be subject to approval by the Community Transit Board and the Seattle Children's Hospital Board of Trustees.

Seattle Children's Hospital
Thomas N. Hansen, MD, Chief Executive Officer

Date 10/16/08

Community Transit
Joyce Eleanor, Chief Executive Officer

Date 10/14/08

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Swedish Cherry Hill Campus
Final EIS and MIMP Comments

Comments on DPD Project Number 3012953

Author: Nicholas Richter

Submitted: 2015-01-16

More than three years since the Notice of Intent was submitted, Swedish and their development partner Sabey have presented what they consider to be a final environmental impact statement and final major institutional master plan. As a former member of the CAC, I have been able to see the plan develop from the initial alternatives to the current proposal. After a significant amount of review of both the documents provided by Swedish Medical Center and other comparable major institutional master plans in Seattle, it is my judgment that the Swedish Medical Center MIMP proposal currently under consideration is unprecedented among MIMP plans in terms of the lack of mitigation, the inappropriate scale for the surrounding community, and the low standards of "success" set by the institution for itself. No other major institution in Seattle has set their goals for compliance so low in a MIMP or sought to place a development of this size in immediate proximity to a residential neighborhood with such marginal mitigation measures.

I regret to state my opposition to the plan. While I was a near neighbor to the hospital, my analysis stems from my background in urban and regional planning in combination with my experience as a consistent participant in the MIMP process over the course of three years. My judgment takes into consideration the proposed benefits of the new development; the regional needs of the Puget Sound; the stated impacts outlined in the EIS and proposed mitigation measures; and the treatment of the community and public during the deliberation process. I currently work in transportation planning in the San Francisco Bay Area and hold a Master's Degree in the field of Urban and Regional Planning.

I actively support the expansion of other institutions (such as Seattle Children's Hospital and the University of Washington) when there is a balance between the needs of the community and the needs of the institution clearly embodied in the proposed plan and demonstrated by the institution's current actions. I do not find that balance in the current plan.

In addition, I also find that the lack of action on the part of Swedish in addressing community concerns over the past three years has eroded my confidence in their ability and/or willingness to achieve the mitigation measures included in this plan. As mitigation of harmful effects is dependent on the implementation of mitigation measures, along with sustained effort to ensure success, and as they have not taken concrete steps to address current and ongoing issues raised by the community, I am forced to conclude that the mitigation measures will be instituted to the minimum level required by law. Lacking adequate resources and/or institutional support, I believe a predictable outcome will be irreparable harm to the livability of the community. In particular, negative impacts including lighting, shadowing, noise, and transportation are among those that likely will not be effectively mitigated, even if it was possible to do so in some cases.

Swedish, in coming to a public process and setting out to create a plan that would last decades, had an opportunity to engage the community, prove their intentions by proactively addressing long standing and known issues, and create a common vision of the future. The MIMP process is meant to empower citizens to work with institutions to do just that. In situations where institutions are committed to collaboration, there can be significant gains through this method. In this particular case, Swedish held public meetings, as required by law, but the process was ineffective and at times adversarial. Consider:

- Some clear stakeholders, such as the neighboring office of the Department of Social and Human Services, remained unaware of the proposed development, planning process activities, and potential impacts on their operations. Their voice and input was not at the table. Contact with DSHS was made by a CAC member, not the Institution.
- The initial alternatives included aggressive expansion into the neighborhood on three of four sides of the campus. These alternatives were clearly contrary to the intent of SMC 23.68.002 (Items A, C, E, and G) and obvious from the first meeting that they were wholly unacceptable to members of the community. The alternatives needlessly wasted time and predictably created hostility between the members of the community and the institution. As a result, deliberation and the public process was harmed.
- Swedish showed disrespect for the time of members of the CAC interested in working towards a solution by continuing to present untenable alternatives well past when the strong objections of both the CAC and public were obvious to the reasonable observer. This "tin ear" ultimately culminated in the CAC rejecting a PDMIMP unanimously in December of 2013.
- Materials requested by the CAC in order to further their participation in presenting alternative ideas or reviewing statements made in documents, such as detailed transportation information from the PDEIS and the 3D SketchUp Model used by the architects of the campus, were withheld from the CAC. In addition, such attempts at participation by CAC members were dismissed as "an unproductive distraction (and outside the code)" (See email between Marcia Peterson, Swedish and Nicholas Richter, cc:ed to the CAC, from 2013-08-09)
- The website and information published on cherryhill.swedishmimp.org has frequently been out of date or lacked important documents needed for public deliberation. In addition, the

current website encourages people to sign up as "supporters" prior to being able to review any information that would enable them to make an evidence based choice.

- Swedish scheduled an important meeting (Meeting #10, held directly after the first time the CAC and community was able to review the PDEIS and PDMIMP) at a different campus than normally scheduled. The change was not effectively communicated. Maintaining strong communication about meeting location and giving priority to public meetings over other functions, such as decorating for a holiday party, are basic components of a public participation plan that demonstrates respect for members of the public. The CAC amended bylaws over objections presented by Swedish to prevent further relocations to other campuses that might create additional burdens to attendees.
- According to the cherryhill.swedishmimp.org website, there have been two community meetings offsite with local stakeholder groups where Swedish has gone out to present since April 2013. This equates to approximately one offsite public outreach event every 10 months.

Further, the express purpose of the MIMP is "to balance the needs of the Major institutions to develop facilities ... with the need to minimize the impact of Major Institution development on surrounding neighborhoods" (SMC 23.69.025). Permission to develop in excess of the usual zoning standards is established through special overlay zoning which is intended to balance the "need to protect the livability and vitality of surrounding neighborhoods" with "a Major Institution's ability to change" (SMC 23.69.002). As previously mentioned, I support development that brings needed services or catalytic change when the planned expansion presents a believable plan that includes a clear accounting of impacts and aggressive mitigation. However, the MIMP process exists because although an institution may have the ability to expand, it is not necessarily entitled to expansion of any type desired, at any given time or place when faced with the needs of the surrounding community[1].

As a result, there are times when the proposals are simply inappropriate for the neighborhood context. The MIMP currently presented is an example of a proposal that is out of sync with the character and development patterns of the local residential neighborhood. The height, bulk, and scale of the proposed Institutional development dwarfs all other buildings in the vicinity of the campus and, if built, would represent one of the greatest disparities between neighboring land uses in the city. No other MIMP has been put forward and accepted with a similar level of intensity in a residential area with such low setbacks and other mitigation measures.

The neighbors of Cherry Hill and Squire Park, with support and investment from the Seattle Department of Neighborhoods, have created one of the most attractive and vibrant areas in the city. Cherry Hill and Squire Park continue to attract new residents and retains, for the time being, many committed residents who have been instrumental in this decades long transformation. While changes to zoning and economics has brought additional change in the urban form and composition of the

[1] To liberally paraphrase Sue Tanner, City of Seattle Hearing Examiner, from the 2009-08-12 Findings and Recommendations in the matter of the Application of Seattle Children's.

neighborhood, the fundamental residential character of Cherry Hill and Squire Park has never been questioned or changed.

The new development proposed at the Swedish Cherry Hill Campus, however, is a direct threat to the character of the neighborhood and long term land use of the area. Swedish and its development partner Sabey have signaled with their proposed alternatives that they are interested in expansion outside of the current MIO boundary: 54% of all actionable proposed alternatives (and 100% prior to the CAC rejection of the MIMP in 2013-12) contained proposed MIO boundary expansions. While the residential character of the surrounding neighborhood remains intact today and thus boundary expansion highly discouraged under SMC 23.69.002 section G, the inclusion of 160' high rise buildings and the dramatically increased intensity of land use on campus will erode the cohesion of the neighborhood character and make expansion more likely during the next major institution master plan process. This is not in the interest of current or future residents, nor the City of Seattle.

The neighborhood context is that of a single family and low-rise residential area. While First Hill, Downtown, and Seattle University all lay to the west of Cherry Hill, virtually all intensive institutional or commercial land uses are to the west of 12th Avenue. In terms of Urban Form and buffer zones, Seattle University and its associated master plan provide for a transition zone from intense institutional use to the residential setting where the Swedish campus is incongruously located. Inside of this environment, the campus is alone, surrounded by residential houses and small scale buildings. While the neighborhood has adapted to the present campus, there is a limit where increased intensity of development is inappropriate.

The current MIMP steps over the line of what would be acceptable for any residential neighborhood. To provide a comparison of other local buildings in the same general height category, as what is being proposed, consider these notable buildings (+/-5 feet) in Seattle. From Emporis.com:

Harbor Steps Southwest Tower	1200 Western Avenue	165ft
Beacon Tower	1501 S. Massachusetts St.	165ft
2201 Westlake	2201 Westlake Avenue	160ft
Swedish Medical Center, First Hill	747 Broadway	158ft
Virginia Mason Tower East	925 Seneca Street	155ft

Each of these buildings (except Beacon Tower) is located in neighborhoods that feature intense development, tall buildings, and density that is compatible with these high-rise buildings, such as Downtown and First Hill. There are few examples of tall buildings outside of the downtown core, and it is doubtful that any would be permitted under current zoning practice. The University Of Washington Tower (325 feet, built in 1975) is at the heart of the University District and, despite its odd height, is not located in a residential neighborhood. Pacific Tower (235 feet, 1932) is on outlier, as is Beacon Tower (165 feet, 1974), both located on Beacon Hill. The City of Seattle has consistently used zoning ordinances to avoid such outliers and by policy does not allow for high-rise buildings in or near residential areas. This is established practice and other MIMPs in the Seattle area that have been previously approved in deviation from this norm on the basis of merit have never featured such an

incompatible mix of high-rise buildings in residential neighborhoods. Aside from Seattle Children's, there are few, if any, examples of a MIMP with an MIO overlay approving height over 105' anywhere in Seattle outside of an urban village.

The most informative comparable MIMP is Seattle Children's Hospital. Like Swedish, the campus is located in a residential setting. Like Swedish, Seattle Children's claims a critical role in the provisioning of vital health services. Like Swedish, the proposed expansion was significant and extensive, involving a similarly sized growth (2.4 msf vs 2.7 msf). There are significant similarities that make it a relevant case study on what is acceptable in a similar neighborhood context. Unlike Swedish, their MIMP is believable, contains buildings that balance the needs of the community and the needs of the institution, sets a high standards for mitigation efforts, and includes concrete commitments.

Topic	Seattle Children's	Swedish Current MIMP
Setbacks	Between 20' and 75'	Between 0' and 25'
Maximum Height	140' furthest from residential areas, 125' next to residential areas	160' next to residential areas
Non-SOV Mode Share	30% (currently at 38%)	Inconsistent in MIMP: Either 50% or 44%.
Money Specifically Pledged to TMP projects in MIMP	Up to **$3.9 million** to SDOT (does not include shuttle services)	**$0.00**
Alternative Commute Mode Employee Incentive	Up to **$700** per year paid to employee, plus a free bike	Unknown, "being investigated"

The comparison demonstrates the inadequacy of the current MIMP provided by Swedish. The addition of 2.7 million square feet of commercial and institutional facilities in a residential neighborhood is a significant event with major impacts. A review of the Swedish MIMP reveals little concrete and lasting commitments to the community to balance the clear impacts associated with this expansion. The mitigation measures in the current MIMP represent *de minimis*, while the plan calls for the maximum possible development. The neighborhood and citizens throughout Seattle should be asking if the plan presented is truly in the interest of the public, or whether the package being offered is a bad deal. The public is offered little and offers made by the institution are all couched in conditional phrasing, such as "pilot project", or alternatively are features that simply are not effective enhancements to the neighborhood.

The existence of a "final MIMP" does not require the acceptance of that MIMP. Seattle Children's Hospital crafted a *much better* MIMP than what has been presented by Swedish and the Hearing Examiner recommended that the City Council deny that plan. Whether considered in comparison to Seattle Children's or on its own merits, the current MIMP should not be accepted as adequate and should be rejected. Swedish is capable of a better plan and Cherry Hill deserves a better plan.

boundaries; and the introduction of incompatible land uses in a residential neighborhood. In addition, the half-block section of 19th Avenue, key to the repeated vision of expansion, would never have been available for redevelopment in this fashion, as has been made exceedingly clear through three years of public comments. Therefore, this is not a justification for excess lot coverage. The acceptability of the additional requested lot coverage should be reviewed on the merits of the development proposed, *not prevented*. If the latter argument was acceptable, then *any* alternative outside of alternative 3 ("distributed", which called for expansion of boundaries to include two to three additional blocks of land) would be acceptable as nothing proposed is as unacceptable and callous as what was proposed there.

The lot coverage calculation that Swedish proposes later on page 42 is also flawed. The 76.5% lot coverage includes questionable credit for their driveway and assumes that the footprint of the Seattle Rehab Center mains unchanged from foot print from the 1970s. Alternatively, if Seattle Rehab Center did redevelop their lot independently, it is likely that Swedish would be unable to achieve their vision and maintain this 76.5% limit.

Page 21, Table B-1: 23.44.012 – Height Limits

The height limit of 160' is inappropriate for this context, especially when combined with the limited setbacks proposed. Swedish should look to Seattle Children's for an example of what is appropriate. The western block should be conditioned to a height of no more than 140'. The center block should be conditioned to a height of no more than 125'. The clock tower should remain the tallest and most prominent feature on campus.

Page 22, Table B-1: 23.44.014 – Setbacks

The setbacks proposed are insufficient for the residential context of Swedish Cherry Hill. Referencing the sections mentioned on page 25 onward: Section A-A should feature a greater setback above 37'; Section J-J and K-K feature insufficient setbacks to create a transition to the low rise residential neighborhood. In addition, the 0' setbacks along 16th Avenue risks creating a highrise canyon in the middle of Squire Park. This is not an appropriate feature for a neighborhood of this character.

Page 35: Heights

The intensity of the proposal is above what can be reasonably accommodated by the neighborhood, especially given the paucity of mitigation and lack of concrete commitments in the MIMP. Squire Park and Cherry Hill is not an appropriate location for high-rise buildings of this magnitude. The neighborhood is not First Hill, nor downtown. While the center of campus and western edge could accommodate structures of increased height, the proposed limits (which exclude mechanicals, resulting in even greater height) would create significant impacts that cannot be mitigated either directly in terms of placement or through techniques such as façade modulation.

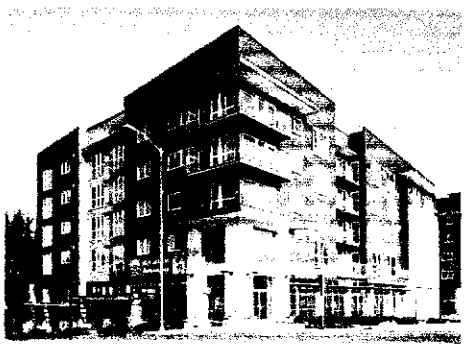
The table below contains a list of heights that I believe are acceptable, with conditions. The two main issues are the overall heights and intensity of development (lot coverage) and the 18th Avenue half-block. Lowering the height limits in this block is not enough to create a transition from the monolithic Kowloon institutional center proposed and the immediately adjacent neighbors along 19th Avenue. Although it may be inconvenient for the institution, separate buildings of differing sizes in this area would provide for a smoother transition. This could also be created through additional 15' conditioned areas with the additional condition that no mechanicals be allowed.

Section	Proposed Height	Conditions
15th/16th Block		
A1: NW Quad.	65'	Enhanced setbacks on Cherry
A2: NE Quad.	65'	Enhanced setbacks on Cherry
A3: Center N Quad.	125'	Enhanced upper setbacks starting at 37'
A4: Center S Quad	140'	As A3, conditioned to 125' at eastern edge.
A5: SW Quad	65'	Enhanced upper setbacks along Jefferson
A6: Carmack House	65'	Enhanced upper setbacks along Jefferson
16th/18th Block		
B1: N Quad.	105'	Enhanced setbacks on Cherry
B2: Center Quad.	125'	Enhanced setbacks on 16th
B3: SW Quad.	105'	Setbacks remain as today
B4: S Quad	37'	Driveway is not "open space"
B5: SE Quad.	40'	Adaptive reuse or historic preservation
18th half block		
C1:	37'	Minimum of three separate buildings on half block
C2:	37'/45'	Min. three buildings in area, additional upper level setbacks
C3:	15'	May be used to connect two buildings. No mechanicals.
C4:	37'/45'	Min. three buildings in area, additional upper level setbacks
C5:	37'	Minimum of three separate buildings on half block

Page 44: The use of building façade modulation and street trees will transition the scale of each future project to its residential neighbors (see Development Standards 3.a.Structure Setbacks and Appendix H: Design Guidelines).

The proposed mitigation of bulk and scale through the use of façade modulation is not effective and cannot replace an actual reduction of the bulk and scale of the project. Changing the colors or creating foot variations here and there does **not** actually reduce the size of the building. Seattle has had a significant boom in buildings that use similar techniques. While they may be appropriate for softening the scale of buildings when surrounded by like development, no amount of façade modulation will hide the fact that a single family home is next to or across the street from a commercial building.

Technically, this commercial building features façade modulation.



Façade modulation can be used to break up mass when buildings are of similar height, bulk, and scale and where setbacks, heights, and other mitigation measures are already effective. However, this technique cannot be relied on to provide mitigation in and of itself. The building on the left, the AMLI complex in South Lake Union, is very clearly a large residential complex when viewed by itself, regardless of the splash of color and modulation of the sides.

Page 49: "[Alternative 12] [p]rovides only 2.75 MSF which is less the stated need of 3.1MSF"

The stated need appears, then, to have a degree of "truthiness" to it. As the need is not absolute and there is by admission of the institution, flexibility inherent in their "needs", the question is whether the current MIMP balances the needs of the community and the needs of the institution. The current MIMP does not achieve that balance.

Page 55: "When calculating FAR certain areas are exempt. Swedish Medical Center requests the exemption of the following areas from the FAR calculation.

[...]

•Electrical Areas (generators, transformers, closets, servers and space that is not occupiable)"

The exemption for server spaces should not be allowed. Sabey, the development partner of Swedish, is also in the business of information technology and currently owns and runs large scale server farms. This exemption creates a clear loophole that could be abused by Sabey to increase the intensity of development by locating servers at Cherry Hill. Since they are explicitly in the IT infrastructure business, this amounts to a potential *carte blanche* to expand at Cherry Hill.

Other MIMPs that have been approved (Seattle Children's and Virginia Mason, as examples) do not have similar exemptions for servers. There is no reason that it should be included here.

Page 65, Table C-4: 23.69.002.B – "The MIMP protects the livability and vitality of adjacent neighborhoods by providing open space, landscaping and site amenities."

The majority of the amenities, such as the health walk, will have zero positive impact on the livability of the neighborhood. Factual errors in this section include:

- The assumption that people riding bicycles would deviate one block to use the 18th Avenue pass through proposed instead of continuing on either 18th or 19th.
- The assumption that anyone would ever use the "health walk" to any meaningful extent.
- That the inclusion of pocket parks or any other Swedish amenity for campus users would have a significant impact on any part of the neighborhood outside of the campus.

The fact of the matter is that Swedish has created this plan for itself and its clients. Creating a nice campus *for yourself* is different than creating a plan that protects the livability and vitality of the *adjacent* neighborhood. The impacts of the plans are manifest, but there is reason to be skeptical about the mitigation efforts (not mentioned in this section *at all*) in the plan and their ability to

materially reduce the impacts that are expected. Swedish can do better than this and should hold itself (or be held) to a higher standard.

Page 66, Table C-4: 23.69.002.F – "The Medical Center has encouraged significant community involvement by meeting with the Citizen's Advisory Committee (CAC) and taking their recommendations into consideration."

This statement is not true. Swedish has held public meetings, as required by law, but has not "encouraged significant community involvement" or taken active steps to encourage any additional involvement beyond the mandated meetings. Please see page 2 and 3 of this document for details. In urban planning theory, community involvement is measured not only on the number of meetings held, but also the level of control afforded to participants and institutional responsiveness to suggestion.

The driving theory is that early and active involvement in the planning process should lead to better results. However, in this case, the process has a severe disappointment for anyone who believes in the power of collaborative planning. Collaborative power is premised on having willing participants. My experience as a CAC member has been that the institution has been recalcitrant towards community involvement and that the majority of community involvement has been driven either directly by CAC members or by members of the community. Suggestions made by the CAC or requests for additional opportunities for community input and direct involvement in the planning process was not acted on. It is not the responsibility of the CAC to run the institution's community involvement process.

While the relationship between the institution and the local neighborhood community could be described as "toxic", the institution shares a significant portion of the blame. Alternative 3, one of the first alternatives presented, was explicitly belligerent towards the neighborhood and was, predictably, received poorly. The institution acted from their position of power to antagonize neighbors and created an unproductive environment of a looming threat against neighbors. Planning is an emotional process and many of the actors in the current MIMP process were previously known to the institution. Alternative 3 was either an appallingly oblivious proposal or an explicitly vindictive attack. The resulting harm caused to neighbors who genuinely felt that their homes were being threatened had a significant negative impact on the atmosphere of the public process and directly delayed the ability of the CAC to carry out its duties.

The failure of Swedish to more productively engage in the process and the lack of action on long standing, known community issues casts doubt on their commitment to mitigation measures outlined in the MIMP and community amenities (no matter how poorly conceived) after the institution has obtained approval of the MIMP. It is *very* telling that 20 years of inaction is suddenly broken immediately prior to coming to the City of Seattle with a big "ask". While Swedish *could* be committed to starting a new chapter in its relationship with the surrounding community, there is little evidence of concrete plans in the current MIMP or actions that it intends to take to mend fences with neighbors.

July 21, 2015

Dear Examiner Tanner,

As a former resident of the Central Area, I am very concerned about the proposed expansion of the Swedish Hospital campus. During the years that I lived on the west side of 19th Avenue between Cherry and Jefferson, I truly fell in love with the diverse community of neighbors who live in this area. The height, scale and bulk of Proposal-12 will adversely affect the quality of life and inflict unnecessary harm on people in the neighborhood.

The existing Swedish facilities on 1st Hill and Cherry Hill are not currently fully occupied, calling into question the need for such a large and bulky building. This project would create a massive disruption for residents during the long construction of such a building, and the presence of such a building would permanently alter the character of the neighborhood in negative ways. If Swedish does need substantially more space for hospital-support facilities, the existing Swedish campuses in Seattle and Issaquah would be better suited for this expansion.

I understand that Swedish does need to update and improve its facilities, but it should not be at the expense of their neighbors. I support the Minority Report, which advocates for a remodel of the existing facilities and new construction on a more reasonable scale that suits the character of the neighborhood. One of the key differences in this plan is the construction on the east side of 18th avenue. Proposal-12 would build a bulky four-story structure on this street that loomed above its neighbors homes, while the Minority Report details the construction of several smaller, free-standing buildings, with green space in between. The Minority Report plan would allow Swedish to create new office spaces that actually fit within the neighborhood setting.

Thank you,

Rebecca Goldberg

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United for Quality Care

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July 14, 2015

Comment on proposed major amendment to Swedish-Providence Cherry Hill campus Major Institution Master Plan (MIMP)

City of Seattle code requires as part of the MIMP process a review of public benefits "resulting from the plan's new facilities and services." SMC 23.69.032.E.2.a. Core to Swedish-Sabey's argument of its public benefit is provision of new, high-tech hospital care. Final MIMP at 69-71. Yet, our experiences of waning commitment to frontline patient care show that underlying patient care concerns offset that benefit. The Hearing Examiner's report must assess the way in which the proposed development will serve the public purpose mission of Swedish. SMC 23.69.032.E.2. We feel Swedish's recent behavior calls to question whether the proposed expansion will serve the hospital's public purpose mission, or merely Swedish's and Sabey's bottom lines.

The 7,000 nurses and healthcare workers at Swedish-Providence who are united in SEIU Healthcare 1199NW want nothing more than for Swedish-Providence to be successful, to serve its public purpose mission, and to continue to expand its capacity to provide patient care. But we've found in recent years that our measures of success as front-line patient caregivers and patient advocates is no longer the same as Swedish-Providence's measures of success. We seek the highest quality of patient care, with the elimination of "never events" like hospital-acquired infections and patient falls, and with patients receiving the care they need in a timely fashion every time, from getting hot nutritious meals that meet their dietary requirements to fully cleaned patient rooms available with no wait to someone there to answer a call light when a patient needs pain meds or help toileting.

Since Providence took over Swedish in 2012, its measure of success has diverged from this vision. Immediately upon acquisition, Providence began a "benchmarking" process that sought to bring our care at Swedish not to excellence in care but to average costs. Following this process we saw an immense layoff of Swedish staff. Caregivers are now expected to maintain Swedish standards of care with Providence or average staffing and supplies.

Now, the 7,000 nurses and healthcare workers are bargaining our first contract since the Providence takeover and we're seeing a similar pattern. We are

proud to have had an instrumental role in Swedish-Providence making an incredible $110 million in profit at its campuses in 2014. We expected the institution would share our interest in reinvesting that money in frontline care and staffing. Yet they not only refuse to do this, they're moving backward, attempting to put even less into frontline caregivers by cutting our healthcare benefits, reducing our retirement security, and walking away from our training partnership which has been hailed by Governor Inslee as a model for growing our future healthcare workforce.

These patterns are relevant to the Cherry Hill MIMP in the context of this institution's role in our community. The city's Major Institution Master Plan process hinges on the concept that the major institutions provide a key benefit to our community in either education or healthcare and thus it is a benefit to the commons when the institutions expand that offsets the cost to the immediate neighborhood. Swedish and the former Providence hospital used to provide just such a benefit but in recent years we have seen it backing away from the staffing and investment it took to achieve its reputation for excellent care and it is employing increasing proportion of "traveler" out-of-town temporary staff rather than giving good jobs to our community. Its benefit is now in the shadow of its competitive drive for the bottom line.

Furthermore, Swedish-Providence's approach to our bargaining and Swedish-Sabey's approach to the MIMP process show an arrogance and disregard for outside voices that cannot be underestimated. While these processes are meant to engage in dialogue, find common interests, and arrive at a win-win position, Swedish's approach to these tables as unwilling to listen, convinced it is the sole expert, and seeking a winner-take-all outcome.

As an organization of 26,000 nurses and healthcare workers we reject the bad healthcare policy premise that Seattle needs multiple neuroscience centers of excellence. We know that patients of the highest acuity need care in a setting that offers Level 1 trauma support—which Cherry Hill does not. We know that duplicating services and expensive technologies results in higher costs to everyone. And we know that hotel rooms are not a healthcare function.

Swedish-Providence nurses and healthcare workers live in Cherry Hill, too, and see that offering a "health walk" and a few benches in no way offsets the millions in additional revenue this expansion will bring to Swedish and Sabey. These are both corporations that can do significantly more. Already, Swedish-Providence has $110 million in the bank that should have gone to our

community and our patients. And with the expansion, that commitment should increase, per SMC 23.69.032.E.3.

When nurses and healthcare workers from the hospital are calling for the denial of its expansion, something is very, very wrong. We want the best for our patients and we feel that until Swedish-Providence returns to its mission of excellent care for our community, any expansion would feed the profit motive rather than providing quality care to more neighbors. We call on the Hearing Examiner to reject the current MIMP and instead require a concrete and significant commitment to our patients and our community—safe staffing, charity care, and a real community benefit.

Dr. Sharon E. Sutton, FAIA
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Seattle, Washington 98104
Cell 206 383 6052
sharonegrettasutton@gmail.com

13 July 2015

Sue Tanner, Hearing Examiner
City of Seattle
700 Fifth Avenue, Suite 4000

re: Swedish Medical Center
Cherry Hill Campus
Final Major Institution Master Plan

Dear Examiner Tanner:

I am writing regarding your review of the above referenced MIMP for its compliance with the standards that must be met in SMC 23.69.032.E.

I am offering an expert opinion as a consultant to Washington CAN, charged with assessing the aesthetic outcomes of the above referenced project for the surrounding neighborhood, especially related to its height, bulk, and scale. I accepted this assignment because this organization's efforts to achieve racial, social, and economic justice in Washington State intersect with my own efforts to advance socially just built environments in cities and neighborhoods.

As an architect, environmental psychologist, and professor, I am uniquely qualified to offer an expert opinion on this project. My scholarship on equitable urban space has been widely published in the academic and popular press, and disseminated through lectures in academic and professional settings, earning me numerous honors and awards. I put my scholarship into action through through community-based teaching, university-community partnerships, and public service.

Most relevant to this project, I served as vice-chair of the Virginia Mason Citizen's Advisory Board (2011–2013) and am currently on its Standing Advisory Committee. I served as chair of the Capital Hill Design Review Board (2007-2011), as architect on the Seattle Design Commission (2000–2004), as peer-reviewer of books and credentials in urban design, and as juror for national architecture and urban design competitions.

To develop my opinion, I visited the site several times and studied numerous documents, including the Final MIMP and Final EIS, CAC Final Report and Recommendations, Director's Report, Notice of Appeal with Haines Letter, Ellen Sollud e-mail (19 November 2014), Nicholas Richter Comments (16 January 2015), Virginia Mason DEIS, Compiled MIMP with Design Guidelines, Children's compiled MIMP with design guidelines, relevant sections of the Municipal Code, and various maps, illustrative exhibits, and aerial views.

My comments on the MIMP are organized into seven sections that discuss the extent to which:

1. Open space maintains the patterns and character of the area.
2. Allowable lot coverage provides adequate setbacks along public rights-of-way.
3. Limits on structure heights mitigate a transition to the adjoining areas.
4. Increased setbacks mitigate a transition to the adjoining areas.
5. Topographic features mitigate a transition to adjoining areas.
6. Landscape standards have been incorporated into setbacks.
7. Measures have been specified to mitigate adverse impacts.

1 Maintaining the Patterns and Character of the Area

SMC 23.69.032A.5h specifies that the Director's analysis and recommendation on the MIMP shall be based upon "the extent to which designated open space maintains the patterns and character of the area." The MIMP does not meet this standard.

Despite the controversy that went on for almost three years about the effect of the project on its neighborhood context, the MIMP contains just a three-page section entitled "Neighborhood Context and Existing Campus" in the Introduction. It states that:

> *Most [streets] have sidewalks on both sides of the right-of-way and street trees in the parking strip. This makes them very walk-able streets allowing the residents to access the local commercial districts and variety of institutions in the neighborhood* (p. 9).

Apparently the MIMP authors only considered the sidewalks for their functional capacity of moving residents from A to B, rather than the degree to which they provide the area with its characteristic pattern and landscape.

Cherry Hill's distinctive rights-of way consist of (1) planting strip A at the edge of the street that varies from about 4' to 12' and protects pedestrians from vehicular traffic (except in a few instances where it has unfortunately been paved over); a 6'-wide sidewalk that seems perfectly in scale with the residential neighborhood; and on some streets planting strip B that occurs between the sidewalk and the property line (5'-wide along 15th and 16th Avenue and 2'-wide along 18th Avenue).

The Director's Report report summarizes sidewalk widening that would take some, if not all of planting strip A. It states that:

Swedish is proposing that the following would be located within the public right-of-way:

- *The perimeter pedestrian sidewalk and landscaping would include: widening sidewalks to SDOT standards* (p. 18).

The widened sidewalks will destroy the pattern and character of the area, and thus the MIMP does not meet the standard for approval specified in SMC 23.69.032A.5h.

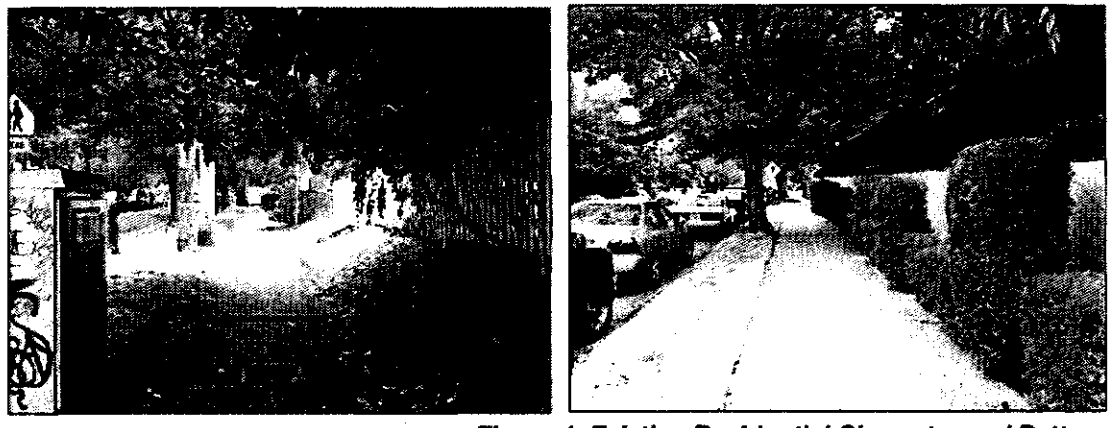


Figure 1: Existing Residential Character and Pattern

The image to the left shows the gracious residential streetscape at 18th Avenue just north of Swedish created by a 10-foot planting strip, characteristic 6-foot sidewalk, and about a 18-foot setback partially enclosed by a wooden picket fence. The image to the right shows a more urbane streetscape along E. Cherry, across from Swedish, created by a 5-foot planting strip, 6-foot sidewalk and about a 20-foot setback beyond a retaining wall and iron fence.

Figure 2. Existing Campus Character and Pattern

The image to the left shows a setback of about 11 feet at the West Parking Garage on the east side of 18th Avenue. The image to the right shows a set back ranging from about 23 to 13 feet at the Northwest Kidney Center and Seattle Medical and Rehab Center on East Jefferson Street.

2. Allowing Adequate Setbacks along Public Rights-of-way

SMC 23..69.032A.5c specifies that the Director's analysis and recommendation on the MIMP shall be based upon "the extent to which allowable lot coverage . . . allows for adequate setbacks along public rights-of-way." The MIMP does not meet this standard.

The MIMP proposal is not only for building higher, it is for building wider. That is, the proposal is for building up *and* out. Building out means going from the current lot coverage of 52 percent to the proposed lot coverage of 76.5 percent, calculated over the entire campus. This amount of lot coverage intrudes into the public rights-of-way, turning pleasant streets into compressed passages.

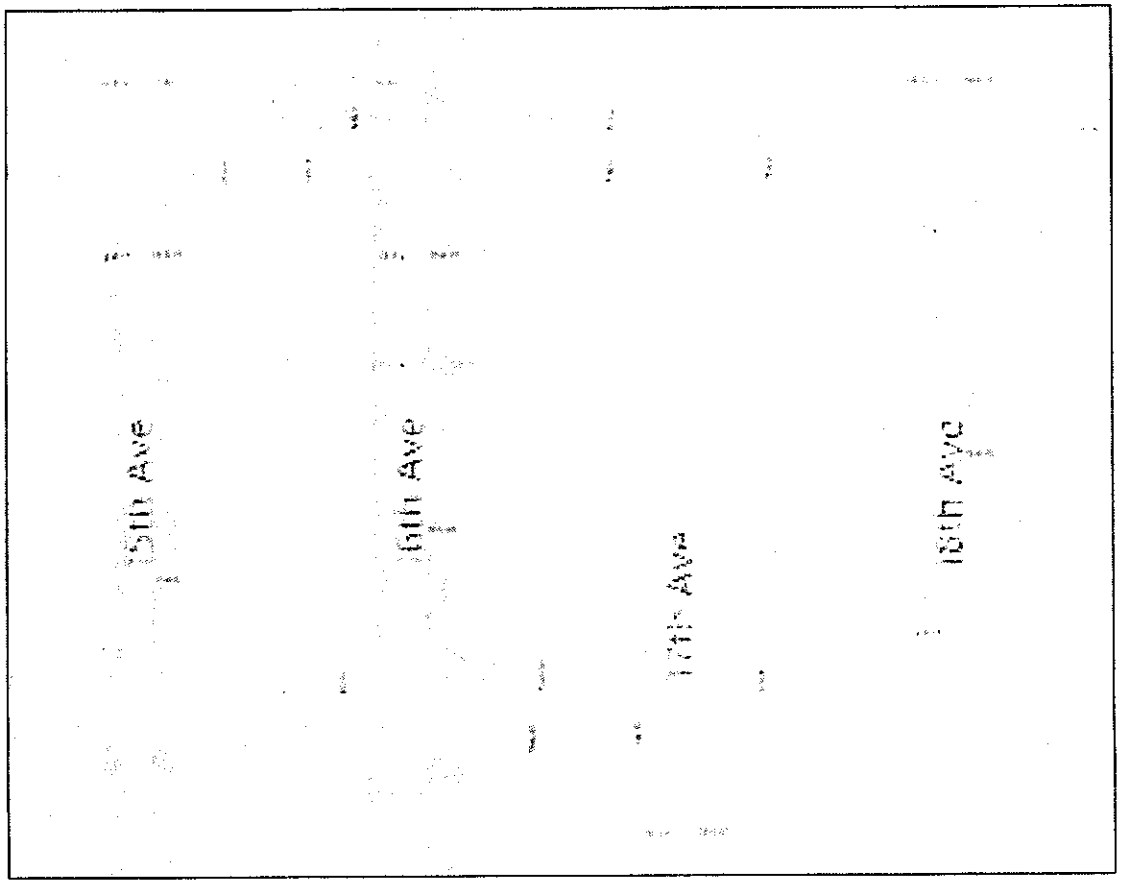


Figure 3: Approximation of the Existing Structure Setbacks
This exercise in coloring the approximate landscaped rights-of-way illustrates the existing gracious setbacks that transition between the Major Institution and surrounding area.

The Director's Report report states that:

> *The proposed ground-level setbacks from property lines at street frontages and the rear setback of 25-feet along the half-block on the east side of 18th Avenue allow for adequate setbacks along public rights-of-way and MIO boundaries. It also allows Swedish Cherry Hill to provide for landscaping, open space, and pedestrian amenities along the sidewalk areas* (p. 58).

I strongly disagree with this assessment. The proposed ground-level setbacks will greatly alter the fit of the campus with the surrounding neighborhood. Except for the unfortunate South Parking Garage, built in 2008, current Swedish buildings setback between 11 and 30 feet, which is smiliar to the setbacks of buildings in the surrounding residential area. This creates a campus that is very much in keeping with the surrounding neighborhood.

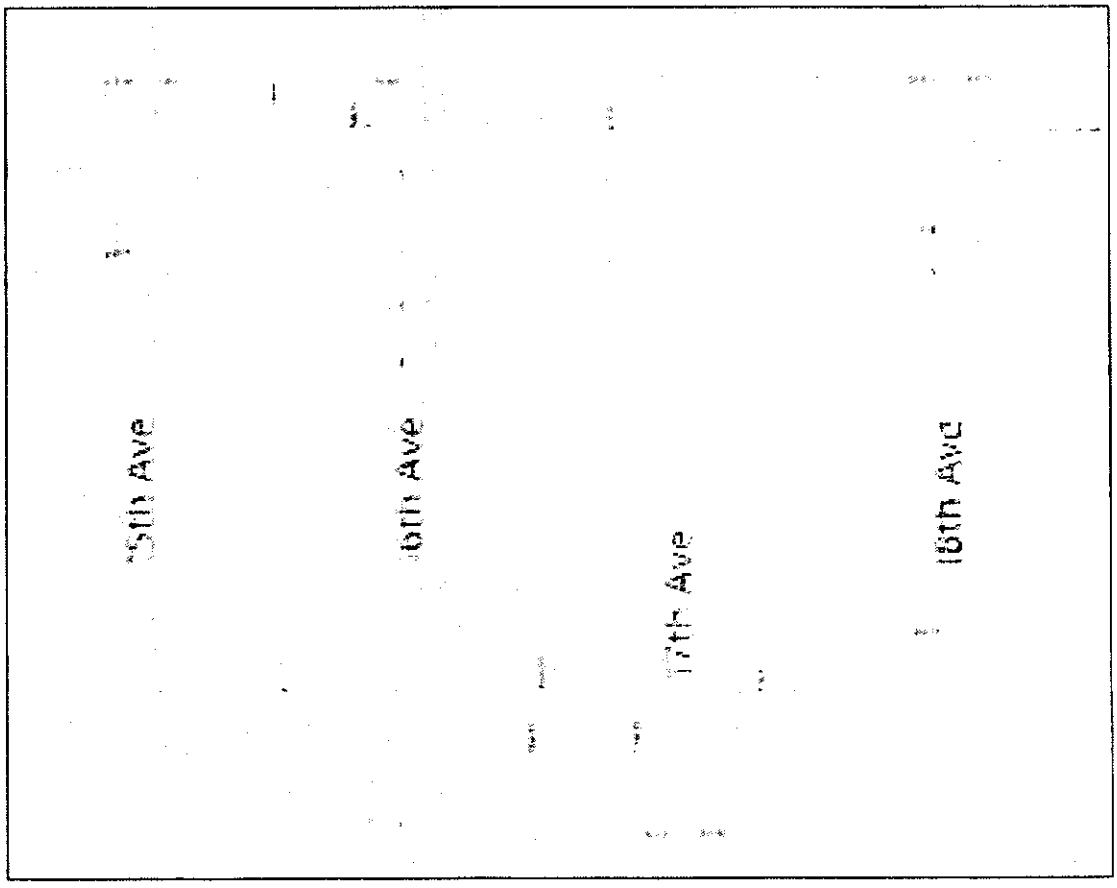


Figure 4: Approximation of the Proposed Structure Setbacks.
This exercise in coloring the approximate landscaped rights-of-way illustrates that the proposed structure setbacks are inadequate to transition from the Major Institution to the surrounding area.

The Director's Report greatly reduces the existing setbacks, though it enlarges them from those initially proposed in the MIMP. A MIMP "revision" presented by Callison at the MIMP hearing on 07.14. 2015 further enlarges the setbacks. However all told, the new proposed setbacks will be either 0 feet, 5 feet, or 10 feet—significantly smaller than the existing setbacks.

The proposed setbacks are totally inadequate along the sidewalk areas, creating tunnel-like streets. Thus the MIMP does not meet the standard for approval specified in SMC 23.69.032A.5c.

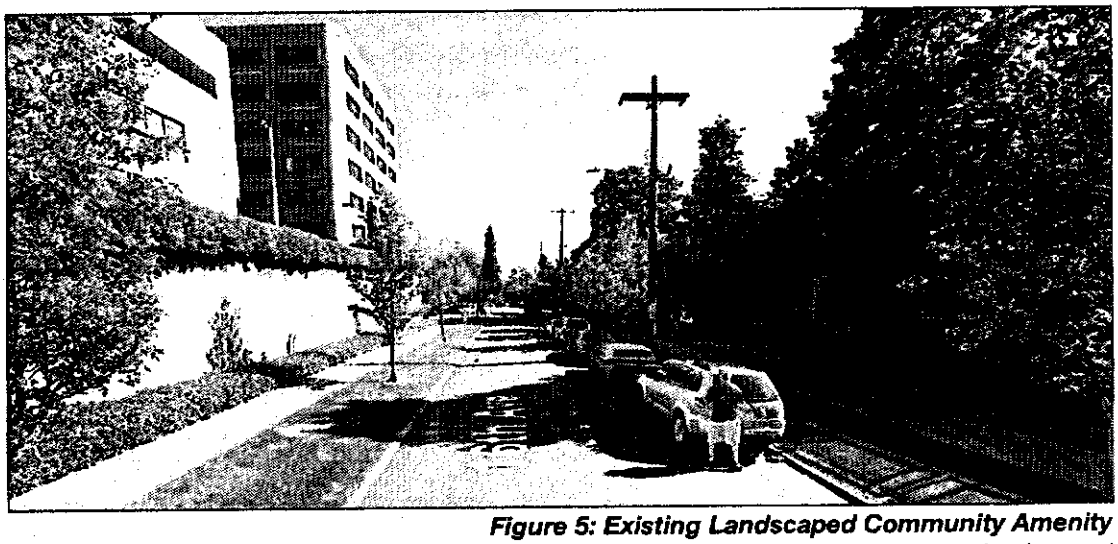


Figure 5: Existing Landscaped Community Amenity

This Google street view of 16th Avenue, taken in May 2014, documents the existing landscaped environment of the campus, which will be diminished by the proposal, not enhanced.

3. Limiting Structure Heights to Mitigate Differences in Height and Scale

SMC 23.69.032A.5a specifies the Director's analysis and recommendation on the MIMP shall be based upon "the extent to which transitional height limits are proposed to mitigate the difference between the height and scale of . . . proposed Major Institution development and that of adjoining areas. Transition may also be achieved through . . . limits on structure height."

Instead of mitigating the differences between the SMC campus and surrounding areas, the MIMP proposes stark disjunctures in height. On the Eastern lock, SF-5000 37' would be up-zoned to accommodate a single bread-loaf structure varying in height from 15 feet to 45 feet, located adjacent to small single-family homes.

The mid-Central Block would be up-zoned to 160 feet—130 feet above the surrounding LR3 (30') in the area and 55 feet above the existing MIO-105-LR3 zone along E. Cherry. The mid-Western Block would be up-zoned to 150 feet—85 feet above the existing MIO-65-LR3 zone.

These heights do not achieve a transition from the surrounding area, nor is one possible on a campus that is so tightly fit within a 3.5-block area. I believe that, to accommodate the hospital needs for increased space one mid-block portion could increase to 125 feet and another to 140 feet, but that the heights in the Eastern Block should be limited to those recommended in the Minority Report.

However as proposed, the heights do not mitigate the difference between the height and scale of the proposed SMC development and that of adjoining areas. Thus the MIMP does not meet the standard for approval specified in SMC 23.69.032A.5a.

4. Increased Setbacks to Mitigate Differences in Height and Scale

SMC 23.69.032A.5a also specifies that the Director's analysis and recommendation on the MIMP shall be based upon "the extent to which transitional height limits are proposed to mitigate the difference between the height and scale of . . . proposed Major Institution development and that of adjoining areas. Transition may also be achieved through the provision of increased setbacks."

The sections in Figures B2 through B10 (pp. 25–33) show that increased setbacks occur randomly, sometimes at 37', sometimes at 65', sometimes at 105', and sometimes not. Viewpoint 11 illustrates this jumble of setbacks along 18th Avenue. The Director's Report report refers to eliminating "wedding cake setbacks," but the proposed changes create an even bigger jumble, though these recommendations have not yet been visualized three-dimensionally. The lack of regulating lines from one side of the street to the other, especially given all the existing conditions, will make creating unified outdoor rooms at the building scale difficult.

As proposed, the jumble of setbacks do not mitigate the difference between the height and scale of the proposed SMC development and that of adjoining areas. Thus the MIMP does not meet the standard for approval specified in SMC 23.69.032A.5a.

Figure 6: Unified Outdoor Rooms

The image on the left is Viewpoint 11 illustrating the jumble of setbacks prior to the recommendations in the Director's Report, which specifies setbacks along various percentages of the building—a condition not represented three-dimensionally. The image on the right is a housing project in Copenhagen illustrating the concept of a unified outdoor room formed by building walls that are varied but have consistent regulating lines.

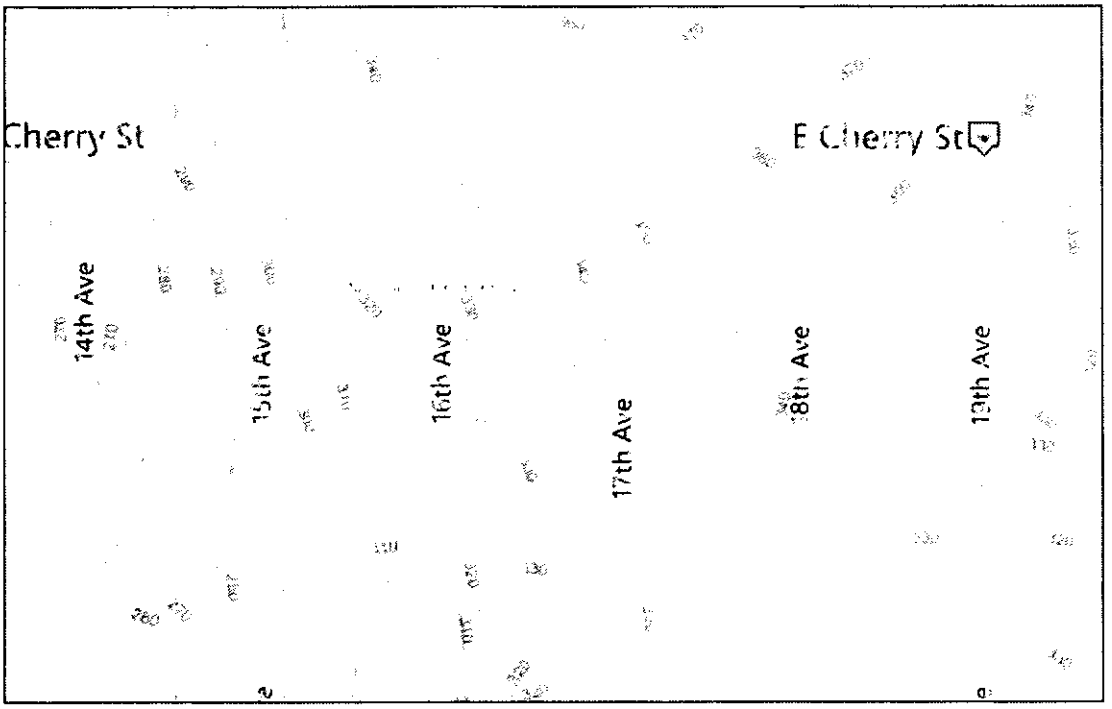
5. Topographic Features to Mitigate Differences in Height and Scale

Finally, SMC 23.69.032A.5a specifies that the Director's analysis and recommendation on the MIMP shall be based upon "the extent to which buffers such as topographic features . . . are present . . . to mitigate the difference between the height and scale of . . . proposed Major Institution development and that of adjoining areas."

Topographic features do not mitigate differences in height and scale, but rather magnify them, generally adding 20–30 feet in height due to the steep downward slope of the site. For example, James Tower sits at an elevation of about 360', its height of 105' increased by 30' in comparison to the single-family residences on 18th and 19th Avenues, which sit at about 330'.

The proposed mid-Central Block structure would sit at an elevation of about 350', its height of 160' increased by 20 feet in comparison to the single-family residences on 16th Avenue, which sit at about 330'. The proposed mid-Western Block structure would sit at an elevation of about 330', its height of 150' increased by 20 feet in comparison to the single-family residences on 16th Avenue, which sit at about 310'.

Especially because the topography magnifies the proposed heights, the proposed height limits do not mitigate the difference between the height and scale of the proposed SMC development and that of adjoining areas. Thus the MIMP does not meet the standard for approval specified in SMC 23.69.032A.5a.



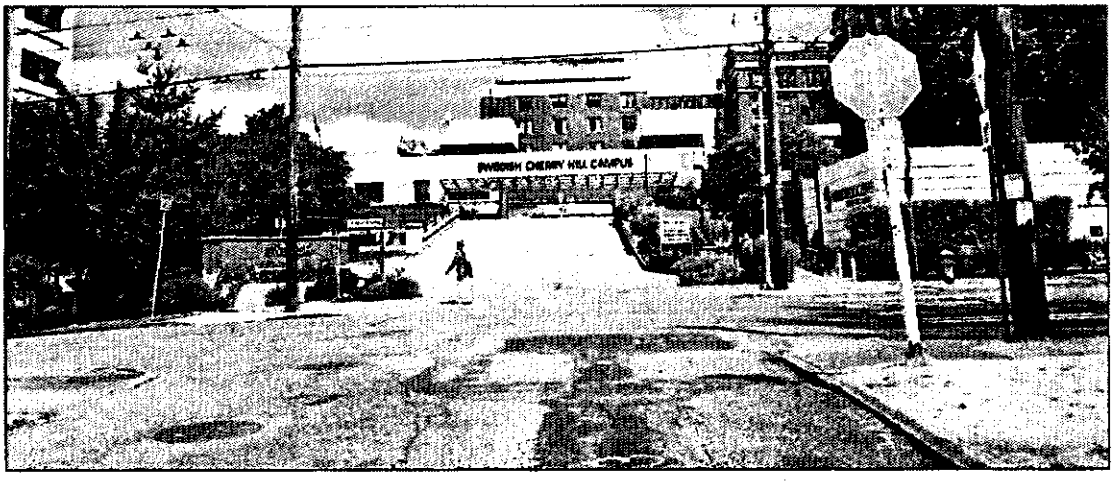


Figure 7: Topography that Magnifies Heights
The terrain slopes up to the low-rise zone but down 20–30 feet to the single-family zone, magnifying the height of campus buildings.

Figure 8: Deteriorated Edge along East Jefferson Street

The southernn edge of SMC is service, which may have contributed to the deterioration of the lower-down residential property. The image to the left is a Sabey-owned parking lot raised on fill that used to be single-family homes. The image to the right is a ramshackle party store.

6. Incorporating Landscape Standards in the Setbacks

SMC 23.69.032A.5h specifies that the Director's analysis and recommendation on the MIMP shall be based upon "the extent to which landscaping standards have been incorporated for required setbacks . . . along public rights-of-way."

Various documents suggest that discussions about the status of the sidewalks may have been misleading. For example, the CAC Report and Recommendations specifies that "elements of the plan must include . . . a minimum 18-foot-wide sidewalk" (p. 30) and worries that increased traffic might result in street widenings that would eliminate the planting strip (p. 46). But the MIMP shows 6-foot wide sidewalks (or un-dimensioned ones that appear about the same) and Viewpoints 2, 3, and 11 indicate narrow sidewalks.

The Director's Report states that the perimeter sidewalks would be widened to SDOT standards, which could potentially remove planting strip A, which is characteristic of the neighborhood. Finally, the "Sidewalks Guidelines" of the Design Guidelines, which do not differentiate between perimeter and interior sidewalks, confirm that the sidewalks will be so narrow that conflicts will occur between walkers and runners. The guidelines explain that "areas flanking the through zone at the property line would allow pedestrians *to standout of the way* of through pedestrian movements" (p. 151, emphasis added).

These varied documents point to multiple problems related to sidewalks: (a) the CAC has been misled about their width, (b) the Director's Report specifies widened perimeter sidewalks in the right-of-way, which would eliminate/reduce the planting strip, (c)

the Design Guidelines fail to differentiate perimeter and interior streets, and (d) the sidewalks are so narrow that pedestrians will have to jump aside to allow joggers to pass.

Because confusion exists related to the landscape standards proposed for setbacks, the proposed sidewalks will either eliminate planting strips, cause pedestrians to stand aside, or both. Thus the MIMP does not meet the standard for approval specified in SMC 23.69.032A.5h.

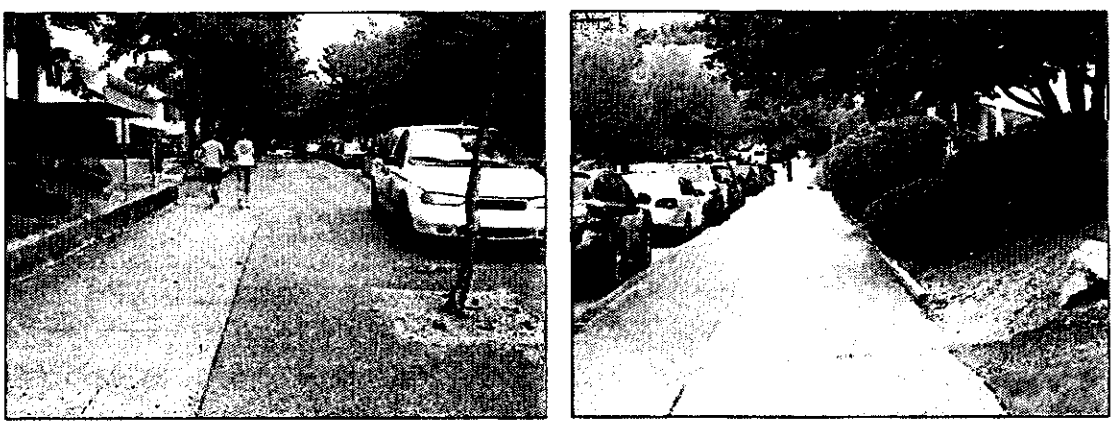


Figure 9: Sidewalks Widened in the Right of Way

The image on the right shows a sidewalk that has been widened to about 10 feet. The image on the left is especially informative. The sidewalk has been widened to about 18 feet and the planting strip to the left of the sidewalk is a bit less than 5 feet. Imagining a building at the edge of that strip gives an idea of what the proposed campus will be like.

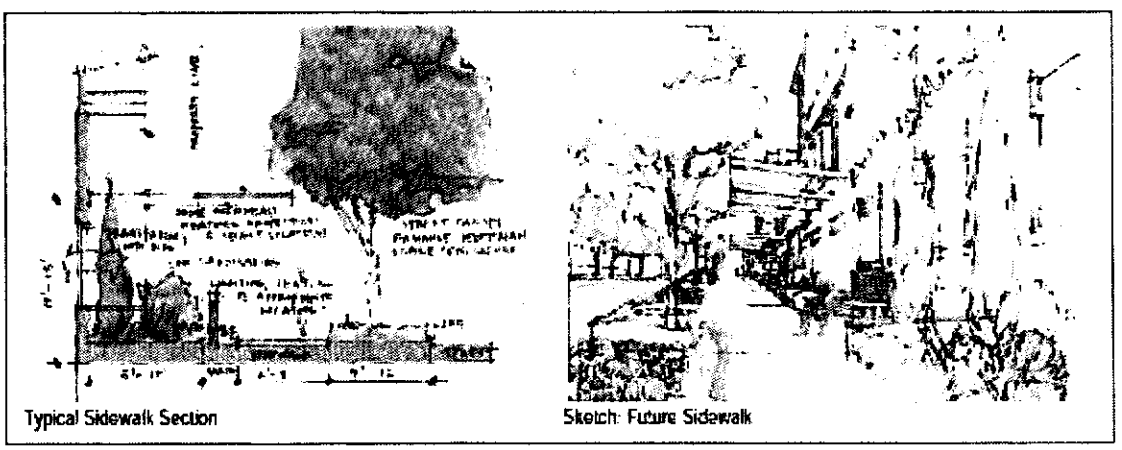


Figure 10: Landscape Standards the Create Pedestrian/Jogger Conflicts

The Design Guidelines specify an area for pedestrian to stand out of the way of joggers.

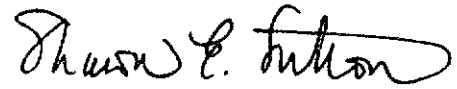
7. Specifying Measures to Mitigate Adverse Impacts

The Design Guidelines are one of the primary tools of mitigating the effects of this large development, but as written they are totally inadequate. First and most important, they are inconsistent with the Director's Report. That is, the Director's Report indicates a variety of elements that are to be checked, like natural drainage and use of native plants, that are not contained in the Design Guidelines. Second, they are missing important elements, like a table of contents and a checklist. Third, they are visually hard to follow. For example, objectives are listed separately from each other and from the goal they address. Finally, the cursory attention paid to sustainability is shocking, given the size of this project, the mission of the institution, and the coming 2030 Challenge. If these Design Guidelines are to be used by a Standing Advisory Committee to assure design excellence, they will require a drastic overhaul. Possible improvements include:

- Table of Contents
- Goals and Objectives (table with goals and related objectives)
- Natural Context and Environment (description of the natural systems, topography, environmental stewardship)
- Neighborhood Context (description of the landscape and architecture)
- Hospital Campus Character (add: guidelines for each of the interior and perimeter streets and for the 18th Avenue rear setback, main entry plaza, tree protection, hospital identity)
- Exterior Spaces (add: guidelines for bicycle parking, walk-ability)
- Greenhouse Gas Emissions (under Site Design) (guidelines for natural drainage, native plants)
- Greenhouse Gas Emissions (under Architectural Character) (guidelines for natural drainage and green roofs, waste management and deconstruction, green building design)
- Rooftops (add: elevator penthouses and rooftop equipment)
- Construction (guidelines for construction impacts, traffic and pedestrian flows)
- Checklist (for the SAC to use in deciding which elements to investigate on a particular project)

In sum, the MIMP—and the director's determination—are inadequate in assessing the significant harm to the livability and vitality of the surrounding neighborhood that this degree of growth will bring about. I hope that you will not accept the Final Major Institution Master Plan for Swedish Medical Center until major changes have been made.

Respectfully submitted,



Dr. Sharon E. Sutton, FAIA
Professor of Architecture, Urban Design, and Planning
Director, Center for Environment Education and Design Studies
College of Built Environments, University of Washington—Seattle
Distinguished Professor, Association of Collegiate Schools of Architecture

7/16/15
To: Hearing Examiner Sue Tanner
From: Sonja Richter
RE: Traffic Studies For Swedish Cherry Hill Expansion

At the testimony today regarding the so called "projects in the pipe line" that were deemed close enough to Swedish Cherry hill to be included in traffic impact studies, I was and am concerned that the Yesler Terrace redevelopment was not included.

The 32 acre Yesler site will have over 625 new apartments, apartments near by such as the Baldwin on 14th that are included in the "new Yesler Terrace" and the development of one million squire feet of commercial and office space just adjacent to Harborview Hospital. Yesler is a huge development and the same streets that serve Swedish Cherry Hill, Seattle University (they plan to increase student population by up to 5,000 students), Harborview Hospital and Swedish First Hill and in the testimony, Virginia Mason as well, will be greatly impacted.

I was taken aback to hear that Yesler Terrace was deemed "too far away" but that Virginia Mason was "close". Please consider checking a map as these two are about equidistant to Swedish Cherry Hill and therefore, Yesler Terrace must be added into the traffic study as to traffic impacts if the study is to be valid.

Without including Yesler Terrace the proposed Swedish Cherry Hill expansion should not be approved.

Sonja Richter

Sonja Richter
827 17th Ave.
Seattle, WA 98122

STEPHEN E. HEANEY

July 13, 2015

City of Seattle
Hearing Examiner Office
P.O. Box 94729
Seattle, WA 98124-4729

Re: Swedish Medical Center Cherry Hill
Application Number 3012953

Hearing Examiner:

I am a property owner at 706 16th Avenue (Seattle 98122). I have read the final MIMP; the originally proposed MIMP; the Final Report and Recommendation of the CAC dated 5/20/15; and the Analysis, Recommendation and Determination of the Director of the Department of Planning and Development (DPD). I am writing in support of the appeal, which has been raised to the EIS.

I am struck by the contrast between the statement of intent found in the City's Municipal Code relating to a Major Institution Master Plan (MIMP) and the recommendations laid out by the Director of DPD. I find it very difficult to see exactly where the balance has been struck between the need of the institution to develop healthcare facilities and the need to minimize the impact of said development on the surrounding community.

It is astonishing that in all of the material that has been considered, there is really very little in the way of a demonstrated need for additional development of the Swedish campus to allow it to fulfill its mission; what is missing is the very essence of the hospital's space needs, without which it is impossible to consider how a balance has been struck. I am shocked that a fairly generic explanation of how healthcare in general has been developing serves to underpin the assertion of Swedish that it must almost double its campus square footage in order to provide healthcare services to the community. Surely, this "evidence" is not what was intended for an Environmental Impact Statement to review, when the law was written. When no proper justification has been provided, there can be no proper review, comment, and resolution of concerns. This lack of documentation is even more intriguing when one considers that in 2002, Swedish declared it was "right sizing" its facilities by selling off "excess" areas to a third party. Again, the EIS should have specifically addressed the need for additional facilities, which Swedish should have been required to detail, but rather than address specific space needs, the EIS was developed based on vague industry-wide metrics.

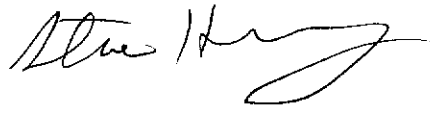
706 16th Avenue, #102 Seattle, WA 98122 Telephone: (323) 934-9392

The sheer scope of the entitlements being sought, and granted by the Director of DPD, is breathtaking. Swedish suggests that its services have benefited the community by treating community members who could not pay for its services. No mention is made of the benefits accruing to Swedish with its proposal to almost double its size. Granting these entitlements bestows significant monetary benefits to the owners of that property--in exchange for what? A neighborhood will now be faced with a massive, bulk-scale density that is completely out of proportion to anything in the area. And what have the neighbors been offered in return? Nothing.

The intensity of the development being recommended is absurd when posed against the background of the existing neighborhood. In terms of traffic alone, the Swedish campus already impacts the neighborhood with significant traffic congestion. What will happen when the campus is built out to its new dimensions? The Director of DPD notes that Swedish will amend its TMP to provide a SOV commute rate goal of 44% upon completion of the build out. The former MIMP required Swedish to establish a goal of 50%, which has never been met...since 1994. Where are the mitigations for the neighborhood? Where are the requirements to measure and enforce this new level? How can this possibly satisfy the requirements for an adequate EIS?

I urge you to reject the recommendations of the Director of DPD; find that the EIS is inadequate; and require Swedish to work with its neighbors to arrive at a plan that actually accomplishes the intent of the MIMP.

Respectfully,



706 16th Avenue, #102 Seattle, WA 98122 Telephone: (323) 934-9392

6 July 2015

City of Seattle
Hearing Examiner
P.O. Box 94729
Seattle, Washington 98124-4729

To the Hearing Examiner:

I have lived at 620 – 20th Avenue, near Swedish Hospital, for over 15 years. This vibrant residential neighborhood is home to people of different income levels, races, and ages. We all treasure our neighborhood's character.

This neighborhood is now gravely threatened by the proposed expansion of Swedish Hospital's Cherry Hill campus. The Department of Planning and Development has recently approved changes to Swedish's MIMP that would allow this dangerous and unnecessary expansion.

I want to join with the many neighbors who who have spoken against the expansion project and who are appealing the DPD's decision now. The proposed new developments at Swedish by Sabey Corporation are a terrible idea.

The proposed new developments are out of scale with our residential neighborhood. When neighbors resisted Children's Hospital's recent expansion, their activism capped building heights at 125 feet, the maximum height appropriate in a residential neighborhood. **Our racially and economically diverse neighborhood is as worthy of this consideration as rich, white Laurelhurst.**

Traffic increases associated with the expansion would harm cyclists, pedestrians, and neighborhood motorists. Swedish has a long history of failing to mitigate the negative effects the cars of their staff and patients inflict on our neighborhood. **If they can't or won't manage the traffic they create now, how can we expect them to cope with an increase?**

Finally, **more medical development in our neighborhood is not needed**. Swedish is not proposing expansion to provide medical care to our underserved families. Rather, they are partnering with a profit-hungry developer, Sabey Corporation, to build high-tech specialist medical office space that will not improve the health of our neighborhood.

Please correct the error of the DPD by granting this appeal to stop Swedish/ Sabey's expansion project and their new MIMP. Make Seattle city government an advocate of citizens in this case, not of greedy developers.

Thank you,

Tatiana Masters
620 – 20th Avenue
Seattle, Washington 98122
(206) 380-5921

July 21, 2015

To: Hearing Examiner Tanner
From: T. Murray Anderson
1607 E. Jefferson St
Seattle, WA 98122

Regarding: Swedish Hospital-Cherry Hill Expansion Proposal

I ask that the Hearing Examiner reject this proposal.

The size of this proposal and the height, bulk and scale of the buildings proposed are totally out of proportion to and not appropriate for this residential neighborhood. To build such large and imposing structures in this neighborhood will overpower the neighborhood and will completely change the character of the neighborhood.

The number of additional people that will be brought to the neighborhood if this project is built as proposed will have a significant impact in terms of the volume of traffic on the streets. I believe the increased traffic will also bring increased risk to the safety of pedestrians in the neighborhood.

This added traffic will exacerbate an already existing problem with on-street parking in the neighborhood. During the CAC process, we were told that patients can get validated off-street parking in the garage but from the number of people who continue to park on the streets, it seems that they are not aware of this, if it is indeed true, or that there are other limitations on receiving validation.

My residence is directly across from Jefferson Tower. I have an ongoing problem of people, mostly going to the hospital, parking across my driveway, blocking me from going out or coming in. Typically, this happens at least once per week, though two or three times in a week is not uncommon. I have also had multiple incidents during the same day, as many as three on a single day.

The curb is painted bright red and I make a point of keeping it painted to make it clearly evident that it is a driveway. In spite of this, people still do not to notice. All they see is a space between two parked cars. Usually they are people going to

the hospital and are in a hurry. Typically, they park their car, get out on the driver's side and walk across the street without out ever turning to look back. For many it is only after they have received a parking citation that they realize it is a driveway.

When I am find my driveway blocked out after being away, I must find on-street parking until the problem is resolved and that can be a challenge. I only expect this will become more of a problem if hospital traffic into the neighborhood increases. While this is just my experience with parking problems, I know that there are many others. Many residents in the neighborhood do not have off-street parking available. We who live in this neighborhood can only anticipate that the problems will get worse.

As for public transportation into this neighborhood, as was stated at the Hearing the #3 and #4 lines are the primary lines serving this neighborhood. Though they are spaced so that the buses are usually not more than 10 minutes apart, still during the day it is not unusual for it to be standing room only by the time the bus turns from 3rd Avenue onto James Street. At least twice during the week of the Hearing, the bus was full—standing room only—by the time it reached 5th Avenue.

On some days many of the riders get off between Harborview Hospital and Seattle University but there have also been days when I have had to stand from downtown all the way to 17th and Jefferson, at the hospital.

This situation is likely to only get worse as more people who depend on public transportation come into the neighborhood due to increased traffic to Swedish-Cherry Hill. This is also a reason buses are not really a viable means for Swedish-Cherry Hill to decrease SOV traffic of its staff.

The noise during both demolition and rebuilding at the hospital will be a serious disruption to the neighborhood. In some areas of the city construction can begin as early as 7:00 AM and can go as late as 7:00 PM. In addition, the truck traffic will be constant throughout the day, further impacting streets that already are carrying a significant traffic load. Most of that traffic will be on residential streets given that the hospital is in a residential neighborhood.

insisted they must be on the Cherry Hill campus. When asked many times if there was any other space available, specifically if there was space in James Tower that could be recovered or how much space might be vacant there, they either sidestepped the question or refused to answer.

Most of us in the neighborhood do not have a problem with Swedish-Cherry Hill being part of the neighborhood nor do we begrudge their wish to grow and to better their service to the community. We just believe that the proposed project is too big to be put into this neighborhood and that the hospital campus is simply too small for a project of this size.

It is my hope to continue—as is the hope of many of my neighbors—to live in this neighborhood for many years to come and to experience a quality of life that comes of being in my own home in a neighborhood. However, I feel that all of this will be jeopardized and that the neighborhood will become less livable if this project is built as proposed.

I appreciate the opportunity to express my views and I hope that the Hearing Examiner was able to take the time to read this in its entirety. I realize that it is a long document but I believe that that is commensurate to the size and scope of the changes that are being proposed for my neighborhood.

Thank for hearing me out.

Sincerely,

T. Murray Anderson

Troy Meyers
1705 E. Columbia Street
Seattle, WA 98122

Tuesday, July 21, 2015

Examiner Tanner
Hearing Examiner
PO Box 94729
Seattle WA 98124-4729

Examiner Tanner,

An additional issue came to light that I wanted to share with you. It is an exchange that I had last week with Sherry Williams, Community Engagement Director, from Swedish. While this might seem a little petty, I think it is illustrative of how Swedish deals with the community.

On my way to the hearing last Monday morning, I noticed that the entire north side of the Cherry Hill campus was marked with construction tape and no parking signs. This was a bit of a surprise as on Sunday afternoon none of this was present. Per Seattle policy "You should verify that the 'No-Parking' easels are in place and properly marked at least 72 hours in advance." I did not have time to thoroughly look at the situation; so I did not take any action until I had my facts straight. On Monday evening I walked over and confirmed that Swedish or their vendor had not complied with the requirement that "printed Public Notice affixed to at least two signs per block prior to the temporary no parking zone going into effect". There were no printed public notices anywhere that I could find.

On Tuesday morning, before the hearing started I mentioned to Ms. Williams that there was work going on and It did not appear to be in compliance with city rules. She became defensive and I told her that I was just letting her know, so she could follow up with the vendor or facilities. I did not hear back anything and Wednesday morning Ms. Williams was not at the hearing so I sent a quick email letting her know it was still an issue and asked her to follow up with me.

I did not hear back, so, Thursday morning I sent another quick email letting her know it still appeared to be an issue. I got a reply simply stating that there was a permit on site. I followed up letting her know I was not able to locate the permit and asked if she was sure that they were in compliance. She simply replied with "Contact the City of Seattle" and a second email with just the word "Yes."

This is/was not about getting Swedish in "trouble." This is about Swedish working with the neighbors to address concerns in an appropriate way. If this is what we have to look forward to once construction starts, the relationship with the neighborhood will only continue to deteriorate. That is unnecessary and unfortunate.

Considering her role and my relationship as a community representative I don't think it is unreasonable for me to expect her to followup appropriately or at the very least make a warm

handoff to someone who can help resolve the concern. Below is the full email thread(Example A) for your reference as well as a photo(Example B) showing that they are not in compliance. I have additional photos of both sides of all signs to fully document the issue. The SDOTs policy is posted at http://www.seattle.gov/transportation/parking/tempnoparking.htm.

As the city tells me this is also a violation, I want to make you aware of an additional issue. On Friday, the final day of their work at the campus, I noticed a concrete truck spilling a white slurry, starting at the campus and continuing for blocks to the north. I am sending a letter to Swedish facilities asking them to address it but if current a past responses are any example, it will simply be ignored or dismissed. Photos(Example C) of that are also included below.

It is also important to note that this is not an isolated example. We have had many neighbor complaints escalated to the community council over the years related to noise, parking, traffic, littering/dumping, loitering etc. Unfortunately, Swedish will only engage in a dialogue when publicly called out on a concern.

Thank you for your time and consideration in this matter.

Sincerely,

Troy Meyers

Troy Meyers

Email Thread - Example A (Reverse chronology, read Up)

Troy Meyers <troy.meyers@squireparkcc.org>
11:59 AM (34 minutes ago)to Sherry
I apologize for not getting back to you last week. I must admit, I was taken aback by your reply. Considering our relationship, and what we are currently working on, I would have hoped that you would be more engaged and proactive. We are on different sides on the expansion but I did not think that meant that you were unwilling or unable to be an active participant in the community.

-- Troy

On Thu, Jul 16, 2015 at 2:47 PM, Williams, Sherry <Sherry.Williams@swedish.org> wrote:
Contact the City of Seattle

Sent from my iPhone - Sherry Williams. ;+)

On Jul 16, 2015, at 2:43 PM, Troy Meyers <troy.meyers@squireparkcc.org> wrote:
I could not find it. Is your vender is in compliance with SMC?

On Thu, Jul 16, 2015 at 12:29 PM, Williams, Sherry <Sherry.Williams@swedish.org> wrote:
Yes there is a City of Seattle permit on site.

Sent from my iPhone - Sherry Williams. ;+)

On Jul 16, 2015, at 10:40 AM, Troy Meyers <troy.meyers@squireparkcc.org> wrote:
The work continues this morning and still no permits are posted.

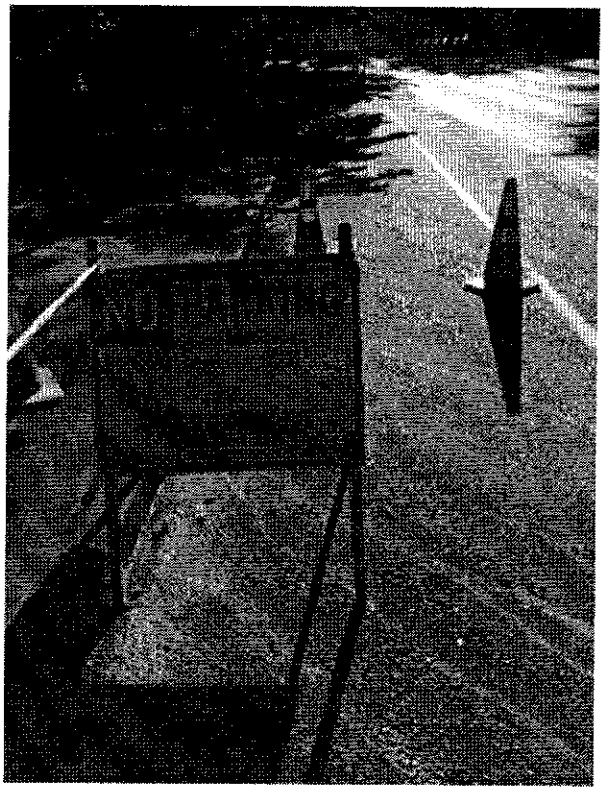
-- Troy

On Wed, Jul 15, 2015 at 9:37 AM, Troy Meyers <troy.meyers@squireparkcc.org> wrote:
The work that I spoke to you about yesterday on the north side of the Cherry Hill is continuing today. As yesterday, none of the temporary parking signs have permits attached as required.

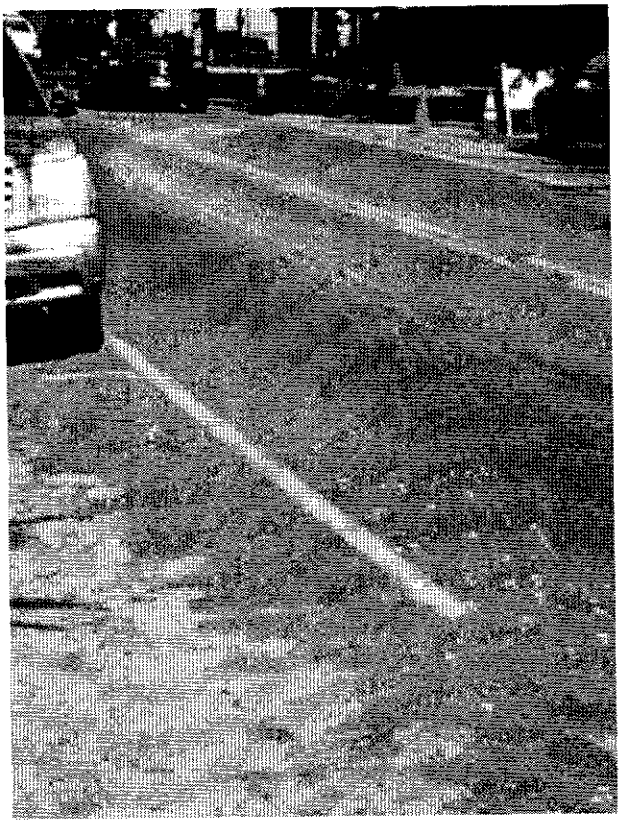
Could you please check into this and report back.

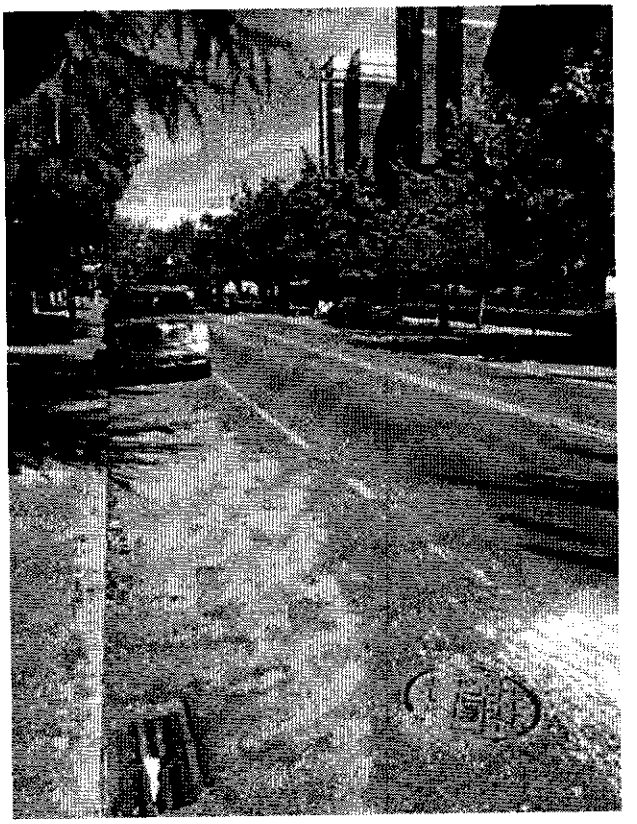
Best Regards,
— Troy

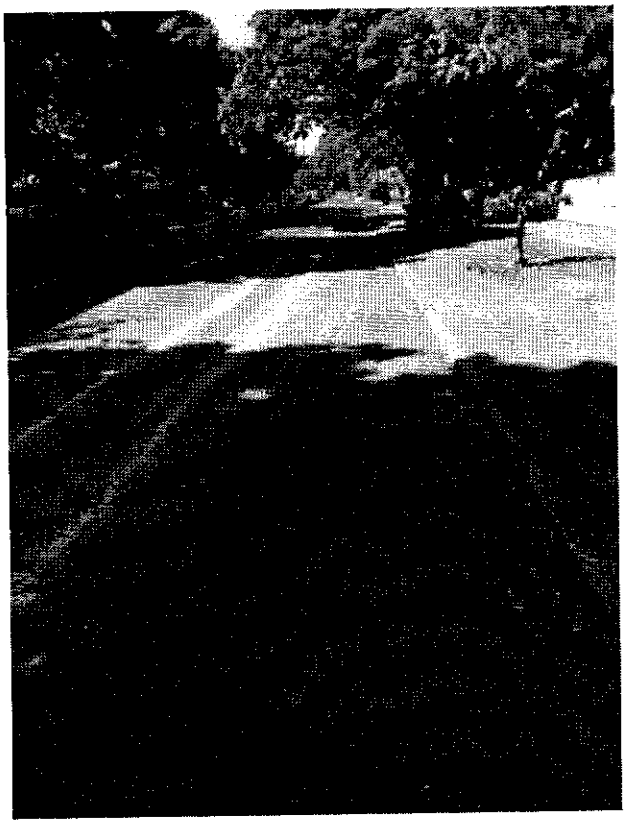
Example B

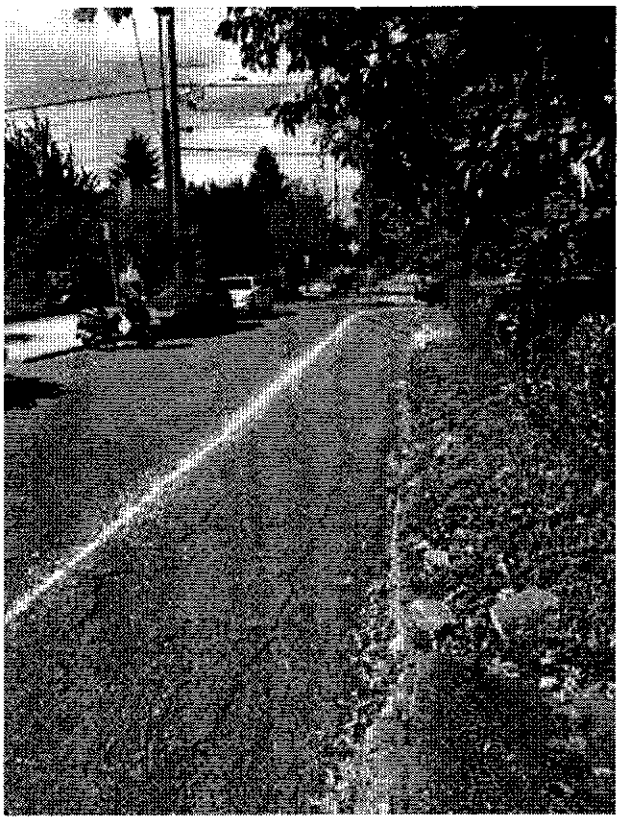


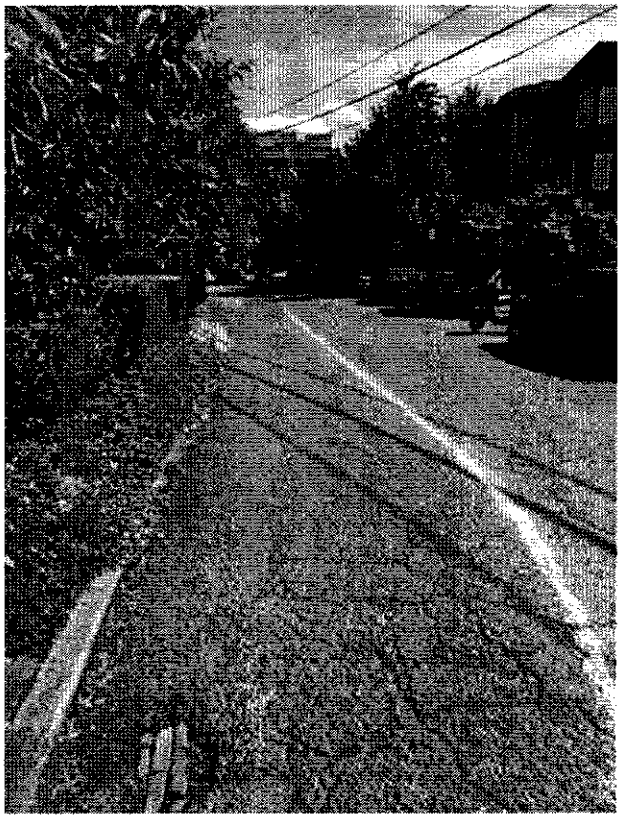
Example C











Troy Meyers
1705 E Columbia Street
Seattle, WA 98122

Monday, July 13, 2015

To Whom it May Concern,

I am Troy Meyers, I live at 17th & Columbia. I am an appellate against the expansion. I'm a member of the Squire Park community Council and I chair the East Precinct Advisory Committee.

The MIMP talks about need and lays out a case for why Providence and Swedish want to expand. I think it's important that we talk about that.

In 2002, after Swedish acquired the Cherry Hill campus they were very public about saying they did not need, at that time, or in future, much of the space on the campus. They did not talk about operable aggregation or deployment of capital as they do now in the MIMP. As we have heard several times now, Marcel Loh, then chief operating officer for Swedish Medical Center/Providence said he "would call it right-sizing the campus" and that "the hospital saw little need to keep the Providence building, which is used mostly for lab space and support services." As a result, Sabey purchased 40% of the campus and began development on a speculative biotech facility. Less then a decade later, Providence's business plans for the Swedish brand changed. Rather than buy back or lease space from Sabey they decided that they needed to expand. This is surprising because Sabey's speculative biotech project failed. That space is now used by Seattle University and private for-profit businesses. We have LabCorp, not serving the campus or just Swedish, but serving doctors offices and other facilities region wide. We have an Inn that supports the entire Swedish System. They tell us it needs to be on the Cherry Hill campus to be convenient for their patients families, this is odd because, while 8 miles away, they publish literature telling families of patients at the Ballard campus that it's convenient to them. The Ballard campus is in an urban village, the First Hill campus is in an

urban village; those locations are better suited to these uses under the cities comprehensive plan. If 8 miles southeast of Ballard is convenient then it follows that 8 miles northwest would be equally convenient for Cherry Hill's families.

It is not surprising that these contradictions exist. The truth is that the expansion isn't based on an aging or even a growing population, those are only part of the equation. The expansion is really about eliminating competition taking marketshare away from other private and public healthcare institutions. This will result in less choice and more expense for our city.

Providence's market expansion plans for the Swedish brand are only part of the story. What we don't know is what are Sabey's mission and needs. When I look at the title page of the MIMP I understand why Callison Architecture would help develop Swedish's plan. But, why is Sabey a developer and property manager helping to develop the MIMP. Sabey is not just a vendor or business partner they own part of this development.

The MIMP process says that because of the public benefit of educational and medical institutions to our region they deserve a special process. I do not support Sabey, a for-profit developer, taking advantage of this process and the MIO. The law was clearly intended to provide for nonprofit medical and educational institutions, not private for-profit real estate developers.

Some items require clarification:

At this hearing, for the first time, it was confirmed that cardiac was to move from Cherry Hill to First Hill. In Mr. Cosentino testimony he said that at some point in the future it would be evaluated to possibly move back to Cherry hill. The fact is the the doctors of Swedish Medical Group have been told that they are moving permanently to a purpose built on the First Hill campus. I am sure that in a system as complex as Providence that all facilities are always being evaluated. While not an outright lie it is certainly disingenuous to suggest it may move back when that is not a reasonable expectation for the foreseeable future. It is clear why they took this tack, had they been more transparent it would have undermined their statement of need.

Mr. Cosentino also stated in his testimony that Providence/Swedish had no choice but to build up because they had elected to not pursue an MIO boundary

expansion. This is false. The original proposal had both a MIO boundary expansion and the 240' tower.

Mr. Cosentino as stated that neighbors suggested that the the *campus be closed* and *move everything to First Hill* or *move everything to UW.* I was at every meeting but one and spoke to many other attendees at that and other meetings and nobody recalls these statements. There is no references to that in the EIS appendixes.

Mr. Hoffman, in hist testimony, misstated this as a public/private project. He also stated that as a non-profit Swedish reinvests 100% of their profits, this is required by law but Providence is very adept at managing "retained income" vs. profits.

There is a significant difference between mitigation under the proposed EIS and public benefit. It is not reasonable to take what they are legal required to do whether this proposed projects are built or not and then say they should be able to build their projects as if this benefit is new. They have also chosen to take bad debt and report it as a lose and also move it under charity care.

Ms. Sherry Williams stated that she regularly attends the Squire Park Community Council meetings. That is true, what she did not mention is that She as been disruptive and also been argumentative and disrespectful to the chair and the members.. Even long after the council adopted a position on the MIMP she demanded equal time to and was clearly their more as a monitor then to participate in the process.

It has been pointed out multiple times that mitigations and community benefits that were promised under the 1994 MIMP and EIS never materialized and the city never held Providence/Swedish and Sabey to them, even after the community protested. It was not until two years ago that we began to see any moment and then only on items that they deemed a risk to their future plans. Now they say trust us but we have decades of bad behavior and we require something far more concrete then *trust us.*

It is offensive that Providence/Swedish have played off of the fears of their patients. Not presenting this as how they will be able to treat additional patients

but how if these plans are not allowed the care will not continue to remain at Cherry Hill or possibly even elsewhere.

Provenience/Swedish has presented witnesses and nurse managers who have made public comments about the importance of having services collocated. Sabey and Provenience/Swedish told us how important the lab is to their success but they have not stated plans to incorporate a lab at the First Hill campus where they are moving services from Cherry Hill. They also choose to outsource this key resource to a vendor for cost reasons. This vendor does not just process tests for the campus or even just the system but for other institutions and doctors offices in the region.

In the public comments in support of the plans, everyone, detailed how great the care is now working with what what they have. Only a handful of those comments detailed additional need and of those indicating need many are more reflective of staffing or far worse, the delaying needed improvements for business reasons such as this expansion. They long ago stopped maintaining parts of the campus. I understand the need to manage the business side of medicine but it is inappropriate to solicit comments of need, as they did, from employees based on these business decisions.

This project is simply incompatible and in conflict with with the cities comprehensive plan. The hight, bulk, scale, intensity and density of these plans is incompatible with the livability of the sounding neighborhood. The *number* of significant unavoidable impacts as detailed in the EIS, along with the fact that this area is designated as a residential urban village demonstrate that that proposed plans can not be absorbed without significant impact to the character, vitality and livability of the entire Central Area,.

The city of Seattle identifies has identified many unavoidable impacts. That is not accurate. Providence/Swedish and Sabey could have, should have and still can work with the neighbors. They characterizes the neighbors as unreasonable. The fact is that they never came into the established community groups to work with the neighbors. The neighbors were expected to come to them.

Most if not all of my neighbors understand and expect our neighborhood to change to support the needs of our growing city. We hear our elected officials, educational institutions and the media talk about a lack of housing. What we don't understand is a proposed development with this height, bulk, scale and intensity being placed in a *residential* urban village. In both current and future plans, the city has specifically identified our neighborhood surrounding the campus as being residential. We're not supposed to be a live/work hub, shopping or transit hub. We are designated residential. We don't have the infrastructure to support a campus of the proposed size.

The proposed expansion will increase noise, pollution, flooding, and congestion. It will decrease safety and livability.

In addition to the introduction above, am also a long time neighbor, a patient and a customer of the Cherry Hill campus. I support and donate to Swedish. I recommend Swedish programs and physicians. Many of my friends work for Swedish. I support Swedish in just about every way possible except for the proposed expansion.

This is been a long painful process for everyone involved as I'm sure is evident by the record number of CAC meetings, public comments, appeals and dissenting minority reports. We've stayed engaged because we have faith in the objectives of the process to balance the needs of the major institutions development with the need to preserve the livability and vitality of our neighborhood. The Central Area's livability will be irreparably harmed due to the lack of transitions, height, bulk, scale and intensity of the proposed project and its traffic and infrastructure demands.

Due diligence was not done. Reasonable alternatives failed to be investigated and identified mitigations are inadequate or incorrect.**The considerable number of these unmitigable impacts will fundamentally change the character and livability of the Central Area. I urge the hearing examiner to reject the EIS as submitted and support the CAC minority report as submitted by Dean Paton.**

Best Regards,

Troy Meyers

Troy Meyers

SWEDISH CHERRY HILL [redacted] MAJOR INSTITUTIONAL MASTER PLAN COMMENTS

Overview

As the Vice-Chair of the 1994 CAC and representative of 19th Ave Block Watch/Squire Park Neighbors, I would like to provide my comments of the current Final MIMP that has been released on December 11,, 2014. After an extensive review of both the current MIMP and other MIMPs that have recently been enacted within the City of Seattle, the current MIMP appears to be grossly out of context with the surrounding neighborhood and unique in the disparity between the heights proposed within the campus and the prevailing heights outside of the campus. Swedish continues to exhibit a "campus only" mentality in the design and construction of the MIMP. This focus on only those activities on their own campus hinders the ability of the institution to understand the neighborhood context and deliver a plan that is successful in balancing the needs of the community and the needs of the institution. This mentality is also in conflict with the Seattle Municipal Code (SMC) itself, which requires striving for a balance with Major Institution growth and mitigating impacts on the existing neighborhood. The SMC recognizes the inherent conflict between major institution structures being out of place in bulk, scale, and intensity within residential neighborhoods.

Alternatives 2 through 11 were significantly similar and unacceptable. Alternative 12 was developed in time for the final MIMP. If the CAC had been able to start with plans that were similar to what is currently presented, a realistic alternative may have been developed over the past year, but this was not the case. In particular, the plan appears to be based on a few faulty premises, including:

- That the campus is located in an area designated and appropriate for major institutions, and not a residential neighborhood.
- That the central plaza is considered open space and that the proposed open space is a net increase of open space since 1994.
- That the heights proposed are compatible with the residential neighborhood.
- That the transportation management plan is adequate.
- That the setbacks are adequate to mitigate the height.
- Rezoning the underlying zoning will make the structures automatically transitional.

Following extensive discussions with the Citizen Advisory Committee and months of community input, the proposed Major Institution Master Plan is still inaccurate. These issues result in a plan that is unrealistic for any community and that will be detrimental to the overall neighborhood, if Alternative 12 as proposed is approved. Swedish should revise Alternative 12 and present more realistic alternatives for CAC review featuring lower heights, greater setbacks, and a better utilization of all parcels located within the MIO boundary:

- A final plan should be rejected unless it is substantially accurate and complete in its factual presentations.
- The face of the document includes Sabey Corporation as a listed major institution partner in the development of the MIMP application. This highlights a major failing in that the SMC does not contemplate a non-hospital entity be identified as the major institution. The plan is supposed to be exclusively for the hospital/medical center and its mission and goals.
- The proposed height, bulk, scale, density and intensity of the plan are incongruous with the neighborhood.
- The proposal to change underlying zoning should be denied. It is unnecessary except to allow other development inconsistent with the MIMP.
- Any promises of neighborhood mitigation and/or amenities must be tied to development milestones.
- No accommodation should be made to allow unlimited computer server space in addition to all other development.
- Transportation management must be enforceable, given the institution's failure to comply with its previous plan over the last 20+ years. Efforts to comply have only begun within the last three years due to the desire to begin new construction on the site.

Background, Purpose and Process

This section fails to state that a project application was deemed a "major amendment" to the 1994 plan, necessitating the initiation of a new MIMP process. This planning process is not entirely voluntary on the part of the institution – it is the result of a Hearing Examiner decision.

The MIMP does not balance the institution's ability to change and the public benefit derived from (that) change with the livability and vitality of adjacent neighborhoods." There is no specifically articulated public benefit to the surrounding neighbors – only aggregate listings of all of the things Swedish does throughout its service area. The MIMP does not demonstrate how it balances the livability and vitality of the adjacent neighborhood.

The timeline also fails to show a date on the CAC recommendations, failing to note the decision making process and failing to note the CAC unanimous rejection of the preliminary draft master plan, to which this document is substantially similar.

"...provided for nine new buildings and a total of 682,500 sf of additional Space..."

This should read, "...provided for nine new buildings totaling 682,500 sf of additional space..." The 1994 MIMP did not allow for nine buildings of X space and then an allotment of additional space. The additional space was comprised of the buildings itself. Under the old MIMP code, discrete building projects provided the public with a sense of predictability and the opportunity to discuss in concrete detail how those projects would meld with the surrounding community. It also requires the hospital to have, and articulate, a clear vision for the future and its role in both the neighborhood and region.

This is an important distinction as the new plan is not project based, but rather provides for a square footage allotment with restrictions placed on that development area "cache". The

purpose of this was to provide the institutions with flexibility to adapt to changes over time, but it has also resulted in some negative side effects. Under the new guidelines, major institutions are incentivized to push for the maximum amount of development area that is politically feasible and neighbors are left with greater uncertainty about what the final campus will look like. This uncertainty increases the importance of the various zoning and other requirements included in the master plan.

The CAC and the City of Seattle should push to enact strong requirements across all elements of the plan to ensure that there is an appropriate balance between the needs of the community and the needs of the institution. The new MIMP code for plan-making has shifted the balance away from the needs of the community, which makes stricter restrictions both necessary and appropriate to maintain this balance as seen in other MIMPs (e.g., Children's Hospital).

"Key milestones in the process to-date include:"
As a note to any City employee or commissioner, it should be noted that the CAC rejected the Preliminary MIMP and EIS in November 2013. These documents were deemed insufficient and lacking in content, substance, and analysis. This rejection was unanimous among the voting CAC members attending that meeting and echoed in all the public comments made and submitted.

Mission
In discussing community benefits under this section, the draft fails to disaggregate all community benefits to show what this particular institution provides. This is not a MIMP of the Swedish system; it is the MIMP of the Swedish Cherry Hill campus. For example, while the Swedish system is offering 48 classes and workshops to the public during the month of July 2014, none are offered on the Swedish Cherry Hill campus. While the Swedish system is offering 43 classes during the current quarter in 2015, three different classes (one offered twice for a total of four classes) are offered on the Swedish Cherry Hill campus. Without a detailed description of benefits of this particular portion of the Swedish system, it is not possible to show any balance between the institution and the neighborhood.

The listing of services on the campus include, on its face, many which do not need to be accommodated on the campus and could locate elsewhere within the Swedish system, including:

- Seattle Science Foundation
- Telehealth Center
- LabCorp

The failure to fully inventory existing uses on the campus makes it difficult to impossible to understand need as it drives the request for massive development and expansion.

Regional Demand
The MIMP asserts a growing demand for services, while reports filed with the Washington State Department of Health show a declining use of hospital beds at the facility. They admit that beds

authorized under their state certificate of need are currently going unused, and then assert they will be needed in the future. There is no evidence provided that this is true.

The assertion that the affordable Care Act will increase hospital admissions is contrary to the policy goals of the act – namely that hospital use will go down with more people being able to access primary care. At Harborview Medical Center emergency room use is falling dramatically as more people are signed up for Medicaid and referred to primary care physicians.

Research functions are prestigious but are not a necessary component of a hospital. Swedish has other property nearby that can accommodate research. In other institutions, research is an integral component of treatment, not requiring significant additional space and/or located in another location. Group Health Cooperative uses the Minor Ave Towers for its research, away from its Capitol Hill campus.

On most other campuses, research functions are integrated and conducted by the medical entity itself (e.g., research at Children's Hospital on pediatric cardiology is embedded in the care of the patients itself). On other campuses, research functions are carried out at off-campus locations using non-profit healthcare provider staff and patients (e.g., Group Health Cooperative). Here there is no real clear delineation between the healthcare provider that is requesting the variance from the established zoning norms and the research conducting the research functions.

Laboratory services that serve a variety of institutions are not logically located at the smallest of those facilities and should be located at its larger campus if they are truly striving for the efficiency. LabCorp currently uses a fleet of twenty (20) vehicles to collect lab specimens and deliver lab results to and from other area hospitals. These vehicles are on the road throughout the day.

This statement attempts to address the rental of space to nonhospital "related" services. In this case, the particular lab service is provided by LabCorp, which provides services to a large number of medical care providers in the region from their rental Cherry Hill space. As a third-party renter, this would be an example of a situation where the neighborhood would question whether or not the issue is actual need for new space or an inflated development need caused by profit-driven decisions on space allocation. It is important to note that LabCorp is merely an example and should not be construed as the sole instance of this. These additional non-Cherry Hill functions place pressures on the space being requested. Many of the additional for-profit medical office rentals may well have a similar type of regional function and loose relationship with the actual campus itself.

Yes, it is helpful to have a full lab on campus, but not a regional and non-campus service. It is not helpful when Providence/Swedish shut down its own lab facility and laid-off all those employees so LabCorp could relocate it service to the campus. These specific additional impacts caused by regional services, as exemplified (but not limited to) the operations of

LabCorp currently, is what is called into question, especially when it is marketed as creating jobs.

As a specific example of these impacts and the correlated pressure that these services place on space needs, LabCorp maintains a fleet of vehicles at Cherry Hill that serve as couriers for samples collected throughout the region.

A conservative estimate of the vehicles present is 20 LabCorp vehicles consuming 20 parking spaces in addition to an additional 80 spaces that are reserved exclusively for LabCorp employees. For regular labs that serve an institution, these courier vehicles are completely unneeded. This logically implies that these 20 spaces are not required by the needs of the campus, but the traffic and additional development required to accommodate these vehicles create impacts on the community.

A conservative estimate on the space requirements for these 20 vehicles is approximately 325 square feet per parking stall. This results in 6,500 additional square feet of space "required" on the campus caused by non-campus services (approximately the same size as a 7 bedroom mansion). This number excludes circulation required for the vehicles to maneuver into the spaces.

This additional need is not caused by the essential functions of the hospital, but rather choices related to space allocations. These 20 stalls reserved for regional services represent approximately 3% of the additional requested parking spaces in Alternative 9 or 10, or 2.5% of the additional requested parking spaces in Alternative 8. Local residents are justified in asking what percentage of the parking and total development requested is induced by similar regional and/or profit driven choices, as opposed to the actual functioning of the hospital. A satisfactory answer has not been presented as Swedish continues to make assertions as above that imply that so long as they derive some benefit, then the space required is immune to scrutiny and should not be further questioned. In light of the fact that additional space is currently rented for regional and primarily non-campus functions, this should not be the case.

There may be other tenants with similar characteristics, but this is not possible to discern since the document lacks sufficient information on other uses located on the campus.

It would be informative to know how the total planned hospital capacity, across all hospitals (or even all hospitals within the Swedish/Providence network), meets or exceeds the regional demand. There are currently large scale expansions planned at Harborview Medical Center, Virginia Mason, Swedish First Hill, University of Washington Medical Center, Seattle Children's Hospital, and, now, Swedish Cherry Hill. The same rational about regional demand and aging populations exists in all planning documents for all of the other hospitals as well.

This, however, assumes that the hospital and campus are not part of a network and that any increase in demand associated with the factors identified must be located in a particular place or that emergency and specialty care usage will increase. This is a simplistic model of demand

and growth and is likely to prove to be false. A preliminary outcome of the enactment of the new health care act is showing hospital and emergency care usage are declining while primary and preventive care usage is increasing.[1]

Programmatic Needs

While several program components are listed in the document, public discussion has revealed that the institution is simultaneously considering moving some of those functions elsewhere in its large system, such as the cardiac programs. As such, this section needs a more truthful explanation of need and potential variability of need.

Neighborhood Context

The description is inaccurate, since Swedish First Hill and Harborview Medical Center are located in the adjacent neighborhood of First Hill. 12th Ave is the natural and designated boundary between First Hill and the Central Area.

This section also fails to note the sequential migration in and out of Catholic, Jewish, and then African-American populations, each moving on as discrimination lessened (either by attitude or legal action to end redlining). The Central Area, including Squire Park, has historically been a diverse residential neighborhood, which is becoming gentrified since redlining practices have declined. This illustrates an ongoing lack of understanding of the neighborhood and its evolution over time.

The references to the commercial and industrial zones around 12th Ave fail to mention that this area is part of an Urban Village. Only one block without a sidewalk exists in the surrounding neighborhood.

Modifications to Development Standards

Where the document discusses transition to the adjacent residential neighborhood, it fails to note that the massive façade of James Tower was developed in apparent violation of the former MIMP and SMC. It was approved without input from any Standing Advisory Committee (SAC) as required by law, and is a massively larger structure than the former MIMP allowed.

The 1994 plan called for addition of a "60-bed project" described as a "skilled nursing facility [that] would be two stories (28 feet) and would have approximately 24,000 square feet." What happened instead was a vastly larger James Tower (how much larger is difficult to determine, since its square footage is not detailed in the Final MIMP). Swedish currently describes the building as "a state-of-the-art medical office building and now houses physician offices, education, and research facilities."[2]

With no SAC to make official comments during the permitting process, there was no formal process for negotiating mitigation for a project much larger than originally approved – a

[1] See "Safety-net hospitals reaping benefit of more insured patients", Seattle Times, May 27, 2014.
[2] Pg. 7.

development that would have likely triggered this new MIMP process a decade ago[3]. This could have also been the trigger for Swedish/Sabey to provide plans for loading berth code requirements, rather than be in non-compliance.

The CAC attempted to consider how this bulk and scale, much larger than anticipated in the previous plan, can be mitigated now – and that is likely through keeping development east of James Tower across 18th Ave at a transitional scale no higher than the 37 feet anticipated in the prior plan[4], in smaller buildings spread along the double-block, rather than one or two block-long buildings.

The proposal for 45' development envelopes on the east side of 18th Ave is out of scale with the adjacent single-family homes it abuts, especially considering the proposal for only a 25' setback from the rear property line and is at the top of the hill. And if 37' high buildings are too tall on small lots in residential neighborhoods (City Council recently restricting such housing to 27') a 600 foot long 37' - 45' building within 25' of the lot-line is surely too tall to be a transition to the residential neighbors.

Development Program

The discussion of "current envelope heights" is in error. There are no current envelope heights and never were. The former 1994 plan approved discrete buildings at specific locations. That plan is now expired, and the applicable zoning today is SF-5000 and LR-3. This is the first plan for the campus that is structured around development envelopes.

Alternative 12

The alternative fails to discuss suggestions that some buildings could be done below grade, although that development would not count toward allowed square footage. Group Health Cooperative has placed some of its development below grade, and a similar design should be considered here. But it is unclear if they plan below grade development to locate more or more intense functions on the campus, which would then drive traffic and other impacts. There has been some verbal reference to such development in CAC meetings, but since it is not governed by a MIMP, and nothing is articulated here about it, it is impossible to know and comment on this further.

The discussion of owned, leased, and non-owned properties fail to discuss that the majority of non-owned properties are former hospital properties sold, traded, or transferred to Sabey Corporation. Property ownership needs to be clearly shown and spoken about, especially since Sabey Corporation is listed at the front of the document as a partner in developing the plan.

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[3] The former MIMP ordinance required new plans be drawn up when certain triggering events, such as an application for a major change in the existing plan, occurred.

[4] The 37' limit and scattered buildings were originally articulated in a 1988 settlement agreement between Squire Park Community Council and Providence Medical Center (PMC) that also included re-development of seven lots PMC had purchased on the west side of 19th Ave between Cherry and Jefferson. This re-development comprised of four empty lots, the corner property, and two Capitol Hill houses re-located on two empty lots for low to moderate income, single-family, first-time home owners.

Consistency with Purpose and Scope of Seattle Land Use Code

While numbers appear to be accurate, the scale of the proposal is lost in this section. The 2.75 million square feet described throughout the document represents 229% of the existing square footage – a massive increase in height, bulk, scale, density, and intensity bordering mostly single-family neighborhoods to the east and south, and a mix of single-family and low rise multi-family residences to the north.

The claim is made that adverse effects are minimized, but the plan fails to push development into areas recently under-developed by Sabey Corporation and its affiliates. Swedish should be planning in a more holistic way for its own need.

The assertion that the MIMP "protects the livability and vitality of adjacent neighborhoods" through open space, landscaping and site amenities is untrue and is presented without factual basis:

- In 1994, the open space constituted 14% of the campus. The 1994 MIMP allowed this open space to be reduced to 10% in exchange for transitional structures and uses along 18th Ave. The so-called "open space" that includes or is adjacent to the major driveway was supposed to be developed under the 1994 MIMP as a portion of the 10% open space. Instead, the current campus open space is under 6%, in non-compliance with its requirements.
- Swedish asserts "discussions include" a community retail store, but includes no enforceable commitment.
- There is discussion about "upgrading" sidewalks that really refers to actually repairing existing sidewalks damaged in the 2001 Nisqually earthquake, or by inappropriate trees' roots heaving the sidewalk into pieces, to comply with the law.
- The 1994 MIMP included a day care center with reduced rates, which was never build
- The 1994 MIMP included a gym that neighbors could access for reduced rates. Although the gym was constructed on Campus, the neighbors are prohibited from accessing it.
- The Inn would be constructed on the 18th Ave site in accordance with the 1994 MIMP.
- The nursing facility would be constructed on the 18th Ave site in accordance with the 1994 MIMP.
- Curb bulbs and other street calming structures and tools would be installed around and on the Campus in accordance with the 1994 MIMP.
- A diagram in the 1994 MIMP shows public access wayfinding along where 17th Ave existed through the Campus. The addition of an ADA compliance entrance/exit is a requirement when Swedish modifies that portion of its Campus.
- Enhancements to the bus stops were also included in the 1994 MIMP. These never materialized. Rather, covered bus stops with seating were eliminated and a rest zone for buses was moved from space adjacent to a parking lot along Jefferson near 22nd Ave to the front of town houses near 19th Ave. This bus rest zone replaces the neighborhood bus stop. Neighbors can no longer board the buses at this location.

The only new "amenity" is the Health Walk, which consists of placards or signs telling folks where to walk along the sidewalk. The proposed landscaping is what will be the pocket parks. It is unclear whether the Health Walk is being counted as part of the 10% open space.

Response to condition J is inadequate. Additional parking is allowed, if not encouraged, if it would "reduce parking demand on streets in the surrounding area." They propose no proportional increase, but neighborhood parking is a major impact of the institution. Even the casual observer at shift change times will see employees in scrubs walking to their cars parked on nearby streets. Drug company salespeople with their characteristic sample cases routinely park in the neighborhood and walk to the hospital. Doctors routinely park their expensive cars within and beyond the RPZ limits without getting tickets. Sabey security drives through the neighborhood to ensure doctors' cars avoid tickets. These impacts were supposed to be mitigated under the previous MIMP, but the 50% SOV transportation management goals were never achieved throughout the 20+ year life of that plan.

Swedish System of Healthcare

If the institution, as it does in this section, wants to tout its system, then the system should be responsible for absorbing institutional growth. As such, much of the need articulated for the Cherry Hill campus should be spread to more institutional settings on its First Hill and other campuses. There is sufficient vacant space on its First Hill Campus to absorb its cardiac programs.

Public Benefits

Here again, they tout system-wide community benefits. And while listing some area-specific organizations supported (some listed are regional and national groups), the document fails to articulate the level of support for these groups over what period of time. Does some of this "benefit" include its parent/partner Providence Health Systems' sponsorship and purchase of naming rights of Providence Park stadium in Portland?

They tout over $37 million in charity care in 2013, but that number appears to be system-wide. No specific benefits to the community surrounding Cherry Hill are cited. A figure of over $64 million in "Medicaid subsidized care" is also cited, but Medicaid is a state/federal program that provides payment to the institution and is not charity provided by the institution.

Under Community outreach, Swedish cannot claim credit for hours volunteered by employees unless there is some connection to making this happen. If Swedish helped facilitate the volunteer work, or provides paid time off for this work, it is not articulated here.

Specific Comments by Page

I agree with Nicholas Richter's comparative analyses of the MIMP maximum height limits throughout Seattle. The current proposals for Swedish Cherry Hill are out of sync with historical precedent. All other MIMP currently approved do not have the same type of mismatch as the currently plan does between neighborhood context and the proposed development.

The closest comparable example would be Seattle Children's Hospital, which has a maximum height four times the tallest surrounding zoned use between the tallest heights proposed for the Swedish campus versus the tallest surrounding zone. This difference in height is mitigated through thoughtful placement, substantial setbacks (***75' to the nearest MIO, which is a MIO-37***), and other amenities not included in the Swedish Cherry Hill plan. If the height for Cherry Hill is determined to be 200', then the only other MIMP that has a higher maximum MIMP height to maximum height of adjacent zoning is the University of Washington. However, this is skewed by the fact that the 240' zone in that plan is a minor area of the campus and only abuts other institutional uses (UW Medical Center). The rest of the campus has a maximum height ratio well under any Swedish Cherry Hill proposed alternatives, as does every other MIMP currently available on the MIAC website.

The Squire Park/Cherry Hill neighborhood is unique for its residential character in an urban setting. These qualities are part of the reason the area is now so highly sought after, but the neighborhood deserves similar consideration to what other neighbors (e.g., Laurelhurst) have received when accommodating the needs of a major institution. This plan does not reflect similar consideration or mitigation in this area.

Setback/Height A-A" (18th Ave half block eastern edge)
The proposed setback of 25' would be similar to the setback found in the underlying zoning. While this is true, the impacts of the commercial use of the building in this half block area are not comparable with a normal residential use. A larger setback has been requested by the neighbors that are directly next to the proposed new building and should be provided.

The proposed heights are out of scale as to height, bulk, density and intensity with the residential character of the neighborhood. DPD, the CAC majority and two of the minority reports concur with the maximum height at 37'. The differences relate to whether there should be one or more buildings along the site. We support multiple builds located along the site, especially when there is a 30' drop from 18th Ave to 19th Ave.

Swedish/Sabey did not hesitate to assume (incorrectly) that it could orchestrate the purchase of numerous homes along 19th, Cherry, and Jefferson in Alternative 3 (but balked when the home owners asked for the same consideration Children's provided to impacted Laurelhurst neighbors).

The proposed maximum lot coverage development standard for the MIO is 76%. The basis for this calculation is the entire MIO and not for individual future project sites.
There is a question of whether 76% lot coverage, and the associated development that comes with it, is appropriate for this context. The lot coverage should be lower in order to encourage the Swedish/Sabey to meet this standard through some of the methods that have been recommended by the CAC and requested by the community. CAC members and the public requested options for the 18th Avenue half block that include multiple smaller buildings. Consideration of these requests are absent from the documents that have been provided.

Again, the central plaza is not open space. The central plaza is circulation space for automobiles – a driveway. Children cannot play here; dogs cannot be walked here. Seattle Code does not allow for driveways to be used to satisfy open space requirements, although Swedish is attempting to make the claim that their driveway is open space (See DEIS 3.3-12). The driveway should count against both lot coverage and any/all calculations that use open space as a basis (e.g. FAR).

"The perimeter Health Walk path on E. Cherry Street, 15th Avenue, E. Jefferson Street and 18th Avenue through sidewalk markers and information stops."
In all cases, there are better routes and better walks in the neighborhood from any point in the neighborhood, including originating at the hospital itself. Neighborhood residents prefer walks along the residential streets rather than campus routes[5]. This is a fundamental flaw of project design and an ongoing critique of the Swedish/Sabey. Amenities for the public are only valuable if the public needs or wants to use them.

"The designated open space is the central plaza and main hospital entrance off of East Jefferson Street." "The drop-off zone on the plaza is included in this area because it can be closed to auto traffic for campus events."
The majority of the central plaza is not open space. It is a central focus point for people arriving by car, but the majority of the plaza consists of space dedicated to circulation. A driveway is not listed on the approved types of public open space (SMC 23.49.016.C.2.A). Additionally, SMC 23.48.020.C.6 (which applies to residential zoning) would not allow the use of the entire plaza as open space. Seattle Children's MIMP also directly addresses this issue by stating, "Parking areas and driveways are not considered usable open spaces"[6]. The central plaza is mainly a driveway and will remain part of the primary circulation for the campus (See DEIS C-56). Access by foot is fairly restrictive and not obvious.

The calculations assert 75,571 square feet of additional open space, but Swedish has not provided a map of what they currently include as "***landscaped*** (my emphasis) open space". It is difficult to believe that Swedish/Sabey is able to increase lot coverage from 56% to 76% (as requested) and also create 1.73 acres of new open space (roughly the area of Yesler Terrace Playfield).

The 1994 MIMP allowed Swedish/Sabey to reduce it's the current 14% open space to 10%. Between 1994 and 2014, Swedish/Sabey continued to reduce its required open space to 5.35% in violation of its 1994 MIMP and Code.

"View corridors or other specific measures intended to mitigate impact of MIO. ...Any proposed sky bridges should be limited to single corridor, two stories and be transparent."

[5] http://www.walkscore.com/walkable-neighborhoods.shtml
[6] http://masterplan.seattlechildrens.org/documents/4_DevelopmentStandards.pdf, Page 84

Harborview provides an excellent example of how a skybridge can be integrated into the institution. This feature provides useable space that may be used to offset the height, bulk, and scale of the project.

Views of the James Tower will be maintained along 18th and from the central plaza.
James Tower is a landmark of the neighborhood. Views of the tower from the Jose P Rizal Bridge should be considered, as well as from 14th Ave. The hospital has always been the landmark on the hill, but the fact that the tower is historic is meaningful. The replacement of a view of the historic landmark tower with a relatively generic medical building detracts from the character of the neighborhood and reduces the overall meaning of the campus to the neighborhood.

James Tower has long been part of the identity of the neighborhood, something that people liked pointing to from the Space Needle as a landmark that identified the rough location where they lived. The new buildings will not evoke the same feelings as the historic bell tower. I'd rather have it moved or taken down to use its location to mitigate the impacts than hide it from view.

"Alternative Proposals for Physical Development – The new square footage over the next thirty (30) years. The ability of the proposed alternatives to meet these square footage goals is fundamental to the medical center meeting its needs."
At time of writing, 5,000 sf in the Jefferson Tower was available for rent to the public by Sabey. In addition, some of the aspects of the plan (e.g. limited development through additional heights for non-Swedish/Sabey owned sites) do not reflect a 30 year mindset for planning for the campus.

As has been mentioned repeatedly in comments both from myself and from neighbors, the question of need is a significant one. The Swedish/Sabey alliance makes it difficult for members of the community to take the assertions of need at face value and if these space requirements are true measurements of need, then one possible outcome of this process is that Cherry Hill is not a suitable location for the hospital – an alternative not proposed.

"Swedish is requesting exemption from FAR consistent with other MIMPs."
Nicholas Richter provided documentation with his comments to show the Swedish-requested exemptions are not "consistent with other MIMPs". The unbound exemption for server areas is an issue.

Sabey Corporation runs datacenters. Data centers are filled with servers. An exemption for server space allows Sabey to effectively build a data center at Swedish Cherry Hill or create rentable spaces for technology intensive companies that focus on the medical industry. For example, if Sabey partners with McKesson Corporation, the present MIMP wording would allow for the development of a building that contains significant server space needed to run their electronic records system for the region. While this would normally be dismissed as a remote possibility, the same entity is driving plans to place 240' buildings in a residential area.

An uncapped exemption for server space is a loophole. It should not be included in the MIMP. According to the plans reviewed, a standard exemption for server and electrical space appears to be 3.25%.

"Existing and Planned Future Development Open space is provided at the NW corner of 15th Ave. and Cherry St. North of the NW Kidney Center building; and at the main entry plaza south of the Center Building. Additional open space is proposed as a new courtyard shown in Figures B-22 and B-23 between the Annex Building and the James Tower."
All of the "open space" listed above currently exists. The space between the Annex Building and the James Tower is already a landscaped open area that the public can use. This is not "new" open space. The corner of 15th Ave and Cherry is semi-private "open space".

In the calculations found on page 52 of the DMIMP, the new alternative will add more than 75,000 square feet of new open space, which will increase the overall open space on campus by 1.89% (approximately half of the landscaped open space the campus had in 1994). Swedish/Sabey claims that they will add open space equivalent to the size of Yesler Terrace Playfield[7]. The assertion that more open space will be provided after adding millions of gross square feet to the campus and increasing lot coverage from 56% to 76% is difficult to believe.

"The MIMP minimizes the adverse impacts associated with development with the use of Development Standards that transition the height and scale between the MIO and the surrounding area."
The proposed development standards are insufficient to guarantee this outcome. The height and scale, while "transitioning" within the campus, is far outside the height, bulk, scale, and intensity of the surrounding neighborhood. As discussed previously, there is no other MIMP current in effect in Seattle or in draft that has a similar level of intensity combined with no mitigation effort.

In particular (i.e. including, but not limited to the following):

- Insufficient setbacks directly next to residential properties.
- Unmitigatable impacts due to shadows caused by the height, bulk, and scale of alternatives presented, which would significantly impact the vibrancy and livability of the neighborhood.
- The sheer mismatch of scale caused by a misunderstanding of the neighborhood context (i.e. "First Hill" vs. Seattle Central Area).
- The weakest transportation management plan proposed in any MIMP.
- Unsubstantiated calculations used for FAR and open space, resulting in overstated benefits caused by the MIMP and understatement of actual FAR.

[7] http://www.seattle.gov/parks/park_detail.asp?ID=4563

- The failure to mitigate impacts as required by Code, not just three or four MIO height limits that graduate from tallest to least tall.

"Response: The MIMP protects the livability and vitality of adjacent neighborhoods by providing open space, landscaping and site amenities."
If these are the mitigation measures that protect the "livability and vitality" of the adjacent neighborhood, then the plan has failed.

- The open space calculations overstate open space on campus by incorrectly including the driveway plaza as open space and excluding existing open space (the area between James Tower and the Annex) in the calculation of the existing open space. The result is that the open space provided by the alternatives is greater than it actually it.
- The open space on campus not connected to the preservation of the livability or vitality of the surrounding neighborhood. A link between the two has not been shown. The proposed open space is half of what it had in 1994. The plan should show the reduction since 1994 and the proposed 7.36% as a net loss, not a gain in open space.
- The health walk is not a welcome amenity.
- Landscaping on campus (e.g. the traffic circle in the driveway plaza) largely does not impact the neighborhood.
- Expansion of neurosciences and cardiology (maybe) services rather than primary, preventative and hospice care.

"Discussions include the establishment of a community retail use within the current annex building that could potentially have sidewalk access as well as access to a new public garden to the north of the annex."
Improving an existing open space is not creating a new open space.

"The proposed campus perimeter health walk will upgrade sidewalks and landscaping to offer safer pedestrian experience and promote individual health achievement."
Swedish Medical Center is already responsible for the condition of the sidewalks adjacent to its property[8]. If, in the process of development, the sidewalks are made unfit, then they clearly would be expected to be replaced (in compliance with current standards) by the developer. Bringing the sidewalks up to current standards to provide a "safer" pedestrian experience is not a mitigation feature. It is compliance with current regulations.

"The Medical Center has encouraged significant community involvement by meeting with the Citizen's Advisory Committee (CAC) and taking their recommendations into consideration."
There is a difference between community involvement and compliance with mandatory regulations related to public meetings.

[8] See SMC 15.70.020 and SMC 23.84A.004.

After more than a year of meetings, the Swedish MIMP has not fully integrated the comments and concerns of the community. The starting position of the institution could be described as "belligerent" and "intimidating" towards the neighborhood, which resulted not in community involvement, but a feeling of community defense and fear. Neighbors along 19th Ave/Jefferson border as well as Squire Park Community Council were named in the King County Superior Court Appeal of the Minor Amendment for providing public comment through the City's processes. Neighbors who participated in the public processes before the CAC was formed were retaliated against and denied CAC membership. Neighbors surrounding the campus were put through unproductive and at times hurtful meetings where these most offensive alternatives were slowly rolled back.

In addition to selecting a starting position that was a distraction from meaningful conversation by CAC members and members of the public, Swedish Medical Center has taken positions that have been detrimental to the public discourse through such acts as: denying requests for information by the CAC; denying requests for materials produced by their contractors; failing to deliver requested materials related to the PDEIS to CAC members; scheduling meetings outside of the neighborhood to discuss critical documents; failing to maintain a properly updated website with materials and resources for community members to review; and suggesting in e-mails that CAC members were acting "outside of the code" when attempting to contribute ideas and commentary for consideration in the process (Example, 2013-08-09T11:29-8:00 from Marcia Peterson).

There has been a consistent and strong turnout by members of the community, but community involvement was not because Swedish had invited them to participate in the formulation of the plan. These community members attended because the alternatives presented were so far beyond what they would find acceptable that they felt compelled to attend in order to prevent lasting and irrevocable harm to the neighborhood. The input that the neighborhood has given has been largely ignored or incorporated to a minor extent in the alternatives, but not in a configuration that would result in different and potentially acceptable alternatives. From my perspective as the Vice-Chair of CAC for the 1994 MIMP, it seems like each alternative had a "poison pill" that would prevent it from moving forward. Commentary on specific aspects that was acceptable between the "different" alternatives lead to new alternatives that embodied the best of the previous alternatives.

Examples:

- Alternative 1a was dismissed prematurely.
- Alternative 2 placed 90 foot buildings within 25' of the property line of SF 5000 properties.
- Alternative 3 proposed boundary expansions that were the source of strong, justified, and predictable opposition by the neighborhood. This alternative should never have been proposed.
- Alternative 4 was poorly executed according to Nicholas Richter (even though it was developed by his suggestion). It placed 105' buildings along properties with LR-3 zoning and 90' buildings along SF-5000.

- Alternative 6 was nearly identical to Alternative 5.
- Alternative 8 proposes redeveloping the historic annex into a new office building with the greatest heights of any alternative.
- Alternative 9 and 10 retain, as do all others as a minimum, the 50' full half block development on the 18th. Heights remain too tall for the context of the neighborhood, but far closer than the original proposals.

It is true that public meetings were held and that they were very well attended by the public, but this does not mean that the CAC was collaboratively or "significantly" involved in the creation of a viable alternative that balances the needs of the institution with the needs to the community. The progress on creating such an alternative was hindered primarily by the ill-conceived alternatives and a seemingly recalcitrant attitude towards the process by the institution/developer. An alternative that creates a reasonable balance between the institution and neighborhood does not currently exist and has not been put forward in the proposed MIMP.

The new MIMP also proposes a One Bus Away kiosk for bus commuters, a summer season farmers market, a quarterly transportation and commuter fair and a Swedish community transportation liaison.
This is the first and only mention of a farmers market in the MIMP. The central plaza siting for a daily summer season farmers market is still not enough to call this driveway open space.

Transportation Management Plan (TMP)

General Comments
The stated current goal for single occupancy vehicle use (SOV) is 50% -- exactly the same goal articulated in the 1994 MIMP that was never met.

Nicholas Richter did a comparative analysis of different current goals and current SOV rates reported in TMP plans from other MIMPs, including Children's Hospital, Virginia Mason, Seattle University, Seattle Central Community College, Harborview Medical Center, and Swedish First Hill.

According to these documents, Swedish is the only major institution of these analyzed that has failed to meet its previous SOV target. All these other Major Institutions met or exceeded their goals. While Virginia Mason may be uniquely situated to take advantage of excellent transit service, Children's Hospital, Seattle University, and Seattle Central Community College have more similar transit services areas with similar levels of connectivity to the surrounding community as Swedish.

Being a world class institution means leading the way and striving for excellence in all areas of operation, including the TMP that forms part of the underlying rationale for the type of heights and development standards allowed by a MIO-zoned area. Swedish/Sabey has not lived up to the standards of a prestigious institution in this area, as it has failed to meet the 1994 goals of

the TMP. The expertise exists and TMP best practices are no mystery. Successful institutions reflect a culture of excellence and a commitment to their plans - the two least ambitious and least successful TMPs belong to the Swedish campuses.

The adjacent TMP for Seattle University sets a daytime SOV goal of 35%. If anything, the academic institutions have a handicap because they must include students in their standards, not just day-time employees as Swedish does.

Children's Hospital has cut its SOV use nearly in half (down to 38%) in the last 20 years, but Swedish cannot achieve its 50% SOV goal in the same period of time. Children's Hospital is in a potentially more challenging location than Swedish. Their success reflects their ability to manage cultural change and adhere to standards that make them leaders in the Major Institution community. Their current goal under its new MIMP is 30% SOV mode share.

The DPD recommendation to withhold permits for construction until the 50% SOV is obtained is valid. Until the last few years, Swedish/Sabey did not file their annual TMP reports. Sabey and its tenant had refused to cooperate with DPD and SDOT concerning providing the required data.

"The proposed TMP is intended to reduce SOV trips to 50 percent, reduce parking demand, and increase the use of alternative modes of transportation (Transit, walking and bicycling)."

This is the same goal that Providence set in 1994 and has failed to meet each year since. Swedish/Sabey is not able to meet this goal. Swedish/Sabey must demonstrate what is going to be different this time around and why such an unambitious target has been adopted. Children's has, over the same period of time that Swedish has failed to meet this goal, reduced their SOV share of commute trips from 73% in 1995 to 38% in 2013[9].

Swedish is asking us to believe that they can accomplish in the next 30 years what they promised to do in 1994 and that Seattle Children's has already done in the meantime despite a less conducive location. Swedish has not during the MIMP process demonstrated any change in its transportation culture at the Cherry Hill campus or addressing ongoing public concerns about existing conditions. Promises have been made, but they were also made in 1994.

"The 2013 Recommended Bicycle Master Plan identified 18th Avenue as a neighborhood greenway"

A determination of where to put the neighborhood greenway should be based on existing infrastructure and bike pathways that will be used rather than circumvented. As such, 18th Avenue is the best site for the greenway. Although 19th Ave could be considered, there is no infrastructure in place to support it and Swedish has remained silent about contributing to the costs, especially since its intended use of 18th Ave is what would make 18th Ave unsafe as a greenway.

[9] See Seattle Children's Master Plan, page 39. It should also be noted that Seattle Children's is located in a more auto-oriented neighborhood with fewer transit options. See www.mapnificent.net.

In contrast, Seattle Children's donated more than $3,000,000 to the City of Seattle to fund bike and pedestrian improvements in the surrounding neighborhood, which resulted in the implementation of the 39th Ave Greenway. These donations were written into their MIMP (page 95) and are a part of their overall TMP. Swedish could learn from the positive results that these efforts have brought to Seattle Children's, both in terms of physical improvement in the neighborhood and the goodwill that has been brought to their institution as a result.

Thank you for your consideration,

Vicky Schiantarelli
c/o 19th Ave Block Watch/Squire Park Neighbors
541 19th Ave Seattle, WA 98122
vickymatsui@hotmail.com

SISTERS OF PROVIDENCE
SERVING IN THE WEST SINCE 1856

Providence Medical Center

FINAL COMPILED MAJOR INSTITUTION MASTER PLAN

Approved by City of Seattle
Ordinance 117238
dated July 25, 1994

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I. INTRODUCTION

A. BACKGROUND AND PURPOSE

Providence Medical Center ("Providence") is a 409-bed tertiary care facility. It is a major referral center for a number of specialties, most notably cardiology, cardiovascular surgery, rehabilitation medicine, and psychiatry. It is also a teaching hospital affiliated with the University of Washington Medical School.

The Medical Center also operates a primary care clinic network of 10 clinics throughout the metropolitan area and a home health and hospice program located off campus providing approximately 50,000 visits per year.

Providence Medical Center has a rich history of providing health care. As reflected in its mission and day-to-day operation, Providence is dedicated to promoting health care access for those in need and provides a significant amount of charity care for those individuals without personal resources. The spirit of charity care is also supported through the development of health services for which reimbursement is inadequate but which are needed by the community. Providence consciously and deliberately establishes systems to identify and assist those in financial need. Providence maintains an open door policy. Beyond these commitments, there is a concerted effort not only to meet the health needs of the poor and elderly, but also to increase the awareness of others regarding these needs. The Mission of the Sisters of Providence continues to be the main focus of Providence's efforts and future direction.

The purpose of this MIMP is to upgrade, improve, and expand Providence's facilities within its Major Institution boundaries in order to continue to be responsive to health care demands. Providence has received City Council approval of its master plan concept and projects to be phased over a 15-year period following master plan approval.

The improvement projects included in the master plan are intended to better serve the Providence community by improving functionality, responding to changing technologies and medical practices, and reducing costs. The improvement projects under the master plan will result in the additional area needed to alleviate crowded conditions, expand cramped and outdated space and facilities, provide space necessary to accommodate the latest in medical technologies and services, and to upgrade and enhance campus grounds and open spaces to improve the aesthetic appearance of the medical center.

The Master Plan is for Providence's main campus, which is located in the Central District of Seattle at 500 17th Avenue. Figure 1 shows the neighborhood context. The plan is subject to the provisions of the City of Seattle Major Institution Policy (Resolution 28081) and Land Use Code (Ordinance 115002). The intent of these regulations is to balance "the public benefits of the growth and change of major institutions with the need to maintain the livability and vitality of adjacent neighborhoods." This Major Institution Master Plan (MIMP) seeks to meet that goal and assure that the MIMP improvements are appropriate within the community.

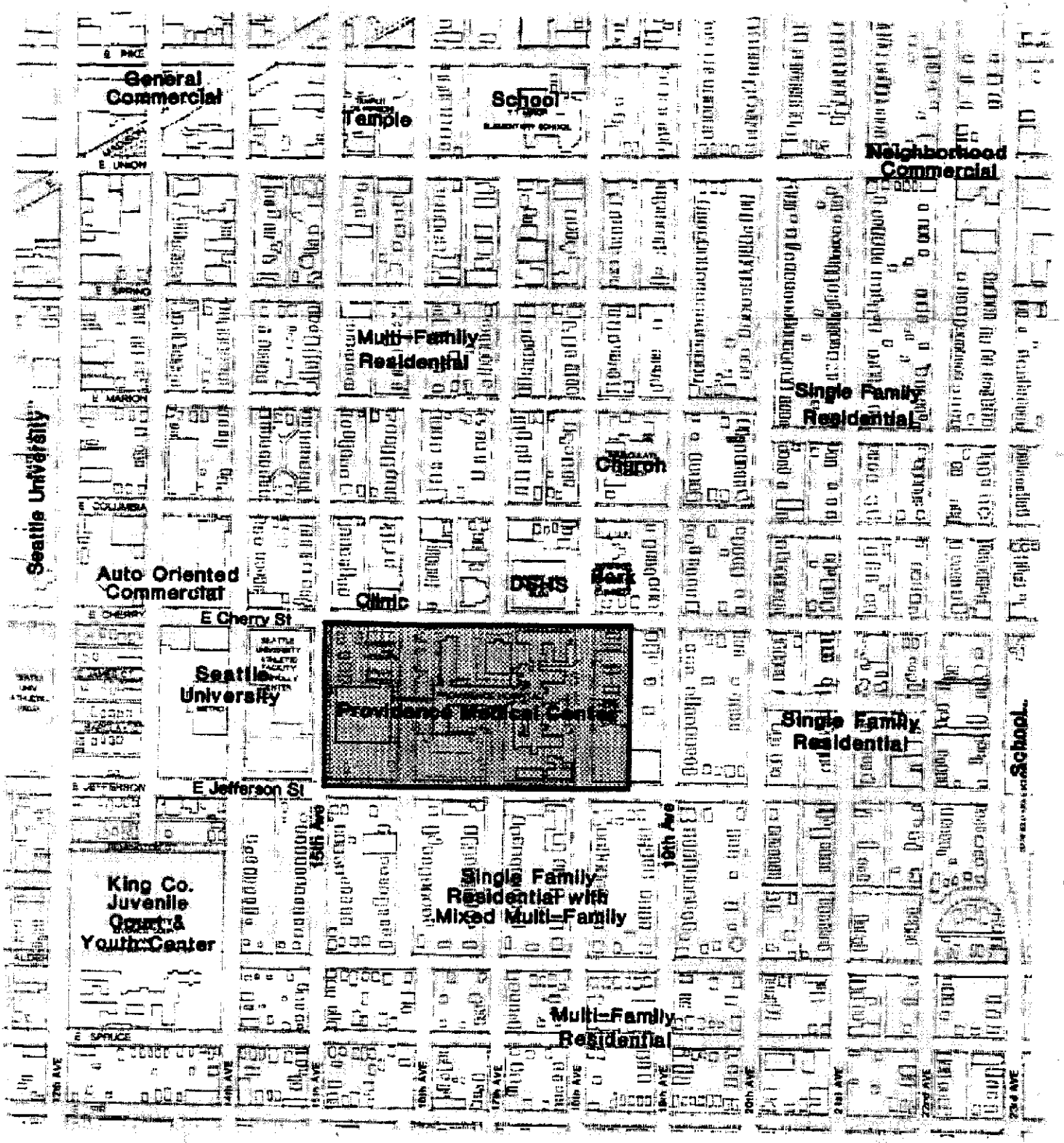


Figure 1
Neighborhood Context

B. PROCESS

All stages of the City's Major Institution Master Plan process have been completed. A Notice of Intent for a MIMP was given February 21, 1991. The formation of a Citizen Advisory Committee (CAC) was completed in coordination with the City's Department of Neighborhoods (DON). CAC membership was approved by the City Council. Numerous meetings of the CAC and other interested parties with Providence staff took place and will continue during implementation of individual projects. Public scoping for the EIS was initiated following the City's Determination of Significance on August 22, 1991. A public scoping meeting was held September 24, 1991 and comments were accepted until October 10, 1991. The Department of Construction and Land Use (DCLU) determined the scope of the Draft EIS on October 28, 1991. The Draft Master Plan and Draft Environmental Impact Statement were issued for public review on June 25, 1992; one public hearing (July 15, 1992) and one public meeting (August 19, 1992) were held. All public comments were due August 31, 1992, which included an extended public review period.

The Final Master Plan and Final Environmental Impact Statement were issued in June 1993. DCLU issued its recommendation January 1994. The Hearing Examiner issued a report and recommendation on April 25, 1994, and after giving all required notices and following required procedure, the City Council adopted Ordinance 117238 approving the MIMP on August 2, 1994. This Final Compiled Major Institution Master Plan includes all conditions required by the City Council for the approved MIMP.

C. MISSION

The mission of the Sisters of Providence in the West began on December 8, 1856, with the arrival in Vancouver, Washington Territory, of Mother Joseph of the Sacred Heart and four other Sisters of Providence. Within three years these women had established one of the first corporations in the Territory, founded with by-laws that stated, "The ends of said Corporation shall be the relief of needy and suffering humanity, in the care of orphans, invalids, sick and poor, and in the education of youth."

As those early Sisters began their work for the good of others, they reached out to those in need, never turning away anyone who could not pay for care. Their door was always open.

Though times have changed, need has not. The Sisters continue to be concerned that people in need are cared for. Providence Medical Center maintains an open door policy, never turning a patient in need of care away.

Providence Medical Center is a non-profit institution. Any income in excess of expenses for personnel, payment of existing debt, and operations is reinvested in facilities, community and medical education, charity care and other services to the community.

Providence Medical Center has provided far more to our community than dollars can attest. Providence offers a wide range of community services, education, research and special programs for the elderly. Each is made up of people who are givers of care with a deep concern for others.

Development under the approved Master Plan will enable Providence to continue to be responsive to the Sisters of Providence public purpose mission to provide the highest quality health care for all members of the public, and will enable this to occur in a more efficient manner. The benefits to the community are reflected in the mission of Providence to:

- Work to meet the current needs of society by caring for those who need health care.
- Provide cost-effective excellence in health care services.
- Provide health care services commensurate with community need.
- Enhance the value and quality of life, honoring the dignity of every patient.
- Heal the whole person spiritually, physically, psychologically.

In addition to meeting these fundamental aspirations, responding to changing health care needs and improving the efficiency of the institution, benefits will include better accessibility of services and improvement of facility appearance. Some public services will be expanded as they are relocated to larger, more efficient space.

II. Approved Development Program Component and Conditions Imposed by City Council

A. EXISTING DEVELOPMENT

Property Ownership

The multi-block Providence campus is bordered by East Cherry and East Jefferson Streets, 15th Avenue and mid-block between 18th and 19th Avenues.

Providence owns 12.4 acres (540,800 square feet) of property located within the existing institutional boundaries of the MIO district as shown in Figure 2. Public rights-of-way located within the MIO district include 16th and 18th Avenues. Other properties within the MIO district are privately owned and are in residential or other institutional use (the Greenery Rehabilitation Center), or are vacant.

Providence owns no property outside of its boundaries and within 2,500 feet of the boundaries, except for a 17% ownership share of Hospital Central Services (a central laundry) located at 1300 East Columbia. This 60,000 square foot facility is located on a 1.41 acre site and is owned by seven hospitals. This facility was organized in 1966. The Seattle University athletic facilities are within 2,500 feet of the Providence MIO boundaries (to the west of Providence).

Facilities [1]

The site is developed with medical facilities that include hospital beds, clinics, offices, guest beds (dormitory style inn for patients and their families), fitness center, day care, support functions, research activities, surface/structured parking, and other accessory uses.

These existing health facilities comprise a total building area of about 1,042,211 gross square feet, including a parking garage of about 211,000 gross square feet. Structure lot coverage is about 256,104 square feet. Total existing parking amounts to 1,031 off-street spaces. Providence obtained an administrative use permit for an additional 39 parking spaces, which has just been constructed. Providence has 376 licensed acute care beds and 33 skilled nursing beds, for a total of 409 beds.

---

1 The plans records system at DCLU lists existing Providence development by various building identifier numbers. Due to changes over the years with building demolitions, renovations, and expansions, the numbering is not sequential to reflect the existing buildings. The following is a key to the city building identifier numbers and references made in the MIMP.

Comparison of Providence Building Identifiers

DCLU Building Plans Key		MIMP Existing Buildings
1.	Providence Hall (demolished)	N/A
2.	1910 Building	1. 1910 Building & Boiler
3.	Annex	4. Administration Wing
4.	West Nursing Tower	5. Annex
5.	Professional Office Building	2. West Tower
6.	Center Building	7. Providence Professional Building
7.	Parking Garage	6. Central Building
* 13.	Medical Tower Building (Jefferson)	8. Parking Garage
14.	Hope Heart Institute	10. Jefferson Medical Office Tower
15.	East Wing	9. Hope Heart Institute
		3. East Wing

* DCLU numbering skips numbers 8 through 12.

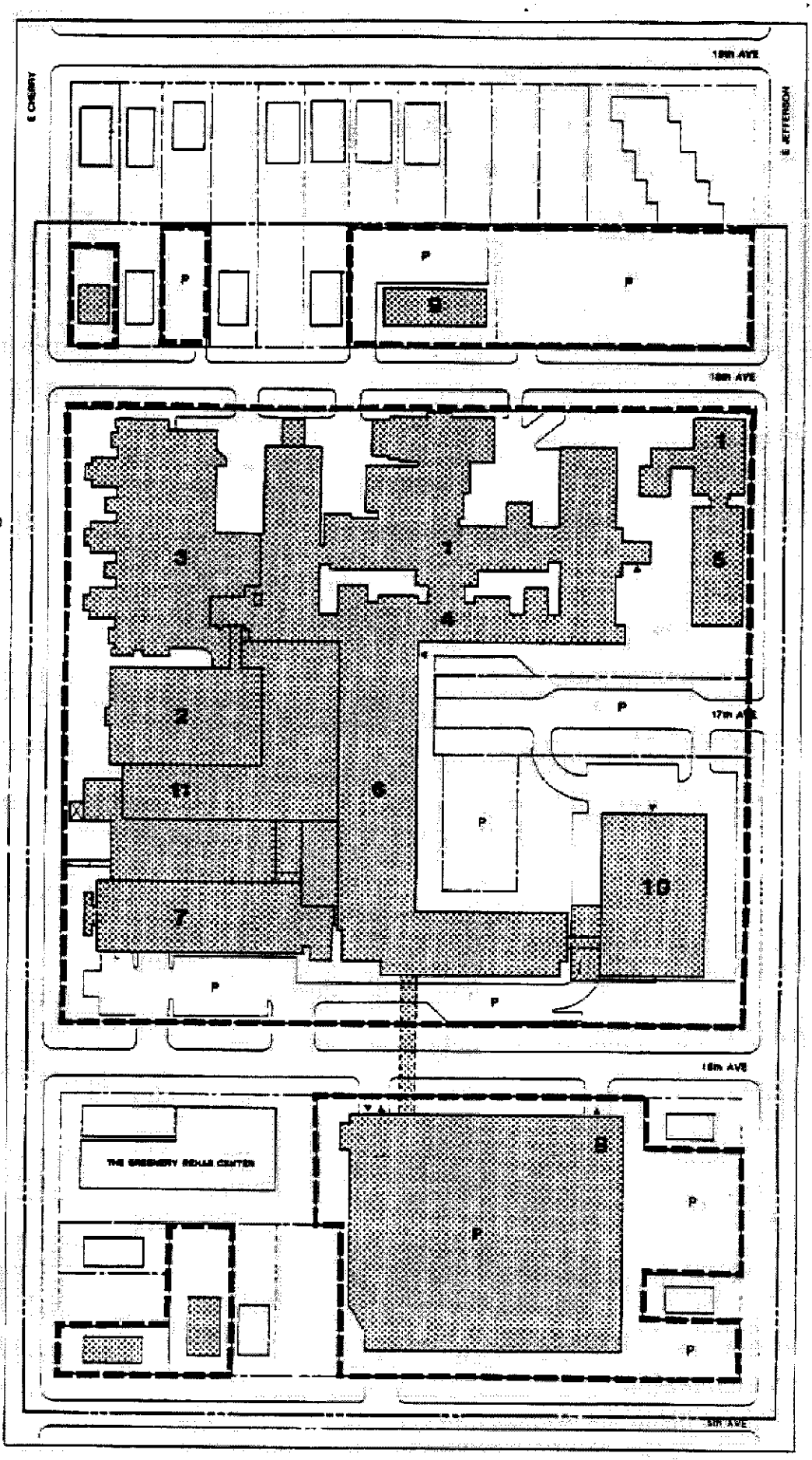


Figure 2
Providence Property Ownership and Existing Development

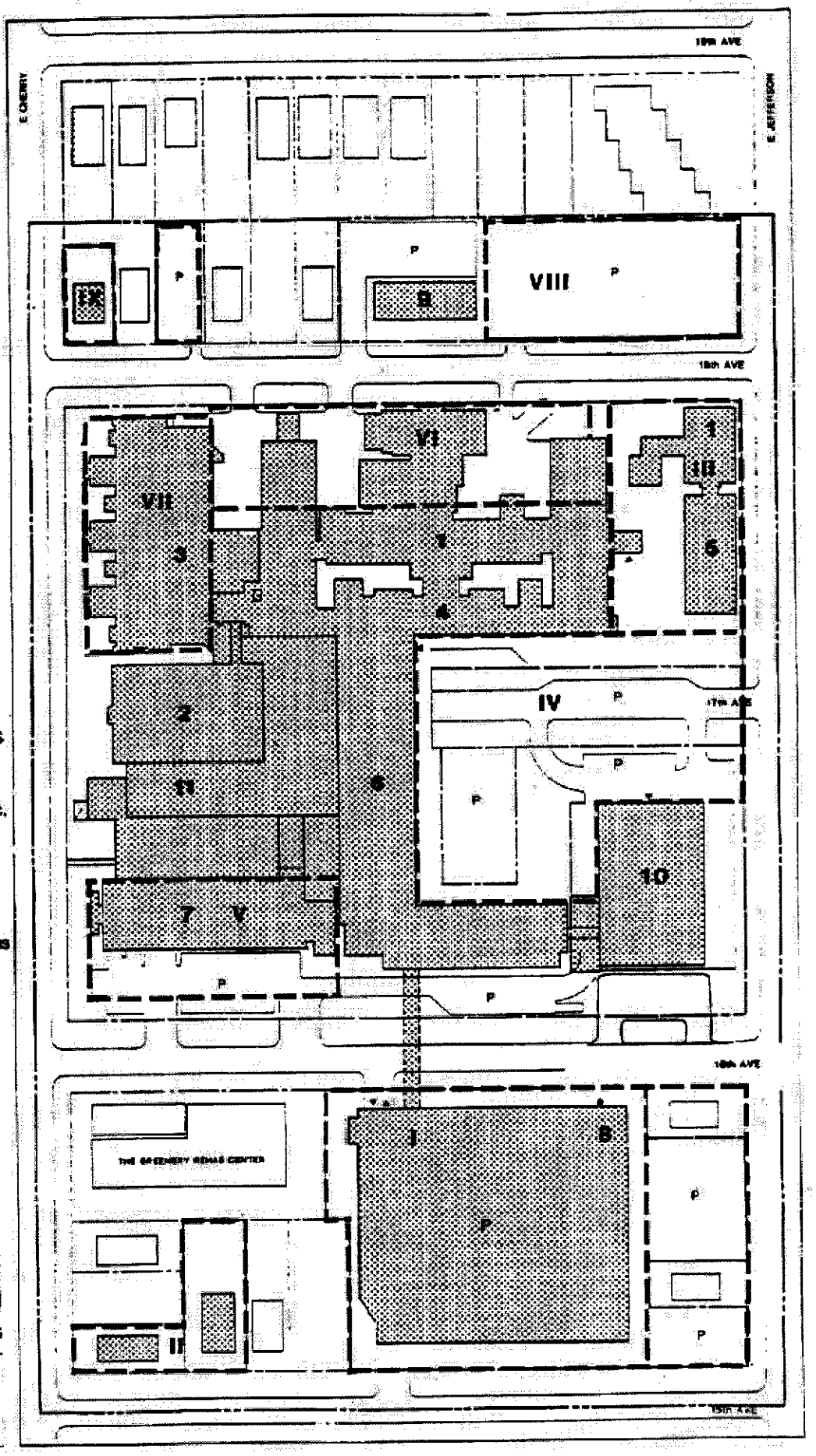
B. DEVELOPMENT APPROVED FOR MIMP

The development that has been approved by the City Council for this MIMP is described by project in Table 1 and depicted on the site plan, Figure 3. The conditions imposed by the City Council for each project are also listed. Conditions that are not "project specific" are included in Section V of this document. In addition, attached are the conditions which have been agreed to by Providence and the Squire Park Community Council that apply to the approved development. The approved development all within the major institution boundaries will add over 15 years approximately 564,500 net new square feet (682,500 sf new construction less 118,000 sf demolition) to the existing campus development as shown in Table 1. An additional 40 licensed acute care beds (for a total of 416 acute care beds) and an additional 27 skilled nursing beds (for a total of 60 skilled nursing beds) have been approved. Figure 4 shows an aerial view of the approved additional development together with the existing Providence facilities. The following discussion describes each project and the conditions imposed.

Table I
Providence MIMP Projects

Phase*	Project	Use	Floors	Building Area per Floor	Total Project Area	Project Height	Mechanical Penthouse
I.	Expand Parking Garage						
IA	Add 2-1/2 half levels to Existing Garage	Parking	–	–	71,000 sf/ 204 spaces	20' (65' max.)	–
IB	Expand Garage to the South	Parking	–	–	118,000 sf/ 502 spaces	65'	–
II.	Relocation of Family Medical Clinic/ Temporary parking	Clinic/ Parking	2	5,000 sf	10,000 sf	30'	–
III.	Relocate Boiler (see Phase VI)	Physical Plant					
	MOB/Replace Providence Professional Building	Clinic/ Office	5	15,000 sf	75,000 sf	65'	15'
IV.	Surgery, Entry Radiology, Oncology Addition, Laboratory, Chapel and Parking	D&T Entry Clinic	2	50,000 sf (below grade) 15,000 sf (above grade)	65,000 sf	20'	–
		Parking	Below Grade	21,000 sf/ 60 spaces	63,000 sf 180 spaces	20'	–
V.	New Patient Wing (includes Critical Care Expansion)	Beds	7	19,000 sf	133,000 sf	90'	15'
VI.	Skilled Nursing (33 Existing + 27)	Nursing	2	12,000 sf	24,000 sf	45'	–
	Boiler Plant (constructed at same time as Phase III)	Physical Plant	2 Below Grade	12,000 sf	24,000 sf		
	Learning Resource Center/ Environmental Services	Education & Support Services	1	12,000 sf	12,000 sf 60,000 sf		
VII.	Add (2) Levels to East Wing (40 beds)	Beds	2	18,000 sf	36,000 sf	30' (105' max.)	15'
VIII.	Providence Inn (40 Rooms) and	Inn	2	15,000 sf	30,000 sf	30'	10'
	Fitness Center with Parking Garage Below (30 Cars)	Gym	1	18,000 sf	18,000 sf 30 spaces	36'	10'
IX.	Day Care/ Play Area	Day Care & Parking	1	3,500 sf	3,500 sf	28'	–
Total					**682,500 sf**		

* The phasing is the sequencing of projects as currently anticipated over the 15-year master plan timeframe. Actual timing and development sequencing may vary depending on changing conditions and needs. Replacement projects require construction of the new facility prior to the demolition of the building being replaced.



EXISTING BUILDINGS

1. 1910 Bldg & Boiler
2. West Tower
3. East Wing
4. Admin Wing
5. Annex
6. Center Bldg
7. Providence Professional Bldg
8. Parking Garage
9. Hope Heart Institute
10. Jefferson Medical Office Tower
11. Materials Mgmt

APPROVED PROJECTS

I. Expand Parking Garage
II. Family Medical Clinic, Parking
III. New MOB
IV. New D&T and Front Entry/Parking
V. New Patient Wing
VI. New SNF, Physical Plant, Support Services
VII. Add Two Levels to East Wing
VIII. New Inn, Gym and Parking
IX. Day Care

P Existing Parking

Figure 3
Approved
MIMP Projects

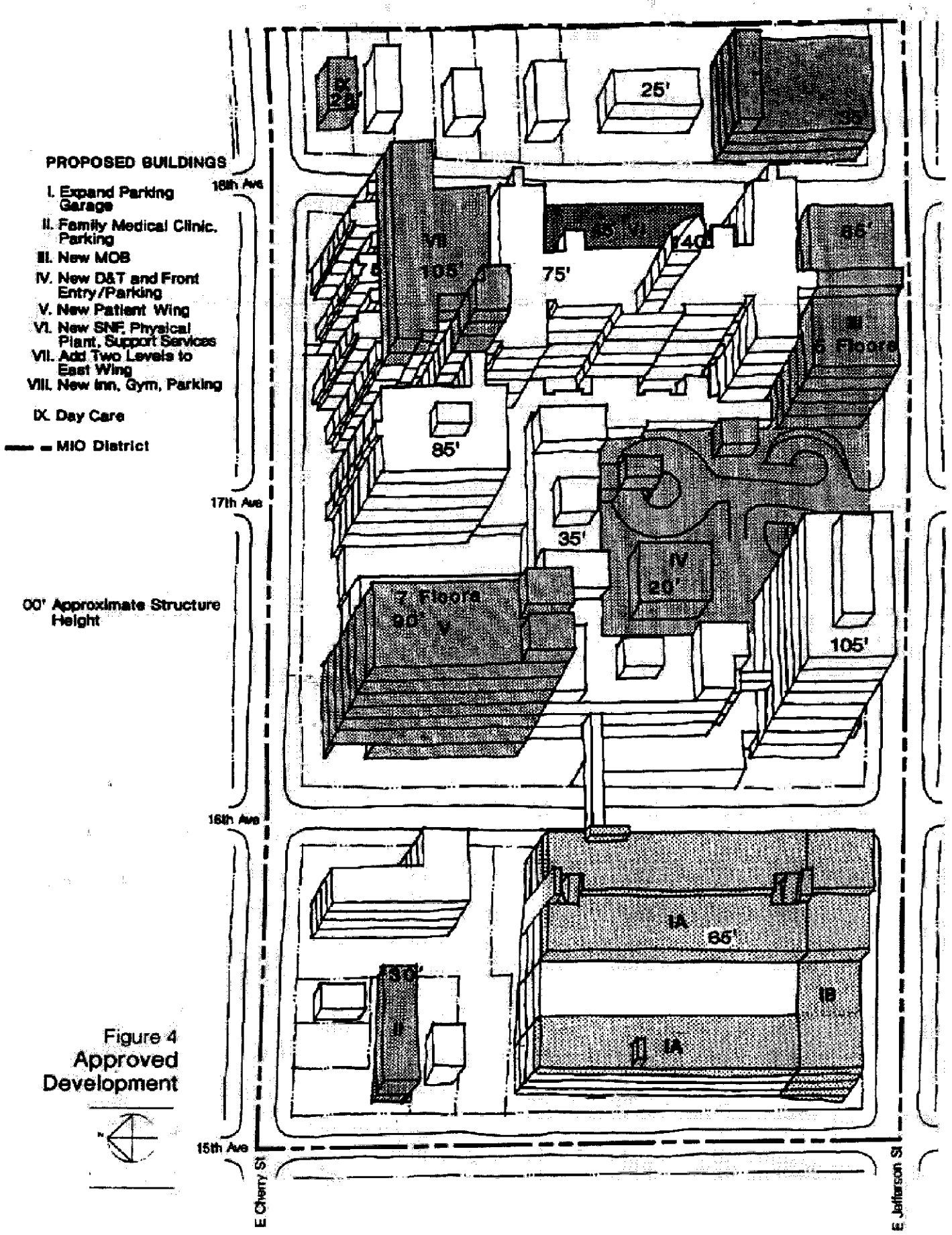


Figure 4
Approved Development

1. Expand Parking Garage

The existing Providence garage between 15th and 16th Avenue near East Jefferson contains about 724 spaces in 4-1/2 stories (9 half-levels). Expansion of the garage for visitor parking has been approved under the Master Plan along with Providence's aggressive Transportation Management Plan to alleviate on-street parking and congestion in the vicinity of the hospital and to help meet the code requirement for off-street parking. Two alternatives for expansion have been approved with implementation dependent on feasibility and the opportunity for property acquisition. If both alternatives are implemented, the garage would be expanded both horizontally and vertically with the actual design and facility size to be determined.

1A. Add 2-1/2 Half-Levels to Existing Structure

This alternative assumes vertical expansion. This expansion would provide approximately 204 additional parking spaces.

1B. Expand the Garage to the South

Expansion of the garage to the south is dependent on acquisition of 2 lots within the Major Institution boundaries by Providence. If the property can be acquired and this alternative is implemented, two existing residences would be removed or demolished. This expansion would be on 5 levels and would result in approximately 502 parking spaces. This expansion would eliminate 39 existing surface parking spaces for a net increase of 463 spaces.

Conditions Imposed by City Council:

For the parking garage expansion (Project 1B), providence will provide a dense planting of evergreens in the required 20-foot south setback to form a "green wall;" mature plants shall be used and attempts shall be made to save or relocate existing specimen trees; plant materials shall be selected that will add visual diversity and transition in scale (taller plants nearer the structure); and, safety shall be a design consideration. The south wall of the parking structure shall provide visual relief through the addition of planters, tiles or other ornamentation. Finally, the building shall be designed to resemble an office building. *(Council Condition 9)*

In order that spillover parking does not adversely impact the surrounding neighborhood, the Expanded Garage may be constructed at one time. Use of the garage may be restricted if deemed necessary by DCLU and SED in order to achieve TMP goals. *(Council Condition 14)*

Providence shall install additional informational signs at intersections of arterial streets on Jefferson and Cherry as well as at campus perimeters to direct patients and visitors to public parking areas on campus. Signs located within the public right-of-way must be approved by SED. *(Council Condition 15)*

Prior to occupancy of the Expanded Garage (Project 1A), curb bulbs shall be installed at the 16th Avenue/ East Cherry intersection. In addition, one traffic circle shall be installed in 16th Avenue East between East Jefferson Street and East Yesler Way at an intersection to be determined by SED with input from the Squire Park Community Council. *(Council Condition 31)*

Prior to occupancy of the expanded garage (Project IA), a curb bulb shall be installed at the 17th and Jefferson intersection and a traffic circle shall be installed on 17th between Jefferson and Yesler at a location to be determined by SED in consultation with the Squire Park Community Council. *(Council Condition 32)*

"Local Access Only" signs shall be installed along residential streets adjoining truck delivery routes. Sign locations shall be determined and installed by SED. The Squire Park community shall be consulted for sign locations. *(Council Condition 33)*

II. Improve Temporary Surface Parking/Relocate Family Medicine Clinic

The Family Medicine Clinic currently located in the Providence Professional Building would be relocated to a new site within the Major Institution boundary at the corner of 15th Avenue and East Cherry Street. There are two vacant deteriorated duplex structures on this property, which were unoccupied for over three years. Providence has leased the duplexes to Operation Homestead to house the homeless on a short-term, temporary basis. The lease was signed with the understanding that the arrangement is temporary and Providence intends to maintain the property for future health care-related use. Temporary open space/surface parking has been approved for this site, once the lease expires the duplexes will either be moved or torn down. A two-story (30 feet), 10,000 square foot clinic (5,000 sf/level) with parking would be constructed in the future.

Conditions Imposed by City Council: None

III. Relocate Boiler and Develop Medical Office Building to Replace Providence Professional Building

A new physical plant and medical office building has been approved within the main site. The boiler replacement is also described with the adjacent Project VI, the Skilled Nursing Facility. The replacement office building will provide on-campus clinic/office space. It will be a five-story (65 feet) building with approximately 15,000 square feet per floor, for a total of approximately 75,000 gross square feet. The street level of the medical office building will likely include such public amenities as deli/coffee bar and pharmacy. During design, every effort will be made to ensure "street friendliness."

Conditions Imposed by City Council:

The new MOB on Jefferson (Project III) shall provide vertical modulation to break up the bulk of the structure. The new MOB will be designed to interpret the 1910 Building. Architectural design measures including facade articulation, modulation, detailing, materials, color, textures, and other scale reducing devices will be incorporated to provide compatibility with surrounding buildings. Building facades should include contrast in materials, scale of detailing, fenestration, modulation, and articulation. The design character of the smokestack and annex building should be reflected in the new building.

The building shall provide one of the two following alternative vertical modulation features to help reduce the appearance of bulk of the structure: 1) The building will "step back" from Jefferson by providing an approximately five foot deep step at the second or third floor and another approximately five foot deep step at the fourth or fifth floor. Under this configuration, the first step could occur in conjunction with a design feature for the approved Gym/Inn structure to the east. 2) Alternatively, the entire "step back" would occur at the top of the building at the fifth floor level, and would be approximately 5 to 10 feet deep. *(Council Condition 10)*

IV. Renovate Front Entrance

Replacement space for key existing functions and facilities below ground level, as well as renovation and enhancement of safety and accessibility to the main hospital for patients, visitors, and employees is planned for the existing front entrance on East Jefferson. These improvement projects would add approximately 65,000 gross square feet and would include:

- Above and below grade development replacement space will include:
  - Laboratory replacement space of about 12,000 square feet at Level A.
  - Radiology/Cardiology replacement space (including MRI and heart catheterization areas) of approximately 21,000 square feet at Level B.
  - Surgery replacement space of approximately 27,000 square feet at Level B.
  - Oncology replacement space of approximately 3,000 square feet.
- Renovation of the main entrance will add approximately 2,000 gross square feet and would include:
  - A new entry drive ramp up from East Jefferson to Level 1
  - Canopied entrance way
  - Remodeling of existing main entry
  - Replacement of existing surface parking below grade of approximately
  - 63,000 square feet/180 spaces
  - Development of a chapel above grade
  - Other related site improvements such as signage, landscaping, and lighting

Conditions Imposed by City Council:

Prior to use of the new parking area at the front entrance (Project IV), signs shall be installed to help regulate use. The area will be used primarily for visitors' parking and hospital visits by physicians. The latter use shall not exceed 30% of the parking area. Signs shall indicate that visitor and physician parking only is permitted during daylight hours (7:00 a.m. to 5:00 p.m.), and that employee parking is permitted during other hours. *(Council Condition 36)*

V. Replace West Tower

To replace the existing West Tower, a seven story nursing tower of approximately 19,000 square feet per floor and a height of 90 feet has been approved.

Conditions Imposed by City Council:

The load/unload area for the New Patient Wing (Project V) shall be located south of the 16th/Cherry intersection. *(Council Condition 16)*

VI. Develop Skilled Nursing Facility

This mixed use development totals about 60,000 square feet in five levels (3 levels are above grade and 2 are below grade).

The 60-bed project, located on the east side of the 1910 Building, will require demolition of a small portion of the existing building. The skilled nursing facility would be two stories (28 feet) and would have approximately 24,000 square feet. A physical plant replacement of about 24,000 square feet below grade is included with/or adjacent to this project. Loading dock and service area improvements would be provided at grade level. In addition, this project includes 12,000 square feet (1 level) Learning Resource Center/Environmental Services. The project would be comparable in design to the 1910 Building. The total above-grade height would be approximately 45 feet, for a total of 3 levels above-grade.

VII. Add Two Levels to East Wing

The East Tower, completed in November 1990, was originally designed for two additional levels. Each of the two additional levels would have approximately 18,000 square feet for a total of 36,000 gross square feet. The total building height would be 105 feet within the maximum allowable height for the site. The additional two levels would be set back from the existing parapet in order to preserve the intricate design.

Conditions Imposed by City Council:

The two-floor addition to the East Wing (Project VII) shall be pulled back away from the 18th Avenue frontage to the first "notch" in from the east side of the existing building, and additional trees shall be added along the 18th Avenue facade to soften the existing blank facade. *(Council Condition 12)*

VIII. Develop Providence Inn/Fitness Center

A new Providence Inn to be used by patients and their families only has been approved for the southeast corner of the campus on 18th and Jefferson. Designed as a three story facility, it would include two floors for the Inn (approximately 40 rooms) and a gym/fitness center on the third level. The first and second floors would be approximately 15,000 square feet and the third floor approximately 14,000 square feet thereby providing transition in height and scale with adjoining uses. A parking garage located below the three levels would accommodate 30 cars. Total building height would be approximately 36 feet.

Conditions Imposed by City Council:

The skybridge proposed to cross the 18th Avenue right-of-way is denied. *(Council Condition 5)*

The east side of the Gym/Inn (Project VIII) shall be set back at least 10 feet from the east property line. The top floor shall be set back an additional 10 feet to allow separation between the institutional building and the single-family zone. To break up the bulk of the facade, the building shall include modulation consisting of 20 to 25 foot long bays, separated by recesses a minimum 5 feet in width and 3 feet in depth. The east side of the structure shall maintain privacy of adjoining structures through the appropriate placement of windows or through use of opaque glass. *(Council Condition 11)*

Prior to occupancy of the Gym/Inn (Project VIII), a curb bulb shall be installed at the 18th/Jefferson intersection. In addition, the load/unload zone shall be located off 18th. SED Plan Review Section shall review the design and location of the curb bulb and loading zone. *(Council Condition 34)*

IX. Develop Day Care/Play Area

The site of the day care facility is on the corner of 18th and Cherry Streets. Total square footage is projected to be 3,500 square feet with an outdoor play area located on the lot Providence owns to the south. Total building height would be about 28 feet. The project would either involve renovation of the existing building or demolition and new construction. The drop-off/pick-up zone would likely be located along 18th Avenue.

Conditions Imposed by City Council:

The 20 foot setback for the Child Care Center (Project IX) shall include dense landscaping. *(Council Condition 13)*

The Child Care Center (Project IX) shall have a residential appearance. The rear yard will be designed to reduce noise for the single-family homes to the south and east with use of acoustical fencing or berms. *(Council Condition 21)*

Prior to occupancy of the Child Care Center (Project IX), a curb bulb shall be installed at the 18th/Cherry intersection. The load/unload zone shall be located off 18th. The SED Plan Review Section shall review the design and location of the curb bulb and loading zone. *(Council Condition 35)*

Summary of Development Square Footage

Table 2 summarizes the net increase in approved campus development. New construction and demolition building areas are detailed. Some 564,500 square feet of net new construction has been approved. This amounts to a 54% increase in total campus development.

Table 2
Existing and New Campus Development

Existing Baseline Gross Square Feet				869,953
Net New Square Feet of Recent Developments				172,258
Existing Development				1,042,211
Approved MIMP Projects		New Construction	Demolition	
* I.	Expand Parking Garage (71,000 + 118,000)	189,000		
II.	Family Medical Clinic/Parking	10,000	5,000	
III.	New MOB/Parking	75,000	50,000	
IV.	New D&T and Front Entry (65,000 + 63,000)	128,000		
V.	New Patient Wing	133,000	20,000	
VI.	New SNF (24,000), Boiler Plant (24,000 sf) Resource Center/Environmental Services (12,000 sf)	60,000	40,000	
VII.	Add Two Levels to East Wing	36,000		
VIII.	New Inn, Gym, & Parking (30,000 + 18,000)	48,000		
IX.	Day Care/Play Area	3,500	3,000	
		682,500	(118,000)	
	Net New Construction			564,500
	New Campus Total			1,606,711

* Assumes both alternatives are developed.

C. CIRCULATION

The development in this MIMP will not cause any substantial modifications to the existing site access and internal circulation systems; however, there are some differences that primarily relate to new parking supply locations. The primary Providence entry/exit location would continue to be from 17th Avenue just north of East Jefferson Street. This access would become a more prominent location because of the proposed increase in 119 parking spaces in this area. Similarly, since the parking garage would contain 706 additional spaces, the traffic circulation activity would increase on 16th Avenue between East Jefferson Street and East Cherry Street. Circulation activity at the parking facility located in the northeast corner of the 18th Avenue/East Jefferson Street intersection would decrease because of the net loss of 77 spaces. Access to the approved 30 below-grade parking spaces for the new Providence Inn would occur from 18th Avenue.

Conditions Imposed by City Council, see Section II.B.1. Parking Garage, and Section V, Additional City Council Conditions.

D. PARKING

A total of 694 net new spaces would be added with the approved MIMP projects as shown in Table 3 (Existing and Approved Parking), existing and new parking would increase off-street parking to 1,725 spaces. Figure 5 shows the location of existing and approved off-street parking. Future code required parking (year 2007) amounts to 1,540 (minimum) to 2,079 (maximum) spaces. The approved parking is above the minimum and below the maximum code required parking in the year 2002 and year 2007. Table 4 details the parking requirements.

The MIMP has been approved to expand the existing garage to add 706 spaces to the existing 724 space garage. A rezone of this part of the Providence MIO district has been granted for the parking garage expansion from MIO-37 (SF 5000) to MIO-65. In addition, below grade parking will be provided at the new front entry/diagnostic and treatment facility and with the new inn/fitness center.

Providence has a new Transportation Management Plan (TMP). A copy is included as part of this document (see Section III).

Table 3
Existing and Approved Parking

Existing Parking On-Campus				1,031 spaces
Existing Code Required Parking				1,152 minimum, 1,555 maximum
Approved MIMP Development		New Spaces	Demolished Spaces	
I.	Parking Garage Expansion			
	IA. Add 2-1/2 levels	204		
	IB. Expand South	502	39	
II.	Family Medical Center and Temporary Parking	10		
IV.	D & T/Entry (Below Grade Parking)	180	61	
V.	New Patient Tower		25	
VII.	New Inn/Gym (Below Grade Parking)	30	107	
		926	232	
	Net New Spaces			694
	Total Campus Parking Spaces			1,725
Future Code Required Parking				1,540 minimum / 2,079 maximum

See Section II.B.1. for conditions on parking.

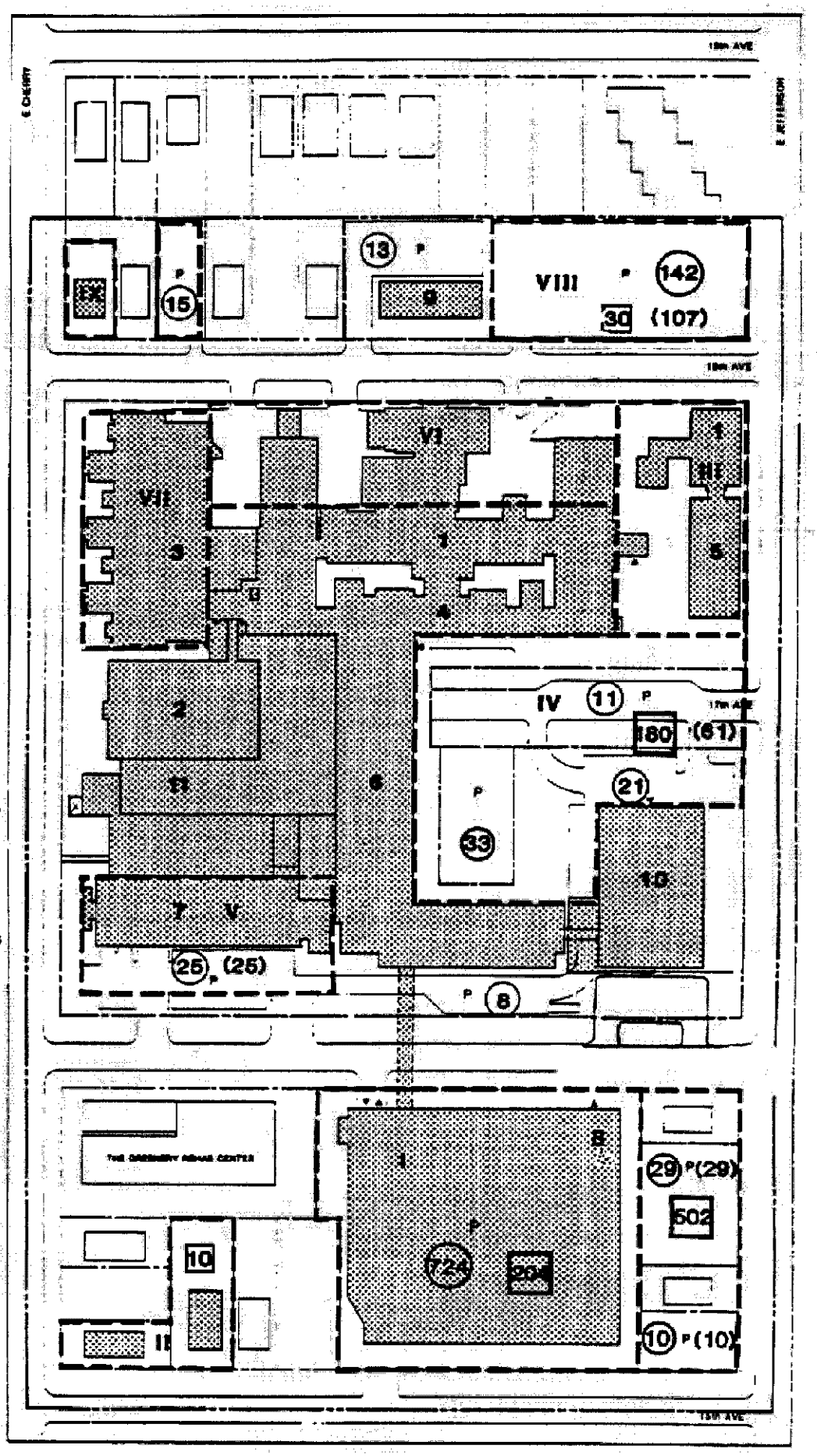


Figure 5
Existing and Approved Parking

Table 4
Providence Parking Requirements

	Total Number Basis (People/SF/Beds/Seats)			Minimum Parking Requirement		
	Existing	2002	2007	Existing	2002	2007
Long-Term Parking						
• Hospital-Based MDs (1 space/80%)	119	169	190	95	135	152
• Staff MDs (1 space/25%)	687	725	758	172	181	190
• Employees @ Peak Hour (1 space/30%)	1,680	2,071	2,071	504	621	621
Subtotal				771	937	963
Short-Term Parking						
• Inpatient Visitors (1 space/6 beds)	409	409	476	68	68	79
• Average Daily Outpatients (1 space/5 outpatients)	1,376	2,191	2,299	275	438	460
• Auditorium (1 space/10 seats)	140	140	140	14	14	14
• Auditorium (non-fixed seats) (1 space/200 sf)	4,859	4,859	4,859	24	24	24
Subtotal				381	544	577
Total Parking Requirement (minimum/maximum)				1,152/ 1,555	1,481/ 1,999	1,540/ 2,079
Total Supply				1,031	1,827 [1]	1,725 [2]

1 The first phase constructs 896 spaces and displaces 100 spaces for a net increase of 796 spaces.
2 The later phase displaces 132 surface spaces and constructs 30 spaces for a net reduction of 102 spaces.

E. OPEN SPACE

Existing open space, landscaping, and screening are shown in Figure 6. The open space functions as visual screening; it unites the campus; and it offers places for relaxation. There is also landscaped open space within public street right-of-ways. The landscaped open space on the Providence property amounts to about 14% of the total site area. This is an area of about 77,000 square feet and includes lawns, groundcover, patios/courtyards, and tree plantings. Sidewalks, roadways, and parking lots are not included.

The general open space concept consists of four elements:

- Campus edges around the periphery of the MIO district include open space buffers, building setbacks, and streetscaping improvements. The edge is a transition to the adjacent neighborhood and also distinguishes the Providence campus. It also provides open spaces that are visually accessible to the public.

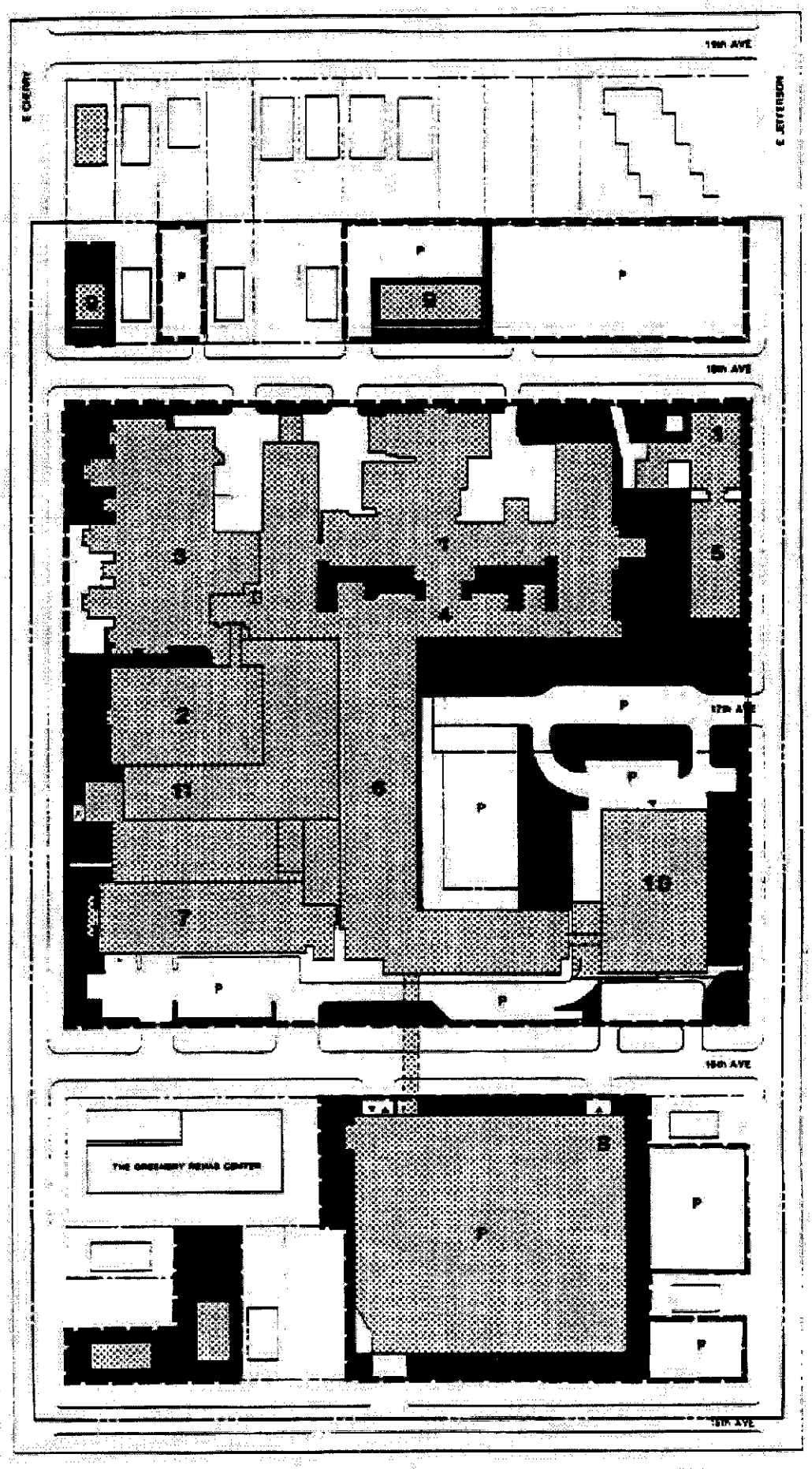
- Both 16th and 18th Avenues provide local access for people and vehicles. A residential-like landscaped boulevard with street trees and human-scale pedestrian improvements is envisioned.

- The main campus "front door" is at 17th Avenue and East Jefferson Street. This is a major entry space that clearly highlights the importance of this campus location.

- Courtyards throughout the campus enable both physical and visual access to landscaped open space. They complement building spaces and contribute to the overall campus character.

Open spaces and landscaping have not yet been designed in detail. The master plan presents a general organizational concept. Detailed open space and landscaping plans would be finalized and implemented at each phase of the approved projects. Street trees along 16th and 18th Avenues would be provided upon completion adjoining Master Plan projects.

Please see Section III.B. for conditions of approval for open space.



Existing Landscape Open Space

Existing Built Form

Other:
Parking, Wide Walks

Figure 6
Existing Open Space

Note: Existing landscaped open space along right of ways is not shown.

F. INFRASTRUCTURE IMPROVEMENTS

Public services and utilities are all available at the site. Existing services/utilities and providers are:

Electricity	Seattle City Light
Natural Gas	Washington Natural Gas
Water	City of Seattle
Refuse Service	City of Seattle
Sanitary Sewer	Metro/City of Seattle
Telephone	US WEST Communications
Police and Fire	City of Seattle

No major changes to infrastructure are planned. However, Providence does propose to replace its boiler and upgrade its physical plant. Utility improvements will be completed as required for each project.

G. PHASING

The Providence Master Plan is approved for a 15-year timeframe to from the date the MIMP was approved by the City Council. The general phasing/sequencing of projects is estimated in Table 1, page 8. It is possible that the sequencing of projects may change and/or projects may shift between phases depending on changing needs.

Generally Master Plan Projects I through IV are expected to be implemented within 10 years. Projects V through IX would occur in the subsequent 5 years. For purposes of impact evaluation, the master plan base year is assumed to be 1992 and the 10-year initial phase horizon is 2002. Projects V through IX would then extend to the year 2007.

The interim use of property awaiting development of the approved Master Plan projects will be substantially a continuation of existing uses. Demolition as part of site preparation may occur some time prior to development and could result in temporary open space or surface parking.

H. STREET, ALLEY, ROW VACATION

No streets, alleys or right-of-ways would be vacated.

I. ON-CAMPUS ALTERNATIVES

The No Action Alternative was considered and evaluated in the EIS. A series of five project alternatives were also identified that ranged from varied sitings of development to downsizing of planned facilities. Each of the alternatives was analyzed in the Draft and Final EIS and in the Draft and Final MIMP.

The first alternative sought to reduce the development scale and massing at the corner of 18th Avenue and Jefferson Street. The second alternative also sought to reduce development scale at the east edge of the campus by distributing development over a larger site area. The third alternative expands Providence ownership and distributes the campus parking supply. The fourth alternative responds to the need to discuss a "downsizing" alternative. The last alternative was intended to complete Providence property ownership within the existing boundary and intensify institutional development. None of the alternatives fulfilled all the Master Plan objectives of Providence.

J. RELATIONSHIP WITH HEALTH POLICIES/HUMAN SERVICE GOALS

Providence is committed to providing health care to the people in the community it serves. Providence is continually working to develop services for the poor, elderly, and mentally ill of our society in spite of mounting fiscal constraints. During 1990, Providence provided over 40.6 million dollars in uncompensated care. With a commitment to provide primary care, our clinics will continue to expand services for the underserved.

The Providence Rainier Clinic offers basic medical care to residents of the Rainier Valley. Patients pay what they can afford. In 1990, the clinic provided over $500,000 in non-billed services. In addition, the Community Pharmacy at Providence Rainier operates a charity prescription program.

The Providence Family Medical Clinic, a family practice residency program serving the Central Area sees more than 24,000 patients a year, over half of whom are on Medicaid. An area of special concern for the clinic is reducing high-risk pregnancies, often made worse by drug addiction. The Clinic has a Women, Infant and Children's Program, a Maternity Access Program, participates in the First Steps Program for high risk prenatal patients and provides prenatal classes and diabetes education. Almost all of the patients provided for under these programs are funded by Medicaid or account for uncompensated care.

Sister of Providence began the House of the Poor as one avenue to fulfill the mission of the Sisters to care for the sick, the elderly, and the poor with compassion and love. Today the House of the Poor has become Providence Regina House. It now serves nearly 18,000 people per year. It provides food for 275 families plus 50 emergency food bags each month. Through its Adopt-a-Family program in which Providence Medical Center employees and others from the community "adopt" a needy family, Providence Regina House serves an extra 500 families each Christmas and Thanksgiving, and 400 families at Easter time. During these times volunteers deliver food, presents, and Easter baskets to their adopted families.

Other Providence Regina House programs include a Homebound program, which delivers food every other week to 35 homebound senior citizens' families and 25 homebound AIDS patients; a free clothing bank; a Baby program that serves 60 neighborhood mothers providing them with diapers, baby food, clothes, and baby furniture; and a Back-to-School program that provides 65 children with school supplies and a new outfit for school.

Providence Regina House also works with three schools to help students learn community service. Each week 20 students help at the food bank separating and packing food and making home deliveries. Students from eight other schools help at Providence Regina House during holidays.

Providence Adult Continuing Education Program (PACE) helps employees to improve and maintain basic skills in math, adult basic education, English as a second language, writing and reading. Medical Center employees work as volunteer tutors to provide support and instruction. Participation in PACE is free and confidential.

Providence Child Care Center provides day care for employees and the community. As part of an agreement with the community, Providence has agreed to provide child care not only as a service to its employees, but reserves child care openings for use by local community residents.

The Safety and Security Department of Providence provides security and patrol of the surrounding community. Providence vans, equipped with radios, rove the neighborhood between 4:00 p.m. and 9:00 a.m. As an example, Providence provided extra patrol and security for the four houses on 19th Avenue while the houses were vacant and waiting for occupancy by the new owners.

Providence strives to provide local community services whenever possible. In the past several months, Providence provided over 50 first aid kits for a neighborhood tree planting and provided a place for rubbish to be discarded during a neighborhood clean-up effort. Providence also provides meeting space for the local community upon request.

Transportation service is provided for elderly and low income patients so that they can get to the appropriate clinic or hospital for their individual health care needs.

In an effort to contain development within its major institution boundary, Providence has turned back to the community 13 residential parcels at prices substantially below market value. Most recently, four lots on 19th Avenue were sold far below market value to the Central Area Public Development Authority for the construction of low income housing. The last remaining parcel located outside Providence's major institution boundary (Providence Regina House) was sold in September 1991.

Providence's cafeteria is open to the public, offering healthy, affordable food service and offers a discount to seniors.

HealthWise, a complementary membership program for seniors 65 and over has over 16,000 members. The program offers free HealthTalks, where specialists discuss various topics directly related to health, pharmacists offer free consultation regarding prescription medications, free consultation on diet and fitness is available, help with questions regarding insurance coverage, free flu shots, free parking, and special discounts in the cafeteria and gift shop. HealthWise provides advice and guidance that make it easier for seniors to use the health care system effectively.

Other human services provided include:

- Health Resource phone information line
- Donation of surplus equipment to Third World Countries
- Employee Assistance Program
- Stop Smoking classes available to employees, patients, and the public

In spite of all the complexities, Providence Medical Center strives to maintain a clarity of purpose. Just as the early Sisters did, Providence seeks to reach out to those in need. Providence Medical Center's rich history of providing for those in need will continue as a fundamental part of its mission. Improved facilities for providing these services will enable Providence to better serve this population.

III. Approved Development Standards Component and Conditions Imposed by City Council

A. Zoning

MIO District

Figures 7 and 8 show the major institution boundaries and zoning designations of Providence and the surrounding area. No boundary changes were sought. The campus includes three Major Institution overlay (MIO) districts, each distinguished by different potential maximum height limits: 37 feet, 65 feet, and 105 feet. A change in development standards for the MIO has been approved for the southwest portion of the campus (from MIO-37' to MIO-65') in order to accommodate an expansion of hospital parking facilities, as described in Section C., Development Projects. (Also see Section III.B., Approved Development Standards) The property to the west of 15th Avenue is designated with a 65-foot maximum height limit by Seattle University's MIO and the property to the north within the Providence MIO has a 65 foot height limit.

Underlying Zoning

The underlying zoning of the Providence campus is comprised of two zoning classifications; single-family residential, with a minimum lot size of 5,000 feet (SF 5000), and low-rise multi-family residential, with a minimum lot area of 800 square feet per dwelling unit (L-3). Changes to those development standards that have been approved are listed in Section III.B., Approved Development Standards. Conditions imposed by the City Council are also listed (conditions that are more project-specific are listed in the previous section of this MIMP, where each project is discussed).

B. Approved Development Standards

The following standards have been approved for the Providence Master Plan subject to the conditions imposed by the City Council. The standards replace the zoning standards of the underlying zoning.

Setbacks

Approved structure setbacks are shown in Figure 9. Generally the setbacks follow the existing structure setback pattern. Development fronting on East Cherry Street will have a setback of 20 feet except for the half-block east of 18th Avenue, which would have a 10 foot setback. Setbacks along East Jefferson Street would be 10 feet except between 15th and 16th Avenues and east of 18th Avenue where there would be 20-foot setbacks. A 10-foot structure setback would be along 16th and the east side of 18th Avenue, which are internal to the Providence campus. A 5 foot setback is approved along the west side of 18th Avenue. A 20 foot setback is approved along lot lines mid-block between 18th and 19th Avenues except for the southern parking lot site where there will be a 10-foot setback. A 10-foot setback is approved along 15th Avenue. Finally, there would be no setbacks from the internal lot lines within the campus. Setbacks can be a averaged to allow for building modulation. Setbacks would not vary due to structure height or relationships with adjacent zones. Any existing encroachments into the setbacks would be allowed to remain. Landscaping would be provided within setback areas.

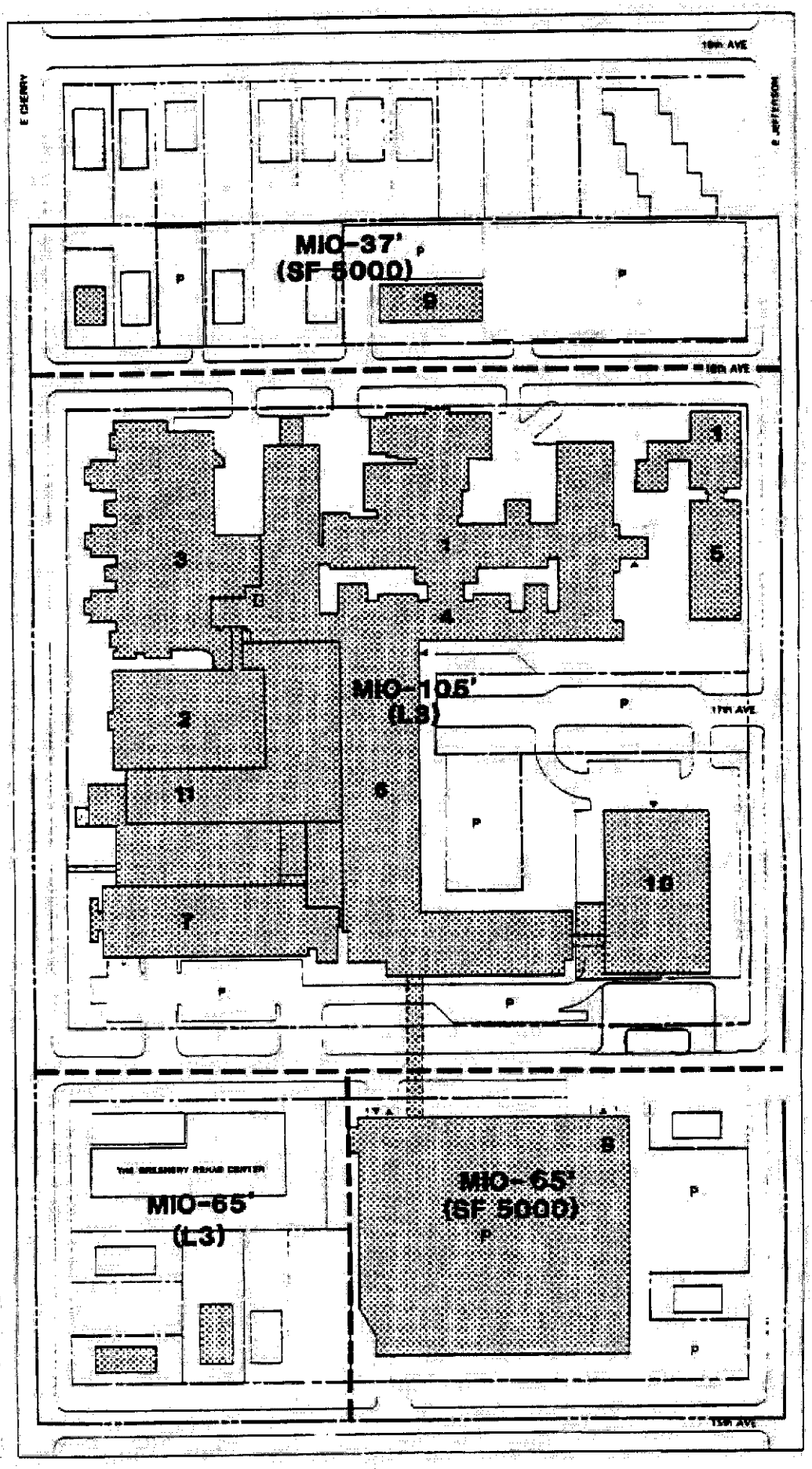
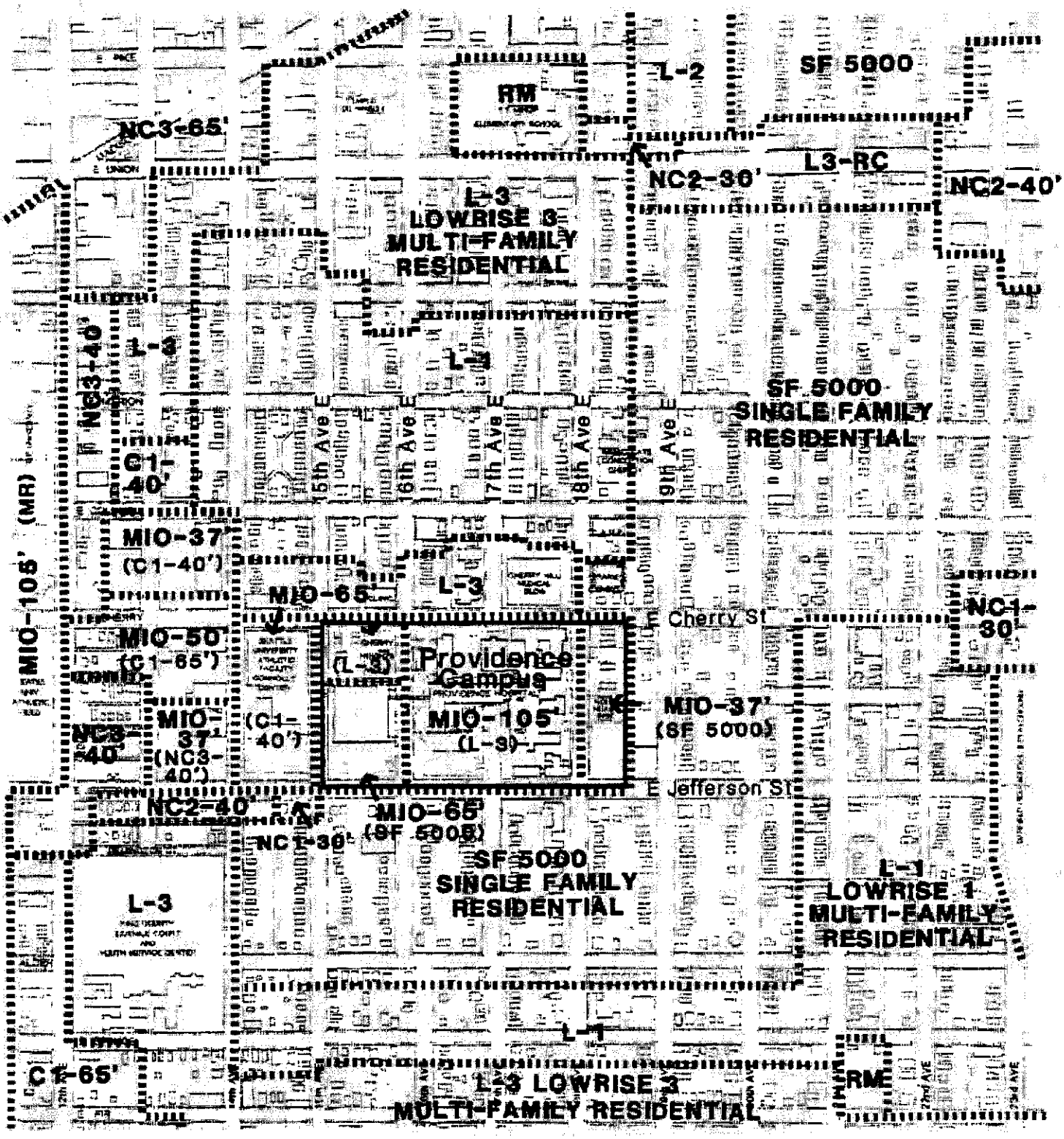


Figure 7
Existing Zoning



LEGEND:

Major Institutions Boundary

Height Limits: L-1 & 2: 25', L-3: 30'

Figure 8
Surrounding Zoning

0 100 200 400 600 Ft

1. 1910 Bldg & Boiler
2. West Tower
3. East Wing
4. Admin Wing
5. Annex
6. Center Bldg
7. Providence Professional Bldg
8. Parking Garage
9. Hope Heart Institute
10. Jefferson Medical Office Tower
11. Materials Mgmt

P Existing Parking

00ft Providence Approved Setbacks

* Setback May be Reduced to 5' If Providence Acquires the Existing Single-Family Properties and Develops Along the Street Under Alternative 2B

NOTE: All Internal Setbacks are Approved at 0 Feet

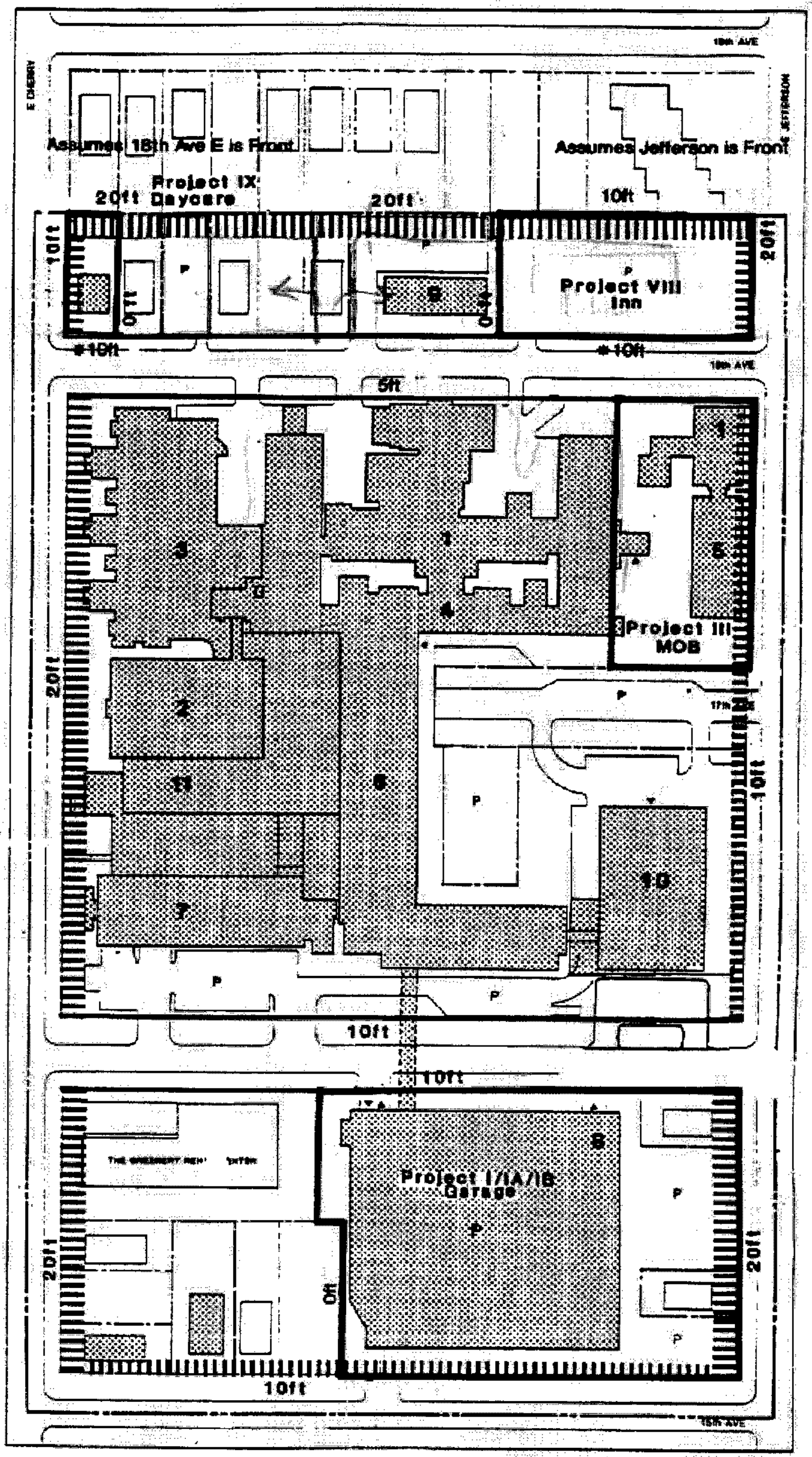


Figure 9
Approved Setbacks

Conditions Imposed by City Council:

The requested 5 foot setback on the west side of 18th is approved, but the required 10 foot setback on the east side of 18th shall be maintained. This setback may be reduced to 5 feet if Providence acquires the existing single-family properties and development along the street under Alternative 2B. Internal setbacks of 0 feet for the parking garage, Gym/Inn, and Child Care Center are permitted. *(Council Condition 4)*

The 10 foot setback along East Cherry Street for the Child Care Center and the 20 foot setback along East Jefferson Street for the Gym/Inn shall be heavily landscaped as a condition of issuance of the MUPs for these projects. *(Council Condition 6)*

For additional setback requirements see individual projects.

Height

Approved height standards are shown in Figure 10. Three height districts are included within the MIO District. The height limits of the underlying zoning have been modified to coincide with the MIO height limits as follows. The block bounded by 15th and 16th Avenues and East Cherry and East Jefferson Streets will have a maximum structure height of 65 feet. The southwest portion of this area has been rezoned to have a 65 foot MIO height limit. The central campus, bounded by 16th and 18th Avenues and East Cherry and East Jefferson Streets would have an MIO height limit of 105 feet. Finally, the half-block bordered by 18th Avenue and to mid-block of lot lines and East Cherry and East Jefferson Streets would have a height limit of 37 feet. Heights would be measured using an average grade technique. Customary code exceptions from rooftop features would apply.

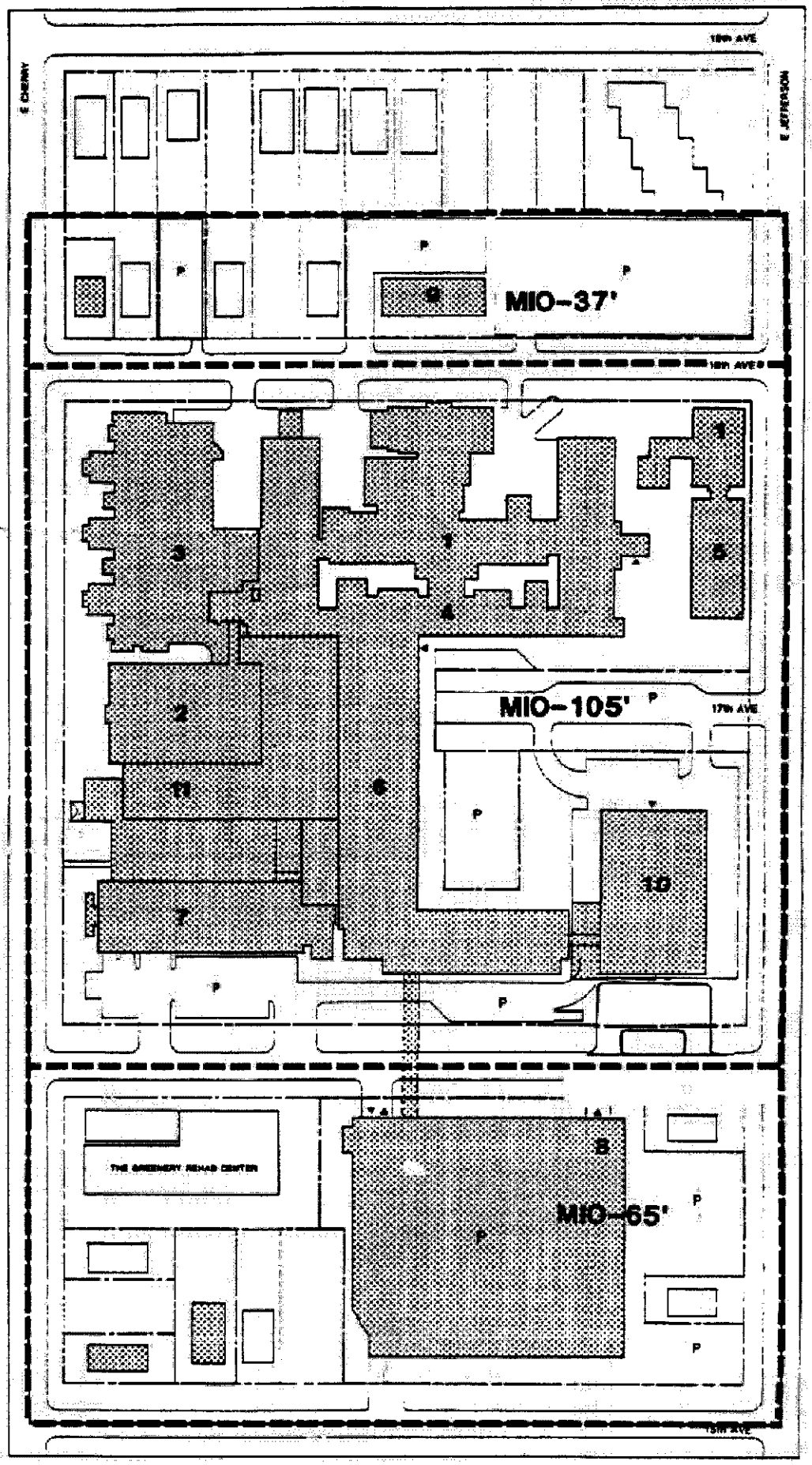
Lot Coverage

The total future Providence site area would amount to 550,600 square feet. The master plan projects would result in an additional lot coverage of about 62,400 square feet, accounting for the fact that some existing structures would be demolished. Lot coverage is summarized in Table 5.

Table 5
Approved Lot Coverage

Approved Site Area	Approved Structure Lot Coverage	Approved % Lot Coverage
550,600	318,504	65%

Since projects have not yet been designed, the exact building structure "footprints" and resulting lot coverage is not known. The estimated lot coverage will likely change as the projects are defined. The approved maximum lot coverage development standard for Providence is 65%. The basis for this calculation is the entire Providence campus and not for individual projects/site.



1. 1910 Bldg & Boiler
2. West Tower
3. East Wing
4. Admin Wing
5. Annex
6. Center Bldg
7. Providence Professional Bldg
8. Parking Garage
9. Hope Heart Institute
10. Jefferson Medical Office Tower
11. Materials Mgmt

P Existing Parking

Figure 10
Approved Height Standards

Density

Table 6 summarizes approved Providence densities.

Both the existing and the MIMP site areas are approximate. For FAR calculation purposes, parking is excluded. Parking is an accessory use serving the institutional functions and is excluded from density calculations. The MIMP site area (and some of the garage building area) is dependent on private property acquisition of two lots. The approved building areas will likely change as projects are architecturally programmed and designed. Since flexibility is required by Providence, a density standard was approved somewhat higher than calculated. A maximum density development standard of FAR 2.3 was approved. This amounts to + 0.3 FAR and about + 139,000 square feet of building area. The basis for the density calculation is the entire Providence campus and not individual projects/sites.

Table 6
Approved Density

Existing Site Area	Existing Building Area	Existing Building Area for FAR Calculation *	Existing FAR	Site Area	Approved Building Area	Approved Building Area for Calculation **	Approved FAR
540,800	1,042,211	814,420	1.5	550,600	1,606,711	1,126,920	2.0***

---

* Excludes existing garage area of 227,791 square feet.

** Excludes existing garage (227,791 sf) and approved garage additions of 189,000 square feet (Projects IA-IB) and 63,000 square feet (Project IV).

*** A density development standard of a maximum Providence campus FAR of 2.3 was approved. The standard exceeds the approved project FAR of 2.0 due to uncertainty in the projects and the need for flexibility.

Landscaping

Landscaping is planned throughout the campus and within setbacks. Street trees may also be provided. Trees, shrubs, groundcover, grass, and flowers would reinforce the open space concept and existing vegetation. Landscape plans are to be prepared with each development project and would specify the specific landscape elements.

Please see the following open space section for conditions on landscaping.

Open Space

The existing landscaped open space area of the Providence campus was estimated. It was defined to include lawns, groundcover, patios/courtyards, and tree plantings. The area is mostly impervious surfaces. Paved areas that are open, such as parking lots, private streets, service areas, and sidewalks were not included. Table 7 summarizes a comparison of existing and approved landscaped open space. Currently this amounts to about 77,000 square feet of land area or 14% of the total Providence campus. The approved development would affect the amount and location of landscaped open space. In the future, with completion of the Master Plan projects, the landscaped open space area amount approved is 10% of the total site. Since the landscaped open space plan is conceptual, the actual designed landscaped open spaces will likely differ in detail, but be consistent with the overall concept. The concept envisions places to eat lunch outdoors, flowering plants all year, overlooks and plantings consistent with the residential neighborhood.

Table 7
Approved Landscaped Open Space

Existing Site Area	Existing Landscaped Open Space Area	Existing Percent	Site Area	Approved Landscaped Open Space Minimum	Percent
540,800	77,000 sf	14%	550,600 sf	55,600 sf	10%

A portion of this landscaped open space includes a screening area around the campus property edges. A total property perimeter length of currently owned Providence land is estimated as 6,248 feet. The equivalent of a 3-foot wide strip of land for landscaped open space would amount to a total area of about 18,744 square feet. This area represents 3.5% of the total existing Providence-owned property. This landscaped open area reflects the urbanized character of the Providence campus.

The landscaped open space development standard for Providence that has been approved is a minimum of 10% of the total property area. It would consist of the various elements shown in the open space concept plan (see Section II.E.). The specific open space and screening standards of the underlying zones are changed to this standard that is tailored to Providence. Flexibility is required in the future when individual projects are designed. The landscaped open space percentage applies to the entire Providence campus and not to individual sites/projects.

Conditions Imposed by City Council:

In conjunction with each phase of development that reduces open space on the campus, the quality of landscaping in remaining open space areas shall be increased. This shall be accomplished by increasing the quality of landscaping in a remaining open space equal in size to the size of the open space being reduced in a particular phase of development. Where feasible, the additional landscaping shall be installed in the setback areas around the perimeter of the campus. Safety shall be a consideration in the design and maintenance of all open space and landscaped areas. The total amount of open space on the Providence campus shall be no less than 1096. *(Council Condition 1)*

Rezone

The block bounded by 15th and 16th Avenues and East Cherry and East Jefferson Streets previously had two MIO height designations. The northern portion of the block with underlying L-3 zoning is MIO 65 feet. The southern portion of the block with underlying SF 5000 zoning was MIO 37 feet. Rezone approval has been granted to designate the entire block MIO 65 feet.

IV. Approved Transportation Management Program Component

A. EXISTING AND APPROVED PARKING AND CIRCULATION

Existing Parking

Existing parking supply in the vicinity of Providence Medical Center includes approximately 1,970 parking spaces. This includes 939 on-street parking spaces and 1,031 off-street parking spaces. Approximately 179 on-street parking spaces are located within the boundaries or on streets that border the hospital campus. This area includes 15th, 16th, 17th, and 18th Avenues between East Cherry Street and East Jefferson Street, and East Cherry Street and East Jefferson street between 15th Avenue and 18th Avenue. The on-street parking spaces were found to be fully utilized during the a.m. and p.m. peak periods in this area.

Off-street parking at Providence Medical Center is provided at several locations throughout the hospital campus. The parking garage, which is the largest facility controlled by the hospital, consists of 724 parking spaces. The garage operates in the 90% to 100% of capacity range during the a.m. and p.m. peak periods.

Approval has been granted to increase the parking supply through implementation of the Master Plan project phases. Completion of the Master Plan would include the following changes in parking supply by phase.

- Phase I: Expansion of the parking garage would add an additional 706 parking spaces to the garage and eliminate 39 existing surface parking spaces for a net increase of 667 spaces.
- Phase II: Construction of the Family Medical Center would include the addition of ten temporary parking spaces.
- Phase IV: Construction of the D & T/Entry would include 180 new parking spaces and the demolition of 61 spaces. This would result in a net increase of 119 parking spaces.
- Phase V: Demolition of 25 spaces in the existing Providence Professional Building.
- Phase VII: Construction of 30 new below-grade parking spaces and demolition of 107 existing surface parking spaces. This would result in a net decrease of 77 parking spaces.

The net result of new parking construction, replacement, and demolition would be 694 spaces. When added to the existing 1,031 off-street parking spaces, the total parking supply would be 1,725 spaces.

The Seattle Land Use and Zoning Code establishes minimum/maximum parking requirements for major institutions. These requirements are determined for various uses, including long-term parking, short-term parking, auditorium, and bicycle parking. Under existing conditions, the minimum/maximum parking requirement for PMC is 1,152/1,555, respectively. Thus, the existing minimum parking required by code exceeds the off-street parking supply of 1,031 by 121 spaces. Completion of Master Plan Phases I through IV by the year 2002 would increase the parking supply to 1,827 spaces. The Seattle Land Use and Zoning Code requirement for 2002 is projected at 1,481/1,999 spaces; therefore, the parking supply would exceed the minimum parking requirement by 346 spaces. Completion of Master Plan Phases V through IX by the year 2007 would result in a decrease in the parking supply from 1,827 in 2002 to 1,725. This decrease results from the displacement of 132 parking spaces and the construction of 30 spaces for a net reduction of 102 spaces. The Seattle Land Use and Zoning Code parking requirements at completion of the Master Plan in 2007 are 1,540/2,079 spaces; therefore, the parking supply would exceed the minimum parking requirement by 185 spaces and would also be less than the maximum code requirement by 354 spaces.

The development in this MIMP would not cause any substantial modifications to the existing site access and internal circulation systems; however, there are some differences that primarily relate to new parking supply locations. The primary Providence entry/exit location would continue to be from 17th Avenue just north of East Jefferson Street. This access would become a more prominent location because of the approved increase in 119 parking spaces that would be provided in this area. Similarly, since the parking garage would contain 706 additional spaces, the traffic circulation activity would increase on 16th Avenue between East Jefferson Street and East Cherry Street. Circulation activity at the parking facility located in the northeast corner of the 18th Avenue/East Jefferson Street intersection would decrease because of the net loss of 77 spaces. Access to the approved 30 below-grade parking spaces for the new Providence Inn would occur from 18th Avenue.

Please see Section II.B.1. and II.C. for conditions on parking and circulation.

B. Approved Transportation Management Program

Attached is the approved Transportation Management Program (TMP), which would replace the existing TMP. The approved TMP is consistent with the required format and contents established by DCLU Director's Rule 4-91 and SED Director's Rule 91-5, effective 12/2/91.

PROVIDENCE MEDICAL CENTER

TRANSPORTATION MANAGEMENT PROGRAM

MEMORANDUM OF AGREEMENT

INTENT

The intent of this Transportation Management Program (TMP) is to reduce impacts to the environment, such as air quality degradation and traffic congestion, resulting from Building Employees commuting to Providence Medical Center main campus ("Providence") in single occupancy vehicles (SOV). Mitigation of these impacts will be accomplished by consolidating commuter trips into fewer vehicles, thereby reducing the number of automobiles driven to Providence. Trip consolidation will be accomplished by the institution providing incentives for use of High Occupancy Vehicle alternatives such as transit, carpooling and vanpooling.

EFFECT OF THIS AGREEMENT

This Agreement supersedes the prior July 1986 Memorandum of Agreement between the parties.

PARTIES TO THIS AGREEMENT

The parties to this Agreement are Providence, the Proponent; the City of Seattle [Seattle Engineering Department (SED) and the Department of Construction and Land Use (DCLU)], and the King County Department of Metropolitan Services (Metro).

AUTHORITY

This TMP is established by City Council Ordinance No. 117238 dated July 25, 1994 as a requirement of Providence Medical Center Master Plan approval, and pursuant to Seattle Municipal Code ("SMC") 23.54.016 and the State Environmental Policy Act (SEPA). This Memorandum of Agreement shall be for the properties and buildings at 500 - 17th Avenue, legally described in Attachment B (the "Property").

PROGRAM GOAL

The goal of this TMP is to reduce the number of commuter trips in Building Employee SOV to Providence to fifty percent (50%) of the total number of weekday peak period (3 p.m. to 6 p.m.) commuter

trips, excluding Building Employees whose work requires the use of a private automobile during working hours.

PROGRAM ELEMENTS

The elements and definitions of the Providence TMP are consistent with those described in SMC 23.54.016 and Director's Rule 4-91.

STANDARD IMPLEMENTATION REQUIREMENTS

All of the Standard Implementation Requirements listed in Director's Rule 4-91 shall apply to this TMP.

ADDITIONAL PROGRAM REQUIREMENTS

In addition to the Standard Implementation Requirements set forth in Director's Rule 4-91, the following are the Additional Program Requirements of this TMP. No further additional requirements shall apply except as modified by all parties to this Agreement in response to the evaluation procedure.

1. Establish and continuously maintain for the duration of this Agreement a Building Transportation Coordinator (BTC) to implement this TMP. The initial BTC will be Karen Lee Kimber.

2. Provide on request to all Providence employees a transit pass to commute to work at a minimum 50% discount of the peak hour rate or the maximum allowed for a Federal subsidy (whichever is lower). Provide vanpool participants a fare subsidy equivalent to the transit subsidy.

3. Provide parking in a preferential location for carpools or vanpools. Carpools of two (2) people shall receive a parking discount equal to at least fifty percent (50%) of the lowest monthly parking rate charged for a parking space on campus. Carpools of three (3) or more and vanpools shall park on campus at no charge.

4. Provide off-street parking for Providence employees commuting in SOV's at a monthly parking fee equal to or greater than the then current public transit authority's market rate for peak period one-zone transit passes.

5. Continue to provide weather-protected, secure bicycle racks at no charge to Providence Building Employees at a preferred location on campus. The design of any additional or new bicycle racks shall be consistent with guidelines provided by the Seattle Engineering Department Bicycle Coordinator. Bicycle parking shall be out of major pedestrian pathways.

6. Pay the costs for Residential Parking Zone (RPZ) stickers for residents residing in the vicinity of Providence and directly impacted by Providence, and pay a portion of the cost for RPZ's for those areas impacted by Providence, Seattle University and other employers, up to a maximum of one (1) sticker for each adult automobile driver residing in a residential unit in said area and one visitor sticker per residential unit. Providence shall not provide Providence employees with RPZ stickers unless the employees are residents within the Providence boundaries or within the area of the RPZ. Attachment C shows the existing area in which Providence is currently paying for RPZ stickers.

7. Encourage and support alternative work schedules including flex time, compressed work weeks and staggered work hours to reduce the amount of traffic generated by Building Employees during peak commute hours of the day, to the extent possible without compromising institutional service requirements.

MODIFICATION OF INCENTIVES

Providence, DCLU or SED may initiate proposals to modify the Additional Program Requirements of this TMP if one or more of, but not limited to, the following conditions occur. The modification will only take effect upon approval by DCLU. (1) If there is a decrease in the level of Metro public transit service (from the level of service being provided as of the date of this Agreement) to Providence and the Central Area, including the failure to provide service from the eastside; or (2) if sufficient capacity is not provided in Park and Ride facilities; or (3) if survey results at any time 6 months or more after execution of this Agreement demonstrate that Providence and/or affiliated organizations leasing space are achieving the Program Goal, then incentives may be decreased by amending this Agreement, provided SOV trips do not exceed the maximum of 50% (as adjusted as provided herein) of commute trips, excluding trips by exempt employees, to Providence.

EVALUATION

The evaluation of this TMP shall be in accordance with the evaluation procedures outlined in Director's Rule 4-91. The first evaluation shall take place two years following execution of this Agreement.

ATTACHMENTS

There are three attachments to this Agreement which are incorporated herein by this reference. They are Attachment A: Director's Rule 4-91; Attachment B: Legal description of the

properties and buildings known as Providence Medical Center; and Attachment C: Map showing area in which Providence is paying for RPZ stickers.

Signed for:

(1) PROVIDENCE MEDICAL CENTER

Signature — Date: 10/13/94

DAVID BANG — CHIEF FINANCING OFFICER

Type or Print Name — Title

(2) KING COUNTY DEPARTMENT OF METROPOLITAN SERVICES

Signature — Date: 1/9/95

PAUL A. TOLIVER — Director of Transit

Type or Print Name — Title

(3) THE CITY OF SEATTLE

a. DCLU

Signature — Date: 11/3/94

R. F. Krochalis — Director of DCLU

Type or Print Name — Title

b. SED

Signature — Date: 12/19/94

John Okamoto — Director

Type or Print name — Title

DCLU

DCLU Director's Rule 4-91
SED Director's Rule 91-5

Applicant CITY OF SEATTLE DEPARTMENT OF CONSTRUCTION AND LAND USE	**Page** of 1 15 **Supersedes** SED 88-1 DCLU 24-88
Subject TRANSPORTATION MANAGEMENT PROGRAMS	**Publication** 07/01/91 **Effective** 12/02/91 **Code and Section Reference** 25.05; 23.44; 22.M; 23.45.122.D; 23.48.18.C 23.49.16.B **Type of Rule** Code Interpretation **Ordinance Authority** 3.06.040 SMC
Index Land Use Codes/Environmental	**Approved DCLU** **Date** Dennis McLerran 11/27/91 **Approved SED** **Date** 11/25/91

Purpose

This Rule establishes the contents and procedures for Transportation Management Plans which are required in conjunction with development proposals.

Background

Seattle SEPA Ordinance, Chapter 25.05, Seattle Municipal Code (SMC) authorizes the Department of Construction and Land Use (DCLU) to grant, condition or deny construction and use permit applications for public or private proposal which are subject to environmental review. This authority must be exercised based on adopted City policies, plans, rules or regulations set forth in Chapter 25.05, SMC.

Adverse traffic or parking impacts associated either with a single development or cumulatively associated with prior, simultaneous, or induced future development, may be identified in the course of environmental review. Reasonable mitigation may be accomplished by requiring, among other things, a transportation management plan (TMP). The SEPA authority for this requirement is found in SMC Section 25.05.675: (B) Construction Impacts, (M) Parking, (R) Traffic and Transportation, and Section 25.05.670, Cumulative Effects Policy.

-Site Improvements (carpool/vanpool parking, bicycle parking, etc.) as required by the Land Use Code

Note: Minor institutions and residential developments may only be required to provide one or more of these components.

C. Discretionary Program Requirements composed of one or more of the following:

-Discounted carpool/vanpool parking
-Transit subsidy or discount
-Increased SOV parking rates
-Rideshare bonuses
-Vanpool sponsorship and subsidies
-Preferential parking location for HOVs
-Alternative working schedules
-Subscription bus service
-Shuttle services
-Telecommuting programs
-Reduction of SOV parking supply
-Fleetpools
-Residential parking zones
-Additional site improvements
-Off-site mitigation
-Guaranteed Ride Home programs
-Shower/locker room facilities
-On-site bicycle training programs (including bicycle education, etc.) to reduce SOV trips
-Coordination of ridesharing programs with other employers
-Other similar programs to reduce SOV trips

D. Evaluation Criteria

Condition(s) imposing TMPs shall include a mandatory goal based either on adopted performance standards, if applicable, or on a level of mitigation established in the respective environmental document (DNS, EIS, MDNS). In most cases the goal will be expressed as a maximum number of daily single occupancy vehicle trips; but may be modified in the condition to be expressed in terms of another measurable standard, including but not limited to maximum peak hour vehicle trips, maximum overflow parking, or maximum number of employee vehicle trips. The Director may require that the goal be phased in over time to take into account initial occupancy and site development. The Director may choose not to impose a specific goal for a TMP where the project involves minor institutions, residential projects, projects which do not establish a specific level of mitigation i an environmental document, or where imposition of a specific goal is not practical or would not further mitigate environmental impacts.

Director, the Director's decision shall state which TMP components are required.

Major Institutions

All expanding Major Institutions (as defined in SMC 23.84.025) are required to provide TMPs. They shall be subject to all the requirements of this rule except that program elements (as set forward in sections I.B and I.C) shall be consistent with Seattle Municipal Code 23.54.016 C. TMPs resulting from Master Plans shall be established in the City Council approval.

Cumulative TMPs

Pursuant to the SEPA Cumulative Effects policy (SMC 25.05.670), individual projects may be required to participate with other known or future developments in cumulative TMPs. Such programs may be required to develop joint marketing, promotion, communication, program development and monitoring efforts. Conditions for cumulative TMPs should establish the roles and responsibilities of TMP participants.

II. TMP Acknowledgment

Prior to issuance of a Master Use Permit for any project requiring a TMP including minor institutions, the applicant and current property owner(s) shall record an acknowledgment of the permit conditions in a form acceptable to DCLU with the King County Recorder (see attachment A). A copy of the recorded document, showing the recording number, shall be filed with DCLU prior to permit issuance. The Director may substitute a memorandum of agreement for the acknowledgment for major institutions and other sufficiently complex Transportation Management Programs. The acknowledgment may be waived by the Director where preparation of the document is not reasonable or for institutions where the TMP measures are a fundamental part of the institution's operation.

III. Standard Implementation Requirements

A. Building or Institution Transportation Coordinator (BTC)

The Building or Institution Transportation Coordinator (BTC) shall be appointed by the building or institution owner(s) and/or responsible party(s) prior to issuance of the Certificate of Occupancy. The BTC shall be responsible for accomplishing program goals. The BTC shall be available to building employees/tenants during normal business hours. The BTC may or may not be housed on site, but shall be available on site during normal business hours to assist employees an promote the TMP. The BTC shall have a clearly identified on-site wor station and telephone listing that are accessible to all employees.

or institution employees. Refreshments or some other incentive for attendance shall be provided.

3. Centralized Major Event

A centralized major event is a staffed promotion conducted for a minimum of four hours for employees of an institution or multi-building development. One may be required for institutions (including major institutions) or where two or more buildings in a single development are located in the same geographic area. Centralized events are preferred to individual events held by each building. Location, information and refreshments or some other incentive for attendance shall be similar to those provided for a four-hour staffed event.

The BTC shall organize and staff promotional events.

The owner(s) and/or responsible party(s) shall finance the event, including cost of materials, facilities, and refreshments and other incentives for attendance.

Metro shall provide planning and staff support, generic marketing materials and the destination brochure (and updates) for the building.

SED shall provide planning and staff support and certain marketing materials it deems appropriate.

C. Commuter Information Center (CIC)

A CIC is a transportation information display in a free-standing, wall-mounted, or kiosk configuration which provides rideshare and transit service information including a destination brochure, targeted specifically to the commuter market. The CIC shall be located in a prominent location, typically in the lobby of a building, or in the employee cafeteria if the building has no lobby or the building limits access to the building for security reasons. The CIC shall be required to be in place prior to issuance of a final certificate of occupancy.

SED shall specify the details of the CIC requirement in consultation with DCLU and Metro, but may be designed to be consistent with the building design.

The BTC shall keep the CIC stocked with transit/ridesharing information.

The building owner(s) and/or responsible party(s) shall construct the CIC according to Metro specifications, shall locate the CIC in a prominent place and shall maintain the CIC in good condition.

SED shall maintain a stock of ridematch applications and may provide the applications with survey forms.

F. Employee Mode Split Survey

An employee travel-mode survey may be required by the Director no mor than every two years to determine travel behaviors, determine mode split, and verify effectiveness of the TMP. The survey returns shall represent a stratified sample of the employee population and meet a 95% statistical confidence level. Analysis of survey data and reporting of findings shall be prepared according to SED and DCLU specifications.

The owner(s) and/or responsible party(s) shall pay for the employee survey.

The BTC shall coordinate and conduct the survey of employees commutin to the building, including distribution and collection of survey form and tabulation of survey results. The BTC shall promptly report survey findings to SED. Alternatively, DCLU may require that independent surveys be conducted with results provided directly to DCLU. Any independent surveys shall be paid for by the building owne and/or responsible party.

SED shall provide a copy of the survey form and standards for the survey. SED shall analyze survey data and calculate progress being made to accomplish TMP goals. SED shall report survey findings to DCLU, Metro and the owner(s) and/or responsible party(s).

Metro may provide analytical assistance to SED as necessary.

G. Building Occupancy Survey

The Director may require a survey or other documentation of building occupancy from the building operator at any time. The information ma be used to verify actual building occupancy in order to determine compliance with TMP standards.

H. Reporting

Quarterly reports shall be prepared and submitted to SED. The report shall include information about numbers of operating carpools and vanpools, number (including a breakdown of type of pass sold) of transit passes whether provided by the building owner or purchased independently by employees, success in achieving TMP SOV goals, and implementation of mitigation strategies. The Director may also require the number of people bicycling and walking to be reported. Reporting forms will be provided by SED. Reports shall include parking rate information and shall identify the lowest parking rate charged to any tenant. The quarterly reports shall be consolidated annually and analyzed and evaluated every two years.

Building or Institution Transportation Coordinator

This position is responsible for implementation and administration of the Transportation Management Plan (TMP) within the building or throughout an entire institution. The BTC position description is included as Attachment B. The BTC may delegate responsibility to staff, and will be available during normal business hours on site to assist employees and promote the TMP.

Building Occupancy Survey

A survey provided by building or institution management of actual building occupancy, often broken down by time of day.

Carpool

Any vehicle certified by the Engineering Department and containing at least two people, one of whom is employed in the project building and who commute together at least four days a week. The number of people necessary to comprise a carpool may be changed by the Director in permit condition(s).

Carpool Parking Discounts

Monthly parking fee charged to Certified Carpools which has been discounted from the lowest monthly fee charged to any building tenant for the type of parking space the carpool vehicle uses.

Carpool Set Aside Spaces

Space reserved for exclusive use by certified building carpools between the hours of 7:00 and 10:00 a.m. Carpool spaces shall be clearly identified by signs. If all spaces have not been taken by carpools by 10:00 a.m., they may be used as short-term parking. If at the end of the first program year the carpool goals are not being met, the rate for the carpool space will be discounted by 50% of the lowest monthly rate charged to any tenant for certified building carpools.

Commuter Information Center (CIC)

A permanent, highly visible, on-site display of the array of available commute modes. The CIC holds information about ridesharing (carpools, vanpools); Metro Transit travel; alternative work hours and other information related to ridesharing.

DNS

A Determination of Non-Significance, which does not result in preparation of an Environmental Impact Statement (Section 25.05.310 and 25.05.340 SMC)

Other Trips

Any mode of travel to and from work which is not an SOV or HOV, including but not limited to walking, bicycling, ferry, motorcycles, and drop-offs from a vehicle continuing through the Central Business District.

Preferential Parking Allocation

Designation of accessory parking such that parking for HOVs and other travel modes (vans, carpools, bicycles, etc.), is more convenient than parking for SOVs. This could include use of covered parking and proximity to building access.

Project Building

The building and/or project (including one or more buildings) which is subject to the condition imposing the TMP.

Promotional Events

Specific site events designed to educate and inform employees or residents of available commute options and HOV incentives. Promotional events could include commute fairs, inclusion of rideshare information in new employee or resident orientation, or distribution of promotional brochures and information.

Residential Parking Zones

A City-approved street designation and permit system limiting on-street parking by non-residents. Development participation could include funding initial studies, initial program set-up, and annual permit costs.

Ridematch Opportunities

A carpool, vanpool, and custom bus matching service provided by Metro. Individuals volunteer to be matched with others having similar commute tri origins, destinations, and schedules.

Rideshare Bonuses

Financial or other bonuses provided on a monthly or other basis to employees who use one or more non-SOV travel modes.

Shower/Locker Room Facilities

On-site facilities or access to nearby facilities which allow bicycle and walking commuters to shower and change clothes.

Vanpool Participant

A commuter who travels to and from his/her home to the project building at least four days a week in a designated vanpool. The participant shall be employed at the project building to be eligible for fare discount offered under any terms of this agreement.

Vanpool Sponsorship and Subsidies

Participation to fund all or portions of vanpool acquisition, operation, and ridership costs.

JTD/tmprule

Attachment B

PROVIDENCE MEDICAL CENTER

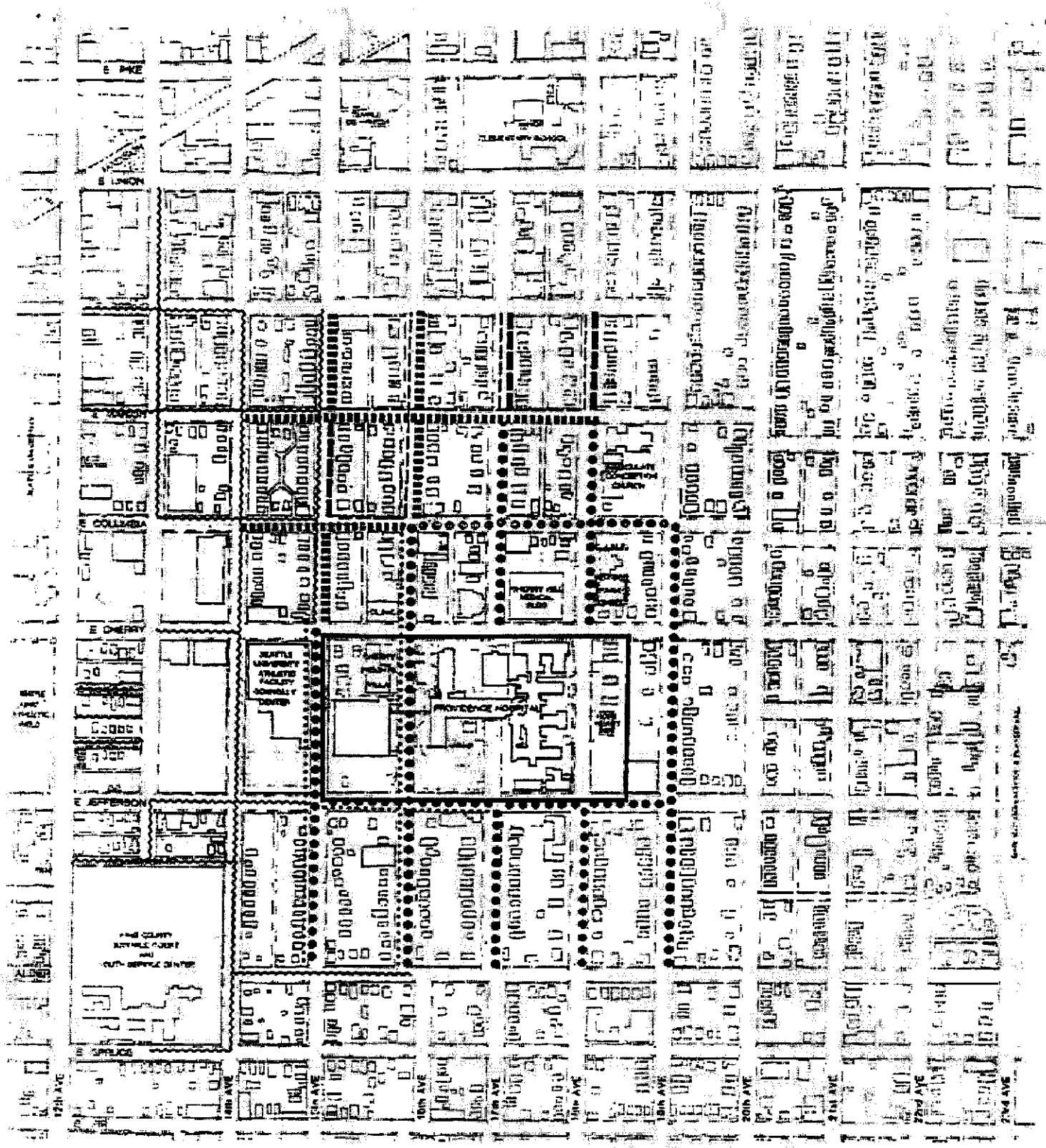
LEGAL DESCRIPTION

Those portions of Blocks 2 through 5, Squire Park Addition to the City of Seattle, as recorded in Volume 8 of Plats, page 6, records of King County, Washington, described as follows:

Block 2: Lot 7, Lots 11 through 19; the southerly 5 feet of Lots 4, 5 and 6; the northerly 47 feet of Lots 5 and 6; and that portion of Lot 4 westerly of a line running from a point 5 feet east of the northwest corner of Lot 4 to a point 10 feet east of the westerly lot line of the northerly 47 feet of Lot 4; and

All of Blocks 3 and 4, together with vacated 17th Avenue adjacent thereto; and

Block 5: Lots 6 and 7; the southerly 1/2 of Lot 10; Lots 11 through 17; Lots 19 through 21; Lots 23 through 29; the southerly 8 feet of Lots 4 and 5; and the westerly 16 feet of the northerly 92 feet of Lot 5.



LEGEND:

- Major Institutions Boundary
- Existing RPZ
- Qualify – Need Petitions
- Qualify – With Petitions
- Seattle University
- Providence Medical Center
- Seattle University and Providence Medical Center

0 100 200 400 600 Ft

Attachment C

Providence Residential Parking Zones (RPZ)

V. Additional City Council Conditions

Providence shall demonstrate that new Buildings III, VI, VII, and VIII interpret design features of the 1910 Building, and that all new buildings incorporate design features of structures in adjoining neighborhoods to the extent possible. New buildings shall have the same design theme, with similar color schemes and materials wherever possible. For corners of the campus at public rights-of-way where new development is proposed, building designs and plantings shall emphasize both the corner and the Providence campus. *(Council Condition 2)*

To mitigate for potential height, bulk and scale impacts on surrounding residential properties, Providence shall seek input from the neighbors and from the Master Plan Standing Committee, regarding design of buildings adjoining residential neighborhoods, including, but not limited to, the Parking Garage (Project 1B), the MOB (Project III), the East Wing Addition (Project VII), the Gym/Inn (Project VIII), and the Child Care Center (Project IX). The process for obtaining comment shall be subject to review by the Master Plan Advisory Committee and shall be approved by DCLU. Neighborhood review shall be guided by the Agreement for Supplemental Mitigation between Providence and the Squire Park Community Council. *(Council Condition 3)*

DURING MASTER USE PERMIT PROCESS

No flat or unmodulated blank facades, particularly at street level, shall be incorporated into the new buildings. *(Council Condition 7)*

Mechanical penthouses and other similar rooftop features shall be incorporated into the overall building design, be visually obscured, and, to the extent possible, oriented away from nearby residential uses. *(Council Condition 8)*

Providence shall be assessed 2.2% of the cost of the 6th/James intersection improvements. The actual dollar amount shall be determined by SED. *(Council Condition 17)*

Providence shall provide documentation to DCLU that buildings will not cause significant adverse lighting impacts. Plans for each new project shall indicate the location, direction, and intensity of proposed exterior lighting. Buildings shall be designed to shield or direct exterior lights away from light-sensitive structures, including nearby residences. Providence shall demonstrate that lights inside the parking garage (Project 1B) will be screened from view to prevent light spill outside of the building. Screening shall be accomplished through the use of baffles, directional lighting or any other features. *(Council Condition 18)*

Providence shall provide evidence to DCLU that buildings will not cause adverse glare impacts. Finishes and windows on new building shall be of a low-reflectivity or non-reflective color or tint. Other methods to avoid glare impacts, such as using recessed windows, retaining vegetation, changing the angle of glass panes shall be used as necessary. *(Council Condition 19)*

A noise analysis shall be submitted with each MUP for projects adjoining residential property. In general, noise-producing mechanical equipment shall be located away from residential properties. The noise study shall demonstrate that continuously generated noise levels from mechanical equipment associated with new buildings will meet Seattle Noise Ordinance standards for residential receiving properties. *(Council Condition 20)*

Providence shall coordinate with City Light on changes or expansions to electrical service to facilitate development of infrastructure to meet demand. Providence shall coordinate with the Customer Service Division as plans for demolition and construction are developed. *(Council Condition 22)*

Providence shall work with the Police Department to incorporate Crime Prevention through Environmental Design techniques into the design of each building. *(Council Condition 23)*

PRIOR TO ISSUANCE OF A BUILDING PERMIT

Areas for recycling bottles, cans, paper, and plastic shall be included in each new buildings. Signs shall be posted to indicate availability of the recycling area to visitors and employees. Recycling areas shall be located to minimize adverse visual impact, noise, and odors. Location of each recycling area and sign wording and location shall be subject to review by DCLU. *(Council Condition 24)*

DURING CONSTRUCTION

In order to minimize construction parking impacts, construction personnel are required to park at an off-site location and be shuttled to and from the site. Providence shall ensure that construction workers do not park on the streets or in private lots in the Providence campus vicinity. Construction activities shall be scheduled so that the most intensive construction and parking activities are spread out over time. Construction material delivery vehicles shall be prohibited from entering or leaving the area during peak hours. Providence shall provide for safe pedestrian and vehicular circulation adjacent to construction sites through the use of temporary walkways, signs, and manual traffic controls (flaggers). *(Council Condition 25)*

Construction hours (to include both demolition and construction activities) shall be limited to non-holiday weekdays between the hours of 7:30 a.m. and 6:00 p.m. This limitation is subject to minor revisions at the discretion of DCLU to allow work of an emergency nature, work required obstruction of street rights-of-way, and minor, usually interior work, of low noise impact. *(Council Condition 26)*

A noise consultant shall be retained to measure construction and mechanical system noises generated by each project adjoining residential property. Measurements shall be taken from receiving properties. If applicable noise levels are exceeded, a variance shall be obtained, or noise reduction methods shall be promptly applied to bring noise levels within Code limits. Construction noise and vibration impacts shall be minimized by shielding noise equipment, avoid excessive idling, locating equipment away from sensitive receivers such as residential uses, and adequate muffling of equipment; scheduling particularly noisy operations to avoid conflicts; providing acoustical screens or enclosures where necessary; assembling building components off-site to the greatest extent possible; identifying a 24-hour contact person to receive noise complaints; and, coordinating construction mitigation. *(Council Condition 27)*

Whenever possible, special measures for noise control of unusually loud equipment or activities shall be used during construction. This equipment shall include special mufflers for machine engine exhausts or air powered equipment and acoustical screens or enclosures to be used as needed. *(Council Condition 28)*

Providence shall use the newest equipment available and shall keep construction equipment in good working condition. In addition, Providence shall reuse demolition materials to the greatest extent possible and ensure that long periods of construction equipment idling are avoided. *(Council Condition 29)*

To the maximum extent possible, Providence shall minimize solid waste by including the salvage, re-use on-site, and recycling of demolition materials. *(Council Condition 30)*

FOR THE LIFE OF THE PROJECT

To facilitate orderly monitoring of the Master Plan, annual reports shall be submitted to DCLU and SED and the Standing Advisory Committee on the anniversary of the adoption of the Master Plan or the fiscal year end, at the choice of Providence.

The annual report shall give basic information on building inventory changes, projects pending and completed, TMP status, Master Plan goals and objectives achieved, conditions met, revision, and other information as appropriate to the monitoring of the progress of the Master Plan. The report shall be in a form thematically compatible with the Master Plan, and attachable as an exhibit to the Master Plan. The report shall also be compatible with TMP reports as determined in the Memorandum of Agreement. *(Council Condition 37)*

Providence shall continue to distribute routing maps to delivery truck drivers to inform drivers of arterial street routes to the freeway system and other major destinations. Providence shall also continue to inform drivers that they are not to use neighborhood residential streets. *(Council Condition 38)*

Signs installed to direct patients and visitors to the campus shall be maintained. *(Council Condition 39)*

Landscape plantings shall be maintained and replaced by Providence as necessary to provide the aesthetic and buffer functions intended. *(Council Condition 40)*

The Master Plan shall be in effect for 15 years from the effective date of City Council approval. *(Council Condition 41)*

VI. Conditions Agreed to by Providence and Squire Park Community Council

Providence Medical Center

ADDITIONAL MITIGATION MEASURES FOR MAJOR INSTITUTION MASTER PLAN*

1. SPECIFIC PROJECT CONDITIONS

a) Expanded Parking Garage Project *(MIMP Project IB)*

- The addition to the garage shall be designed to mitigate light and glare from spilling on to the residential properties to the south across Jefferson.

- The addition to the garage facade shall be designed to appear less "garage-like" and to take on a character of a building compatible with the community setting. One possible design technique will be to provide window-type openings, rather than long horizontal openings typically associated with the levels of a garage.

- Landscaping within the 20-foot buffer to the approved garage along the Jefferson Street frontage shall be of sufficient quality and quantity to create an immediate visual "green screen" upon construction. Mature evergreen and deciduous plant material of large caliper will be used. Attempts will be made to save (possibly relocate) any significant existing specimen trees at the time of the approved development. Flowers and plants with color will e added to add visual diversity particularly where; most visible to pedestrians, such as along adjoining sidewalks. The design may suggest a transition in scale, with taller plantings near the garage facade and lower plantings to the south. Safety will be a design consideration along with opportunities to create places to enjoy the landscaping. Lighting will be included to avoid dark areas.

b) Family Medical Clinic / Parking *(MIMP Project II)*

- The setback areas will be extensively landscaped with high quality and visibility accessible landscaping, in lieu of the requirement for 25% open space. Mature (minimum 4" caliper when installed) will be used along the 15th Avenue frontage.

c) New MOB *(MIMP Project III)*

- The new MOB will be designed to interpret the architectural character of the existing 1910 Building. Architectural design measures including facade articulation, modulation, detailing, materials, color, textures, and other scale reducing devices will be incorporated to improve building compatibility with its context. Building facades would include contrast in materials, scale of detailing, fenestration, modulation, and articulation. For example, detailed sills, belt courses, cornices, and bricks to complement the adjacent building would be utilized. While the smokestack and annex building cannot be retained, their design character will be reflected in the new building.

* The additional mitigating measures agreed to by Squire Park Community Council and Providence Medical Center are not enforceable by the City except for those measures incorporated into the City Council decision.

- In addition to the foregoing, the building will provide one of the two following alternative vertical modulation features to help reduce the appearance of bulk of the structure:

    - The building will "step back" from Jefferson by providing an approximately 5 foot deep step at the 2nd or 3rd floor and another approximately 5 foot deep step at the 4th or 5th floor. Under this configuration, the first step could occur in conjunction with a design feature for the approved Gym/Inn structure to the east.

    - Alternatively, the entire "step back" would occur at the top of the building at the 5th floor level, and would be approximately 5'-10' deep.

d) New D & T and Front Entry/Parking *(MIMP Project IV)*

- The new parking area at the front entrance will be used primarily for visitors parking and hospital visits (not permanent parking) by physicians (and not to exceed 30% of this parking area). During the evenings employees will use the garage for parking after visiting hours.

e) New Patient Wing *(MIMP Project V)*

- Vehicle access to the new patient wing will be limited to 16th Avenue. No driveways or access are proposed along Cherry Street. Driveways along 16th Avenue will be setback from the intersection at Cherry Street to the satisfaction of the Seattle Engineering Department. Any site improvements, including landscaping, will maintain unobstructed sight lines to improve traffic visibility and safety.

f) New SNF, Physical Plant, Support Services *(MIMP Project VI)*

- The building will be designed to interpret the architectural character of the existing 1910 Building. Architectural design measures including facade articulation, detailing, materials, color, textures, and other scale reducing devices will be incorporated to improve building compatibility with its context. Building facades would include contrast in materials, scale of detailing, fenestration, and articulation.

  For example, detailed sills, belt courses, cornices and bricks to complement the adjacent building would be utilized.

g) Add Two Levels to East Wing *(MIMP Project VII)*

- The two-level addition to the East Wing will be set back from the existing building facades to protect the privacy of the homes to the east. The view angle will be oriented to the distance and overlook rooftops rather than into residences.

- When this project is implemented, additional mature trees will be added along the 18th Avenue facade to soften the existing blank facades on 18th.

h) New Inn, Gym, Parking, and Skybridge *(MIMP Project VIII)*

- The skybridge will be eliminated.
- Providence will provide an entrance on 18th for loading and unloading.
- Design will include residential elements, such as pitched roofs, modulation, parapets, and roof overhangs to improve compatibility.
- The east side will include building design, fencing, landscaping, etc., that will help preserve the privacy of the single-family homes, including yards, to the east. Windows will be placed, oriented, and designed to help preserve the privacy of the existing single-family residences.

i) Day Care *(MIMP Project IX)*

- The rear play yard will be designed to reduce noise for the single-family homes to the south and east from children playing, with use of acoustical fencing or berms.
- The times of day that the children will be playing in the yard will be posted at the day care.
- The day care will be designed to have a residential character and to protect the privacy of the neighbors to the south and east. Design elements similar to those discussed for Project VIII above will be incorporated.
- A safe loading and unloading area off 18th will be provided for the children.

2. No flat or unmodulated blank facades, particularly at street level, will be incorporated into the new buildings. Modulation, fenestration, architectural detailing, and window treatment will seek to create pedestrian scale and interest.

3. Traffic bulbs will be installed on 18th at Jefferson at the time of construction of Project VIII.

4. Open space over the entire campus will not be less than 10% on the Providence campus. In conjunction with each phase of development that reduces existing open space on campus, the quality of the landscaping in remaining open space areas shall be increased. This shall be accomplished by increasing the quality of landscaping in a remaining open space area that is equal in size to the size of the open space that is being reduced in a particular phase of development. Where feasible, the additional landscaping will be installed in the setback areas around the perimeter of the campus. Safety will be a consideration in the design and maintenance of all open space and landscaped areas.

5. Providence will involve the Squire Park Community Council in the detailed design process for the new projects and for major landscaping projects as discussed above, by seeking their comments and ideas during the design process.

6. Mechanical penthouses, elevator overruns and other similar rooftop equipment shall be visually obscured. The design will incorporate these elements into the overall building appearance. To the extent possible, these rooftop building elements will be located and oriented away from nearby residential uses. Overlooks upon this equipment from nearby residential uses. Overlooks upon this equipment from nearby development will be avoided, and if they occur, the improvements shall be appropriately screened. Noise shall be directed up and away from sensitive residential noise receivers.

Critique of Providence-Swedish Health Services Community Benefit Claims and Providence-Swedish Financial Information
Xochitl Maykovich
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BACKGROUND: NON-PROFIT HOSPITAL PREFERENTIAL TREATMENT and COMMUNITY BENEFITS

As in other states, private non-profit hospitals in Washington enjoy special treatment that for-profit hospitals and other for-profit business do not. Non-profit hospitals

- are exempt from a wide range of taxes and fees, including federal and state corporate taxes and state and local property taxes;
- can issue tax-exempt bonds to borrow money at interest rates much lower than those paid by for-profit businesses; and
- are able to raise money through contributions that are tax-deductible for the donors.

In exchange for this very valuable preferential treatment, non-profit hospitals are expected to serve a charitable mission by providing *community health benefits* that address serious unmet community health needs.[1] In effect, the tax savings and other perks that private non-profit hospitals enjoy are an investment of public resources in the private sector – an enormous public subsidy – aimed at lessening the burdens on government.[2]

But what, exactly, are "community benefits"? According to The Access Project, a respected national healthcare advocacy and reform group:

> **Community health benefits** are "the unreimbursed goods, services, and resources provided by healthcare institutions that address community-identified health needs and concerns, particularly those of people who are traditionally uninsured and underserved."[3]

This is a good, though rather broad account of community benefits. And there is confusion about which specific goods and services should count as genuine community benefits.

In determining whether a particular healthcare service or program qualifies as a genuine community health benefit, it is important to answer the following questions:

1. **Does the hospital lose money by providing the service?**
   - Only the actual unreimbursed cost to the hospital of providing the service should be counted as a community benefit expenditure.

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[1] Internal Revenue Service Revenue Ruling 69-545, 1969-2 C.B. 117 (1969). In 1956, the Internal Revenue Service required sufficient levels of charity care as a requirement for maintaining tax-exempt status for hospitals. This directive was later amended in 1969 to a broader but vaguer requirement for the provision of community benefit, part of which included the provision of free and reduced care.

[2] In WA, the law requires free "charity care" for people with incomes at or below the Federal Poverty Level (FPL), and at least partial discounts for people who earn 101-200% of the FPL. RCW 70.170 et. seq.; WAC 246-453 et. seq.

[3] The Access Project, *Community Benefits: The Need for Action, an Opportunity for Healthcare Change* (2000), p. 2.

2. **Does provision of the service generate revenue, perhaps in other areas of the hospital, that compensates the hospital for the cost of providing the service?**
    - For example, if a hospital offers free informational sessions on weight loss surgery that serve to attract paying customers to the hospital's operating rooms, then the cost of providing these sessions is actually a marketing expense rather than a genuine community benefits expenditure.
3. **Is the service *voluntarily* provided with the *intent* of serving those in need?**
    - "Bad debt" is not a genuine community benefit expense. Bad debt consists of charges that the hospital decides to write off after unsuccessfully – sometimes aggressively – attempting to collect from patients. Writing off debts after a failure to collect clearly does not reflect an *intentional* and *voluntary* commitment to serving those in need.
4. **Is the program or service typically provided by for-profit hospitals, too?**
    - Many of the goods and services claimed as community benefits by non-profit hospitals are also provided by for-profit hospitals – and at similar expenditure levels – which suggests that the provision of such goods and services is motivated by business sense rather than by a sense of charitable mission.
5. **Are members of the affected communities involved in the development and implementation of the program?**
    - A genuine community benefit program requires real collaboration with affected communities. Hospitals should actively involve community members in a process for assessing unmet healthcare needs in the community and planning to address those needs.
6. **Does the program address actual unmet healthcare needs among uninsured patients, low-income people, communities of color, immigrants, or another traditionally underserved population?**

Over the past several years, in response to increasing scrutiny at the national and local levels, non-profit hospitals have launched public relations campaigns – sometimes quite sophisticated – to tout their provision of community benefits. However, with the six questions above as a guide, it becomes clear that not all of the spending reported by non-profit hospitals should be counted as genuine community benefit spending.

CLOSER INSPECTION: PROVIDENCE-SWEDISH HEALTH SERVICES

Providence-Swedish Health Services (SHS) covers metropolitan Seattle, with 5 full-service hospitals, 2 free-standing emergency room and specialty centers and a network of more than 100 clinics.

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In calendar year 2014, SHS claims to have spent more than $133 million providing "community benefits."[4] Upon closer inspection, though, much of that probably should not count as spending on genuine community benefit programs.

Government-sponsored medical care shortfalls: $72.4 million – SHOULD NOT COUNT

SHS claims that it spent $72,378,668 on the "unfunded portion of government-sponsored medical care" in 2014. The bulk of this "spending" is likely related to so-called "Medicaid shortfalls": the difference between the *cost* of care and the reimbursement received for services provided to patients covered by Medicaid, the joint federal-state insurance program for low-income individuals.

Many non-profit hospitals claim Medicaid shortfalls as a community benefit, and some influential industry groups – including the Catholic Health Association of the United States (CHA), of which Swedish's parent, Providence Health & Services (PH&S) is a member – defend doing so. However, the rationale for counting these expenses as community benefit expenditures is weak at best:

- *Every* provider that participates in the Medicaid (and Medicare) program, whether for-profit or non-profit, bears the burden of low reimbursements. And there is *little difference in levels of participation – and in the levels of unreimbursed costs – between for-profit and non-profit hospitals*. For-profit hospitals, like non-profits, are eager to participate in these programs because participation secures a reliable and significant stream of revenue from the government. Moreover, for-profit hospitals serve Medicaid patients without the special tax treatment afforded to non-profit hospitals.
- Both the federal and state governments disburse additional payments to hospitals in order to offset the costs of providing care to large numbers of Medicaid patients.

Medical education and research: $30.2 million – SHOULD NOT COUNT

SHS claims that it spent $30,187,713 for "medical residency programs, nursing and other education and medical research in 2014. Non-profit hospitals routinely claim as a community benefit expenditure the costs of training and continuing education programs for residents, interns, nurses, technicians, and other employees. And, again, some influential industry groups – including the CHA – defend doing so.

However, even if SHS has arrived at the *unreimbursed* cost of maintaining such programs – by subtracting out all direct medical education funding it receives from third party payers; any tuition or other fees it receives from students and trainees; and all of the other grants and subsidies it receives to help offset the cost of the programs – such spending does not qualify as a

[4] *See* SHS website, accessed May 12, 2015: http://www.swedish.org/about/overview/mission-outreach/community-engagement/community-benefits and the 2014 Community Benefits Booklet available on the same site.

genuine community benefit expenditure. Simply put, trainees are part of the hospital clinical staff, providing patient care and other necessary services and thereby helping to generate revenue for the hospital.[5]

John Colombo, an expert on non-profit healthcare law and policy issues at the University of Illinois College of Law, put the point eloquently in remarks to the IRS:

> Expenditures that relate to training employees or staff, or which result in a direct economic benefit to the hospital, should not count as community benefits.
>
> In these cases, whatever community benefit results from the expenditure is offset by a benefit to the institution. For example, one non-profit hospital tried to claim that the costs of Spanish classes for its staff were "community benefits." Training your staff to better serve your customers, however, should not be viewed as a community benefit any more than training staff in administrative procedures or how to fill out insurance reimbursement forms. If money spent on training employees counts as community benefit, then every well-run business in the United States deserves tax exemption. Similarly, if a hospital employs medical interns, they get the benefit of cheap labor; if we're going to give a hospital community benefit credit for providing a "clinical environment" for training interns, then we should offset that against the benefit of having cheap labor. Am I providing a community benefit by employing law students as research assistants and paying them a pittance? After all, they are being trained in legal research. The answer is "of course not;" I'm primarily benefiting myself.[6]

Finally, it should be remembered here that a genuine community benefit program is one that addresses unmet healthcare needs among *traditionally underserved populations* such as low-income patients. Medical education and research programs in general serve a useful social function by training the next generation of caregivers and identifying new treatments, but they typically do not provide healthcare goods or services targeted at *underserved* groups.

Negative margin / "subsidized" services: $4.6 million – MORE DISCLOSURE NEEDED

SHS claims that it spent $4,576,548 in 2014 on "subsidized services" – "clinical and social services provided despite a financial loss because it meets an identified community need that is not met elsewhere in the community." If these programs and services are intended to address unmet health needs among underserved populations and if the *actual unreimbursed cost* of providing such services is properly quantified – subtracting out any offsetting revenue generated

[5] In other words, the financial formula might look like this: (intern-generated revenue + direct medical education subsidies) > medical education costs.

[6] John Colombo, letter to Ronald J. Shultz, Senior Technical Advisor, Tax-Exempt and Government Entities, Internal Revenue Service, 25 July 2007, section II.C.

directly or indirectly by these services – then spending on such services qualifies as a genuine community benefit expenditure.

However, the lines are not always so clear. For example, most for-profit hospitals maintain emergency rooms and provide a range of emergency services – though they may lose money doing so – either because they are required by law to maintain an emergency room or because emergency services draw paying patients into the hospital, patients who then generate revenue by consuming services in other areas of the hospital. Either way, the unreimbursed cost of maintaining an emergency room does not clearly qualify as a genuine community benefit expenditure. Similarly, the costs of providing "clinical and social services" needs to be analyzed in the context of any additional revenue these patients provide when/if they need other hospital services.

In order to determine whether the $4.6 million that SHS reports spending on subsidized services should count as genuine community benefit spending, we would need to know:

- exactly which programs and services are included here;
- which underserved populations each program or service is intended to serve; and
- how much money each program or service loses and how much offsetting revenue SHS receives to cover those losses.

We currently do not have access to any of this information.

Community health, non-billed services, community building activities, and other: $5.7 million – MORE DISCLOSURE NEEDED

SHS claims that in 2014 it spent $5,679,739 on "free services such as patient education, health screenings, immunizations and support groups, as well as donations to community partners." If such programs do not generate, directly or *indirectly*, sufficient revenue to cover the actual cost to the hospital of running the programs, then the unreimbursed cost of those programs may qualify as a genuine community benefit expenditure.

Again, however, caution is warranted here. It is often difficult to distinguish a free or reduced-price service that provides a genuine community health benefit from a marketing program that generates revenue, perhaps indirectly, by attracting new paying customers to the hospital. For example, Swedish might host, free or for a minimal fee, an educational session to on joint replacements or a breastfeeding class for new mothers. Providing such sessions may be, in part, a community benefit, but it also serves to advertise the hospital's services or to attract expectant mothers. Many for-profit hospitals also engage in such activities, presumably for good business reasons.

So, unless SHS provides a line-item breakdown of its unreimbursed costs for providing these programs and services, it is impossible to tell how much of the reported spending in this area goes toward genuine community benefit activities and how much goes toward marketing.

Charity care: $20.6 million – MORE DISCLOSURE NEEDED

SHS claims that it spent $20,560,363 in 2014 providing "free and discounted medical care for patients in need." Spending in this area for uninsured, underinsured or otherwise unable to pay patients – what some people call "traditional charity care" – does, indeed, count as genuine community benefit spending, provided that:

- the care is provided to those in need *without expectation of payment* from the patient or from third-party payers;
- the care is valued *at cost* rather than at the inflated "gross charge" rate or even the Amounts Generally Billed – this involves accurately estimating the actual cost to the hospital of providing care to patients who receive a partial discount on their bills as well as those whose bills are written off completely;[7] and
- only the *actual unreimbursed cost of care* is considered, subtracting out any offsetting reimbursements that SHS receives for providing charity care, perhaps from disproportionate share hospital payments.

There are three areas of concern that deserve special attention here.

First, the reported amount of charity care may be grossly inflated, depending on how SHS calculates the value of the "partial discounts" it gives to those in need. Consider a hypothetical case involving an uninsured patient called "Ms. X" at Swedish-Cherry Hill (CH) in Seattle:

- The "markup ratio" at CH is roughly 3.7:1, which means that, on average, the full list price ("gross charges") for services at CH is 4 times what it costs the hospital to provide care.[8]
- Ms. X incurs $10,000 in gross charges for care at CH. CH, using a secret formula related to "amounts generally billed" to insured and/or Medicare patients, bills Ms. X $6,000 (this is a made-up number, we don't know what a typical commercially-insured person pays at CH).
- Ms. X has an income at 270% of the Federal Poverty Level; she applies for and receives a 60% charity care discount off of her bill of $6,000 for services provided at CH.[9]
- This means that Ms. X will be expected to pay $2,400 for her care.

[7] SHS's website does quote a number, $20.6 million, that they claim is estimated cost, and does not include the unpaid cost of Medicare, Medicaid or bad debt. Our estimated $4.8 million in charity care from Swedish-Cherry Hill in 2014 alone would seem to be in line with this $20.6 million for all of SHS – but the point is, we are making guesses and estimates, rather than having complete disclosure by SHS.

[8] The Washington Department of Health calculates the markup ratio for each hospital in the state using a formula: (total patient service revenue + other operating revenue)/operating expenses. Using that formula, Swedish Cherry Hill had a markup ratio of 3.73 in 2014.

[9] The current SHS charity care policy allows for a 60% discount off of "original charges" for patients earning 270% of the Federal Poverty Level (FPL). We are assuming that the 60% was applied to the already reduced chargemaster number, using the Amount Generally Billed formula. For 2014, 270% of FPL = $31,509 for an individual or $64,395 for a family of four.

- Because the markup ratio at SHS is 3.7:1, the actual cost to the hospital of serving Ms. X is only $2,703.[10]
- So, when Ms. X pays her $2,400 bill, CH loses $303.[11]

How much charity care does CH report in this case? Perhaps CH takes the $4,000 discount granted on Ms. X's original "gross charges" bill + the $3,600 discount under their charity care policy and then reduces that amount by the "markup ratio" (3.7:1) to estimate that $1,801 in charity care was provided in this case.[12] But, if this is how SHS estimates the cost of charity care in cases of partial discounts, then it is here reporting $2,040 in charity care expenditures when, in fact, it lost just $303 - the patient paid nearly the full *cost* of her treatment.[13]

Second, even if the estimated $4.8 million worth of charity care that Swedish-Cherry Hill Hospital reported in 2014 has been appropriately valued, it amounts to a mere 1.2% of the $413 million in net patient service revenue the hospital reported in 2014. It's difficult to see why an organization that devotes just over 1% of its patient revenue to charity care should qualify as a charitable institution for tax purposes.

Finally, regardless of how much money SHS as a whole devoted to charity care in 2014, the question remains whether those who need it most are receiving charity care at SHS facilities.

- The process to apply for charity care at SHS hospitals is cumbersome. According to its official financial assistance form, SHS requires that extensive documentation evidence of income, expenses and assets – including copies of the patient's and household members' recent paychecks, income tax returns, and investment statements as well as information on bank accounts, mortgage balance and possibly more – be submitted by the patient within 14 days.[14] For someone who is struggling to recover from serious illness or injury, this can be a daunting task.
- The SHS financial assistance - charity care policy is clear that it covers only *medically necessary* services at *hospitals,* as defined by WAC 246-453-010(7).[15] As a result, a low-income uninsured patient needing specialist services or follow-up outpatient care may not be eligible for any financial assistance under SHS's policy.

Lack of transparency and accountability

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[10] $10,000 ÷ 4.219 = $2,370

[11] The patient pays a $2,400 bill for care that it cost the hospital $2,703 to provide; $2,400 - $2,703 = $303 loss.

[12] $7,600 ÷ 3.73 = $2,040.

[13] Clearly, there is a lot of room for error here, given that 1) it is not clear what the 60% discount off of "original charges" applies to, and 2) it is not clear what percentage CH cuts off of the chargemaster for uninsured patients.

[14] See the SMC Financial Assistance Form. Downloaded June 11, 2015.

[15] SHS Financial Assistance – Charity Care policy, effective April 2014. Downloaded June 11, 2015, from http://www.swedish.org/patient-visitor-info/billing/financial-assistance. The 14 day minimum is set by WA code: WAC 246-453-020.

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One issue that plagues all of SHS's community benefit reporting is lack of transparency: the public does not have access to the underlying information that would validate or invalidate SHS's claims. We simply do not know whether the charity care spending that SHS reports includes "partial discounts" to patients who, in fact, paid the full cost of their care; nor do we know to what extent the "community programs and services" on which SHS spent money combine advertising and marketing activities with genuine health outreach. This puts the "nearly $133 million" in community benefits in 2014 in greater perspective. Moreover, $133 million in the context of over $2 billion in estimated operating revenue for the system in 2013 – so, about 7%, even if we took the $133 million at face value.

Until SHS provides greater disclosure – or, more to the point, until some organization or agency with sufficient power *demands greater accountability* from SHS– we simply will not know whether SHS provides genuine community health benefits commensurate with its preferential tax treatment and appropriate to a corporation of its size and wealth.

Providence Health & Services, Swedish Health Services and Cherry Hill

Providence Health & Services, which includes Swedish Health Services remains large and profitable. Fiscal 2014 (ending 12/31/14) was a stronger year than 2013: with stronger margins, more days cash on hand, and more acquisitions completed.

In 2014, PH+S (including Swedish)[16]:

- booked **$12.5 billion in operating revenue**
- posted **operating profits of $219.2 million** (1.8% "operating margin")
    - This is up from just $37.7 million and a 0.3% operating margin in 2013.
- posted **total profits** (including investment returns) **of $771.4 million** (5.9% "total margin")[17]
- now has over **$6 billion in cash** (190 days of cash on hand).
- Benefited from Medicaid expansion as charity care at estimated cost declined by $107 million, or 34%.

All of Swedish:[18]

- booked $2 billion in operating revenue (2013)
- $59m in operating profit (2013)

[16] 2014 financial figures are from the Providence Health and Services annual financial statements for the year ending 31 December 2014. Providence no longer reports out detailed Swedish-specific results.
[17] This is a really big number compared to operating margin, about $476 m of "non-operating income coming from "gains from affiliation," which includes PacMed, Kadlec and St. John's Health Center.
[18] From http://www.swedish.org/about/overview/facts-figures/revenues-expenses. Limited numbers available.

  - The 5 campuses summed together equal $110 million in total profit for *2014*. Management said in bargaining that they expected this number to be $112 million. The 990 and Swedish website are better sources for system total profit, but given how past numbers compared to each other, I feel pretty comfortable with this $110 million figure, as long as it is stated as: "Swedish's 5 hospital campuses profited $110 million in 2014."
- In 2014 Swedish claimed to provide $20.6m in charity care, a decline of 45% from 2013.[19]

Cherry Hill[20]

2014 Financial results (FYE 12/31):

- $413.3m in net patient service revenue
- $13.6m in operating and total margin, or 3.2%
- $4.8m in charity care, at estimated cost, a decline of 39%.

And PH+S executives remain well compensated:

- PH+S system-wide **CEO Rod Hochman** banked **$1.9 million in total compensation** in 2013. He took over as CEO 7/1/13.[21]
  - As a division president at PH+S in 2012, his first year with Providence, **Rod Hochman** banked **$1.8 million in total compensation.**
  - This is not yet comparable to John Koster's $4.5 million total compensation package in 2012, and his $3.4 million in 2013, a year in which he served only 6 months as CEO.
- Todd Strumwasser, Lead Administrator at Swedish's First Hill and Cherry Hill campuses, earned $703k in 2014.[22]

[19] http://www.swedish.org/about/overview/mission-outreach/community-engagement/community-benefits. Accessed June 5, 2015.
[20] Cherry Hill financial results come from the year-end reports it submits to the WA Department of Health.
[21] Hochman's and Koster's 2013 compensation information is from the Providence Health and Services – WA/AK IRS 990 form. Hochman's and Koster's 2012 compensation is from the Providence hospitals' employees report to Washington Department of Health.
[22] 2013 report to WA DoH on Executive Compensation at Cherry Hill and First Hill/Ballard campuses. A separate administrator, Jennifer Graves , was the lead at Ballard.