STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

In Re: Certificate of Need Decision on PROVIDENCE SACRED HEART MEDICAL CENTER & CHILDREN'S HOSPITAL PROPOSAL TO ADD 152 ACUTE CARE BEDS TO SPOKANE COUNTY, PROVIDENCE SACRED HEART MEDICAL CENTER & CHILDREN'S HOSPITAL (formerly known as Sacred Heart Medical Center & Children's Hospital), Petitioner, In Re: Certificate of Need Decision On the PROPOSED SETTLEMENT TO ALLOW PROVIDENCE SACRED HEART MEDICAL CENTER TO ADD 75 ACUTE CARE BEDS IN SPOKANE COUNTY, DEACONESS MEDICAL CENTER AND VALLEY HOSPITAL AND MEDICAL CENTER, Petitioners, In re: Settlement Evaluation of the Certificate of Need Application Submitted on Behalf of SACRED HEART MEDICAL CENTER AND CHILDREN'S HOSPITAL,	Master Case No. M2009-1141 (Lead) Master Case No. M2010-667 Master Case No. M2010-669 **AMENDED** FINDINGS OF FACT, CONCLUSIONS OF LAW AND FINAL ORDER

PROVIDENCE SACRED HEART)
MEDICAL CENTER & CHILDREN'S)
HOSPITAL CENTER & CHILDREN'S)
HOSPITAL (formerly known as Sacred)
Heart Medical Center & Children's)
Hospital),)
)
Petitioner.)
_____)

APPEARANCES:

Petitioner Providence Sacred Heart Medical Center & Children's Hospital (Sacred Heart), by
Foster Pepper PLLC, per
Michael K. Vaska, Lori K. Nomura and Melissa S. Engelmann, Attorneys at Law

Department of Health Certificate of Need Program (Program), by
Office of the Attorney General, per
Richard A. McCartan, Assistant Attorney General

Petitioner and Intervenor Spokane Washington Hospital Company, LLC, d/b/a Deaconess Medical Center and Valley Medical Center (Deaconess)
Inslee, Best, Doezie & Ryder, P.S. per
John F. Sullivan, Attorney at Law

PRESIDING OFFICER: John F. Kuntz, Review Judge

RECONSIDERATION

The Department of Health Certificate of Need Program (Program) filed a Motion for Reconsideration Under RCW 34.05.461, requesting a reconsideration of the rejection of the Program's alternative of granting Sacred Heart a certificate of need to transfer up to 75 beds from Holy Family. The Program further moved for a reconsideration of the refusal to consider the revised bed count in applying the bed need methodology. After review of the briefs and reconsideration of the evidence, the

Presiding Officer amends the Findings of Fact, Conclusions of Law and Final Order issued as follows in **bold type**.

INTRODUCTION

A hearing was held in this consolidated matter on February 7-8, and February 15-16, 2011. The issues at hearing were: Sacred Heart's appeal of the Program's decision denying Sacred Heart's application to add 152-bed acute care beds to its existing Spokane facility; Deaconess's appeal of the Program's proposed settlement granting Sacred Heart a certificate of need for a 75-bed acute care expansion; and Sacred Heart's appeal to preserve all of its rights, including its right to contest the number of set up and available beds in the Spokane Planning Area (up to and including the 152-bed acute care beds originally requested.)

ISSUES

Did Sacred Heart's application for a certificate of need to establish 152 new acute care beds meet the criteria set forth in WAC 246-310-210, WAC 246-310-220, WAC 246-310-230, and WAC 246-310-240?

Did Sacred Heart's application for a certificate of need to establish 75 new acute care beds (as represented in the settlement evaluation) meet the criteria set forth in WAC 246-310-210, WAC 246-310-220, WAC 246-310-230, and WAC 246-310-240?

SUMMARY OF THE PROCEEDING

At the hearing, the Program presented the testimony of Bart Eggen, Executive Manager. Sacred Heart presented the testimony of Helen Andrus; Chad Campbell; Jody Carona; Elaine Couture; Sharon Fairchild; Frank Fox, Ph.D.; Doug Hammond;

David Martin; Glenn Melnick, Ph.D.; and Greg Palmenteer. Deaconess presented the testimony of David Martin; Chad Campbell; Jody Carona; Doug Hammond; Bart Eggen; Mark Thomas; Sharon Fairchild; Elaine Couture; Helen Andrus; Dan Houghton; and Jim Hendricks.

The following Program exhibits were admitted:

Exhibit D-1: Paginated certificate of need record for Sacred Heart's application (1,998 pages).[1]

Exhibit D-2: Program's inspection report following its inspection of the Holy Family, Deaconess, and Valley Medical hospitals.[2]

The following Sacred Heart exhibits were admitted (except where indicated):

Exhibit (i): Department of Health Administrative Record (AR) for the certificate of need proceeding (Bates numbers 1-1851).

Exhibit (ii): CHS Hospitals' April 2, 2009 Public Comment (Letter from Deaconess and Valley to Mark Thomas, and attachment titled "Deaconess Medical Center and Valley Hospital and Medical Center Response to the Application of Sacred Heart Medical Center to Add 152-Acute Care Beds and 21 Level II Nursery Beds in Spokane Hospital Planning Area.") This document was not included in the administrative record produced by the Department of Health on November 8, 2010. Sacred Heart requested by e-mail dated January 14, 2011, that the Program supplement the record to include this document.

[1] There are duplicate documents in the Sacred Heart application record, including the settlement evaluation.

[2] The Program identified two additional exhibits at the prehearing conference and identified the inspection report as Exhibit D-4. *See* Prehearing Order No. 11, page 5. At hearing, the Program identified Exhibit D-4 (the inspection report) as Exhibit D-2. To avoid confusion in the hearing record, the inspection report exhibit will be identified as Exhibit D-2.

Exhibit (iii): Sacred Heart Rebuttal to CHS Hospitals' Opposition to Proposed Settlement (Letter from Andy Agwunobi to Janis Sigman dated April 28, 2010, and attachment titled "Sacred Heart Response to CHS' Public Comment on Proposed Certificate of Need Settlement.") This document was not included in the administrative record produced by the Department of Health on November 8, 2010. Sacred Heart requested by e-mail dated January 14, 2011, that the Program supplement the record to include this document.

Exhibit (iv): Transcript of January 7, 2011, deposition of Chad Campbell.

Exhibit (v): Transcript of January 13, 2011, deposition of Jody Carona.

Exhibit (vi): Transcript of January 11, 2011, deposition of Douglas C. Hammond.

Exhibit (vii): Transcript of January 7, 2011, deposition of David R. Martin.

Exhibit (viii): Transcript of January 11, 2011, deposition of Gregory R. Palmanteer.

Exhibit (ix): March 26, 2009 email re: SHMC CON (INT 0067-68) (Chad Campbell DX 2).

Exhibit (x): 2/10-13/09 email chain re CRS #6512 (INT 0087-89) (Chad Campbell DX 6).

Exhibit (xi): Email chain with attachments re: beds (INT 0069-74) (Chad Campbell DX 7; Hammond DX 14).

Exhibit (xii): Form CMS-2552-96, #36-503 (Chad Campbell DX 9).

Exhibit (xiii): Deaconess Medical Center Census Data 2008 to 2009 (INT 0230-234) (Chad Campbell DX 11).

Exhibit (xiv): Providence Sacred Heart's First Set of Requests for Production and Interrogatories to Intervenors Deaconess Medical Center and Valley Hospital & Medical Center,

and Objections, Answers and Responses Thereto (Chad Campbell DX 12).

Exhibit (xv): January 11, 2008 letter with attachments to Janis Sigman re: hospital sales review application (Chad Campbell DX 13).

Exhibit (xvi): November 5, 2008 email re: VHMC 123-bed verification (INT 0107) (Palmanteer DX 3).

Exhibit (xvii): Excerpts from Spokane Washington Hospital Company, LLC, Certificate of Need Application for Acquisition of Deaconess Medical Center January 2008 (excerpts of which constitute Hammond DX 2; excerpts of which constitute Carona DX 1).

Exhibit (xviii): Excerpts from Spokane Valley Washington Hospital Company, LLC, Certificate of Need Application for Acquisition of Valley Hospital and Medical Center January 2008 (excerpts of which constitute Martin DX 4; excerpts of which constitute Carona DX 2).

Exhibit (xix): November 21, 2008 Health Facilities letter agreement with Valley and Deaconess (INT 0240-0242) (Carona DX 3).

Exhibit (xx): 12/4/08-2/8/10 email chain with attachments re: Valley bed survey for DOH (INT 0103-106) (Carona DX 4; Palmenteer DX 4).

Exhibit (xxi): November 5, 2008 email re: VHMC 123-bed verification (INT 0251) (Carona DX 5).

Exhibit (xxii): 2/3-9/09 email chain re: meeting with Dennis (INT 0460-64) (Carona DX 6).

Exhibit (xxiii): Email chain re: beds (INT 0304-307) (Carona DX 7).

Exhibit (xxiv): Excerpts from Washington State Health Plan, Volume 2: Performance Standards for Health Facilities and Services (Carona DX 8).

Exhibit (xxv): February 10, 2009 email re: memo for today's meeting (INT 0465) (Carona DX 10).

Exhibit (xxvi): Email chain re: beds (INT 0300-303) (Carona DX 11).

Exhibit (xxvii): Spreadsheet re: bed confirmation, July 2009 (Carona DX 12).

Exhibit (xxviii): Spreadsheet re: bed confirmation, July 2009 (Carona DX 13).

Exhibit (xxix): April 2, 2009 Deaconess Medical Center and Valley Hospital and Medical Center letter re: SHMC CON (Carona DX 15).

Exhibit (xxx): April 16, 2009 Deaconess Medical Center and Valley Hospital and Medical Center letter re SHMC CON (Carona DX 16).

Exhibit (xxxi): Exhibit K to CHS conversation application (excerpts of which constitute Hammond DX 1; excerpts of which constitute Palmanteer DX 1 and DX 2).

Exhibit (xxxii): September 11, 2006 email with attachments re: EHS information, Deaconess Medical Center Facilities Master Planning Outline (Hammond DX 3).

Exhibit (xxxiii): 2/10-11/09 email chain re: CRS #6512 (INT-0295) (Hammond DX 4; Chad Campbell DX 8).

Exhibit (xxxiv): December 23, 2002 EHS letter re: DMC 5 Center alterations (Hammond DX 5).

Exhibit (xxxv): December 23, 2002 EHS letter re: Deaconess Medical Center CRS 6834 (Hammond DX 6).

Exhibit (xxxvi): February 3, 2003 EHS letter re: Deaconess Medical Center floor covering 4th floor (Hammond DX 7).

Exhibit (xxxvii): November 16, 2004 Application for Construction Review for 5th Floor of Deaconess Hospital (Hammond DX 8).

Exhibit (xxxviii): Email chain re: CRS #6512, set up and available beds (Hammond DX 9).

Exhibit (xxxix): 11/5-7/08 email chain re: conference call Friday (INT 0426-428) (Hammond DX 10; Carona DX 9; Chad Campbell DX 1; Palmanteer DX 6).

Exhibit (xl): Series of floor diagrams/drawings (INT 0090-92) (Hammond DX 11; Carona DX 14; Chad Campbell DX 3).

Exhibit (xli); Spreadsheet re: bed confirmation July 2009 (INT 0086) (Hammond DX 12; Chad Campbell DX 5).

Exhibit (xlii): Spreadsheet re: bed confirmation July 2009; series of floor diagrams/drawings (INT 0074-85) (Hammond DX 13; Chad Campbell DX 4).

Exhibit (xliii): January 7, 2011 Deaconess Medical Center Selected Medicare Cost Report Data (Hammond DX 15; Chad Campbell DX 10; Palmanteer DX 5).

Exhibit (xliv): Schedule 3.32, Seller's Knowledge, Document Number 01696 (Martin DX 1).

Exhibit (xlv): Community Health System, Due Diligence Visits, Document Number 000802 (Martin DX 2).

Exhibit (xlvi): Kroll Valuation Services Preliminary Draft – For Discussion Purposes Only, Document Numbers 001774 and 001779 (Martin DX 3).

Exhibit (xlvii): Valley Hospital & Medical Center Census Data 2008-2009 (INT 0235-0238) (Martin DX 5).

Exhibit (xlviii): January 7, 2011 Valley Hospital & Medical Center Selected Medicare Cost Report Data (Martin DX 6).

The following Deaconess exhibits were admitted (except where indicated):

Exhibit A: Program record including, but not limited to, the Program's original evaluation and its settlement evaluation, and the public comments submitted by Deaconess and Valley to the original CON application and the proposed settlement.

Exhibit B: Excerpts from the CON application relating to the acquisition of Deaconess Medical Center.

Exhibit C: Excerpts from the CON application relating to the acquisition of Valley Hospital and Medical Center.

Exhibit D: Excerpts from the Program's evaluation of the CON application involving the acquisition of Deaconess.

Exhibit E: Excerpts from the Program's evaluation of the CON application related to the acquisition of Valley Hospital.

Exhibit F: Omitted.

Exhibit G: Excerpts from the Program's evaluation of the conversion application involving Deaconess and Valley, including the evaluation by the Office of the Attorney General.

Exhibit H: Documents relating to the bed count at Deaconess.

Exhibit I: Documents relating to the bed count at Valley Hospital.

Exhibit J: An excerpt from the Washington State Health Plan adopted in 1987.

Exhibit K: Omitted.

Exhibit L: Documents relating to Deaconess and Valley's licensed bed capacity.

Exhibit M: Deaconess and Valley's census data for 2008 and 2009.

Exhibit N: Sacred Heart Medical Center's Utilization Forecast.

Exhibit O: Sacred Heart's Talking Points, dated May 6, 2009.

Exhibit P: Sacred Heart Medical Center's Communications Workgroup, dated May 28, 2008.

Exhibit Q: Sacred Heart's Talking Points, dated May 29, 2008.

Exhibit R: Sacred Heart's CON Executive Council meeting notes, dated June 27, 2008.

Exhibit S: Sacred Heart's notes of Project Prioritization meeting, dated August 5, 2008.

Exhibit T: Sacred Heart's Q & A draft.

Exhibit U: July 10, 2009, e-mail from Maureen Goins to Sharon Fairchild.

Exhibit V: Sacred Heart's PowerPoint presentation beginning with the title "Background: Competitive Threat."

Exhibit W: Providence Health Care's notes of Capital Project Prioritization meeting, dated August 5, 2008.

Exhibit X: An excerpt from the PowerPoint presentation to Greater Spokane, Inc., Board of Directors, dated December 15, 2008.

Exhibit Y: Excel spreadsheet relating to Sacred Heart's construction costs with handwritten notes.

Exhibit Z: Sacred Heart's inpatient unit closure summary report, dated July 24.

Exhibit AA: Sacred Heart's statistics and ratios for various scenarios.

Exhibit BB: Bed need methodology Step 10 Scenario A, revised July 14, 2008.

Exhibit CC: September 24, 2010, article from the Spokesman Review relating to Sacred Heart Medical Center layoffs and declining volumes.

Exhibit DD: Omitted.

Exhibit EE: Program's evaluation of three certificate of need applications proposing to add acute care bed capacity to the southeast King County planning area.

Exhibit FF: Providence Health Care's March 27, 2009 announcement of layoffs at two Spokane area hospitals.

Exhibit GG: Omitted.

Exhibit HH: Sacred Heart Medical Staff Briefing dated January 17, 2011.

Exhibit II: DOH Bed Count – Deaconess Medical Center.

Exhibit JJ: DOH Bed Count – Holy Family Hospital.

Exhibit KK: DOH Bed Count – Valley Hospital and Medical Center.

Exhibit LL: January 24, 2011 email from Greg Palmanteer re In Nurse Call.

Exhibit MM: Photographs of Valley Hospital North.

Exhibit NN: Washington State Department of Health Accounting and Reporting Manual for Hospitals.

Exhibit OO: Sacred Heart and Deaconess 2008 Patient Origin All Discharges.

Exhibit PP: Not Admitted.

The Presiding Officer ruled that the parties could file closing briefs in lieu of closing arguments pursuant to RCW 34.05.461(7). The closing brief schedule was extended and the hearing record closed effective March 28, 2011. *See* Post-Hearing Order No. 1.

On June 13, 2011, the Program filed a Motion for Reconsideration Under RCW 34.05.461. The Presiding Officer issued an Order on Reconsideration Briefs (and Second Order on Reconsideration Briefs), which set forth the timeline for the submission of responsive pleadings by Sacred Heart and Deaconess. The final date for the submission of responsive pleadings was continued to July 22, 2011.

PROCEDURAL HISTORY

On October 23, 2008, Sacred Heart submitted a certificate of need application to add 152 beds to its hospital in Spokane, Washington.[3] At the time of the application, Sacred Heart was licensed as a 623-bed facility.

In June 2009, the Program denied Sacred Heart's application, finding no need existed for the proposed 152-bed project under WAC 246-310-210. Sacred Heart requested a reconsideration of the Program's decision in July 2009. The Program denied this request in August 2009. Sacred Heart then requested an adjudicative proceeding to appeal the Program's decision denying its application. Deaconess and Valley were permitted to intervene in Sacred Heart's appeal.

In March 2010, the Program and Sacred Heart proposed a settlement of Sacred Heart's appeal. In the proposed **settlement**, Sacred Heart would be approved for 75 additional beds (50 "new" beds and 25 "transfer" beds). Deaconess objected to the proposed settlement. The Program issued Certificate of Need No.1422 to Sacred Heart allowing for the 75-bed expansion on May 14, 2010.

On June 10, 2010, Deaconess filed an Application for an Adjudicative Proceeding to appeal the Program's decision adopting the settlement agreement and issuing Certificate of Need No.1422.

[3] At the same time, Sacred Heart applied for a 21-bed intermediate care nursery. AR 1741. The application for the nursery beds was approved by the Program in its evaluation of the application, and no party challenged this approval decision. The intermediate care nursery approval decision is not at issue in the present case.

On June 11, 2010, Sacred Heart filed its Application for Adjudicative Proceeding (Cross Appeal) to preserve all of its rights in the proceeding. The three proceedings were consolidated on the joint request of the parties.

I. FINDINGS OF FACT

1.1 A certificate of need is a non-exclusive license to establish a new health care facility. *See St. Joseph Hospital & Health Care Center v. Department of Health*, 125 Wn. 2d 733, 736 (1995). A certificate of need is required when an existing hospital seeks to increase the number of licensed beds. RCW 70.38.105(4)(e). The applicant for a certificate of need must show or establish that it can meet all of the applicable criteria. WAC 246-10-606. The applicant must show the proposed project: is needed; will foster containment of costs of health care; is financially feasible; and will meet the structure and process of care. *See* WAC 246-310-200(1).

1.2 An application is time sensitive, as it represents a snapshot in time and the statistical data available during that snapshot in time. The snapshot in time includes several specific cutoff dates. These include a cutoff date for: the submission of the application and response to the Program's screening questions (Program questions following its initial review of the application); the submission of public input regarding the application; and the closure of the application record prior to the Program's evaluating the application and issuing its decision. *See generally* RCW 70.38.115(6), (8), and (9).

1.3 The first cutoff date represents the date by which the applicant's application is considered complete. *See* WAC 246-310-090(2) and (3). Once the applicant answers the screening questions, the applicant is generally not permitted to

change its application or the information upon which it is based. The second cutoff date is the end of the public input period, after which the interested or affected parties are prohibited from commenting on the applicant's application. *See* WAC 246-310-180. The third cutoff date represents when the Program has concluded the public hearing or at the end of the comment period. Any contact with the Program following this cutoff date is ex parte communication and is prohibited. *See* WAC 246-310-190(1).

Bed Need Methodology

1.4 Like other certificate of need projects (for example, kidney dialysis projects or ambulatory surgical facilities), the application for need uses information that is known about the use of a particular health care service in a service area (usually a county) measured against the anticipated population growth to calculate whether need exists for additional service by a future date. Determining the bed need methodology evaluates the need for hospital acute care beds using known information (planning area resident hospital discharges for a specific period prior to the application) and anticipated population growth in the service area to calculate whether need exists for additional hospital beds by the end of a planning horizon or "target year" (generally seven years from the known data).[4] *See* AR 1864 (State Health Plan, Criterion 4.a).

1.5 Unlike other certificate of need projects, there is no statutory or regulatory process establishing a bed need methodology to calculate bed need. In the absence of a statutory or regulatory process, the Program relies on the 12-step methodology contained in the State Health Plan to evaluate whether additional hospital beds are

[4] The State Health Plan defines the term "target year" but not the term "planning horizon." See AR 1859. At the hearing, the parties used "target year" and "planning horizon" interchangeably.

necessary.[5] The State Health Plan was terminated effective June 30, 1990. *See* RCW 70.38.919.[6] Although terminated in 1990, both the Program and applicants continue using the State Health Plan methodology to assess hospital bed need.

1.6 Both the Program and applicants have consistently followed the State Health Plan bed need methodology in measuring the need for additional acute care beds within a service area. The predictability afforded by the consistent use of the State Health Plan methodology argues for its continued use. This does not prohibit an applicant from submitting an alternative approach to show need exists.

1.7 The State Health Plan provides information to assist the applicant in applying the bed need methodology. The plan includes guidance regarding occupancy standards (the percentage or amount of time a bed is "occupied" with a patient) and guidance regarding bed capacity (when a bed is "available" or could be available for patient use). AR 1871–1872 (occupancy standards) and AR 1873 (bed capacity).

1.8 A hospital bed is not occupied 100% of the time. The number of occupied beds depends on the number of patients being treated at the facility on any given day. The number of patients is determined by an average daily census (a count of the number of patients within a given facility and taken at midnight or noon each day). The average daily census is then translated into the number of available beds in the facility. For example, if a facility had 200 beds but an occupancy rate of 50%, the hospital can

[5] Washington State Health Plan, Volume 2: Performance Standards for Health Facilities and Services (Approved May 12, 1987). See Application Record (AR) pages 1852–1897.

[6] RCW 70.38.919 was itself repealed in 2007. *See* E2SSB 5930, section 52(3)(b) and 52(4). AR 1352.

be considered to have 100 "available" beds within the facility (the 100 unoccupied beds being "available.")

1.9 The future bed need is not measured in isolation to the applicant's facility but requires a count of beds of all of the hospital facilities currently in the service area.[7] The State Health Plan specifies that the bed count includes all of the beds which are available or could be available for patient use. More specifically, the State Health Plan provides the bed capacity standard to include beds which:

A. Are currently licensed and physically could be set up without *significant capital expenditures* requiring new state approval;

B. Do not physically exist but are authorized unless for some reason it seems certain those beds will never be built.

See State Health Plan, AR 1873 (Criterion 12) (a)(1) and (2) (emphasis added).[8] What constitutes a "significant capital expenditure" is not defined. *See* Transcript (TR) page 76, line 21 to page 77, line 3. Factors for a "significant capital expenditure" include the amount of time, money, and process (permits and construction review) it takes to make a bed available for patient care.

1.10 The Department of Health collects information regarding the number of hospital beds in the state and service area for a variety of programs and purposes. This includes bed information for: the certificate of need program (chapter 70.38 RCW); and

[7] The state of Washington is divided into four health service areas by geographic grouping. Spokane is located in health service area 4 (Adams, Asotin, Columbia, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens, Walla Walla, and Whitman counties).

[8] The bed capacity standard also expects to identify which licensed beds cannot realistically be set up (for example, bed space converted to office space that cannot be converted back to bed space) or which will be eliminated. *See* Criterion 12(a)(3) and (4).

the hospital licensing program (chapter 70.41 RCW). The different programs do not count the number of beds using the same standards.

1.11 The method used to count the number of beds affect whether the bed need methodology calculations show a need for additional acute care beds. This is because:

A. A hospital, and the number of licensed beds (the number of beds obtained under the hospital license under chapter 70.41 RCW) a hospital has, affects whether a facility must also obtain a certificate of need (under chapter 70.38 RCW) to increase its "available" beds. More specifically, if a facility has been using less than the number of beds it is licensed **for, it** can expand up to the licensed number without obtaining a certificate of need.

B. For its public year-end report under the licensing program (chapter 70.41 RCW), the Department collects information on a facility's "available" bed count. To be considered an "available" bed, the bed must be set up (ready for patients) and staffed (professional staff ready to treat patients). The number of "available" beds under this definition is normally less than the facility's licensed bed number. *See* Exhibit NN.

C. As defined in the State Health Plan, an "available" bed can be a bed that is licensed (a facility has the authority to set the bed up) but not currently set up. *See* AR 1873 (State Health Plan, Criterion 12.b). This measure produces an available bed number that is less than the licensed bed number, but greater than the "available" bed number used for the year-end report under chapter 70.41 RCW. The Department obtains this bed count through a survey, which is a form sent to the hospitals in the appropriate service area.

1.12 Why is it important to know the number of available beds? The importance of accurately knowing the number of available beds is the effect it has on the ability of the applicant or another facility in the service area to expand its capacity (that is beds) to treat patients. While an existing facility can expand up to the number of available beds up to its licensed capacity without a certificate of need, a facility or applicant seeking to expand its hospital bed beyond the number it is currently licensed

for may only expand by obtaining a certificate of need. This creates competition between facilities within the same service area for any available bed need. As Washington's health planning system does not have the ability to eliminate existing surpluses of bed need capacity (see AR 1860, Item 5), it is important to obtain an accurate bed count early in the application process to ensure the growth of bed capacity is consistent with the planned and orderly fashion contemplated by the certificate of need act. *See* RCW 70.38.015(2).

1.13 The Program does not inspect facilities to verify whether the number of available beds reported by a facility is, in fact, accurate. What the Program will do is obtain the count of available beds from several reported sources that are available to it during the evaluation process to consider whether the available bed count information they receive from the applicant is within the range of beds being reported to the Program.

1.14 While this additional information is useful in determining whether the bed numbers being reported is reasonable, it contributes to confusion during the application process regarding what is the "accurate" number of available beds. Using a consistent set of numbers throughout the evaluation process (the snapshot in time) is extremely important. The use of a consistent set of numbers ensures the development of health services and resources in a planned, orderly fashion and without unnecessary duplication or fragmentation. *See* RCW 70.38.015(2). **In any certificate of need application, additional information may become available during the pendency of the application review or during the adjudicative proceeding. However, the**

snapshot in time principle recognizes that effective decision-making is only possible if there is a cutoff, after which such information will not be received or relied upon.

SACRED HEART ORIGINAL APPLICATION

1.15 Following the completion of its modernization plan, Sacred Heart filed the application for additional acute care beds because it determined that it was already using all of its 623-bed licensed capacity. Given the construction necessary to complete its proposed expansion, Sacred Heart planned to expand its bed capacity in stages (21 beds by 2011; the remaining 131 beds as each additional floor was completed).

1.16 As part of its application, Sacred Heart included the average daily census figures for the time period 2002–2008 (ranging from 55.9% in 2002 up to 70.9% by 2008). Sacred Heart's average daily census figures did not meet the State Health Plan minimum level of occupancy for a hospital of its size (that is, 75% occupancy). Sacred Heart believed a more realistic measure was the use of an adjusted average daily census figure (the average daily census figure divided by a 0.75 efficiency factor, which represented age and gender differences and infection control issues). When viewed under the adjusted average daily census percentages, Sacred Heart found higher occupancy standards (ranging from 74.6% to 94.5%) over the same time period and which were more consistent with the State Health Plan minimum occupancy levels. *See* AR 29-31. The use of an adjusted average daily census percentage is not provided for and is not consistent with the minimum occupancy guidelines consistently used in the State Health Plan need methodology.

1.17 Except for its use of an adjusted average daily census, Sacred Heart followed the bed need methodology contained in the State Health Plan. AR 35–38. Sacred Heart submitted three different versions of the methodology, relying on different assumptions for each version. Of the three different versions, the methodology submitted by Sacred Heart in its initial application should be used. *See* AR 161–172. The other two versions were submitted later in the application process (specifically in the screening period and rebuttal period). These two versions either change the underlying calculations or do not allow for adequate public comment.

1.18 Sacred Heart based its application projections on planning area resident hospital data discharges for the years 1998-2007. Sacred Heart's application set a planning horizon or target date of seven years from 2007 (the date for the last known patient data). Sacred Heart's target date in step 10 of the 12-step bed need methodology process was 2014. Sacred Heart also calculated bed need for an additional 11 years beyond the target year (2015–2025). *See* AR 172. Sacred Heart determined that the first year that additional acute care beds would be needed was 2012 (a need for 12.44 beds). AR 172. The bed need continued to increase, reaching a need for 76.91 beds by the 2014 target year, and growing to a need for 146.01 by 2016.

1.19 Sacred Heart was required to count the total number of available hospital beds in the Spokane service area to calculate bed need for the service area. At the time Sacred Heart applied, there were six hospitals in the Spokane service area: Deaconess; Sacred Heart; Deer Park; Providence Holy Family; Valley Hospital and

Medical Center; and St. Luke's Rehabilitation Institute.[9] Sacred Heart determined that the total number of available beds in the facilities equaled 1,168 beds. In reaching this bed figure, Sacred Heart included the 72-beds at the St. Luke's Rehabilitation Institute. Sacred Heart did not submit evidence that the 72-beds at the St. Luke's facility were acute care beds. For this reason, Sacred Heart should not have included the 72-beds into the total bed count.

1.20 In calculating the 1,168 number, Sacred Heart identified that "available beds" were ones that are licensed and currently set up or which could be set up at a relatively low cost. *See* AR 37. Sacred Heart then compiled the available bed figure using the year-end report statistics under chapter 70.41 RCW (the beds both available and currently staffed). AR 37–38; *see* Exhibit NN. So Sacred Heart referred to the State Health Plan available bed definition but used the chapter 70.41 available bed year-end figures for its calculations. By so doing, Sacred Heart accelerated when additional bed need would occur to a point within the seven year (target year) period.

1.21 As a part of the application evaluation, the Program requested that the six hospitals complete a survey for use in determining available bed capacity. All of the hospitals (except Deer Park, which closed in 2008) completed and returned the Program's survey. AR 1566–1570. The bed count surveys totals reflected additional available beds at Deaconess, Holy Family, and Valley. Even by removing the 72-beds at St. Luke's Rehabilitation facility, the number of available beds for use in calculating the State Health Plan methodology is 1,199 beds, rather than the 1,168 bed figure used

[9] Deer Park Hospital, which had 25 beds, closed its facility effective March 4, 2008. For that reason, the 25 Deer Park Hospital beds are not counted in the bed supply after 2007.

by Sacred Heart.[10] Performing the State Health Plan bed need methodology using the 1,199 figure shows there is no need for additional acute care beds until 2016 (a need for 7.65 beds). For that reason, there is no need for additional beds by Sacred Heart's chosen seven year planning horizon (the target year of 2014).

1.22 Need also requires that Sacred Heart prove that all residents of the service area (to include low-income persons, racial and ethnic minorities, women, handicapped persons, other underserved groups, and the elderly are likely to have adequate access to the proposed health services. **See WAC 246-310-210(2)**. In its application, Sacred Heart submitted a copy of its current admission policy that it would continue to use in the hospital. AR 193-195 (Exhibit 18). In addition, Sacred Heart provides services to Medicare and Medicaid eligible patients. AR 20. Sacred Heart also exceeded the eastern Washington Region charity care statistics for 2004-2007. AR 48-49 and AR 551-575 (Exhibit 10 to February 2009 Supplemental Information.)

Financial Feasibility

1.23 Sacred Heart reported that the capital expenditure for the 152-bed project would be $79,402,781, which included a break-down of the estimated capital costs for each service affected by the project. AR 60-62. This included the calculated increase in capital costs per patient day with or without the 152-bed project during the period 2008 through 2018. AR 62 and AR 208-209 (Exhibit 23).

[10] The figure for 2007 (the last year including the 25 Deer Park beds) is 1,224.

1.24 Sacred Heart performs an analysis of selected financial ratios to support its requested project, including an analysis by acute bed need, which exceeds the state's benchmark figures. AR 67 (Table 33). The Department of Health Hospital and Patient Data Systems (HPDS) analysis of the short and long-term financial feasibility of the Sacred Heart's project shows that the application could meet the immediate and long-range operating costs of the project. AR 800-802. Using the HPDS financial ratio analysis, Sacred Heart's application exceeded the fiscal year-end ratios during the period 2008–2018, which were better than the financial ratios from all of the community hospitals in Washington in 2007.

1.25 Sacred Heart based its future revenue projections, in large part, on an increase of patient stays in the service area. In other words, Sacred Heart anticipates increased revenues because of an increase in beds, which allows for additional patients in those beds. As there is no increased bed need, given the surplus of beds or bed availability (no increase of patient stays), Sacred Heart's revenue projections are not supportable. In 2007 alone, Sacred Heart is only meeting an occupancy rate of 66% and that translates to 189 available beds or surplus of beds out of Sacred Heart's 551 bed total. AR 30 (Table 16). Without increased revenue, Sacred Heart will need to adjust its costs to meet the outstanding construction debt. Such costs will likely be borne by the patients.

1.26 Sacred Heart anticipated that the cost of the project (which it planned to do in multiple stages) would be satisfied by adjusted patient day net profits. As Sacred Heart anticipates recovering the project costs through increased revenue, Sacred

Heart's assumption will result in an unreasonable impact on the costs and charges for health services unless it receives the anticipated revenue stream. Because Sacred Heart's assumption cannot be supported (that is, it will not have the increased revenue stream because it will not receive the increased number of beds**)**, then Sacred Heart cannot meet the WAC 246-310-220 criteria.

1.27 Sacred Heart intends to finance the 152-bed project by obtaining long-term debt that is allocated from the parent corporation (Providence Health and Services) and the parent corporation's accumulated reserves. Sacred Heart incurring such debt from its parent corporation is an acceptable business financing practice. The unaudited balance sheet for Sacred Heart's parent corporation reveals that the necessary funds are available. Sacred Heart does not harm itself or its parent corporation by incurring such debt. This is based on the parent corporation's total assets, total liabilities, or general financial health.

Structure and Process (Quality) of Care

1.28 Sacred Heart anticipates adding full time equivalents (FTEs) to its staff in several areas in the event it is permitted to add the 152 beds to its facility. The FTEs are in several specific staffing areas, which include nurses, technicians, and other individuals in patient care areas. Sacred Heart does not anticipate any problems in adding staff due to the nature of salary and benefit packages it can offer. Sacred Heart created a comprehensive approach to hiring. There was no indication that Sacred Heart could not reach its employment goals using its comprehensive hiring approach.

1.29 As it already provides similar health care services to the Spokane community through its hospital, Sacred Heart did not anticipate any difficulty in continuing to provide support services in the event it was authorized to go forward with the proposed 152-bed project.

1.30 Sacred Heart currently provides Medicare and Medicaid services to the Spokane service area. The quality of its services is both surveyed and accredited by the Joint Commission. **AR 1627-1631**. In addition, the Department's Investigation and Inspection Office conducts regular compliance surveys, including two surveys conducted during the period 1999-2008. Those surveys only revealed issues that are consistent with similar hospitals, which were promptly corrected by Sacred Heart. For that reason, the quality of services provided by Sacred Heart meets or conforms to both state and federal regulations.

1.31 Sacred Heart has provided care in the Spokane community prior to its application, including working with other facilities in the community to provide post-hospitalization care. Continuing to provide such care to the community (both hospitalization and post-hospitalization care) would, on its face, promote continuity of care. If there were no other facilities to provide such care, it would be appropriate to grant Sacred Heart's application.

1.32 However, there are existing providers that are both available and accessible to provide such care in the Spokane service area. Determining the need for acute care hospital beds looks to the need for **additional acute care** beds in the service area and not whether the **individual** facility needs more beds. More

specifically, it is not a determination whether the Sacred Heart facility meets the requirements but whether the proposed additional beds are needed in the Spokane service area. Sacred Heart provides care in areas that other hospitals do not (such as Level II trauma and psychiatric care). While Sacred Heart does provide these services, this reason alone does not reduce the existing surplus of hospital beds in the service area for all other types of health care.

1.33 Deaconess, Valley, and Sacred Heart dispute whether there is an accurate count of available beds in the Spokane service area. While there is a dispute over the total number of beds, there is no dispute that the hospitals in the service area (including Sacred Heart) have a surplus of bed space based on the occupancy rates on any given day. The addition of more beds in light of surplus of availability would create an unnecessary duplication of services. Such an unnecessary duplication creates a fragmentation of services. A fragmentation of services does not promote a continuity of care.

Cost Containment

1.34 As a part of its application to add 152 acute care beds, Sacred Heart considered and rejected four alternative approaches. The alternatives were:

A. Do nothing.
B. Modernize and expand Sacred Heart as proposed in the **application** project.
C. Modernize and expand Sacred Heart at a much higher cost.
D. Build on a new site a women's and children's hospital or a new general community hospital.

AR 76.

1.35 Sacred Heart ruled out the least expensive option (do nothing). Sacred Heart previously incorporated efficiencies in its facility and determined that further expansion was necessary to meet any potential need in the Spokane area. Doing nothing would not relieve the crowding for some of the services that Sacred Heart experienced.

1.36 Sacred Heart also ruled out modernizing and expanding its facility as an option. As a part of this option, Sacred Heart considered building a new hospital tower with underground parking and replacement of the power plant. Sacred Heart estimated that this option would cost $1 billion dollars, an amount it considered to be cost prohibitive. Sacred Heart considered some of the intermediate alternatives (such as additional upgrades to hospital facilities and modernization of existing equipment costing somewhere between $250 to $465 million **dollars**) as less attractive than the ultimate decision to seek an additional 152 acute care beds.

1.37 A variation of the new facility alternative was moving the women and children services or the adult psychiatric services to Providence Holy Family. Doing so would allow use of the freed up beds on the Sacred Heart campus. This option was ruled out because it would remove acute care services from the Holy Family treatment area or would require additional construction to accommodate the transfer of the psychiatric services.

1.38 Sacred Heart ruled out the final option (a new site for either a new general community hospital, a women and children's hospital, or building a new facility on a new/different site) because of costs involved (spending $153 to $450 million) and it

would require the duplication of support services already available in Sacred Heart's current facility.

1.39 While each of these options was well thought out, none of the Sacred Heart options sufficiently addresses the existing surplus of available beds in the service area. Given the existence of a surplus number of beds, there is no need to create or add more beds to the facilities in the Spokane service region area.

1.40 Sacred Heart submitted its projections for the total project construction costs, which totaled $133,612,230. Sacred Heart's construction cost anticipated the addition of 173 beds (the 152 acute care bed request and the 21 intermediate care nursing level II bassinettes.)[11] **The Hospital and Patient Data System (**HPDS**)** based its review on a comparison of construction costs reviewed in other certificate of need requests. While acknowledging that construction costs can vary depending on a variety of factors (the type of construction; quality of materials; custom vs. standard design; the building site; and other factors), the HPDS analysis found the Sacred Heart proposed construction costs were within the range of construction costs for other certificate of need projects. AR 800.

1.41 Sacred Heart anticipated that approval of its application for the 152-bed project would improve the delivery of health services, given that the additional beds would increase the flexibility of services Sacred Heart could provide (the appropriate placement of patients at the appropriate clinical level of care). Sacred Heart does experience some displacement of patients caused by the unavailability of beds in

[11] The 21 intermediate care nursing Level II bassinettes, and that portion of the total construction costs that are represented by the bassinettes, are not a part of the appeal.

sub-areas of the hospital (for example, intensive care and cardiac intensive care). *See* AR 28. To the extent that additional beds are available, it is reasonable to anticipate that the flexibility of a facility's sub-areas to provide patient services would improve with additional beds.

SACRED HEART SETTLEMENT APPLICATION

1.42 In June 2009, the Program denied Sacred Heart's application. Following an unsuccessful request for reconsideration, Sacred Heart filed a timely request to appeal the Program's decision. Deaconess intervened in the proceeding.

1.43 On or about January 25, 2010, Sacred Heart and the Program began discussing a settlement of Sacred Heart's appeal. AR 1599–1626; AR 1634; and AR 1661. The Program provided the interested parties with the proposed settlement in March 2010. AR 1733-1739. The Program issued its proposed settlement evaluation and awarded 75 acute care beds to Sacred Heart by issuing Certificate of Need No. 1422 on May 14, 2010. AR 1850-1851. As with the original application, the bed need methodology was calculated using the 12-step State Health Plan bed methodology.

1.44 There is not a detailed "application" contained in the application record that represents Sacred Heart's position during settlement.[12] The application record does contain handwritten notes taken in December 2010 that record discussions between Sacred Heart and the Program (*see* AR 1599 to 1607) and a draft outline of

[12] As the final decision-maker, the Presiding Officer reviews Sacred Heart's application to see if it met all of the applicable criteria, not the Program's review of the application. *See DaVita v. Department of Health*, 137 Wn. App. 174, 182 (2007).

the settlement terms being negotiated between Sacred Heart and the Program (*see* AR 1635). In addition, the Program or Sacred Heart used the State Health Plan bed need methodology to calculate bed need using six different available bed count figures. *See* AR 1663 through 1731.

1.45 As a result, Sacred Heart's settlement "application" must be inferred from information contained in the original application, information found in Sacred Heart's request for reconsideration (which was denied by the Program), and the settlement terms as discussed in the Sacred Heart–Program settlement evaluation.

Settlement Application: Need Methodology

1.46 Although it requested a seven-year planning horizon in its original application, Sacred Heart requested a ten-year planning horizon as a part of its settlement request. Sacred Heart changed its planning horizon position to accommodate or provide relief for some of the over-crowding in its facility. Sacred Heart notes the Program has given some projects an additional three years to complete a project in the past (that is, additional time beyond the standard 7-year approach in the State Health Plan) for the purpose of evaluating a project over the time period similar to that of amortizing the expense of the project). *See* AR 1580.

1.47 The settlement need methodology required corrections at several steps of the methodology. *See* AR 1820-1822. In addition to the corrections, information obtained during the settlement comment period reduced the number of available beds in

the Spokane service area from 1,199 to 1,101.[13] *See* AR 1845-1846. Adjusted for the corrections and the change in the number of available beds, the settlement methodology calculations showed that there was no bed need by 2014 (the original target year) but there would be a need for 51.02 additional beds by 2017, increasing to a need for 85.51 additional beds by 2018. Using these calculations, Sacred Heart and the Program believed that it would be appropriate to settle the appeal by awarding 75 additional beds (50 new beds and 25 beds relocated from Holy Family) to Sacred Heart. In so doing, Sacred Heart requested, and the Program accepted, an extension of the target date from the 2014 date originally requested by Sacred Heart to 2017.

1.48 Consistent with the requirements of WAC 246-310-610(4)(c), the Program and Sacred Heart submitted the proposed settlement to the parties with WAC 246-310-010 affected person[14] status (Valley Medical Center; Deaconess Medical Center; Service Employees International Union 1199 NW; and Premera Blue Cross) for comment. AR 1733-1740. In the proposed settlement, Sacred Heart requested, and the Program considered, the approval of 75 beds at the Sacred Heart facility. The proposed settlement differed from the original Program decision by: extending the target year from seven years (2014) to ten years (2017); removing patient days for residents receiving care from St. Luke's Rehabilitation Institute; and reducing the number of available beds from 1,199 in the original decision to 1,101 beds in the

[13] As with the original application, the number of beds available in 2007 was higher by the 25 beds at the Deer Park facility. The 25 beds were not included in calculation for 2008-2020. *See* AR 1845-1846.
[14] An "affected person" means an interested person who is: located in applicant's service area; testified at the public hearing or submitted written evidence; and requested in writing to be informed of the Department's decision.

proposed settlement decision for use in the methodology calculation. The proposed settlement decision found there was a need for 75 additional beds (consisting of 50 new beds and 25 transfer beds from Holy Family).[15]

1.49 Sacred Heart's settlement request only works (only shows need for the additional 75 beds) if the planning horizon is extended from seven years (as requested in the original application) to ten years. The over-crowding that Sacred Heart seeks to relieve (its stated reason for extending the planning horizon) is no different than it was when Sacred Heart made its original application. Sacred Heart does not address why, given that it has not reached the State Health Plan minimum occupancy levels, additional beds will resolve this issue. **Based on a review of the information in the settlement application, Sacred Heart fails to provide additional information to support its requested change from a seven year planning horizon to a ten year planning horizon.**

1.50 Need also requires that Sacred Heart prove that all residents of the service area (to include low-income persons, racial and ethnic minorities, women, handicapped persons, other underserved groups, and the elderly) are likely to have adequate access to the proposed health services. As a part of its application, Sacred Heart submitted a copy of its current admission policy that it would continue to use in the hospital. AR 193-195 (Exhibit 18). In addition, Sacred Heart provides services to Medicare and Medicaid eligible patients. AR 20. Sacred Heart also exceeded the

[15] Both Sacred Heart and Holy Family are part of the Providence hospital chain.

eastern Washington Region charity care statistics for 2004-2007. AR 48-49 and AR 551-575 (Exhibit 10 to February 2009 Supplemental Information).

Settlement Application: Financial Feasibility

1.51 In its original application, Sacred Heart reported that the capital expenditure for the 152-bed project would be $79,402,781 (out of a total project cost of $133,612,230 for the acute care beds, Level II bassinettes and construction). Sacred Heart anticipated having 89 of the 152-bed project built out and available by 2013. *See* AR 13-14. Doing so would expend nearly 90 percent of the total project cost at the start of the project.

1.52 The Department's Hospital and Patient Data System (HPDS) analysis of the short and long-term financial feasibility of Sacred Heart's original project showed Sacred Heart could meet the immediate and long-range operating costs for the project. AR 800-802. Sacred Heart's settlement project, as the initial project, exceeded the fiscal year end ratio test.

1.53 As with its initial application, Sacred Heart based its future revenue projections on an increase in patient stays (the increased number of beds, allowing for an increased number of patients treated, which creates the additional revenue). Given the number of available beds currently within the service area, there is no additional bed need. Without increased revenue, Sacred Heart will be required to adjust its costs to meet any outstanding construction debt arising out of the project. Such costs will likely be borne by the patients.

1.54 Sacred Heart anticipated that the cost of the project (which it planned to do in multiple stages) rests on adjusted patient day net profits. As Sacred Heart's anticipates recovering the project costs through increased revenue, Sacred Heart's assumption on the impact on the costs and charges for health services will be reasonable only if it receives the anticipated increased revenue stream. The alternative is also true: if Sacred Heart does not increase its revenue stream, approving the project will result in an unreasonable impact on the costs and charges for health services. Because Sacred Heart's assumption cannot be supported (it will not have the increased revenue stream because there will be no increase in the number of beds), Sacred Heart cannot meet the WAC 246-310-220 criteria.

1.55 Sacred Heart intends to finance the 152 bed project by obtaining long-term debt that is allocated from the parent corporation (Providence Health and Services) and the parent corporation's accumulated reserves. Incurring such debt from its parent corporation is an appropriate business financing practice by Sacred Heart. The parent corporation's unaudited balance sheet reveals the necessary funds are available. Sacred Heart does not harm itself or its parent corporation by incurring such debt, given the parent corporation's total assets, total liabilities, or general financial health.

Settlement Application: Structure and Process (Quality) of Care

1.56 Sacred Heart anticipates adding FTEs to its staff in several areas in the event it is permitted to add the 152 beds to its facility. The FTEs are in several specific staffing areas, which include nurses, technicians, and other individuals in patient care

areas. Sacred Heart did not anticipate any problems in adding staff because of the salary and benefit packages it could offer. Sacred Heart created a comprehensive approach to hiring, and there was no reason to determine it could not reach its employment goals.

1.57 As it already provides similar health care services to the Spokane community through its hospital, Sacred Heart did not anticipate any difficulty in continuing to provide support services in the event it was authorized to go forward with the proposed 152-bed project.

1.58 Sacred Heart currently provides Medicare and Medicaid services to the Spokane service area. The quality of its services is both surveyed and accredited by the Joint Commission. **See AR 1627-1631**. In addition, the Department's Investigation and Inspection Office conducts regular compliance surveys, including two surveys conducted during the period 1999-2008. Those surveys only revealed issues that are consistent with similar hospitals, which were promptly corrected by Sacred Heart. For that reason, the quality of services provided by Sacred Heart meets or conforms to both state and federal regulations.

1.59 Sacred Heart had provided care in the Spokane community prior to its application, including working with other facilities in the community to provide post-hospitalization care. Continuing to provide such care to the community (both hospitalization and post-hospitalization care) would, on its face, promote continuity of care. If there were no other facilities to provide such care, it would be appropriate to grant Sacred Heart's application.

1.60 However, there are existing providers that are both available and accessible to provide such care in the Spokane service area. Unlike applications for other certificate of need services, determining need for acute care hospital beds looks to the need for beds and not for facilities. More specifically, it is not a determination whether the Sacred Heart facility meets the requirements but whether the proposed additional beds are needed in the Spokane service area. While Sacred Heart provides care in areas that other hospitals do not (such as Level II trauma and psychiatric care), this reason alone does not reduce the existing surplus of hospital beds in the service area for all other types of health care.

1.61 The parties dispute whether there is an accurate count of available beds in the Spokane service area. Even though the parties dispute the total number of beds, there is no dispute that hospitals in the service area (including Sacred Heart) have a surplus of bed space based on the occupancy rates on any given day. The addition of more beds in light of surplus of availability would create an unnecessary duplication of services. Such an unnecessary duplication creates a fragmentation of services. A fragmentation of services does not promote a continuity of care.

Settlement Application: Cost Containment

1.62 As part of its original 152-bed application, Sacred Heart considered four alternative approaches (do nothing; modernize and expand in areas beyond those proposed in the project; modernize and expand at a higher cost; or build on a new site a women's and children's hospital or a new general community hospital.) Sacred Heart rejected these four alternatives and determined the 152-bed project was the superior

alternative. During the settlement process a fifth alternative was identified (adding 50 new beds and re-locating 25 licensed beds from Holy Family). The Program and Sacred Heart agreed on this fifth alternative to settle the matter.

1.63 Sacred Heart chose the 75-bed settlement alternative because it determined that none of the other alternatives identified above were superior in terms of cost, efficiency, or effectiveness. Using a seven-year planning horizon, there is no need shown in the State Health Plan bed need methodology calculations (a surplus of 46.91 beds in 2014). AR 1845. Nor is there need in the next year (a surplus of 17.29 beds in 2015). *Id*.

1.64 Given that there is a surplus of beds throughout the seven-year planning horizon, the best choice among the five alternatives is the "do nothing" approach. The bed need analysis is to choose the best alternative for the service area and not the facility. Even acknowledging that Sacred Heart has some displacement of patients caused by the unavailability of sub-area beds (e.g., intensive care and cardiac intensive care), there is still a surplus of available beds within the Spokane service area to provide hospital services to patients.

1.65 Sacred Heart's total construction costs anticipated adding 173 beds (the 152-bed acute care beds and the 21 intermediate care Level II bassinettes.) The HPDS analysis of Sacred Heart's original construction costs found the costs were within the range of construction costs for other similar certificate of need projects. *See* AR 800. If the test is determining whether the proposed construction costs fit within the range of similar projects, there is nothing in the proposed settlement alternative to dispute the

HPDS analysis on the costs, scope, and method of Sacred Heart's proposed settlement construction information.

1.66 As it anticipated in its original application, Sacred Heart expects that the 75-bed expansion will improve the delivery of services, reasoning that such additional beds will increase the flexibility of services within its facility. To the extent that Sacred Heart had additional beds available, it is reasonable that Sacred Heart could improve the delivery of its services to patients with the additional beds.

JANUARY 2011 PROGRAM BED COUNT

1.67 Sacred Heart questioned whether the bed counts submitted by Deaconess and Valley were correct (were not over-counted) during the discovery process. In response to this inquiry, the Program conducted a physical inspection of the Deaconess, Valley, and Holy Family facilities on January 18-19, 2011, to verify the actual bed count for the three facilities. *See* Exhibit P-2. No inspection was conducted at the Sacred Heart facility.

1.68 The Program's revised bed count following the January 2011 inspection reveals a 17-bed increase over the bed count obtained during the settlement negotiations (from 1,101 beds in the proposed settlement to 1,118 beds in the inspection count). *See* Program Post-Hearing Brief, page 7.

1.69 Sacred Heart requested a bed count to ensure the accuracy of the Deaconess and Valley bed totals. The Program conducted the bed count in response to the request on January 18-19, 2011. Based on its January 2011 physical bed count, the Program determined that no additional bed need existed in the Spokane service

area. Even though it determined that no additional bed need existed, the Program proposed to authorize a 75-bed increase to Sacred Heart so long as the 75-bed increase consisted of a transfer of the beds from the Providence Holy Family facility to Sacred Heart. The Program considered its proposal under the "superior alternative" criterion in WAC 246-310-240(1) or a "sixth" alternative to Sacred Heart's original 152-bed request.

1.70 The Program's proposal (the "sixth" alternative that authorized a 75-bed transfer from Providence Holy Family) was not included in the earlier March 2010 settlement proposal. There is no evidence in the Sacred Heart application record to show that the Program submitted this sixth alternative position to the affected parties (Deaconess, Valley, Holy Family' SEIU Healthcare, and Premera Blue Cross) pursuant to WAC 246-310-610(4)(c).[16]

II. CONCLUSIONS OF LAW

Evidence in Certificate of Need Decisions

2.1 The Department of Health is authorized and directed to implement the certificate of need program. RCW 70.38.105(1). The applicant must show or establish that its application meets all of the applicable criteria. *See* WAC 246-10-606. The Program issues a written analysis which grants or denies the certificate of need application. The written analysis must contain sufficient evidence to support the Program's decision. *See* WAC 246-310-200(2)(a). Admissible evidence in certificate of

[16] **While the Program on reconsideration believes that a 75-bed transfer from Holy Family will resolve the issue, Sacred Heart does not support this approach. Compare the Program's Motion for Reconsideration, pages 2-9 to Sacred Heart's Response, page 2, lines 11-14, and page 10, lines 7-21.**

need hearings is the kind of evidence on which reasonably prudent persons are accustomed to rely in the conduct of their affairs. RCW 34.05.452(1). The standard of proof is preponderance of the evidence. WAC 246-10-606.

Presiding Officer as Agency Fact-Finder

2.2 The Presiding Officer (on delegated authority from the Secretary of Health) is the agency's fact-finder and final decision maker. *DaVita v. Department of Health*, 137 Wn. App. 174, 182 (2007) (*DaVita*). The Presiding Officer may consider the Program's written analysis in reaching his decision but is not required to defer to the Program analyst's decision or expertise. *DaVita*, 137 Wn. App. at 182-183. The appeal process does not begin the application process anew. *University of Washington v. Department of Health*, 164 Wn.2d 95, 104 (2008).

2.3 In acting as the Department's final decision maker, the Presiding Officer reviewed the application record (including any supporting documentation such as HPDS and Comprehensive Hospital Abstract Reporting System (CHARS) data provided as part of the application record. The Presiding Officer also reviewed the hearing transcripts and the closing briefs submitted by the parties pursuant to RCW 34.05.461(7).

Use of Bed Need Methodology

2.4 To evaluate whether need exists for additional beds, the Department relies on the 10-step bed methodology set forth in the State Health Plan. The State Health Plan was "sunsetted" in 1990:

> For the purpose of supporting the certificate of need process, the state health plan developed in accordance with RCW 70.38.065 and in effect on

> July 1, 1989, shall remain effective until June 30, 1990, or until superseded by rules adopted by the department of health for this purpose. The governor may amend the state health plan, as the governor finds appropriate, until the final expiration of the plan.

RCW 70.38.919. In 2007, the Legislature adopted E2SSB 5930 that repealed RCW 70.38.919. The Office of Financial Management was required to develop a statewide health care strategy to include a new plan to assess and direct certificate of need determinations. While the plan was to be ready by January 1, 2010, no such plan exists now.

2.5 The Department may consider other non-codified standards developed by other organizations with recognized expertise related to a proposed undertaking. *See* WAC 246-310-200(2)(b)(v). In the absence of any statutory or regulatory bed need methodology, and pursuant to its authority under WAC 246-310-200(2)(b)(v), the Presiding Officer will use of the State Health Plan methodology as an analytical tool in review of Sacred Heart's application.

Certificate of Need Criteria

2.6 Whether a certificate of need should issue to an applicant is based on a determination that the proposed project:

(a) Is needed;

(b) Will foster containment of costs of health care;

(c) Is financially feasible; and

(d) Will meet the criteria for structure and process of care identified in WAC 246-310-230.

WAC 246-310-200(1).

SACRED HEART ORIGINAL APPLICATION

Need

2.7 To prove that need exists for additional hospital beds, Sacred Heart must initially meet the criteria in WAC 246-310-210.[17] The criteria are:

> (1) The population served or to be served has need for the project and other services and facilities of the type proposed are not or will not be sufficiently available or accessible to meet that need.
>
> (2) All residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services.

WAC 246-310-210.

2.8 The State Health Plan methodology contains a 12-step analysis to forecast acute care bed need. The first four steps develop trend information regarding utilization of hospital beds to evaluate the need of additional beds in a service area. The next six steps calculate the baseline for calculating the need for non-psychiatric beds. Step 11 addresses short stay psychiatric beds that are not at issue here. Step 12 allows for necessary adjustments in the methodology to reflect the special circumstances of a service area

2.9 The State Health Plan 12-step methodology to forecast need for non-psychiatric acute care hospital beds is as follows:

Develop trend information on hospital utilization

Step 1: Compile state historical utilization data (i.e., patient days within

[17] Some of the WAC 246-310-210 sub-criteria are not discussed in this decision because they are not relevant to the Sacred Heart project. *See* WAC 246-310-210(3), (4), (5), and (6).

major service categories) for at least ten years preceding the base year.[18]

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

Step 3: For each year, compute the statewide and HSA (health service area) average use rates.[19]

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.

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.

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…[20]

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 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

[18] The base year is the "most recent year about which data is collected as the basis for a set of forecasts." Exhibit D-1, Page 1859 (State Health Plan Page C-25).

[19] The state of Washington is divided into four health service areas.
[20] Step 7B is an alternative to step 7A, and does not apply to the facts at hand.

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 the weighted average occupancy standards, and determine each planning area's non-psychiatric bed need. Calculate the weighted average occupancy standard as described in the Hospital Forecasting Standard 11.f. This should be based on the total number of beds in each hospital (Standard 11.b[21]), including any short-stay psychiatric beds in general acute-care hospitals. Psychiatric hospitals with no other services should be excluded from the occupancy calculation.

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 in-patient bed need from step 11 of the short-stay psychiatric hospital bed need forecasting method.

Step 12: Determine and carry out any necessary adjustments in population, use rates, market shares, out-of-area use and occupancy rates.

2.10 Based on Findings of Fact 1.4 through 1.21, Sacred Heart did not prove by a preponderance of the evidence that the application met the WAC 246-310-210(1) criteria (incorporating the State Health Plan bed need methodology).

2.11 Based on Finding of Fact 1.22, Sacred Heart proved by a preponderance of the evidence that its application met the WAC 246-310-210(2) criteria.

Financial Feasibility

2.12 To obtain a certificate of need for additional hospital beds, Sacred Heart must show that its project is financially feasible under WAC 246-310-220. That regulation requires a showing that:

[21] Standard 11b provides the hospital occupancy standards used in forecasting need. (See footnote 6.) Exhibit D-1 Page 1871 (State Health Plan Page C-37).

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

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

(3) The project is appropriately financed.

WAC 246-310-220.

2.13 Based on Findings of Fact 1.23 through 1.24, Sacred Heart proved by a preponderance of the evidence that the application met the criteria set forth in WAC 246-310-220(1) (incorporating the 1987 State Health Plan need methodology).

2.14 Based on Findings of Fact 1.25 through 1.26, Sacred Heart did not prove by a preponderance of the evidence that the application met the criteria set forth in WAC 246-310-220(2).

2.15 Based on Finding of Fact 1.27, Sacred Heart proved by a preponderance of the evidence that its application met the criteria set forth in WAC 246-310-220(3).

Structure and Process (Quality) of Care

2.16 Sacred Heart must show that its hospital bed project meets the structure and process of care requirements as set forth in WAC 246-310-230. That regulation provides:

> A determination that a project fosters an acceptable or improved quality of health care shall be based on the following criteria.
>
> (1) A sufficient supply of qualified staff for the project, including both health personnel and management personnel, are available or can be recruited.
>
> (2) The proposed service(s) will have an appropriate relationship, including organizational relationship, to ancillary and support

services, and ancillary and support services will be sufficient to support any health services including the proposed project.

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

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

(5) There is reasonable assurance that the services to be provided through the proposed project will be provided in a manner that ensures safe and adequate care to the public to be served and in accordance with applicable federal and state laws, rules, and regulations. The assessment of the conformance of a project to this criterion shall include but not be limited to consideration whether:

(a) The applicant or licensee has no history, in this state or elsewhere, of a criminal conviction which is reasonably related to the applicant's competency to exercise responsibility for the ownership or operation of a health care facility, a denial or revocation of a license to operate a health care facility, a revocation of a license to practice a health care profession, or a decertification as a provider of services in the medicare or medicaid program because of a failure to comply with applicable federal conditions or participation; or

(b) If the applicant or licensee has such a history, whether the applicant has affirmatively established to the department's satisfaction by clear, cogent and convincing evidence that the applicant can and will operate the proposed project for which the certificate of need is sought in a manner that ensures safe and adequate care to the public to be served and conforms to applicable federal and state requirements.

2.17 Based on Finding of Fact 1.28, Sacred Heart proved by a preponderance of the evidence that its application met the WAC 246-310-230(1) criteria.

2.18 Based on Finding of Fact 1.29, Sacred Heart proved by a preponderance of the evidence that the application met the WAC 246-310-230(2) criteria.

2.19 Based on Finding of Fact 1.30, Sacred Heart proved by a preponderance of the evidence that the application met the WAC 246-310-230(3) criteria.

2.20 Based on Findings of Fact 1.31 through 1.33, Sacred Heart did not prove by a preponderance of the evidence that its application met the WAC 246-310-230(4) criteria.

2.21 Based on Findings of Fact 1.30, Sacred Heart proved by a preponderance of the evidence that its application met the WAC 246-310-230(5) criteria.

Determination of Cost Containment

2.22 To obtain additional hospital beds, Sacred Heart must also show that it meets the determination of cost containment set forth in WAC 246-310-240. That regulation provides:

> A determination that a proposed project will foster cost containment shall be based on the following criteria:
>
> (1) Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable.
>
> (2) In the case of a project involving construction:
>
> (a) The costs, scope, and methods of construction and energy conservation are reasonable; and
>
> (b) The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.
>
> (3) The project will involve appropriate improvements or innovations in the financing and delivery of health services

> which foster cost containment and which promote quality assurance and cost effectiveness.

WAC 246-310-240.

2.23 Based on Findings of Fact 1.34 through 1.39, Sacred Heart did not prove by a preponderance of the evidence that its application met the WAC 246-310-240(1) criteria.

2.24 Based on Finding of Fact 1.40, Sacred Heart proved by a preponderance of the evidence that its application met the WAC 246-310-240(2) criteria.

2.25 Based on Finding of Fact 1.41, Sacred Heart proved by a preponderance of the evidence that its application met the WAC 246-310-240(3) criteria.

SACRED HEART SETTLEMENT APPLICATION

2.26 RCW 70.38.115 provides the settlement process for certificate of need appeals:

> (c) If the department desires to settle with the applicant prior to the conclusion of the adjudicative proceeding, the department shall so inform the health care facility or health maintenance organization and afford them an opportunity to comment, in advance, on the proposed settlement.

RCW 70.38.115(10)(c); *see also* RCW 34.05.060. Before a settlement can be accepted as a resolution of a certificate of need appeal, the proposed settlement must comply with the certificate of need criteria in WAC 246-310-210 through WAC 246-310-240.[22]

[22] Deaconess raises issues regarding the timing and level of participation in the settlement process. WAC 246-310-610(4)(c) provides for the opportunity to comment on the settlement process. It is not clear whether an intervenor has settlement process rights beyond those set forth in WAC 246-310-610(4)(c). Given the Presiding Officer's decision, this issue need not be reached.

The calculation of need follows the need methodology contained in the 1987 State Health Plan.

Need – Settlement Proposal

2.27 Based on Findings of Fact 1.4 through 1.14 and 1.42 through 1.49, Sacred Heart did not prove by a preponderance of the evidence that the application met the WAC 246-310-210(1) criteria (incorporating the 1987 State Health Plan bed need methodology).

2.28 Based on Finding of Fact 1.50, Sacred Heart proved by a preponderance of the evidence that the application met the WAC 246-310-210(2) criteria.

Financial Feasibility – Settlement Proposal

2.29 Based on Findings of Fact 1.51 through 1.52, Sacred Heart proved by a preponderance of the evidence that its application met the criteria set forth in WAC 246-310-220(1).

2.30 Based on Findings of Fact 1.53 through 1.54, Sacred Heart did not prove by a preponderance of the evidence that the application met the criteria set forth in WAC 246-310-220(2).

2.31 Based on Finding of Fact 1.55, Sacred Heart proved by a preponderance of the evidence that the application met the criteria set forth in WAC 246-310-220(3).

Structure and Process (Quality) of Care – Settlement Proposal

2.32 Based on Finding of Fact 1.56, Sacred Heart proved by a preponderance of the evidence that the application met the WAC 246-310-230(1) criteria.

2.33 Based on Finding of Fact 1.57, Sacred Heart proved by a preponderance of the evidence that the application met the WAC 246-310-230(2) criteria.

2.34 Based on Finding of Fact 1.58, Sacred Heart proved by a preponderance of the evidence that the application met the WAC 246-310-230(3) criteria.

2.35 Based on Findings of Fact 1.59 through 1.61, Sacred Heart did not prove by a preponderance of the evidence that the application met the WAC 246-310-230(4) criteria.

2.36 Based on Findings of Fact 1.58, Sacred Heart proved by a preponderance of the evidence that the application met the WAC 246-310-230(5) criteria.

Cost Containment – Settlement Proposal

2.37 Based on Findings of Fact 1.62 through 1.64, Sacred Heart did not prove by a preponderance of the evidence that the application met the WAC 246-310-240(1) criteria.

2.38 Based on Finding of Fact 1.65, Sacred Heart proved by a preponderance of the evidence that the application met the WAC 246-310-240(2) criteria.

2.39 Based on Finding of Fact 1.66, Sacred Heart proved by a preponderance of the evidence that the application met the WAC 246-310-240(3) criteria.

PROGRAM JANUARY 2011 BED COUNT

2.40 The Program proposes that Sacred Heart substitute the January 2011 bed count for the methodology calculation in the March 2010 Settlement proposal (that is, the settlement negotiated between Sacred Heart and the Program). This suggestion **should be** dismissed **in this case** for a number of reasons. First, the Program did not

include this bed count methodology in the March 2010 settlement proposal that was forwarded to the interested parties pursuant to the requirements in WAC 246-310-610(4)(c). The Program issued Certificate of Need No. 1422 in May 2010, which not based on the January 2011 bed count. An attempt to change the March 2010 settlement proposal after the comment period for the affected parties and after the Program issued Certificate of Need No. 1422 is **both** too late in the **settlement** process **and does not comply with the WAC 246-310-610(4)(c) settlement process (the process that allows comment on the settlement proposal by all of the health care facilities or health maintenance organizations which requested being informed of the department's decision)**.

2.41 Second, Sacred Heart (the applicant here) never requested a 75-bed expansion consisting only of a transfer of 75 beds from Holy Family. That was not part of Sacred Heart's settlement proposal (the March 2010 settlement). *See* Providence Sacred Heart's Post-Hearing Brief, pages 8-9; Providence Sacred Heart's Post-Hearing Response Brief, pages 2-3, and 15. It was the Program's proposal to transfer all 75 beds from Holy Family to Sacred Heart. **Based on the revised bed counts, the Program *changed its settlement position*.[23] *See* Program Post-Hearing Brief,**

[23] The Program argues that the Presiding Officer either misunderstood the process or underestimated his authority. Program's Motion for Reconsideration, page 3. It is true that authority exists to grant an alternative under WAC 246-310-240 as suggested by the Program. However, implicit within the WAC 246-310-240 authority and certificate of need law in general is the requirement that fair consideration of a party's proposal requires timely submission. The authority to consider alternatives does not require the Presiding Officer to adopt the Program's 11th hour change in position.

page 2, dated March 21, 2011. Sacred Heart never requested this alternative and it never accepted the Program's proposal.[24]

2.42 Sacred Heart and Holy Family are part of the Providence network of hospitals (Providence Health and Services), but Holy Family is not a party to this proceeding (either as intervenor or an interested or affected party). The parties did not provide any legal authority that authorizes the Presiding Officer to require a non-party (Holy Family) to participate in such a transfer absent the non-party's consent. Although Holy Family is part of the Providence Health and Services network, it is not the applicant here. Neither is Providence Health and Services. Sacred Heart is the applicant here.

2.43 Even if the request had been made by Sacred Heart, the request (whether it is characterized as a settlement proposal, a new application, or an amended application) is not timely. If it is a new application, such a request is not appropriate. A request for an adjudicative proceeding does not begin the application process anew. *See University of Washington v. Department of Health*, 164 Wn.2d 95, 104 (2008). If it is an amended application, the amendment is not timely because it is long past the public comment period. *See* Findings of Fact 1.2 and 1.3; *see generally* WAC 246-310-160 and WAC 246-310-180. The information is long past the application cutoff date in April 2009. **If it is a settlement proposal, it was not properly completed under the settlement process set forth in WAC 246-310-610.**

2.44 Third, in its Motion for Reconsideration Under RCW 34.05.461, the Program appears to conflate the authority it has during the application process

[24] In contract law terms, the Program made the offer but Sacred Heart did not accept the offer.

(before the matter enters the hearing phase) with its authority after the application is appealed (after the matter enters the hearing phase) under chapters 70.38 RCW and 246-310 WAC. While the Program can make settlement offers during the hearing phase of the proceeding, it cannot make the final decision on the adoption of the settlement.[25] Once the hearing process begins, the Presiding Officer has the final decision making authority over the application. *See DaVita v. Department of Health*, 137 Wn. App. 174, 182 (2007). The Program does not have any more authority over the outcome of the settlement process than does any other party to the action.

2.**45** **T**he admission of evidence is within the sound discretion of the Presiding Officer. *See University of Washington v. Department of Health*, 164 Wn.2d 95, 104 (2008). The Program made its January 2011 bed count, in large part, to see if the case could be settled short of a full administrative hearing. The Program made every attempt to determine the count of available beds that existed as of the April 2009 cutoff date (the date the Program closed the application to begin its evaluation of the Sacred Heart application). The Presiding Officer acknowledges that the Program took extreme care in conducting the bed count and the Presiding Officer did, in fact, admit the exhibit (Exhibit D-2).

2.**46** However, the use of evidence created long after the snapshot in time in the certificate of need application process acts to undermine the statutory objective of expeditious decision making. ***See University of Washington v. Department of***

[25] An example of the confusion created by the Program's January 2011 bed count was discussed at the beginning of the hearing. *See* TR 26, line 20 to TR 29, line 13.

***Health*, 164 Wn. 2d at 104 (both the statutes and administrative rules clearly contemplate that the decision will be made quickly).** The exhibit was created one month prior to the scheduled hearing date but nearly two years after the close of the April 2009 public comment period. The proximity to the hearing date and length of time after the public comment period acted to prevent the parties from having meaningful input regarding the evidence (both in the public comment period and the settlement comment period). *See University of Washington v. Department of Health*, 164 Wn.2d 104. The Presiding Officer concludes the use the January 2001 bed count evidence in deciding the Sacred Heart matter is not appropriate on policy grounds.

2.47 Finally, the Presiding Officer has the duty of protecting the hearing process just as the Program has a responsibility to protect the application process. The responsibility to protect the hearing includes the protection of the "snapshot" in time anticipated in certificate of need applications. *See University of Washington v. Department of Health*, 164 Wn. 2d at 103 (the "snapshot" anticipates the snapshot of facts around the time application is filed); *see also* Finding of Fact 1.14. The "snapshot" in time does not anticipate the amendment of the information on which an application can be based, except where there is evidence that the information was unavailable to the parties at the time of the application. While accuracy of information is important, it is disingenuous to suggest that a decision rests on inaccurate information when a party or parties

could have or should have obtained the "accurate" information as a part of the application process.[26]

III. ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is ORDERED:

3.1 The Sacred Heart application to add 152 acute care beds to its facility under Master Case No. M2009-1141 is DENIED.

3.2 The Sacred Heart application for the addition of up to 152 acute care beds to its facility under Master Case No. M2010-669 (the Cross Appeal) is DENIED.

3.3 The Deaconess appeal for the reversal of the Program's approval of the proposed settlement and award of Certificate of Need No. 1422 to Sacred Heart under Master Case No. M2010-667 is GRANTED. The Deaconess appeal for the entry of an order denying a certificate of need to Sacred Heart for the addition of 75 acute care beds to the license of its existing facility (based on the March 2010 settlement proposal) under Master Case No. M2010-667 is GRANTED.

Dated this _9__ day of **August**, 2011.

_____/s/_____
JOHN F. KUNTZ, Review Judge
Presiding Officer

[26] **Nothing precluded any party from requesting an order to remand the matter back to the Program to amend the application record at any point it believed the information on which the application was based was not accurate information**.

NOTICE TO PARTIES

This order is subject to the reporting requirements of RCW 18.130.110, Section 1128E of the Social Security Act, and any other applicable interstate or national reporting requirements. If discipline is taken, it must be reported to the Healthcare Integrity Protection Data Bank.

A **petition for judicial review** must be filed and served within 30 days after service of this order. RCW 34.05.542. The procedures are identified in chapter 34.05 RCW, Part V, Judicial Review and Civil Enforcement. A petition for reconsideration is not required before seeking judicial review. If a petition for reconsideration is filed, the above 30-day period does not start until the petition is resolved. RCW 34.05.470(3).

The order is in effect while a petition for reconsideration or review is filed. "Filing" means actual receipt of the document by the Adjudicative Service Unit. RCW 34.05.010(6). This order is "served" the day it is deposited in the United States mail. RCW 34.05.010(19).

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