STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

In Re: CERTIFICATE OF NEED PROGRAM'S DECISION REGARDING INTERMEDIATE CARE NURSERY APPLICATIONS OF SWEDISH HEALTH SERVICES AND OVERLAKE HOSPITAL MEDICAL CENTER, SWEDISH HEALTH SERVICES, a Washington nonprofit corporation, Petitioner.	Master Case Nos. M2011-1344 M2011-1505 FINDINGS OF FACT, CONCLUSIONS OF LAW, AND FINAL ORDER

APPEARANCES:

Petitioner, Swedish Health Services (Swedish), by
Bennett Bigelow & Leedom, P.S., per
Brian W. Grimm, Attorney at Law

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

PRESIDING OFFICER: Frank Lockhart, Health Law Judge

A hearing was held in this matter on August 6, 2012, regarding Swedish's Certificate of Need Application to establish Level II nursery services at its facility in Issaquah. Certificate of Need granted.

ISSUE

Did Swedish's application for a Certificate of Need to establish a Level II nursery meet the criteria set forth in WAC 246-310-210, WAC 246-310-220, WAC 246-310-230, and WAC 246-310-240?

PROCEDURAL HISTORY

In July 2007, the Program granted a Certificate of Need (CN) to Swedish to build a hospital in Issaquah. Swedish planned to offer Level I (basic care) services for newborns at the new Issaquah facility.

In October 2010, while the hospital was being built, Swedish submitted a CN Application to establish Level II (intermediate) nursery services at the facility.

In August 2011, the Program denied Swedish's CN application to add Level II nursery services.[1] Swedish timely filed a petition for adjudicative hearing.[2]

One of the main reasons given by the Program in its denial of Swedish's CN application was that the Issaquah facility was not yet opened when Swedish applied for the CN. Thus, the Program argued, Swedish could not demonstrate the requisite need, structure, process of care, and legal compliance to qualify for a CN. The Program expanded this argument in a Motion for Summary Judgment, filed June 7, 2012. However, the Presiding Officer denied this Motion in Prehearing Order No. 2, and held that RCW 70.38.105(4) does not require a facility to be fully operational before the facility may apply for a CN.

The Adjudicative Hearing was held August 6, 2012.

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[1] In February 2011, Overlake Hospital also submitted a CN Application to approve Level II nursery services to its facility in Bellevue. The Program conducted a concurrent review of both Overlake's and Swedish's Applications, over both parties' objections. A CN was subsequently awarded to Overlake. However, Overlake is not a party to this action. The only issue at hearing is whether Swedish met the criteria for a CN.

[2] Swedish actually filed two petitions for adjudicative hearing, the first one in September 2011, anticipating that Overlake Hospital would intervene as a party, and the second one in October 2011, in anticipation that Overlake would withdraw as a party. Overlake withdrew in March 2012. The two cases were consolidated under the current case style.

SUMMARY OF THE PROCEEDING

At the hearing, the Program presented the testimony of Karen Nidermayer, Program Analyst. Swedish presented the testimony of Kevin Brown, Swedish's Chief Executive Officer; Jane Uhlir, M.D., Swedish's Executive Director of Women and Infant Services; Marilyn Nemerever, R.N., Swedish's Nurse Executive; and Frank Fox, Ph.D., CN consultant.

The only exhibit at hearing was the Application Record. (All citations to the Application Record herewithin are in footnote form, citing to the Bates Stamp number, as in "AR 343." All citations to the transcript of the administrative hearing are likewise cited, as in "Tr 99.")

Pursuant to RCW 34.05.461(7), the parties were permitted to file briefs in lieu of closing argument.

DEFINITIONS/EXPLANATIONS

A Certificate of Need (CN) is a non-exclusive license to establish a new health care facility, or expand the facility, or add certain services. *See, St. Joseph Hospital & Health Care Center v. Department of Health*, 125 Wn. 2d 733, 736 (1995).

A neonate is a newborn infant up to one month of age.

Level I is the description given to basic nursery care given to healthy term neonates, neonates born from uncomplicated pregnancies, and stable neonates born at 35-37 weeks gestation.[3] If a hospital's CN includes obstetrics, it does not need an additional CN to offer Level I services.

[3] AR 449.

Level II is the description given to intermediate nursery care given to selected complicated pregnancies and/or mildly to moderately ill neonates. Level IIA care refers to mildly ill neonates with problems that are expected to resolve rapidly, while Level IIB care refers to moderately ill neonates who may require conventional mechanical ventilation for brief periods. Level II care includes neonates born at 32 weeks or later. Level II services require a separate CN approval.[4] Swedish requests a CN for Level IIB services.

Level III services are for severely ill neonates, complicated pregnancies, and/or neonates born as early as 28 weeks. Swedish is not seeking a Level III CN.

I. FINDINGS OF FACT

1.1 Swedish Health Services (Swedish) is a nonprofit, 501(c)(3) organization primarily located in King County and Snohomish County.

1.2 Swedish was granted a CN in 2007 to establish a hospital facility in Issaquah, Washington. The original facility plans only included Level I service to newborns because Swedish had originally expected that patients requiring Level II services would be treated at Swedish's Seattle hospital or another hospital.

1.3 However, during the building process, Swedish came to believe that patients would be better served if the Issaquah facility had the ability to offer Level II services.[5] In many cases, the need for Level II care is not foreseeable, i.e., Level II care can be needed even with a healthy mother and an uncomplicated pregnancy

[4] WAC 246-310-020(1)(d)(i)(B).

[5] AR 9.

where an unexpected event happens during delivery that requires IV antibiotics or mechanical ventilation for the neonate.[6] (Level I nurseries do not have mechanical ventilators, nor do Level I services include umbilical or peripheral catheters, arterial IVs, or feeding tubes.)[7] In those situations, Level II care is often required in a matter of minutes, and transporting the neonate to another facility puts both the neonate and the mother at risk.[8]

1.4 Swedish filed a CN Application in October 2010, seeking not to add beds but to designate 14 of its already-approved 175 hospital beds as Level II beds.[9]

1.5 In order to qualify for a CN, an applicant must demonstrate that the proposed project (a) is needed; (b) is financially feasible; (c) will meet certain criteria for structure and process of care; and (d) will foster containment of costs of health care.[10] Swedish's application was reviewed under these criteria in the adjudicative process.

Is the Proposed Project "Needed"?[11]

1.6 As part of its CN Application, Swedish provided statistical tables showing the projected regional need for Level II services over the next 10 year period.[12] The mathematical model used to formulate these projections employed a statistical

[6] Tr 134-135.

[7] Tr 150 and AR 449-450.

[8] Tr 137-138 and 147-148.

[9] The term "beds" is used here colloquially. The actual device is a small crib or bassinet. The issue here is not the design of the bed, but the ability to offer Level II services.

[10] See, Section II, Conclusions of Law.

[11] See "Determination of Need" WAC 246-310-210.

[12] AR 292-297. See also, Tr 183-189.

regression analysis[13] (based on the previous 10 years of data) to more accurately show trend adjustment.[14]

1.7 Based on its statistical analysis of the region's providers, residents, historical discharges, in-migration of new patients, out-migration of patients, average hospital stays, and market share growth, Swedish documented a need for eight additional Level II beds by 2013 and 14 additional beds by 2018. Swedish's analysis included both internal need (existing Level I patients at Swedish who would need Level II care) and external need (new patients coming into Swedish as Level II patients).[15] Thus, Swedish's CN Application was requesting to designate 14 of its previously approved hospital beds to be converted into Level II beds (converted in two phases, the first eight being completed by 2013, and the remaining six converted by 2018).

1.8 The Program agreed that had it accepted Swedish's statistical methodology, it would have determined that Swedish did demonstrate need for the

[13] Regression analysis is a statistical technique for predicting the relationship among multiple variables.

[14] Tr 178-183 and 213-220. The Program objected to the use of this type of trend adjustment model (statistical regression analysis) because it was "unusual" to see it used in tertiary services (Tr 69 and 72-73.) However, it is widely used in a statistical modeling and forecasting, and it is becoming more commonplace in CN applications. The Presiding Officer notes that it was recently used in a University of Washington Medical Center Application for Level II & III services, and a Multicare Health Systems Application for Level III services, both of which were approved by the Program. (Tr 175-176.) As applicants for CN become more sophisticated and experienced, it is to be expected that the types of statistical models used to predict regional need will become more complex. There was extensive explanation of this model at hearing, and the Presiding Officer finds it to be an acceptable methodology. The statistical analysis for Swedish was performed by Frank Fox, Ph.D. (Economics). Dr. Fox is the former director of the Washington State Hospital Commission where he was instrumental in the development of the Comprehensive Hospital Abstract Reporting System (CHARS), which is widely used in CN cases. Dr. Fox was admitted without objection as an expert in economics, statistical healthcare economics and healthcare planning. (Tr 167-171). The Presiding Officer found his testimony to be very credible.

[15] AR 296 with discussion at AR 35-37. See also, Tr 177-189.

stated Level II services.[16] As indicated, the Presiding Office finds the statistical methodology acceptable.

1.9 However, when comparing total planning area need against total area providers, Swedish was relying on figures that indicated that Evergreen Hospital's Level II capacity was 30 beds. During the review process, the Program clarified that Evergreen's Level II capacity is actually only 29 beds.[17] Correcting this assumption increases Swedish's projected bed need by a factor of one, that is, the correct need analysis would show a Level II bed need of 15 beds by the year 2018, not 14 beds.[18]

1.10 Another facet of need analysis is whether low-income, minorities, handicapped persons, and other underserved groups will have access to the proposed project.[19] As previously indicated, Swedish is a non-profit organization and a significant percentage of its revenue goes towards charity care.[20] The Program conducted a thorough review[21] of this sub-criterion and concluded that Swedish met this facet of the need analysis, and the record supports that finding.

1.11 The Presiding Officer finds that Swedish demonstrated a need in the planning area for nine Level II beds by 2013 and 15 Level II beds by 2018.

[16] Tr 49-50.

[17] AR 338.

[18] AR 314 and Tr 189.

[19] WAC 246-310-210(2).

[20] Tr 99 and AR 40.

[21] AR 342-344.

Is the Proposed Project Financially Feasible?[22]

1.12 Swedish Health Services is a not-for-profit corporation which owns and operates three hospitals in Seattle, one hospital in Edmonds, and the new facility in Issaquah. As part of its CN Application, Swedish provided extensive pro forma forecasts and financial analyses of its Level II project.[23] As noted, Swedish was previously granted a CN to build the Issaquah hospital, and the current CN Application is to convert 14 of the previously approved 175 hospital beds into Level II beds. The hospital as a whole, being new, is expected to operate at a loss until 2014, when it expects to generate a net income of 9.6 million dollars without the addition of Level II. With the addition of Level II services, the net income forecast for 2014 rises to 9.7 million dollars.[24] As the Program noted in its CN evaluation, the creation of a 14-bed Level II nursery does not impair the overall financial viability of the Issaquah facility.[25] In fact, the addition of Level II services would increase the financial strength of the Issaquah facility.[26] The immediate and long-range capital and operating costs of the project can be met, and the creation of Level II services will not have an unreasonable impact on health costs.[27] In its CN analysis, the Program concluded that Swedish's project could be appropriately financed.[28] The record supports this conclusion.

[22] See "Financial Feasibility" WAC 246-310-220.

[23] AR 49-48.

[24] Tr 195-197.

[25] AR 346.

[26] Tr 197.

[27] Tr 197-201.

[28] AR 344-350.

Will the Project Meet Certain Criteria for Structure and Process of Care?[29]

1.13 The criteria for structure and process of care, spelled out in WAC 246-310-230, includes five areas that must be considered when reviewing a CN Application, to wit: adequate staffing, appropriate organizational structure and support, conformity with licensing requirements, continuity of health care, and the provision of safe and adequate care.[30]

1.14 Swedish certainly has experience in building, staffing, and operating hospitals. As indicated, Swedish currently operates five hospitals in or near Seattle, (making it the largest non-profit health care provider in the greater Seattle area), and provides 36 percent of the Level II care in King County.[31] As part of its CN Application, Swedish provided budgets and charts showing the types, number, and salaries of full time employees (FTE) specific to the Level II project at the Issaquah facility;[32] a training plan by which new hires would be trained at the existing Swedish First Hill hospital (which has a large operating Level II and Level III nursery) and then transferred to the Issaquah facility;[33] a recruitment plan utilizing its existing connections to nursing schools and utilizing transfers from its other four hospitals;[34] and detailed plans of its coordination of in-house ancillary services (such as pharmacy, laboratory, nutrition,

[29] WAC 246-310-230.

[30] See, Section II, Conclusions of Law.

[31] AR 17-18 and 307.

[32] AR 266-275.

[33] AR 58.

[34] AR 59.

social services, etc.) with the Level II service, based on models it has successfully used in its existing hospitals.[35]

1.15 Because the Issaquah facility was not yet open at the time of its Level II CN Application, the final selection of many staff members, including the Medical Director of the Level II nursery, had not yet been made. Swedish did state in its application that it intended to staff the Issaquah facility with physicians from the pool of those practicing at Swedish's First Hill facility[36] and provided a list of potential transferring physicians[37] and a detailed draft contract and job description[38] for the Level II nursery Medical Director position.[39]

1.16 The requirement of "continuity of care" under the criteria for structure and process of care is spelled out in WAC 246-310-230(4) as follows: "The proposed project will promote continuity in the provision of health care, not result in an

[35] AR 58-62.

[36] AR 260.

[37] AR 78.

[38] AR 277-287.

[39] The whole issue of identifying the Medical Director became unnecessarily problematic. Swedish did not identify the Medical Director by name because they did not believe they had to identify a particular individual at the time they submitted their application. In their response to the Program screening questions, Swedish indicated (AR 260) that if the CN was granted, a Medical Director would be selected prior to the facility being opened (relying on a practice that the Program had allowed in the Legacy Healthcare Vancouver Hospital CN in 2002). Swedish then requested (AR 266) that if these responses were deemed incomplete, that they be given an opportunity to provide additional information pursuant to WAC 246-310-090(2)(c)(i) to which the Program responded that no further information was required. (AR 301). Thus, Swedish was surprised when the Program's Motion for Summary Judgment argued that their failure to identify a Medical Director meant Swedish did not satisfy the Structure and Process of Care criteria. Much time was spent arguing this issue in motions and at hearing. However, as indicated, the whole issue of identifying the Medical Director by name is a non-issue. There is no requirement in statute or CN regulation that the actual Medical Director be named in the CN Application. The requirement in WAC 246-310-230 "Criteria for Structure and Process of Care" is that the applicant demonstrate that there is a sufficient supply of qualified staff that can be recruited and that the proposed service has appropriate organizational structure. In terms of the Medical Director, Swedish met that criteria.

unwarranted fragmentation of services, and have an appropriate relationship to the service area's existing health care system." It seems logical that the phrase "fragmentation of service" would apply to both an individual patient's care and overall delivery of services in the planning area. The goals of the Washington State Perinatal Level of Care Guidelines,[40] used by both the Program and hospitals, are to "improve the outcome of pregnancy, increase the access to care for pregnant women and newborns, and to optimize [the] allocation of resources."[41] Level II services are available west of Issaquah at Evergreen Hospital in Kirkland and at Overlake Hospital in Bellevue. However, Snoqualmie Valley Hospital, located east of Issaquah in the middle of the Swedish/Issaquah Planning Area[42] does not have Level II services. To require residents of Issaquah or east of Issaquah (an area approximately two-thirds of the Swedish/Issaquah Planning Area) to drive past Swedish's Issaquah facility on I-90 and then to take the congested I-405 corridor to get to either the Overlake or Evergreen facility does not increase the access to care for pregnant women.[43] To require Level I neonates who need unanticipated Level II care (such as mechanical ventilation to help them breathe or IV drugs), care that can suddenly be needed in minutes,[44] to separate them from their mothers and transport them to another facility does not improve the

[40] AR 448-464.

[41] AR 447.

[42] AR 73.

[43] Tr 43-44.

[44] Tr 136-137.

outcome of pregnancy. Approximately one in four newborns will need Level II care,[45] and the need for Level II services is increasing.[46] The ability of a facility to offer Level II services to patients, where a certain percentage of those patients will absolutely need those services, promotes continuity of care. The ability of a facility to offer the nearest Level II services to the largest portion of its planning area promotes access to care.

1.17 Based on the evidence presented, the Presiding Officer finds that Swedish met the criteria for structure and process of care.

Will the Proposed Project Foster Containment of Health Care Costs?[47]

1.18 The final criteria for analyzing the viability of a CN Application is a determination of cost containment, as described in WAC 246-310-240, which includes an analysis of whether there are superior alternatives to the proposed project in terms of cost, efficiency, or effectiveness.

1.19 Clearly, for women giving birth at the Issaquah facility, having immediate access to Level II services should those services be needed (as they are in 26% of cases),[48] versus being transported to another facility, is a superior alternative in cost, efficiency, and effectiveness. Clearly, for women (and their families) in the eastern two-thirds of the Swedish/Issaquah Planning Area, the proximity of the Issaquah facility

[45] AR 316.

[46] Tr 133-134. The need for Level II services is increasing partly due to advancements in reproductive procedures which increase the number of twins and triplets born, and also allow older women up to the age of 50 to become pregnant. Additionally, increased technology allows for successful treatment of complicated pregnancies, such as pregnancies occurring with morbidly obese women, diabetic women, hypertensive women, and women on medication due to medical issues.

[47] WAC 246-310-240.

[48] AR 316.

is a superior alternative to driving or being transported further west to either the Overlake or Evergreen facilities. While the Overlake and Evergreen facilities are important, valuable, and professional facilities, there is nothing in the Application Record to indicate that they are superior alternatives.

1.20 The "superior alternative" criteria of WAC 246-310-240 can (and should) also be read to consider whether there were superior alternatives available to Swedish within the Issaquah facility. Swedish considered three alternatives and presented descriptions with pros and cons in their CN Application.[49] Swedish's presentation and analysis was logical and comprehensive.

1.21 As indicated, Swedish's Issaquah facility was already approved for a CN and was under construction when Swedish applied for an additional CN to add a Level II nursery. Thus, the construction costs for the overall facility (including the Level I nursery) were already approved. The proposed project would convert a percentage of the already-approved Level I beds into Level II beds. The construction costs are minimal and reasonable. As indicated, the Program did conclude, under the financial feasibility analysis, that the project could be adequately financed. Not only does the addition of the project increase the financial strength of the Issaquah facility, but it would improve the delivery of Level II services in a manner that is medically safer, faster, and reduces costs to patients.

1.22 The Presiding Officer finds that Swedish met the criteria of cost containment set forth in WAC 246-310-240.

[49] AR 64-69.

Conclusions of Findings of Fact

1.23 Although Swedish was granted a CN to build the Issaquah facility, the Program argued that Swedish was precluded from applying for an additional CN for Level II services because the Issaquah facility was not yet open.[50] The Presiding Officer concludes that such argument is not based on law[51] nor is it good public policy in this case. Swedish met all the criteria for a CN for a Level II nursery and should be granted one. The only question remaining is for how many Level II beds?

1.24 As indicated, when Swedish submitted its CN Application, its calculation of "planning area need" took into account that a certain percentage of that need would be filled by other hospitals in the planning area. However, in its calculations, Swedish assumed that the number of Level II nursery beds at Evergreen Hospital was 30 when in fact Evergreen only operates 29 Level II beds.[52] The testimony at hearing was that had Swedish used the correct number, that the result would have increased the number of Level II beds that Swedish was requesting by a count of one in every year, to a total of 15 Level II beds.[53] Because the Presiding Officer has determined that the methodology of Swedish's calculations is valid, and that the "need for Level II bed"

[50] This was despite the fact that the Program had taken the opposite approach with Legacy Healthcare's Vancouver Hospital in 2002 and granted Legacy a CN for Level II services before the hospital was open.

[51] See Prehearing Order No. 2.

[52] Evidently, there was shared confusion about the number of Level II beds that Evergreen operates. In its CN Application, Overlake Hospital used a 25-30 bed figure in calculating Evergreen's number of beds (AR 332). Swedish attributed 30 Level II beds to Evergreen and used that figure in its calculations. But in a letter to the Program dated June 20, 2011 (AR 309-310), Evergreen stated that it operates 29 Level II beds. In Rebuttal Comments (AR 313-314) submitted July 6, 2011, Swedish stated that the corrected figures meant they (Swedish) needed an additional bed. The Program acknowledged that Evergreen had 29 beds on August 22, 2011 (AR 338), but evaluated Swedish's Application using the 30 bed figure.

[53] Tr 189-190.

figures are therefore valid, and because the testimony regarding the mistaken assumption of the number of beds at Evergreen was uncontroverted at hearing, there is simply no reason not to grant a CN to Swedish for 15 Level II nursery beds.

II. CONCLUSIONS OF LAW

2.1 The Department of Health is authorized and directed to implement the CN program. RCW 70.38.105(1). Level II (intermediate care) nurseries require a certificate of need. WAC 246-310-020(1)(d)(i)(B). The applicant must show or establish that its application meets all of the applicable criteria. WAC 246-10-606. The Program issues a written analysis which grants or denies the CN application. The written analysis must contain sufficient evidence to support the Program's decision. WAC 246-310-200(2)(a). Admissible evidence in CN 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.

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 engages in a de novo review of the record. *See, University of Washington Medical Center v. Department of Health,* 164 Wn.2d 95 (2008) (citing to *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.

2.3 In acting as the Department's final decision maker, the Presiding Officer reviewed 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). The Presiding Office applied the standards found in WACs 246-310-200 through 246-310-240 in evaluating Swedish's CN Application.

2.4 WAC 246-310-200 sets forth the "bases for findings and actions" on CN Applications, to wit:

> (1) The findings of the department's review of certificate of need applications and the action of the secretary's designee on such applications shall, with the exceptions provided for in WAC 246-310-470 and 246-310-480 be based on determinations as to:
>
> (a) Whether the proposed project is needed;
>
> (b) Whether the proposed project will foster containment of the costs of health care;
>
> (c) Whether the proposed project is financially feasible; and
>
> (d) Whether the proposed project will meet the criteria for structure and process of care identified in WAC 246-310-230.
>
> (2) Criteria contained in this section and in WAC 246-310-210, 246-310-220, 246-310-230, and 246-310-240 shall be used by the department in making the required determinations.

2.5 WAC 246-310-210 defines the "determination of need" in evaluating CN Applications, to wit:

> The determination of need for any project shall be based on the following criteria, except these criteria will not justify exceeding the limitation on increases of nursing home beds provided in WAC 246-310-810.

(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. The assessment of the conformance of a project with this criterion shall include, but need not be limited to, consideration of the following:

. . . .

(b) In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities similar to those proposed;

. . . .

(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. The assessment of the conformance of a project with this criterion shall include, but not be limited to, consideration as to whether the proposed services makes a contribution toward meeting the health-related needs of members of medically underserved groups which have traditionally experienced difficulties in obtaining equal access to health services, particularly those needs identified in the applicable regional health plan, annual implementation plan, and state health plan as deserving of priority. Such consideration shall include an assessment of the following:

(a) The extent to which medically underserved populations currently use the applicant's services in comparison to the percentage of the population in the applicant's service area which is medically underserved, and the extent to which medically underserved populations are expected to use the proposed services if approved;

(b) The past performance of the applicant in meeting obligations, if any, under any applicable federal regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal financial assistance (including the existence of any

unresolved civil rights access complaints against the applicant);

(c) The extent to which medicare, medicaid, and medically indigent patients are served by the applicant; and

(d) The extent to which the applicant offers a range of means by which a person will have access to its services (e.g., outpatient services, admission by house staff, admission by personal physician).

2.6 WAC 246-310-220 sets forth the "determination of financial feasibility" criteria to be considered in reviewing CN Applications, to wit:

> The determination of financial feasibility of a project shall be based on the following criteria.
>
> (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 can be appropriately financed.

2.7 WAC 246-310-230 sets forth the "criteria for structure and process of care" to be used in evaluating CN Applications, to wit:

> 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 included in 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 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 accord with applicable federal and state laws, rules, and regulations. . . .

2.8 WAC 246-310-240 sets forth the "determination of cost containment" criteria to be used in evaluation a CN Application, to wit:

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.

2.9 Based on the above Findings of Fact and Conclusions of Law, the Presiding Officer concludes that Swedish met the criteria for a CN to establish a Level II nursery at its Issaquah facility. Because the methodology Swedish used to calculate the number of needed beds was sound, with the mathematical error (the assumption of Evergreen's bed number) not being Swedish's fault, Swedish should be approved for 15 Level II beds, rather than the 14 beds originally requested.

III. ORDER

A CN is approved for Swedish Health Services to convert 15 of its acute care beds to Level IIB services, phased in at 9 beds by 2013 and 15 beds by 2018.

Dated this _7___ day of November, 2012.

_____/s/_____.
FRANK LOCKHART, Health Law Judge
Presiding Officer

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.

Either party may file a **petition for reconsideration**. RCW 34.05.461(3); 34.05.470. The petition must be filed within 10 days of service of this order with:

Adjudicative Service Unit
P.O. Box 47879
Olympia, WA 98504-7879

and a copy must be sent to:

The petition must state the specific grounds for reconsideration and what relief is requested. WAC 246-10-704. The petition is denied if the Presiding Officer does not respond in writing within 20 days of the filing of the petition.

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).

For more information, visit our website at:
http://www.doh.wa.gov/PublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/Hearings.aspx.