STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

In Re:

CERTIFICATE OF NEED DECISION BY DEPARTMENT OF HEALTH REGARDING KADLEC REGIONAL MEDICAL CENTER APPLICATION TO ADD 144 ACUTE CARE BEDS TO EXISTING HOSPITAL,

KADLEC REGIONAL MEDICAL CENTER, a Washington non-profit Corporation,

Petitioner.

and

EVALUATION OF THE FOLLOWING TWO CERTIFICATE OF NEED APPLICATIONS PROPOSING TO ADD ACUTE CARE BED CAPACITY TO THE BENTON/FRANKLIN PLANNING AREA KADLEC REGIONAL MEDICAL CENTER PROPOSING TO ADD 114 ACUTE CARE BEDS TO THE EXISTING HOSPITAL IN RICHLAND; KENNEWICK GENERAL HOSPITAL PROPOSING TO ADD 25 ACUTE CARE BEDS TO THE AUBURN CAMPUS IN KENNEWICK,

KENNEWICK PUBLIC HOSPITAL DISTRICT,

Petitioner.

Master Case Nos. M2010-1529 (Lead)
M2011-375

PROPOSED FINDINGS OF FACT, CONCLUSIONS OF LAW, AND INITIAL ORDER

APPEARANCES:

Petitioner, Kadlec Regional Medical Center (Kadlec), by
Bennett Bigelow & Leedom, P.S., per
Brian W. Grimm and Anastasia K. Anderson, Attorneys at Law

Petitioner, Kennewick Public Hospital District, dba
Kennewick General Hospital (Kennewick), by
Foster Pepper PLLC, per
Christopher G. Emch and Lori K. Nomura, Attorneys 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: John F. Kuntz, Review Judge

A hearing was held in this matter on May 19-21, 2014, to address certificate of need (CN) applications filed by Kadlec and Kennewick.[1]

ISSUES

1) Whether Kadlec's CN application for 114 acute care beds meets all of the CN requirements? If so, how many acute care beds should be awarded?

2) In the alternative, whether Kadlec's CN application for 75 beds meets all of the CN requirements?

3) In the alternative, whether Kadlec's CN application for 55 beds meets all the CN requirements?

4) Whether Kennewick's CN application for acute care beds meets all of the CN requirements? If so, how many acute care beds should be awarded?

[1] Kennewick General Hospital is now doing business as Trios Health. It will be identified as Kennewick, which is consistent with the earlier pleadings in this matter.

SUMMARY OF PROCEEDINGS

At the hearing, the Program presented the testimony of Mark Thomas, CN Program Analyst. Kennewick presented the testimony of Glen Marshall, Chief Executive Officer, Kennewick; and Jody Carona, Health Facilities Planning and Development. Kadlec presented the testimony of Rand Wortman, CEO, Kadlec Regional; Lane Savitch, President, Kadlec Regional Medical Center Medical Center; and Frank Fox, Ph.D., Health Trends.

The Presiding Officer admitted the following Program exhibit:

P-1: The 1324-page Application Record.

The Presiding Officer admitted the following Kennewick exhibits:

KGH-1: Application Record;

KGH-2: Kennewick's request for reconsideration with exhibits, dated December 1, 2010;

KGH-3: The Program's response to Kennewick's request for reconsideration, dated December 28, 2010;

KGH-4: The Expert Record of Jody Carona, Health Facilities Planning & Development, dated March 5, 2012; and

KGH-5: The Expert Rebuttal Report of Jody Carona, Health Facilities Planning & Development, dated March 19, 2012.

The Presiding Officer admitted the following Kadlec exhibits:

KRMS-1: Application Record;

KRMS-2: 1987 Washington State Health Plan, Volume II;

KRMS-3: Expert Report of Frank G. Fox Jr., Ph.D., March 5, 2012; and

KRMS-4: Expert Rebuttal Report of Frank G. Fox Jr., Ph.D., March 16, 2012.

The parties were permitted to file post-hearing briefs in lieu of closing arguments pursuant to RCW 34.05.461(7). The hearing record closed June 30, 2014.

References to the Application Record or to the transcript of the hearing are notated as AR or TR herein.

I. PROCEDURAL HISTORY

This case is procedurally complex. Acute care beds are beds in a hospital setting. In November 2009, Kadlec applied for a CN to add either 55 acute care hospital beds, 75 acute care hospital beds, or 114 acute care hospital beds to its hospital in Richland, Washington. Kennewick also applied for a CN to add 25 acute care hospital beds. In its evaluation, the Program awarded Kadlec 55 acute beds and denied Kennewick's 25-bed application. Both parties appealed the decision. Kadlec appealed the Program's decision not to award either the 75 or 114 acute care bed applications. Kennewick appealed both the Program's decision to award any beds to Kadlec and the Program's decision not to award them 25 beds.

The Presiding Officer consolidated the Kadlec and Kennewick application cases. The Presiding Officer granted the Program's Motion to Dismiss Kadlec's request for 75 and 114 beds. Kadlec appealed this decision. The Presiding Officer stayed the hearing on Kennewick's appeal of the 55 beds and request for 25 beds pending the appeal. The Thurston County Superior Court upheld the Presiding Officer's dismissal of the 75 and 114 beds requests. However, the Division II Court of Appeals disagreed

with both previous rulings and remanded the case for hearing before the Presiding Officer. The Court of Appeals held:

> We conclude that the Department denied Kadlec's application for a CN authorizing the addition of 114 beds and that the Kadlec consequently had the right to an adjudicative proceeding before the HLJ. Therefore, we reverse the superior court decision affirming the HLJ dismissal order and remand to the HLJ for an adjudicative proceeding on Kadlec's 114 bed request.

Kadlec Regional Medical Center v. Department of Health, State of Washington, 310 P. 3d 876 (2013). Thus, the 2014 administrative hearing in this matter was heard more than five years after the 2009 applications were initially filed. At the hearing, Kennewick withdrew its appeal of the Program's award to Kadlec of 55 acute care beds.

I. FINDINGS OF FACT

Background

1.1 This case is about whether a CN for more than 55 acute care hospital beds should be awarded for the Benton/Franklin County planning area.[2] This planning area includes two major hospitals: Kadlec in Richland, Washington, and Kennewick in Kennewick, Washington. These two hospitals filed separate applications to obtain additional acute care beds.

1.2 A CN is a non-exclusive license to establish a new health care facility.

[2] A "hospital planning area" is a geographic area designated for population-based planning of hospital services. *See* KRMC Exhibit 2, Glossary page 3. The definition does not specifically identify the Benton/Franklin County planning area. However, the parties do not dispute it is the appropriate planning area for this matter.

See St. Joseph Hospital & Health Care Center v. Department of Health, 125 Wn.2d 733, 736 (1995). A CN is required when an existing hospital seeks to increase the number of acute care beds. RCW 70.38.105(4). To obtain a CN, an applicant must establish that it can meet all of the applicable criteria, namely that 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).

1.3 On November 3, 2010, the Program approved Kadlec's CN to add 55 acute care hospital beds to its Richland, Washington hospital.[3] During the prehearing conference, Kennewick withdrew its challenge to the approval of Kadlec's CN to add 55 acute care beds. *See* Prehearing Order No. 13 (May 6, 2014).

1.4 Thus, at the hearing Kadlec sought a CN for 59 more acute care beds (the difference between 114 beds less the 55 beds previously awarded). At the hearing, Kennewick opposed any award of any more acute care beds to Kadlec in addition to the 55 acute care beds. In the alternative, Kennewick argues that if the Presiding Officer concludes that there is a need for more acute care beds in the Franklin/Benton County service area, then the additional beds should be awarded to Kennewick.

[3] Although it is outside the snapshot in time, the Presiding Officer notes that Kadlec has already added the 55 beds to its facility bed count. *See* TR 226, lines 21-23 (Wortman).

A. Is there a need for more acute care beds in the Franklin/Benton County Planning Area?

Bed Need Methodology

1.5 There is no statutory or regulatory methodology for calculating acute care bed need. The methodology used to calculate acute care bed need is found in the State Health Plan (SHP).[4] Exhibit KRMC-2. The SHP provides information to assist the applicant in applying the bed need methodology. The SHP includes guidance regarding occupancy[5] standards (the percentage or amount of time a bed is "occupied" with a patient) and guidance regarding bed capacity (when a hospital is full or reached full capacity). *See* Exhibit KRMC-2, pages C-37 and C-39. It is impossible to operate at 100 percent occupancy, as there must be unused capacity to accommodate any unexpected surges in patient volume. *See* TR 259 (Savitch). A hospital with 100-199 beds is "full" if 65 percent of the beds are occupied. KRMC-2, page C-37 (all of the occupancy standards were reduced by five percent subsequent to the drafting of the SHP).

[4] The SHP was terminated effective June 30, 1990 and no longer has any legal effect. *See* RCW 70.38.919. In the absence of any other regulation or methodology, the Program and CN applicants continue to rely upon the SPH methodology as a tool for calculating acute care bed need. *See* WAC 246-310-200(2)(b)(ii) (the Program may consider standards developed by professional organizations in Washington state).

[5] Occupancy is measured by the number of patients. The number of patients is determined using an average daily census (a count of the number of patients within a given facility, taken at either 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 100 beds but only 50 beds are occupied, it has an occupancy rate of 50 percent. The hospital can be considered to have 50 beds available within the facility.

1.6 The SHP methodology contains a 12-step analysis to forecast acute care bed need. The first four steps develop trend information regarding the utilization of hospital beds to evaluate the need for additional beds in a service area. The next six steps calculate the baseline for calculating the need of 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 special circumstances of the service area.

1.7 Similar to other CN projects (for example, kidney dialysis or ambulatory surgical facility projects), the CN applicant uses information (the number of currently available acute care beds) in a planning area (here Benton/Franklin County) and calculates whether additional beds are needed to address the anticipated population growth in the planning area. The Office of Financial Management (OFM) determines the population projections (adjusted population growth) for the state and counties. *See* RCW 43.62.035. OFM provides a range of population projections: high, medium, and low. The OFM population projections are used to calculate whether there is a need for additional acute care beds between the base year (here 2009) and the target year (here, 2019).

1.8 Kadlec's application for more beds than their 55 bed award, assumes that OFM's high population projection is the most accurate. Kennewick and the Program disagree. They argue that OFM's medium population projection is most accurate.

RCW 43.62.035 indicates a preference that the medium population projection be used in the SHP methodology. The Presiding Officer finds that the Program used the correct OFM population projection; OFM medium population preference should be used in this case because it allows more specificity in calculations than the high population projection: the medium population projection breaks down population by age. This specificity is needed in this case because older patients (65+ years) use hospitals at a rate five times more than the 0-65 years old population. *See* KRMC-2, at C-30.[6]

1.9 Kadlec also argues that a ten-year target date be used for calculations. Kennewick and the Program argue that the Program correctly used a seven-year target date. The Presiding Officer finds that the correct target date for this analysis is seven years. This is because it is most accurate: long term forecasts (ten years for example) are generally unreliable. *See* KRMC-2, at C-30. The SHP recommends that forecasts should only go as far into the future as needed to answer the question at issue and most past CN acute care bed calculations have used the medium bed calculation. *Id*.[7]

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[6]. The OFM's medium population projection uses an "age cohort." Their age cohort is broken down into two groups (age 0-64; age 65+). See TR 143, line 2 through TR 144, line 7 (Thomas); *see also* AR 41.

[7] Past CN acute care bed applications have only used the OFM medium population projection in calculating the SHP methodology. While RCW 43.62.035 indicates a preference that the medium population projection be used in the SHP methodology, use of the medium population projection is not mandatory.

Determination of Need

1.10 WAC 246-310-210(1) sets out the first need criterion:

> 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.

1.11 The Kadlec hospital's River Pavilion (the site proposed for this CN project) was originally designed as a 10-story building, of which six stories are currently in use. Kadlec's project would build the top four stories in phases for the 114-bed application at a cost of $83,526,703. AR 22 and 24. It would increase its acute care bed count from the current 188 beds to 302 beds by the completion of the project in 2016. AR 22.

1.12 Kadlec used the 10-step SHP methodology to calculate need and performed several iterations of the SHP methodology using both the OFM medium and high population forecasts. Kadlec's calculation using the OFM medium population forecast showed a need for 28.94 beds in 2016 (the seventh year) and 54.02 beds in 2019 (the 10th year). *See* KRMC-3, Appendix C. Using the OFM medium population forecast would support Kadlec's 55 bed application by 2019, but it would not support either the 75-bed or 114-bed applications.

1.13 Need is calculated using the SHP acute care bed methodology for the relevant planning area. Benton/Franklin County is the relevant planning area here. The Program calculated need for the Benton/Franklin County planning area using the SHP methodology. The Presiding Officer agrees with and herein adopts the Program's calculations at hearing. The Presiding Officer finds there is a need in the

Benton/Franklin County planning area for 18 acute care beds (17.9 beds rounded up).[8] The Program at hearing testified that their corrected calculations show a need for 17.95 beds in 2016.[9] AR 1090.

1.14 However, Kadlec believed the OFM medium population forecast would inaccurately reflect the need in the Benton/Franklin County planning area. In 2004, Kadlec applied for 58 acute care beds. It was originally awarded only 19 beds; during the settlement it was awarded 16 additional beds. During the 2004 application process, OFM recommended the use of the OFM high population forecast. AR 12. Kadlec reasoned that the actual statistics for population again supported using the OFM high population forecast and therefore the medium forecast did not accurately reflect the historic growth in the Benton/Franklin County planning area. AR 12. Calculating the SHP methodology using the OFM high population forecast, Kadlec found a need for 91.71 acute care beds by 2016 (the seventh year following the 2009 base year) and 118.02 acute care beds by 2018 (the ninth year following the 2009 base year). Exhibit KRMC 3, Appendix B. Thus, the SHP methodology calculations only supports

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[8] The Program's original methodology calculations showed an acute care bed need of 61 beds. AR 727; TR 48 (Thomas). On its face, this number of beds could support either the Kadlec 55-bed project or the Kennewick 25-bed project. However, the Program's initial calculations contained several errors, including the adding of rehabilitation days in the calculation of the use rate but excluding dedicated acute care rehabilitation beds from the current supply. *See* TR 52-53 (Thomas). It actually shows a lower acute care bed need in 2016 for that reason.

[9] *See* the December 20, 2010 CN Program decision denying Kennewick's Request for Reconsideration. *See also* WAC 246-310-560.

Kadlec's 114-bed project by the ninth year after the 2009 base year if (as Kadlec argues): (1) the size of its project used a 10-year target year rather than the standard 7-year recommended by the CN Program; and (2) the methodology calculation used the OFM high population forecast.

1.15 Although it preferred calculating the need methodology using the OFM high population forecast, Kadlec recognized the OFM high population forecast did not perform the age cohort breakdown. The age cohort information is necessary given the higher hospital use by the age 65 plus population. Kadlec's expert (Dr. Frank Fox) calculated the SHP need methodology using additional information to address that concern. Dr. Fox substituted the age 65 plus Washington state average growth population projections (12.1 percent) rather than the Benton/Franklin County planning area age 65 plus average growth population projections (10.4 percent) in his calculations. TR 405, line 5 through TR 406, line 15 (Fox); *see also* Exhibit 3, Appendix B.

1.16 While his need methodology may be "accurate" as calculated, the calculations are not the most accurate. Dr. Fox admitted his methodology calculations relied on information that was/is not contained inside the application record. TR 406 (Fox). Kadlec's record does not provide sufficient data to allow the replication of the calculations. TR 613, line 9, through TR 614, line 3 (Carona). The Presiding Officer finds that Kadlec has not submitted sufficient evidence to substitute its methodology for the calculation of the SHP methodology using the OFM medium series.

Even if the OFM high population forecast was the appropriate forecast, the Presiding Officer finds that the percentage growth of the age 65 figure should be the one for the Benton/Franklin County planning area, and not the state average as used by Kadlec.[10]

1.17 Kennewick filed a CN application to add 25 beds to its existing Auburn facility, to be built in two phases. Phase 1 will make 13 beds operational by late 2012. The remaining 12 beds would be made operational by January 2014. Kennewick followed the SHP methodology and used the OFM medium population series in calculating whether need existed for additional acute care beds in the Benton/Franklin County planning area. AR 756 (Footnote 1). Kennewick determined that there would be a need for 22.4 acute care beds by the seventh year (2015) (using 2008 rather than 2009 as the base year). AR 765 and 811. So this number is sufficient to support 22 of the 25 beds Kennewick requested for its project. Kennewick's CN application would meet the WAC 246-310-210(1) need criterion.

1.18 Kadlec has already been awarded 55 acute care beds in error and that award became a verity on appeal. *See St. Joseph Hospital & Health Care Center v. Department of Health*, 125 Wn.2d 733, 736 (1995). Given that the award for 55 acute care beds was not supportable, the Presiding Officer finds there is no need available in

[10] While not the controlling factor, the Presiding Officer finds there is idle bed capacity in the Benton/Franklin planning area. Kennewick was running at a 50 percent occupancy rate. TR 375 (Dr. Fox). For a total bed count of 101, (the Auburn and Southridge facilities) this would mean that there were roughly 50 beds available in the planning area. Given that the measure is need for the planning area and not necessarily for the applicant, this is another factor arguing against using the OFM high population projection.

the Benton/Franklin County planning area to support Kadlec's CN application for either 75 or 114 acute care beds.

Charity Care

1.19 WAC 246-310-210(2) sets out the second need criterion:

> 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.

1.20 Kadlec currently provides health care services to the population defined in WAC 246-310-210(2). This is shown by Kadlec's participation in both the Medicare and Medicaid program and its stated intention to continue to provide Medicare and Medicare services. Kadlec also provided a copy of its current admission policy that it would continue to use at its Richland, Washington hospital. The policy outlines Kadlec's process for admitting patient for treatment without regard to "race, religion, sex, or age." AR 229-232 (Application Exhibit 14); and AR 233-235 (Application Exhibit 15).

1.21 Kadlec provides charity care to residents in the region and submitted a copy of its charity care policy as proof of its commitment to continuing to provide such care. The Department of Health's Hospital and Patient Data Systems (HPDS) program measures a facility's participation in charity by measuring a three-year average against a regional average for such contribution. The HPDS section of the Department of Health provides the Program with statistical information regarding CN applications. For charity care reporting, HPDS divides Washington State into five regions (King County; Puget Sound (less King County); Southwest; Central; and Eastern) and examines the

amount of charity care provided by the CN applicant in comparison to the region. AR 698. In Kadlec's case, its three year average as a percentage of its gross revenue and a percentage of its adjusted gross revenue exceeds the measurement for a comparable period in the applicable Central Washington region. Kadlec meets the WAC 246-310-210(2) requirement.

1.22 Kennewick currently provides health care services to the WAC 246-310-210(2) population. Kennewick participates in the Medicare and Medicaid program and states it intends to continue to provide Medicare and Medicare services. Kennewick also provided a copy of its current admission policy and would continue to use at its Kennewick, Washington hospital. The policy outlines Kennewick's process for admitting patients for treatment without regard to "race, religion, sex, or age." AR 791-792 (Kennewick Exhibit 5).

1.23 Kennewick provides charity care to residents in the region and submitted a copy of its charity care policy. The policy proves Kennewick is committed to providing charity care. AR 793-796 (Kennewick Exhibit 5). The Program measured Kennewick's charity participation for a three year period using the Hospital and Patient Data Systems (HPDS) data. The HPDS section of the Department of Health provides the Program with statistical information regarding CN applications. For charity care reporting, HPDS divides Washington State into five regions (King County; Puget Sound (less King County); Southwest; Central; and Eastern) and examines the amount of charity care provided by the CN applicant in comparison to the region. In Kennewick's

case, a comparison of its three-year charity care average as a percentage of its gross revenue and a percentage of its adjusted gross revenue does not exceed the measurement for the comparable period in the Central Washington region. However, the percentage of charity care is sufficient to prove that it meets the charity care condition as required under WAC 246-310-210(2) criteria.

B. Are Kadlec's and Kennewick's Proposed Project Financial Feasible?

Immediate and Long Range Capital & Operating Costs

1.24 WAC 246-310-220(1) sets out the first financial feasibility criterion:

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

An applicant's ability to meet the criterion is measured by using the applicant's pro forma (defined as an accounting statement or a balance sheet) to determine if the applicant's pro forma reasonably projects the project is meeting its immediate and long-range capital and operating costs by the third year of operation. This is measured using the Hospital and Patient Data Systems (HPDS) financial ratio analysis.[11]

1.25 Kadlec projects the capital expenditure for the 55-bed expansion to be $65,456,228. AR 701. Kadlec will use parts of a bond issue, commercial loans, and board designated reserves to finance the project. Kadlec's pro forma shows that its

[11] The ratios include: Long term debt to equity; current assets/current liabilities; assets funded by liabilities; operating expenses/operating revenues; and debt service coverage. *See* AR 702 and AR 1224 (Kadlec) and AR 704 and 1299 (Kennewick).

income from the proposed expanded facility will meet its immediate and long-range capital and operation costs by the third year of operation. AR 1225. Kadlec will break even in CN year one, and continues to meet the capital and operating costs by CN third year. A review of the HPDS financial ratio analysis showed that Kadlec's ratios are above or within reasonable range of the HPDS averages. AR 702 and AR 1224. Kadlec meets the WAC 246-310-220(1) criterion.

1.26 Kennewick's reported capital expenditures for the 25-bed project are projected to be $519,215. AR 703 and 745-746. Kennewick will use designated reserves to finance the project. The 25-bed project is included in the $6 million of the reserves (budgeted for routine capital upgrades) during the same time frame of this project for capital expenditures. AR 703, AR 768, and AR 1298. However, Kennewick's 2009 fiscal year end report shows only $5.8 million in reserves. As a result, HPDS indicates future depreciation and profits will be needed to cover the capital expenditures. AR 1298.

1.27 A review of the HPDS financial ratio analysis shows that all of Kennewick's ratios for the proposed project are outside the HPDS averages, including a significant drop in debt service coverage. AR 1299. Kennewick has an approved CN project to build a new hospital at another physical site: Southridge. The approved CN project explains why the Kennewick ratio averages are outside the HPDS ratios. In fact, Kennewick acknowledges the financial ratios are the same ones HPDS found for the Southridge project. This was intentional, as Kennewick reasoned that it would operate

both facilities (Auburn and Southridge) under the same hospital license. Because it intends to operate both facilities under the same license, Kennewick believes the fact that the current and projected ratios for the 25-bed Auburn project fall below the HPDS ratios does not indicate a problem for the project in the short term. The Presiding Officer disagrees.

1.28 Although the project projects positive growth financially in each of the years, Kennewick's hospital does not have a strong enough financial base to insure that it can meet the long-range capital and operating costs during this period. The HPDS financial ratio analysis shows this. The evidence does not support that Kennewick can meet capital expenditures and operating costs for an additional 25 acute care beds.

Do the Projects Create An Unreasonable Impact on Health Care?

1.29 WAC 246-310-220(2) sets out the second financial feasibility criterion:

> The costs of the project, including any construction costs, will probably not result in an unreasonable impact on the costs and charges for health care.

The measure here is to compare whether the CN applicant's costs for the proposed project are reasonable when considered to past project costs.

1.30 In the 55-bed project, Kadlec proposes to add the beds in multiple phases beginning in 2010. Of the $65,456,228 related to the 55-bed project, 65 percent of the project relates to construction, 5 percent to equipment, 19 percent is allocated to financing costs, and the remainder is related to taxes and planning. AR 61 and 704. The HPDS analysis of the forecasted rates at Kadlec hospital shows the net profit by

adjusted patient days ranges from $259 in 2015 to $318 in 2017. AR 1225. These figures support a finding that Kadlec's 55-bed project will probably not create any unreasonable impact on the cost and charges for health services in the planning area.

1.31 The total cost of the Kennewick project is $519,215 and does not include any construction. AR 767-768. The project breakdown shows that 86 percent relates to fixed and moveable equipment, with the remaining 14 percent related to taxes and review fees. AR 707. The HPDS analysis of Kennewick hospital's forecasted rates for the 25-bed project shows a net profit of $93 in 2014, $58 in 2015, and $91 in 2016. AR 1300. Adding the costs of the 25-bed project alone is unlikely to have an unreasonable impact on the costs and charges for health services.

Can the projects be appropriately financed?

1.32 WAC 246-310-220(3) sets out the third financial feasibility criterion: The project can be appropriately financed. The CN applicant's project source of financing is compared to the financing source for similar past projects. Kadlec intends to finance the 55-bed project by issuing a bond issue, commercial loans, and available reserves. AR 66 and AR 1225. Kadlec's proposed financing method is consistent with sound business practices because it has the assets and financial ability to obtain the money needed to finance the propose project. Doing so will not negatively affect Kadlec's total assets, total liabilities, or Kadlec's general financial health. Kennewick intends to use existing reserves for the project and the reserves currently available. AR 708 and AR 1300. Financing using existing reserves is an appropriate and acceptable business

practice that is even better than using a bond issue. Using the existing reserves would not negatively affect Kennewick's total assets, liability, or general financial health.

C. Structure and Process (Quality) of Care

Can Qualified Staff Be Hired?

1.33 WAC 246-310-230(1) sets out the first structure and process of care criterion:

> A sufficient supply of qualified staff for the project, including both health personnel and management personnel, are available or can be recruited.

Kadlec anticipates adding full time equivalents staff (FTE) to the hospital in specific staffing areas of management, nursing, technicians, and other related support positions beginning in 2010 to prepare for the phased increases. AR 73-74. Table 20 shows the breakdown of Kadlec's projected FTE needs. AR 393 (Kadlec Exhibit 20) AR 709. Kadlec has three full-time staff recruiters to identify and hire employees and anticipates it will have no difficulty in recruiting staff. Additionally, Kadlec has established training programs that allow for the reimbursement of tuition and training costs. Finally, Kadlec has developed a relationship with the Washington State Nursing Association that allows for the creation of a number of programs that relate to nursing salaries and incentive program linked to quality outcomes. AR 74.

1.34 Historically, Kennewick is successful in recruiting staff. AR 774. Kennewick anticipates adding nursing, ancillary care, and related support full time equivalent staff (FTEs) to the hospital in support of the project. AR 939 (Kennewick

Supplemental Information, dated February 20, 2014). There will be a steady increase in the number of staff throughout the 2013-2016 period. *Id*. Kennewick has clinical training sites it shares with local colleges, community partnerships with local agencies, and tuition reimbursement and scholarships for qualified employees. AR 774-775.

Will the Services have an Appropriate Relationship to Ancillary and Support Services?

1.35 WAC 246-310-230(2) sets out the second structure and process of care criterion:

> 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.

Kadlec currently provides health services to the residents of the planning area. It is an acute care medical center providing quality patients services along with the appropriate ancillary and support services internally and in the Benton-Franklin County planning area. AR 75. Kadlec will develop support services in proportion to the number of approved acute care beds. These services will include, but are not limited to, emergency services, diagnostic imaging, and laboratory services. AR 75.

1.36 Kennewick currently provides services to Franklin County residents and the surrounding areas. If approved, Kennewick will operate both the Auburn and new 74-bed Southridge campuses under a single hospital license for an integrated system. AR 775. The clinical care and ancillary and support services includes, but is not limited

to, cardiopulmonary (respiratory) services, case management, in-patient physical therapy services, and social services. AR 775.

Do the Projects meet Medicare and Medicaid Requirements?

1.37 WAC 246-310-230(3) sets out the third structure and process of care criterion:

> 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.

1.38 Kadlec currently provides Medicaid and Medicare services and will continue to provide such services in the future. AR 77. The Joint Commission analysis shows that Kadlec's facility is in full compliance with the applicable Medicaid and Medicare standards based on its August 2008 on-site survey. AR 1149-1151[12] AR 711.

1.39 Kennewick currently provides Medicaid and Medicare services and will continue to provide such services in the future. AR 711. The Joint Commission analysis shows that Kennewick's facility is in full compliance with the applicable standards based on the August 16, 2008 on-site survey. AR 1256-1259.

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[12] The application file refers to a report on the Department of Health Investigation and Inspection (IIO) website. However, the information on websites can change over time. Because there is no hard copy of the IIO reports for either Kadlec or Kennewick in the application file, they are not considered in reaching this decision. The Presiding Officer respectfully requests that future application records include a copy of the IIO survey.

Continuity of Health Care

1.40 WAC 246-310-230(4) sets out the fourth structure and process of care criterion:

> 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 services area's existing health care system.

1.41 Kadlec anticipates that additional beds will greatly assist in promoting continuity of care. It currently provides health care services to the planning area through relationships with community facilities to provide a variety of post-acute care services. AR 75. Approval or denial of the project will not change Kadlec's relationship with the community providers or its provision of services. *Id*.

1.42 Kennewick provides health care services to the residents of Franklin County and the surrounding areas. If the 25-bed Auburn project is approved, Kennewick intends to operate the two hospital campuses (Auburn and Southridge) as one integrated system. AR 775. Kennewick's clinical/patient care ancillary and support services are designed to support the totality of the hospital district. AR 776. Because of the overextension of Kennewick's financial standing under the WAC 246-310-220(1) criterion, the project could lead to a reduction of services if the future revenues are insufficient to cover expenses. For this reason, Kennewick does not meet this criterion.

Safe and Adequate Care

1.43 WAC 246-310-230(5) sets out the fifth structure and process of care criterion:

> 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.

1.44 Kadlec has a history of providing safe and adequate care. AR 77. As stated in Paragraph 1.39 above, this includes meeting all Medicaid, Medicare, and state laws, and regulations. This also includes meeting certification reviews by other external review agencies as the Clinical Outcome Assessment Program (COAP). AR 77.

1.45 Kennewick has a history of providing safe and adequate care. AR 777. As stated in Paragraph 1.40 above, Kennewick meets all relevant Medicaid, Medicare, and state laws and regulations in this area.

D. Cost Containment

Superiority Analysis

1.46 WAC 246-310-240(1) sets out the first cost containment criterion:

> Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable.

Where there is a single CN applicant, the determination is whether the proposed CN project is better than no project or other relevant alternatives to the proposed project. WAC 246-310-240. Where there are several CN applicants, there is an

additional step. The additional step is to compare the applicants and determine whether one CN project is a superior alternative to the other proposed project. Given that there is need for additional acute care beds, the "no project" alternative" does not apply to the Kadlec or Kennewick CN applications comparison here.

1.47 Kadlec examined three alternatives other than the "no project" alternative: a 114-bed expansion through a four floor expansion of its facility; a 75-bed expansion through a four floor expansion; or a 55-bed expansion of the facility. AR 78-87. These three alternatives were evaluated to see whether a new building on campus made more sense, or whether to expand the existing six-story River Pavilion. Given the cost, Kadlec determined the expansion of the existing six-story facility made more financial sense. AR 78, AR 80-81. Given the need finding in Paragraph 1.7 above, the Presiding Officer will examine the 55-bed alternative. Under this option, Kadlec would add 29 beds by 2010 and another 26 in 2013.[13] Kadlec would use the 55-bed option to alleviate some of the occupancy issues that existed when it filed its application in 2009. As previously stated, it would require an expenditure of $65.4 million. AR 115. It would require building out the four additional floors, but would only equip one of the four floors. AR 115.

[13] The Presiding Officer assumes these beds have, in fact, been added as of the date of May 2014 hearing.

1.48 Kadlec argues its CN application is the better alternative when compared to Kennewick's application, given its greater internal need for acute care beds. A CN applicant's internal bed need is generally not a basis for awarding additional beds. As stated in Paragraph 1.4 above, the need for acute care beds is based on the need in the service area and not in the CN applicant's facility. The fact that Kadlec may provide additional services or a greater amount of tertiary services when compared to Kennewick does not reduce the existing surplus of acute care beds in the Benton/Franklin County planning area.[14]

1.49 Kennewick examined four options as a part of its CN application process: continue with the current capacity and apply for a bed expansion in 2011 (which would be two years after its current December 2009 application); continue with the current capacity and apply for a bed expansion using the OFM high series population projection; apply to amend the "intent to issue CN" approving the Southridge Campus to include an additional 25 beds; or apply for a bed expansion using the OFM high series population projection to add 75-100 beds that would be split between the Auburn and Southridge campuses. AR 779. Of the four options, Kennewick chose to amend its CN application for Southridge and add 25 beds, which would be added to the Auburn campus.

[14] *See* In Re Certificate of Need Decision on Providence Sacred Heart Medical Center, Master Case No. M2009-1141. (Amended Findings of Fact, Conclusions of Law and Final Order, pages 25-26).

1.50 Although Kennewick identified four options, there is a possible "fifth" option.[15] Kennewick would be retaining a number of its beds at the Auburn facility after the construction of its Southridge facility. Kennewick could re-allocate some of the remaining beds from the Woman's/Children's program to afford Kennewick the beds it would otherwise need in its requested 25-bed CN application. *See* AR 716; *see also* TR 664-665 (G. Marshall). Redistribution of beds in this manner would not require a CN.

1.51 Given the choices made by the applicants, the question is whether the Kadlec 55-bed option or the Kennewick 25-bed option is "superior." Kadlec either meets or is within reasonable range of the HPDS financial ratios while Kennewick is not. *Compare* AR 1224 (Kadlec) and AR 1299 (Kennewick). In fact, Kennewick's current and projected ratios, as measured using the HPDS state averages, are below for all three years (2014-2016) on all five of the HPDS financial ratios. TR 65-67 (Thomas); AR 704 and AR 1299. Kennewick explains its performance in the HPDS ratio analysis by stating the 25-bed application and the Southridge application are under the same license. If the HDPS review of the ratios anticipates new facilities will underperform financially, the 25-bed application (which was filed one year after the Southridge application) would be viewed in the same light. However, Kennewick is conflating the

[15] CN applicants provide alternatives as a part of the CN application process. Neither the CN Program (the evaluation process) nor the Presiding Officer in the fact-finding process, are restricted to those alternatives.

premise for the two projects. New projects must be given time to reach profitability; given their "newness" they have no history of occupancy. An existing facility like Kennewick's 25-bed project should not be given the same consideration, as it has an occupancy history. This is especially true given Kennewick's historically low occupancy rate at the existing Auburn facility. AR 593. For that reason, Kadlec is the superior applicant in this comparison.

1.52 In addition, Kadlec's project costs are less than Kennewick's project costs on a capital cost per bed basis. AR 663-665. Kadlec also produced evidence that its operating expenses per patient day were lower than Kennewick's. AR 82-84, and AR 663-664. Kadlec provides a higher amount of complex care, as measured by the top 30 weighted diagnosis related group and by case-mix intensity. *See* AR 26-28. The Presiding Officer finds that these factors, along with Kadlec's superior performance in comparing the HDPS ratios, all weigh favorable for Kadlec under cost containment superiority criterion under WAC 246-310-240(1).

Costs, Scope and Methods of Construction.

1.53 WAC 246-310-240(2) sets out the second cost containment criterion:

> 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.

1.54 HPDS staff examined the construction costs of the Kadlec project. AR 1226. The HPDS determination for this criterion is whether Kadlec's project costs

are within the range of past construction costs for similar projects. The construction costs vary depending on the type of construction, the quality of materials used, and the type of the project designed and the building site being used. Kadlec is building out in the facility it currently occupies. It will construct the new area to the latest LEED energy and hospital standards. *See* AR 236-239. Kennewick did not identify any construction related to its proposed project, as the 25-bed project would merely require equipment. AR 743 and AR 754. Kennewick did identify some construction or modernization issues regarding Auburn's aging physical plant in support of the justification of its Southridge facility CN application. AR 744-745. Kennewick budged $6,000,000 for routine capital upgrades. The $519,201 cost of the 25-bed costs was included in the $6,000,000 capital upgrade budget. AR 768. The Presiding Officer finds that Kennewick will spend for routine capital upgrades at the Auburn facility whether the 25-bed project goes forward or not. When considered in that light, it is not necessary to attribute any of the $6,000,000 in this matter to the current 25-bed project.

Appropriate Improvements or Innovations in the Delivery and Financing of Health Services.

1.55 WAC 246-310-240(3) sets out the third cost containment criterion:

> 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.

1.56 HDPS reviewed the Kadlec project costs. Kadlec's project will improve system efficiency for the hospital and patients, given the new beds will give more

flexibility to place patients in the most appropriate clinical level. This will include Kadlec moving toward current treatment standards such as single patient rooms and cohesive program efficiencies. AR 82-83 and AR 1227. These factors go to reducing overall costs to Kadlec and potentially will increase the quality of care provided by the facility.

1.57 HPDS reviewed the Kennewick project to determine whether it would improve the delivery of health care services. A review of the 25-bed project shows Kennewick cannot meet its immediate or long-range capital and operating costs, given that its performance is below all of the relevant HPDS financial ratios. *See* AR 1299; *see also* Findings of Fact 1.24 and 1.25 above.

II. CONCLUSIONS OF LAW

2.1 The Department of Health is authorized and directed to implement the CN 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 Presiding Officer (on delegated authority from the Secretary of Health) is the agency's fact-finder and initial decision maker. *DaVita v. Department of Health*, 137 Wn. App. 174, 182 (2007) (*DaVita*). The standard of proof in this case is preponderance of the evidence. WAC 246-10-606.

2.2 The Presiding Officer may consider the Program's written analysis in reaching a decision but is not required to defer to the Program analyst's decision or expertise. *DaVita* 137 Wn. App. at 182-183. CN cases are de novo reviews. The Presiding Officer has great latitude to decide what are the relevant evidence and the

relevant snapshot in time. *University of Washington v. Department of Health*, 164 Wn.2d 95, 104 (2008).

2.3 Admissible evidence in CN hearings is the kind of evidence on which reasonably prudent persons are accustomed to rely upon in the conduct of their affairs. RCW 34.05.452(1). The Presiding Officer may use the rules of evidence as guidelines. RCW 34.05.452(2). The Presiding Officer has latitude to determine what evidence is relevant. *See University of Washington Medical Center v. Department of Health*, 164 Wn. 2d 95, 104 (2008). Here, the Presiding Officer finds that the relevant evidence is the evidence available before the initial decision maker (Program). This approach is called the snapshot in time. This ruling helps prevent a revolving door of remands to obtain even more accurate, current data upon which to make a decision.

Use of Bed Need Methodology

2.4 The Presiding Officer may consider 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 a statutory or regulatory standard to evaluate acute care bed need, the Presiding Officer relies on the 10-step methodology set forth in the SHP to determine need.

Certificate of Need Criteria

2.5 Whether a CN should issue to an applicant is based on whether 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).

Need

2.6 To prove that need exists for additional acute care hospital beds, an applicant must initially meet the WAC 246-310-210 criteria.[16] The relevant 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 the 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 care service or services.

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

[16] Some of the WAC 246-310-210 sub-criteria are not discussed in this decision, as they are not relevant to the Kadlec or Kennewick applications. See WAC 246-310-210(3), (4), (5), and (6).

necessary adjustments in the methodology to reflect special circumstances of the service area.

2.8 The SHP 12-step methodology is:

Develop trend information on hospital utilization

Step 1: Compile state historical utilization data (i.e., patient days within major service categories) for at least 10 years preceding the base year.

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 rate.

Step 4: Using the 10-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.[17]

[17] Step 7B is an alternative to step 7A, and does not apply to the facts at hand.

Step 8: Forecast non-psychiatric patient days for each hospital planning area by multiplying the area's trend-adjusted use rate 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 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), including any short-stay psychiatric beds in general acute-care hospitals. Psychiatric hospitals with no other services should be excluded from the occupancy calculations.

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 rate, market shares, out-of-area use and occupancy rates.

2.9 Based on the totality of the evidence, the Presiding Officer concludes there is need for 18 acute care beds (rounded up from 17.95) in the 2016 target year. Kadlec meets the WAC 246-310-210(1) need qualification for the 18 acute care beds. Kadlec was previously awarded 55 beds under CN #1430, dated November 3, 2010.

Given that Kennewick withdrew its appeal of the 55 beds, the Program's evaluation is affirmed regarding the award of the 55 acute care–beds under CN #1430 and is not reduced to 18 acute care beds.

2.10 Based on the totality of the evidence, the Presiding Officer concludes that Kadlec meets the WAC 246-310-210(2) criterion.

2.11 Based on the totality of the evidence, the Presiding Officer concludes that Kennewick meets the WAC 246-310-210(1) criterion for 18 acute care beds.

2.12 Based on totality of the evidence, the Presiding Officer concludes that Kennewick meets the WAC 246-310-210(2) criterion.

Financial Feasibility

2.13 In support of the CN application for additional hospital beds an applicant must show the CN project is financially feasible under WAC 246-310-220. That regulation requires a showing that:

> (1) That 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.

2.14 Based on totality of the evidence, the Presiding Officer concludes Kadlec meets the WAC 246-310-220(1), (2), and (3) criteria.

2.15 Based on the totality of the evidence, the Presiding Officer concludes that Kennewick did not meet the WAC 246-310-220(1) criterion, but does meet the WAC 246-310-220(2) and (3) criteria.

Structure and Process (Quality) of Care

2.16 In support of the CN application for additional hospital beds, either Kadlec or Kennewick (or both) must show the CN project is financially feasible under WAC 246-310-230. That regulation requires a showing that:

> 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 propose 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 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 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 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 the totality of the evidence, the Presiding Officer concludes that Kadlec meets the WAC 246-310-230(1), (2), (3), (4), and (5) criteria.

2.18 Based on totality of the evidence, the Presiding Officer concludes that Kennewick meets the WAC 246-310-230(1), (2), (3), (4), and (5) criteria.

Determination of Cost Containment

2.19 In support of the CN application for additional hospital beds, either Kadlec or Kennewick (or both) must show the CN project is financially feasible under WAC 246-310-240. That regulation requires a showing that:

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.

2.20 Based on totality of the evidence, the Presiding Officer concludes that Kadlec meets the WAC 246-310-240(1), (2), and (3) criteria.

2.21 Based on totality of the evidence, the Presiding Officer concludes that Kennewick does not meet the WAC 246-310-240(1) criterion or the WAC 246-310-240(2) and (3) criteria.

III. ORDER

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

3.1 The Program's evaluation that awarded 55 acute care beds to Kadlec is AFFIRMED.

3.2 Kadlec's application for 114 acute care beds in Richland, Washington is DENIED.

3.3 Kadlec's application for 75 acute care beds in Richland, Washington is DENIED.

3.4 Kennewick's application for 25 acute care beds in Kennewick, Washington is DENIED.

Dated this _2___ day of September, 2014.

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

NOTICE TO PARTIES

When signed by the presiding officer, this order shall be considered an initial order. RCW 18.130.095(4); Chapter 109, law of 2013 (Sec. 3); WAC 246-10-608.

Any party may file a written petition for administrative review of this initial order stating the specific grounds upon which exception is taken and the relief requested. WAC 246-10-701(1). A petition for administrative review must be served upon the opposing party and filed with the adjudicative clerk office within 21 days of service of the initial order. WAC 246-10-701(3).

"Filed" means actual receipt of the document by the Adjudicative Clerk Office. RCW 34.05.010(6). "Served" means the day the document was deposited in the United States mail. RCW 34.05.010(19).The petition for administrative review must be filed within 21 calendar days of service of the initial order with:

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

and a copy must be sent to the opposing party. If the opposing party is represented by counsel, the copy should be sent to the attorney. If sending a copy to the Assistant Attorney General in this case, the mailing address is:

Agriculture and Health Division
Office of the Attorney General
P.O. Box 40109
Olympia, WA 98504-0109

<u>Effective date</u>: If administrative review is not timely requested as provided above, this initial order becomes a final order and takes effect, under WAC 246-10-701(5), at 5:00 pm on _____. Failure to petition for administrative review may result in the inability to obtain judicial review due to failure to exhaust administrative remedies. RCW 34.05.534.

Final orders will be reported to the National Practitioner Databank (45 CFR Part 60) and elsewhere as required by law. Final orders will be placed on the Department of Health's website, and otherwise disseminated as required by the Public Records Act (Chap. 42.56 RCW) and the Uniform Disciplinary Act. RCW 18.130.110. All orders are public documents and may be released.

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