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Via E-File

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

Re: Swedish Cherry Hill MIMP—Response to Public Comment

Dear Examiner Tanner:

As you know, this law firm represents the applicant, Swedish Medical Center ("Swedish"), in its effort to obtain approval of a new Major Institution Master Plan ("MIMP") for the Swedish Cherry Hill campus. This letter responds to the public comment letter submitted on July 15, 2015, by the Bricklin-Newman law firm on behalf of its client, Washington Community Action Network ("WashCAN"). WashCAN also filed an appeal of the adequacy of the Final Environmental Impact Statement ("FEIS").[1]

Typically, the applicant's presentation on a pre-decisional MIMP hearing takes place after public comment, which allows the applicant an opportunity to respond to concerns raised by the public. Here, most of the members of the public who testified did so on the first day of hearing, prior to the applicant's presentation. Several WashCAN members offered their oral and written comment at this time. In addition, in an effort to ensure the public had its say, the Examiner allowed the public to submit written and oral comment throughout the consolidated hearing, even after the close of the applicant's responsive testimony.

Despite being present at the entire hearing, Bricklin-Newman did not offer any expert testimony on MIMP transportation issues during the pre-decisional hearing, and withheld its comment letter until *after* the conclusion of the applicant's case on the merits of the MIMP, and after its witnesses testified during the SEPA appeal. The Bricklin-Newman letter is more in the style of legal briefing than public comment, despite the Examiner's decision that legal briefing on the merits of the MIMP would not be accepted. Such gamesmanship does not further the pre-decisional hearing's purpose of providing the Examiner and Council with the information they need to make an informed decision on the MIMP. Under the circumstances, the Examiner could have stricken the WashCAN letter from the record transmitted to Council.[2] However, since the

[1] This letter does not address issues related exclusively to FEIS adequacy, which will be briefed separately according to the briefing schedule set by the Examiner.

[2] The Bricklin-Newman letter also includes as an attachment a letter from a transportation planner who testified on WashCAN's behalf in the EIS appeal portion of the proceeding. The Examiner sustained the applicant's objection

Examiner exercised her discretion to admit the WashCAN letter, the applicant offers this letter to respond to the factual and legal points raised in the Bricklin-Newman letter.

This letter begins by arguing that the height, bulk, and scale are appropriate for major institutional development and consistent with Code requirements. The next section establishes that the Urban Village strategy is not an appropriate consideration on a MIMP decision. The third section demonstrates that the public benefit that will result from Swedish's expansion—similar to the public benefits detailed in MIMPs the Council approved for other institutions—meets the requirements of the Major Institutions Code. The fourth section reiterates Swedish's need for expansion and provides a counter to the testimony of Jack Hanson (upon which WashCAN relies). The letter concludes by discussing the importance and effectiveness of the TMP to address transportation impacts.

The MIMP Properly Addresses Issues Related to Height, Bulk, and Scale

The Major Institutions Code requires the institution to minimize the impacts of the development on the adjacent neighborhood, chiefly at the MIO boundaries. Thus, the proposed MIMP (1) responds to the neighborhood comment that the MIO not be expanded by constraining future development to the existing MIO, with no street vacations; (2) provides adequate transitions at campus edges; (3) provides reasonable mitigation of height, bulk, and scale through campus setbacks proposed by the CAC majority.[3] The tallest height limits are in the center of campus—not visible from the sidewalk of Cherry Street, thanks to generous upper-level setbacks—and on the western (i.e., downhill) parts of campus. Expert testimony established that, but for minor change on 18th and the center of 15th Avenue, the proposed MIMP includes no height limits along the campus edges that exceed existing MIO height limits. In fact, there is a proposed downzone on East Jefferson, directly adjacent to the existing single-family neighborhood.

The WashCAN letter proceeds from a faulty premise: that major institutional development is bound by the development standards of the underlying zone. In fact, the Swedish Cherry Hill campus, in common with many of Seattle's major institutions, was built decades before Seattle enacted a comprehensive zoning scheme that created underlying zoning of lowrise or single family. In recognition of the disparity between the long-established institutional uses (and their accompanying bulk) and the subsequently adopted zoning designations, and in an effort to prevent the major institutions from expanding horizontally to consume ever more of

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to the traffic letter and struck it from the record. The Examiner's exclusion of the traffic letter in this MIMP portion of the proceeding was entirely appropriate. WashCAN made no effort to offer expert traffic testimony during the MIMP portion of the proceeding, even though the same expert testified at length during the SEPA appeal. The Examiner properly rejected WashCAN's tardy attempt to insert its expert's written opinion into the MIMP portion of the hearing, after the close of the applicant's case on the MIMP and with no opportunity for cross-examination—especially where WashCAN had clear opportunity to present this expert witness during the MIMP portion.

[3] The setbacks in the MIMP pre-dated the recommendations of the full CAC. At the hearing on the MIMP, Swedish confirmed that it accepts the ground-level setbacks proposed by the CAC and asks the Examiner to recommend that Council so condition the final MIMP.

their neighborhoods, the Council adopted the Major Institutions Code at Ch. 23.69 SMC. Within the Major Institution Overlay created by this chapter, all design standards may be set by an adopted MIMP.

This was not always the case. Prior to 2001, the Major Institutions Code required MIMPs to comply with at least one underlying development standard: setbacks. *See* former SMC 23.12.120 ("In no case shall a setback from the boundary be less than required by the greater of the underlying zoning, or the zoning for property adjacent to or across a public right-of-way from the institution."). That proved unworkable, so the Council amended the Code to eliminate any minimum setback, in common with all other development standards. Ord. 120691 (2001) (§ 2 repealing Ch. 23.12 SMC; § 21 adopting current setback language without the requirement to match underlying zoning). Now, the Major Institutions Code directs the institutions to establish design standards sufficient to meet their institutional needs while emphasizing transitions from the edges of the MIOs to the neighboring areas.

Under the current Code, setbacks of the underlying zone are not even a consideration when evaluating proper setbacks for the MIO. The Code commands major institutions to:

> Make the need for appropriate transition primary considerations in determining setbacks. Also setbacks may be appropriate to achieve proper scale, building modulation, or view corridors

SMC 23.69.004.*I*. Because the Major Institutions Code does not require any setbacks, any setback provided helps to mitigate the effects of institutional development. The same analysis applies to height limits, façade modulation, upper-level setbacks, lot coverage, open space, and any other development standard found in the SMC.

Dr. Sutton, whose MIMP testimony WashCAN incorporated by reference,[4] may be expert in some areas, but hospital design is not one of them. She has never worked on the design of a hospital or medical center, and her only experience with medical centers was her service on the Virginia Mason CAC.[5] Other than her personal aesthetic sense, she was not able to articulate any basis for her opinion that the bulk proposed by Swedish was too large for the neighborhood. She could point to no industry standard on which the City could rely to set "appropriate" ground- and upper-level setbacks, and instead relied on vague reference to existing conditions (while mischaracterizing existing paved driveways and parking areas as "green open space"). Dr. Sutton's opinions were undermined by the CAC majority's recommendations regarding setbacks, as well as the testimony of John Jex, an architect with 35 years of experience designing medical

[4] Dr. Sutton testified in the EIS appeal and provided public comment during the MIMP hearing. Swedish presumes that WashCAN intended to incorporate only her MIMP public comment rather than seeking to influence the substantive MIMP decisions with SEPA testimony.

[5] The Examiner may recall that Dr. Sutton was the sole member of the CAC minority for Virginia Mason. In that proceeding, she opposed Virginia Mason's plan for 240' bed towers in a neighborhood where the underlying zone allowed 300' towers, arguing that the proposed development was too large for that high rise neighborhood.

institutions. The City may not impose a condition reducing development capacity without reference to specific facts and standards, which this record lacks, a deficiency that Dr. Sutton's testimony does not resolve.

The MIMP Is Consistent With Relevant City Plans, and the Examiner Lacks Jurisdiction to Condition the MIMP to Ensure Consistency

WashCAN, in common with many opponents of Swedish's expansion, argues that the MIMP should be rejected because the MIO is outside the urban village, and therefore, the Comprehensive Plan does not allow institutional growth at this MIO, despite the fact the hospital was established at this location long before the Comprehensive Plan was drafted. These arguments do not succeed because the Council may condition the MIMP in only two ways: to ensure compliance with the Major Institutions Code, or to mitigate environmental impacts identified in the EIS consistent with an adopted SEPA policy. Neither source of authority applies to ensure consistency with the urban village strategy; this section discusses both.

In Washington, a comprehensive plan is only a general guide and not a document designed for making specific land use decisions. The zoning code controls and trumps inconsistent provisions of the comprehensive plan. *See, e.g., Citizens for Mount Vernon v. City of Mount Vernon*, 133 Wn.2d 861, 873, 947 P.2d 1208 (1997).[6] A use must comply with a comprehensive plan only if the zoning code expressly incorporates the comprehensive plan into the decisional criteria for a proposal. Here, the Seattle Municipal Code does not require that an MIMP be consistent with the Comprehensive Plan in order to gain approval. See SMC 23.69.024-.032. Accordingly, the Hearing Examiner and City Council lack authority to condition or deny the MIMP based on the Comprehensive Plan.

The City Council confirmed years ago that the Comprehensive Plan's urban village strategy cannot be considered as part of the Major Institution Master Planning process:

> The City's Land Use Code (SMC Title 23) and substantive SEPA policies (SMC 25.05) authorize reference to the City's Comprehensive Plan as a basis for review of a proposed MIMP only with respect to specific Comprehensive Plan policies identified in those ordinances, neither of which include policies related to the 'urban village' strategy described in that Plan. Therefore **the Council lacks authority to consider those policies** as a basis for its decision whether to approve the proposed MIMP

[6] *See, also, e.g., Tugwell v. Kittitas County*, 90 Wn. App. 1, 8, 951 P.2d 272 (1997); *Hansen v. Chelan County*, 81 Wn. App. 133, 138, 913 P.2d 409 (1996); *Weyerhaeuser v. Pierce County*, 124 Wn.2d 26, 43, 873 P.2d 498 (1994); *Bassani v. Board of County Commissioners for Yakima County*, 70 Wn. App. 389, 396, 853 P.2d 945 (1993); *Lakeside Industries v. Thurston County*, 119 Wn. App. 886 (2004); *Pinecrest Homeowners Association v. Cloninger & Associates*, 151 Wn.2d 279 (2004); *Cingular Wireless v Thurston County*, 131 Wn. App. 756, 129 P.3d 300 (2006).

Ordinance No. 123263 (2010), Attachment A, Findings, Conclusion, and Decision of the City Council at Conclusion 28 (emphasis added). The Council wrote this language in response to the Hearing Examiner's analysis of the relevance of the Urban Village Strategy to MIMP adoption, specifically the Children's MIMP recommendation.[7] The Examiner's jurisdiction to recommend MIMP approval or conditioning is constrained by the Council's quasi-judicial precedent on this point, so the question of whether the campus is within an urban village is irrelevant.

This makes sense; the location of Swedish Cherry Hill was determined in 1910, 85 years prior to the creation of the urban village strategy and delineation of urban villages. Indeed, the hospital stood for decades before the City designated the underlying zoning as "lowrise" and "single family." The MIO recognizes and legitimizes the inconsistency created solely by City regulatory action.

The Major Institutions Code twice references a single section of the Comprehensive Plan. SMC 23.69.030.E.13.a & 23.69.032.E.3. Both instances relate to assessment of the ways the institution plans to achieve the "goals and applicable policies under Education and Employability and Health in the Human Development Element of the Comprehensive Plan." As explained in the MIMP and the Director's Report, the proposal is consistent with the applicable goals of the Human Development Element of the Comprehensive Plan.[8]

The increased development capacity of the MIMP is in line with the letter and spirit of the Major Institutions Code, as well as the rezone criteria (which are relevant only insofar as Swedish Cherry Hill seeks taller MIO height limits within the existing MIO). Consistency with the Comprehensive Plan is achieved through compliance with the rezone criteria of Ch. 23.34 SMC:

> Compliance with the provisions of this chapter shall constitute consistency with the Comprehensive Plan for the purpose of reviewing proposed rezones . . . .

SMC 23.34.007.C. The Director's Report contains an exhaustive, and correct, analysis of the MIMP's compliance with the rezone criteria. No additional conditioning is necessary to meet the requirements of the zoning code in general, or the Major Institutions code in particular.

Under SEPA, mitigation measures or project denial must be based on policies formally designated by the City as a basis for the exercise of its substantive SEPA authority. SMC 25.05.660.[9] The City's substantive SEPA policies are contained in SMC 25.05.675 and do not

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[7] Swedish Cherry Hill borders the urban village on 15th Avenue. Children's Hospital is separated from the nearest urban village by at least 10 blocks.

[8] WashCAN correctly surmises that the MIMP did not address goals that on their face do not apply to a medical major institution. WashCAN letter at 15 n.7. The Major Institutions Code does not require a MIMP to list Comprehensive Plan policies for the sole purpose of explaining that they do not apply.

[9] *Accord* WAC 197-11-660; *see also Nagatani Brothers v. Skagit County*, 108 Wn.2d 477, 739 P.2d 696 (1987); *Maranatha Mining, Inc. v. Pierce County*, 59 Wn. App. 795, 801 P.2d 985 (1990).

include a policy that addresses the urban village strategy.[10] The policies on Land Use and Height, Bulk, and Scale do provide that, subject to the Overview Policy, a decisionmaker may condition or deny a project to achieve consistency with the goals and policies of Section B of the Land Use Element of the Comprehensive Plan (and other policies not applicable here, specifically, the shoreline and critical areas policies). SMC 25.05.675.J, .G. But Section B of the Land Use Code does not forbid major institutions outside urban villages. To the contrary, Policy LU65 recognizes that major institutions are located in single family areas, and provides that their impacts shall be mitigated through the master planning process. This is precisely what is occurring here. In the absence of a SEPA policy addressing major institutional development outside urban villages, the Council lacks authority to impose a SEPA condition to mitigate any perceived inconsistency with the urban village strategy.[11]

Swedish Provides, and Will Provide, Substantial Public Benefit

Major institutions must provide public benefit in exchange for the additional development capacity of an MIO, and in every MIMP the Council has approved heretofore, the main element of the public benefit derived from the change of a major institution is the continuing vitality (and very existence) of the institution itself. Seattle's major institutions provide tens of thousands of jobs, and the health and education opportunities they provide are crucial to the City's quality of life. Swedish Cherry Hill, in particular, provides specialized healthcare such as treatment of brain, spine, and cardiac and vascular disease that is the envy of hospitals the world over. In addition, Swedish Cherry Hill, in common with its sister medical major institutions, provides millions of dollars' worth of uncompensated care every year. WashCAN's letter acknowledges this fact: "Swedish Medical Center provides these benefits – it is a hospital."[12]

Beyond the substantial public benefit associated with the continuing operation of a non-profit specialty hospital, Sherry Williams testified to other public benefits associated with Swedish Cherry Hill operations. Many of these benefits are listed at pages 69-72 of the MIMP. They include several not directly related to healthcare: food donations, employee drives, sponsorship of community charities, and support of athletic programs, among others. They also include healthcare-related benefits, such as: community heart screenings, mobile mammography services, stroke support group meetings, and other services. Ms. Williams testified these benefits will continue under the new MIMP.

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[10] Indeed, SMC 25.05.675 includes no SEPA policy that specifically addresses the "consistency with adopted plans or policies" element of the environment, so the Council lacks authority to impose a condition to ensure such consistency generally.

[11] Swedish does not concede any inconsistency. The Comprehensive Plan identifies the Cherry Hill campus as appropriate for major institutional uses and development.

[12] Some public comment suggested that because hospitals are required to provide uncompensated care, they should not be permitted to count it as public benefit. But the requirement diminishes neither the benefit to the public nor the cost to the institution. Hospitals are required to provide care, but they are not required to exist, and without the additional development capacity allowed by the Major Institutions Code, many of them would not.

In total, the public benefits identified in the proposed MIMP are very similar in kind and scope to the benefits the Council has previously approved for Virginia Mason, Seattle Children's, and a number of other medical major institutions. WashCAN seeks to hold the Swedish Cherry Hill MIMP to a higher standard—a standard not set forth in Code and never before applied to another major institution.

WashCAN members spoke to the effect of healthcare debt on the indigent, and their stories implicate areas of significant public concern and appropriate debate regarding society's allocation of healthcare resources. Swedish agrees that charity care should be readily accessed by those who qualify, but compelling though these stories may be, nothing in the Seattle Municipal Code gives the Examiner the jurisdiction to condition approval of the MIMP based on providing certain levels of charity care.

The Major Institutions Code is not a vehicle for the City to govern the business practices of the institutions. The Council and its Hearing Examiner regulate land use, not hospital functions. The Hearing Examiner does not have jurisdiction over collective bargaining, staffing ratios, or any number of other issues that WashCAN asks the Examiner to address in her recommendation to Council. Nothing in the Major Institutions Code suggests that the City has the authority to condition the land use decision on the MIMP to address impacts unrelated to land use.

WashCAN's letter faults the business practices of Swedish Cherry Hill and Providence generally, invoking issues over which the City has no jurisdiction, while providing no context or standards by which a decisionmaker could evaluate a healthcare provider's practices. How much unrestricted cash should a medical system keep on hand? How much uncompensated care should a hospital system provide? Should the appropriate amount be calculated as a percentage of its operating profits such that it diminishes in years the hospital operates unprofitably? What should the procedure for applying for charity care entail? These questions, and similar questions prompted by WashCAN's letter, are not answered on this record, nor are they issues for the Hearing Examiner to address in this matter in any event.

WashCAN also points out that both the number of charity care patients and the value of Swedish Cherry Hill's uncompensated care decreased from 2013 to 2014, which is correct as far as it goes. It does not indicate, as WashCAN implies, that Swedish Cherry Hill is improperly turning away patients in need. Rather, it represents the impact of the Affordable Care Act (ACA), which was fully implemented in January 2014, resulting in 15 million previously uninsured Americans gaining coverage through the expansion of Medicaid, and by virtue of State Insurance Exchanges. Prior to January of 2014, those persons would have entered the health system through emergency rooms across the country, and many of those related charges would have been written off as unfunded charity care. The ACA's positive effect of increasing the number of insured has lowered the charity care of many non-profit health systems throughout the country, including Swedish Cherry Hill.

The MIMP and Testimony Established Swedish's Need for Expansion

Swedish established its need for growth through expert testimony, emphasizing trends in healthcare, growth of specific patient utilization at Cherry Hill, and through testimony concerning outdated facilities, including ORs and patient rooms. Swedish seeks first to construct modern facilities sufficient to meet its existing licensed bed capacity, which has already been recognized by the State of Washington through the Certificate of Need process. But the MIMP is a plan for campus-wide growth with no expiration date, with a planning horizon of 20-30 years. It anticipates growth in areas that do not require new beds, such as the dental clinic Dr. Winston testified Swedish intends to construct at Cherry Hill, as well as many other areas.

Of course, it is also possible that Swedish will require additional beds in the future and will seek approval for those through the state Certificate of Need system. When it does so, Swedish will likely use some of the MIMP's additional development capacity to accommodate those beds, as well, but it is not appropriate to defer to the state Certificate of [bed] Need analysis to make the determination of total development capacity 20 or 30 years into the future.

WashCAN protests that Swedish should not have been allowed to present evidence of the methods through which need is calculated during the Hearing Examiner hearing, but sufficient information was provided in Appendix G, and insofar as additional explanation is necessary, the pre-decisional hearing is the appropriate venue. By Code, the CAC "may review and comment on the . . . need for the expansion," but need is "not subject to negotiation." SMC 23.69.032.D.1. Swedish explained its need to the CAC early in the process, and further clarification is appropriate at the hearing stage. The evidence received during the hearing establishes that, if anything, Swedish's projected need was conservative.

The MIMP presents Swedish's strategy for the Cherry Hill campus as a specialty hospital including a Cardiac/Vascular Institute and a Neuroscience Institute, supported with general primary care service for the community. The Swedish Cherry Hill methodology (MIMP Appendix G) presents the factors that were taken into account to arrive at a future operational size for these Swedish Institutes, including population growth (total population and over-65), use rates of services being developed, emerging medical and technology trends, assumptions around the consolidation and integrated nature of emerging health systems, market share (current and projected), in-migration of patients, average daily census (ADC) trends (current and projected), occupancy assumptions, and average length of stay of patients (ALOS) all to determine the necessity of the service being delivered at Swedish Cherry Hill. This information has been presented in Appendix G and throughout the MIMP document. Swedish's expert, Jeff Hoffman,[13] testified at length that the assumptions made in Appendix G are reasonable for a health system such as Swedish.

[13] Mr. Hoffman testified as an expert during the MIMP hearing and was subjected to cross-examination by the public, including by WashCAN's attorney. He did not testify during the SEPA appeal.

In spite of all of the information in Appendix G and presented at the hearing, Jack Hanson's written and oral testimony frequently recited that Swedish "has failed to provide information sufficient to demonstrate a genuine need for expansion." Because he held himself out as an expert in medical center planning, and because the WashCAN letter relies on his analysis, Swedish provides the following rebuttal to Mr. Hanson's analysis.

A near neighbor to the institution, Jack Hanson is a policy analyst, not an expert on hospital facilities planning beyond "bed need." Swedish's needs assessment includes much broader needs beyond beds, including lab and research, clinic, education, hotel, and long-term care. Mr. Hanson has no professional experience in these distinct areas, and no master planning experience whatsoever. Swedish does not seek any additional beds at this time, and even if it did, the question of bed need is exclusively within the jurisdiction of the state, not the City. This improper reliance on bed need analysis permeates Mr. Hanson's testimony.

In addition to the fundamental error of relying on bed need methodologies, much of Mr. Hanson's testimony depends on the equally flawed premise that Swedish Cherry Hill is a general acute care hospital, comparable (indeed, interchangeable) with Swedish First Hill or Virginia Mason. As the MIMP and testimony established, Swedish Cherry Hill is actually a highly specialized care facility more similar to children's hospitals, heart hospitals, and obstetrics hospitals. It is the home of Swedish Cardio/Vascular Institute, the home of the Swedish Neuroscience Institute, featuring gamma and cyber knife technology for brain surgery, as well as home to Swedish's critical inpatient rehabilitation and psychiatric services. As Mr. Cosentino testified, these clinical service lines serve members of the Seattle community with the highest level of complex disease and emergencies. In fact, to underscore this definition, patients entering the Swedish First Hill campus for cardiac and neurosciences care are most often transferred to Swedish Cherry Hill to receive this care. Cherry Hill has no routine, general medical/surgical capability.

These two fundamental errors explain many, if not most, of the questions Mr. Hanson raises. Specialty hospitals require more building gross square footage per bed, more space for long-term care services, and more available beds (in the form of lower planning occupancy rates), among others. Planning for future space implicates far more than simple bed counts—and the current license for Swedish Cherry Hill allows 385 beds (compared to 200 currently in use).

On page three of his written comments, in the paragraph titled "Concerning Population Growth and Demographic Shifts," without disputing the demographic data that Swedish put forward in Appendix G, Mr. Hanson requests that this data "require explicit discussion in order to establish Providence / Swedish claim that the aging of the population will drive increased demand at Cherry Hill." The Washington Office of Financial Management demographic data Mr. Hanson seeks was presented in Appendix G. MIMP at 133. The testimony established that the significant aging of our population will substantially drive the need for more health care services, and Swedish Cherry Hill is no different. Mr. Hoffman provided detailed testimony about use rate trends for Cardiac and Neuroscience services that are being served at Cherry Hill.

Also on page three, under the heading "Concerning Healthcare Facility Utilization Changes Due to Healthcare Reform Efforts," Mr. Hanson seeks more detail discussion on the impact of the Affordable Care Act (ACA) than was presented in Appendix G. There, Swedish stated its assumption that while there will be an immediate influx of new patients due to the ACA, once that influx occurred, "service demand will stay about the same." MIMP at 133. Swedish also stated its assumption that it is already taking care of the really sick (just with no insurance or payment), and in the future these very sick people will have insurance. *Id.* Mr. Hoffman agreed with this assumption and if Mr. Hanson disagrees he should present data that refutes that assumption rather than simply request "more discussion."

Rather than present any opinion on how he believes changing delivery reforms, including payment reforms, will impact Swedish Cherry Hill, Mr. Hanson simply suggests that the MIMP does not account for these reforms. Yet, Appendix G does discuss the likely impact of the ACA reforms. Mr. Hoffman testified that these delivery reforms, specifically as they shift to more value-based payment methodologies, will cause smaller community hospitals to eliminate low-volume, high-complexity services, including many cardiac and neuroscience service lines. This will increase the need for high-complexity institutes such as those at Swedish Cherry Hill and thus drive the in-migration of patients to Swedish Cherry Hill.

On page four of his testimony, in the paragraph titled "Concerning Changes in Patient Volume and Relative Market Share," Mr. Hanson states that Swedish Cherry Hill's MIMP provides no data on market share or number of patients treated. Not only is this historical data publicly available, but Appendix G of the MIMP presents the current market share number and current patient volume in terms of an average daily census (ADC) of patients in the hospital. It also projects and presents the estimate of future patient volume based on Swedish's assumptions. While Mr. Hanson may want "more discussion," it is simply not true to state "Providence Swedish offers no numbers" and "no specific information on the number of patients…" and "nor does it offer estimates of additional patient volumes expected in the future." Appendix G offers the current market share, estimates on future market share, current ADC and estimates of future ADC, and patient volume both in numbers and graphics.

Mr. Hanson also presents the size (square footage and bed increases) of approved master plans of other healthcare organizations in the area as evidence of limited need Cherry Hill expansion. Mr. Hanson makes the inaccurate assumption discussed above: that all hospitals are equal and provide the same services. As a highly specialized facility, Swedish Cherry Hill provides services that are not provided at the other hospitals Mr. Hanson lists. Cherry Hill's highly specialized services will also create significant in-migration from outside King County. This in-migration was 8% in 2012, and is now 11% for 2014 and is estimated to continue to increase. In addition, because Swedish Cherry Hill is currently licensed for 385 beds, all other expansions take the Swedish Cherry Hill bed expansion into account when determining incremental new bed need and capacity into their planning.

On page six, in the section titled "Concerning the Space Need Projection for the Hospital," Mr. Hanson argues that Swedish Cherry Hill's MIMP does not provide support for the

need to continue to use its beds and argues further that the bed rooms, some of which are more than 50 years old, do not need to be upgraded to a more contemporary standard to serve today's more complex cases. To the contrary, the MIMP explains why this is necessary, and additional testimony by Swedish witnesses also gave clear and concise reasoning for this need.

Mr. Hanson's graphic of historical inpatient volume shows a rapidly increasing trend of use, but attempts to minimize this import of this increasing trend. Swedish Cherry Hill takes this trend seriously. The MIMP presents data that showed in 2012, Swedish staffed 200 beds. Testimony established that current ADC is now exceeding 168 patients per day (midnight census July 2015), requiring over 240 staffed beds. Only modest future growth will require use of all 385 beds allowed under Swedish Cherry Hill's current license.[14]

Mr. Hanson quotes from Washington State Health Plan to establish the proposition that "bed projections should not be made for more than seven years into the future"—a proposition relevant only if Swedish were seeking additional beds. As a policy analyst, Mr. Hanson has the intellectual luxury to pontificate about the reliability of future forecasts and to suggest that only five-year and seven-year forecasts should be considered. The clinician leaders of Swedish Cherry Hill must live in the real world of healthcare delivery, financing, and hospital construction where facilities must be feasible and functional for 40+ years. Swedish must plan well into the future on hospital facility development, particularly when they need to make $500 million to $1 billion decisions related to a single hospital campus such as Cherry Hill. So using the best analytical tools and methodologies, and making reasonable assumptions about the future, Swedish Cherry Hill must take a longer view on planning for the necessary beds in the future.

Again conflating general acute care facilities with specialized facilities, Mr. Hanson argues that Swedish Cherry Hill should use 75%-80% occupancy for planning purposes.[15] Mr. Hoffman confirmed that such numbers are appropriate for general hospitals, but they are not appropriate for highly specialized facilities such as children's hospitals, heart hospitals, and Swedish Cherry Hill. When such critical care patients needs a bed, they need it immediately, so planners use a lower occupancy of 65%-70% to ensure one will be available. Swedish Cherry Hill used a 69% occupancy to plan future beds in 2040, which Mr. Hoffman confirmed was a reasonable assumption for a specialized, high-complexity care hospital.

Relying again on general acute care facility numbers, Mr. Hanson argues that "a standard well below the 3,500 BGSF per bed is appropriate."[16] Properly comparing Swedish Cherry Hill to other specialty institutions shows that the 3,500bgsf/bed planned for in the MIMP is slightly conservative. Also, as Mr. Hoffman testified, contemporary per bed benchmarks are increasing

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[14] Again, Swedish Cherry Hill is NOT requesting additional licensed beds. They are requesting the ability to rebuild beds they already have so they can be of better use for their patients.

[15] Mr. Hanson elides over the difference between planning occupancy percentages and occupancy percentages as a measure of operating performance. The former is used to plan hospital facilities that must be workable for 40+ years, while the latter measures current operating efficiency.

[16] Note that the metric of "building square footage" per bed does not mean Swedish intends to build 3,500 square foot bed rooms. The numerator is the square footage of the entire hospital, including clinical and outpatient space.

even in general acute care facilities as more space is added for outpatient treatment and diagnostics capability. Adding these spaces to a hospital setting creates greater efficiency and flexibility between the outpatient and inpatients but the per bed benchmark increases.

On page nine of his testimony, Mr. Hanson questions the need for more cardiac and neuroscience research—despite the fact that heart disease and stroke are the first and third leading causes of death in the United States. This is one of the lone areas in which Mr. Hoffman testified that Swedish was not conservative in its size estimates, at 2,200 bgsf per physician, but the 1,400 bgsf number that Mr. Hanson suggests is far too low. Mr. Hanson's number rests on a number of flawed assumptions (i.e., that a research facility does not require convenient bathrooms and does not require electrical and mechanical space) and should be disregarded.

On page ten, Mr. Hanson argues that the campus hotel does not require as much square footage as projected. But hospital hotels are not typical hotel facilities. They must all be handicap accessible to accommodate patients and their families and include amenities such as in-room kitchens and living space. Benchmarks of 1,000-1,500 building square feet per room are on the conservative side of the planning range.

On page eleven, Mr. Hanson challenges the space calculation for education functions. While some education space is planned into the hospital BGSF per bed, Cherry Hill is used as the education center for the Swedish system. This is a very efficient way to use education space, auditoriums, simulation labs, etc. By building a co-located training space and using it for a greater number of people, the use of this asset is ultimately more efficient and the Health System can provide better training resources for its employees. So because it is used for more than just Swedish Cherry Hill employees, and for joint classes with Seattle University, additional education space is reasonable to consider.

One of the goals of Chapter 23.69 SMC Major Institutions Code is to "[a]ccommodate the changing needs of major institutions." SMC 23.69.002.H. Neither WashCAN nor Jack Hanson offered a competing needs assessment in response to Swedish's data and testimony. Expert testimony offered by Jeff Hoffman confirmed that the data and assumptions made by the Swedish MIMP consultant, Terrie Martin, were reasonable. The overwhelming evidence in the record supports the analysis of Swedish's need, and the Examiner should reject WashCAN's arguments.

The Proposed TMP Will Reduce Transportation Impacts

Swedish worked with Commute Seattle and transportation consultants to craft a TMP that will reduce SOV trips to and from the campus, thus mitigating the impacts related to future traffic increases associated with build-out of the hospital. Commute Seattle has a proven track record of creating and managing successful TMPs, and both the applicant's and City's experts testified that the proposed TMP has a high likelihood of success, as well.

Furthermore, the significant traffic impacts revealed in the FEIS assumed 50% SOV rate, not the 38% Swedish has agreed to set as its goal. Uniquely among master plans in Seattle, this 50% SOV rate is required to be met prior to the occupancy of any new building on the campus. As the SOV rate declines at a rate thereafter of 1% every two years, fewer SOV trips will further reduce impacts. Mr. Cosentino and Commute Seattle established that Swedish management is committed and determined to decrease the SOV commute rate at the Cherry Hill campus. Expert testimony established that sufficient transit capacity currently exists, and Metro could add additional capacity if necessary.

To that end, Mr. Swenson, Mr. Perlic and Mr. Shaw (for DPD) all testified that, despite WashCAN's assertions to the contrary, there presently exists available capacity for additional ridership on transit routes serving the Cherry Hill campus. All parties agreed that when a transit route approaches capacity, Metro will take steps to add to that capacity. Additional capacity could take the form of more frequent buses and/or larger, articulated buses (which are not currently used to serve the campus), according to Mr. Swenson and Mr. Perlic.

Conclusion

For the reasons listed above and those discussed at the hearing, the arguments presented by WashCAN in its comment letter have no merit. The Hearing Examiner should reject them and recommend approval of the MIMP to the City Council.

Sincerely,

FOSTER PEPPER PLLC

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