STATE OF WASHINGTON
DEPARTMENT OF HEALTH

March 16, 2017

Gregory McBroom
Life Point Law
31919 6th Ave S Suite A100
Federal Way, WA 98003-5365

Brian Grimm
Matthew Gordon
Perkins Coie LLP
1201 3rd Ave Suite 4800
Seattle, WA 98101-3099

Richard McCartan, AAG
Office of the Attorney General
PO Box 40109
Olympia, WA 98504-0109

RE: Master Case No. M2016-232

Dear Parties:

Enclosed please find Findings of Fact, Conclusions of Law, and Final Order dated March 16, 2017.

Any questions regarding the terms and conditions of the Order should be directed to Janis Sigman, Program Manager at (360) 236-2956.

Sincerely,

Michelle Singer, Lead Adjudicative Clerk
Adjudicative Clerk Office
PO Box 47879
Olympia, WA 98504-7879

cc: Janis Sigman, Program Manager

Enclosure

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

In Re: CERTIFICATE OF NEED APPLICATION OF SIGNATURE HEALTHCARE SERVICES, LLC, TO ESTABLISH A PSYCHIATRIC HOSPITAL IN PIERCE COUNTY, Petitioner ALLIANCE FOR SOUTH HEALTH Intervenor	)	Master Case No. M2016-232 DECLARATION OF SERVICE BY MAIL

I declare under penalty of perjury, under the laws of the state of Washington, that the following is true and correct:

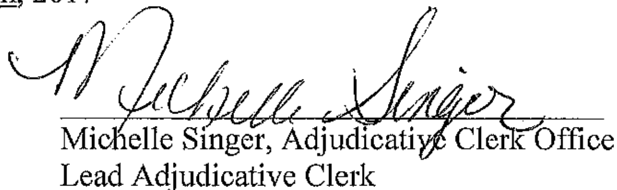
On March 16, 2017, I served a true and correct copy of the Findings of Fact, Conclusions of Law, and Final Order, signed by the Review Officer on March 16, 2017, by placing same in the U.S. mail by 5:00 p.m., postage prepaid, on the following parties to this case:

Gregory McBroom
LifePoint Law
31919 6th Ave S Suite A100
Federal Way, WA 98003-5365

Brian Grimm
Matthew Gordon
Perkins Coie LLP
1201 3rd Ave Suite 4800
Seattle, WA 98101-3099

Richard McCartan, AAG
Office of the Attorney General
PO Box 40109
Olympia, WA 98504-0109

DATED: This 16th day of March, 2017



Michelle Singer, Adjudicative Clerk Office
Lead Adjudicative Clerk

cc: Janis Sigman, Program Manager

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
OFFICE OF THE SECRETARY

In Re:	Master Case No. M2016-232
CERTIFICATE OF NEED APPLICATION OF SIGNATURE HEALTHCARE SERVICES, LLC, TO ESTABLISH A PSYCHIATRIC HOSPITAL IN PIERCE COUNTY, Petitioner, ALLIANCE FOR SOUTH SOUND HEALTH, Intervenor.	FINDINGS OF FACT, CONCLUSIONS OF LAW, AND FINAL ORDER

APPEARANCES:

Signature Healthcare Services, LLC, by
Life Point Law, per
Gregory A. McBroom, Attorney at Law

Alliance for South Sound Health, by
Perkins Coie LLP, per
Brian W. Grimm and Matthew P. Gordon, Attorneys at Law

Department of Health, Certificate of Need Program, by
Robert W. Ferguson, Attorney General, per
Richard A. McCartan, Assistant Attorney General

PROCEDURAL HISTORY ON REVIEW

This matter comes before the Review Officer for administrative review of the Findings of Fact, Conclusions of Law, and Initial Order (Initial Order) dated September 28, 2016, of the Presiding Officer, John F. Kuntz. The Initial Order granted a certificate of need

ORIGINAL

(CN) to build a psychiatric hospital in Pierce County, Washington, to the Alliance for South Sound Health (Alliance) and denied the application of Signature Healthcare Services, LLC (Signature). The Initial Order was served on the parties on September 29, 2016. Signature filed a Petition for Administrative Review (Petition) on October 20, 2016. The Alliance and the Certificate of Need Program (Program) each filed a response to the Petition on November 23, 2016.[1]

SIGNATURE'S PETITION FOR REVIEW

In its Petition, Signature cites four categories of alleged error in the Initial Order. First, Signature claims 15 errors or omissions in the Statement of Issues. Second, Signature identifies three errors in the Summary of Proceedings. Third, Signature alleges 37 errors the Findings of Fact. Finally, Signature claims five errors in the Conclusions of Law. Signature suggests that the "Department should reverse and reward an intent to issue a CN to Signature for a hospital of 90-174 psychiatric acute care beds."

THE ALLIANCE'S RESPONSE

The Alliance opposes Signature's Petition. It argues Signature's CN application should be denied because Signature failed to demonstrate its application meets CN criteria. In the event Signature's application is found to be sufficient, the Alliance contends its own application should prevail under a comparative superiority analysis.

THE PROGRAM'S RESPONSE

The Program also opposes Signature's Petition. The Program argues that while both Signature and the Alliance passed the CN criteria, the Alliance's application is superior

[1] On November 8, 2016, the Review Officer issued an order granting the Joint Motion for Continuance expanding the time for the Alliance and the Program to respond.

under WAC 246-310-240(1) for four reasons. First, the Alliance's project will open earlier. Second, the Alliance will have better continuity of care and established relationships. Third, the Alliance's project will be located adjacent to an acute care hospital and will be associated with two acute care hospitals. Finally, the Alliance will better serve low-income patients. In contrast, the Program alleges there are no factors showing Signature's application is superior even though it proposes a greater number of beds and has a lower overall cost. The Program also refutes Signature's argument that both projects could be approved because the combined bed total would exceed the need in the planning area.

ISSUES

1) Does the Alliance's application to establish a psychiatric hospital in Pierce County meet all the required Certificate of Need criteria under WAC 246-310-210, 246-310-220, 246-310-230, and 236-310-240?
2) Does Signature's application to establish a psychiatric hospital in Pierce County meet all the required Certificate of Need criteria under WAC 246-310-210, 246-310-220, 246-310-230, and 236-310-240?

I. PROCEDURAL HISTORY AND SUMMARY OF PROCEEDINGS

1.1 The Alliance is a joint venture by MultiCare Health Systems (MultiCare) and Catholic Health Initiative – Franciscan Health (Franciscan). On November 14, 2014, the Alliance submitted a letter of intent to establish a psychiatric hospital in Pierce County, Washington. On December 16, 2014, the Alliance submitted a CN application to establish a 120-bed psychiatric hospital in Tacoma, Pierce County, Washington. AR[2] 386.

[2] Application record.

1.2 On October 3, 2014, Signature submitted a letter of intent to establish a psychiatric hospital in Pierce County, Washington. On November 10, 2014, Signature filed a CN application to establish a 174-bed psychiatric hospital in Tacoma, Pierce County, Washington. On January 16, 2015, Signature filed an amended CN application to establish a 174-bed psychiatric hospital in Tacoma, Pierce County, Washington. AR 2.

1.3 The Program conducted concurrent review of the Alliance's application and Signature's amended application, including the respective responses to a pivotal unresolved issue. The Program issued its evaluation on January 15, 2016, in which it conditionally granted the Alliance's application if the Alliance agreed to comply with 12 required conditions.[3] AR 2452. The Alliance agreed to all the specified conditions. AR 2778. On February 1, 2016, the Program issued CN #1563 to the Alliance. AR 2779-2781.

1.4 The Program denied Signature's application. On February 12, 2016, Signature filed a Request for Adjudicative Proceeding to challenge the Program's evaluation approving the Alliance's application and denying Signature's application.

1.5 The Alliance filed a Motion to Intervene which was granted by the Presiding Officer on April 11, 2016. *See* Order Granting Alliance for South Sound Health's Petition for Intervention.

1.6 On April 15, 2016, the Program provided the Application Record to the parties. Upon discovering the Application Record was incomplete, the Program supplemented the Application Record on May 16, 2016.[4]

[3] RCW 70.38.115(4) authorizes the issuance of a conditional CN.
[4] *See* Signature's Exhibit P-2. Signature offered the documents for inclusion in the Application Record and the Presiding Officer chose to include the documents as an exhibit.

1.7 A hearing on Signature's Request for Adjudicative Proceeding was held on June 27, 28, and 29, 2016.

1.8 At the hearing, the Alliance presented the testimony of Frank G. Fox, Ph.D., Principal, Health Trends; Carl Halsan, Principal, Halsan Frey LLC; Tim Holmes, Vice President, Behavioral Health, MultiCare Health System; Samuel Huber, MD, Chief Medical Officer, Behavioral Health, MultiCare Health System; Natalia Kohler, Finance Officer, East Region and Behavioral Health, MultiCare Health System; and Anne M. McBride, Division Director, Behavioral Health Services, CHI Franciscan Health. Signature presented the testimony of Bob McGuirk, CN Analyst; and Michael Sherbun, Signature's Vice President of Clinical Services.[5] The Program presented the testimony of CN Executive Director Bart Eggen.[6]

1.9 The Presiding Officer admitted the following exhibits at hearing:

<u>The Program</u>

Exhibit D-1: The 2781-page Application Record.

<u>Signature</u>

Exhibit S-2: June 10, 2016, Signature additions to the Application Record. Attachments B, C, and D were admitted. Attachment A (documents related to Signature's Clark County application) was not admitted.

1.10 The parties submitted briefs in lieu of closing arguments as authorized under RCW 34.05.461(7). The initial closing briefs were due on July 22, 2016, and the responsive

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[5] The hearing was scheduled for two and one-half days. *See* Pre-Hearing Order No. 2 dated June 13, 2016, page 7. Near noon on day three, Signature attempted to call Bob Russell, CN Program Analyst. After hearing arguments, the Presiding Officer held the parties to the schedule in the pre-hearing order and declined to allow Mr. Russell's testimony. *See* TR 673-679; Post-Hearing Order No. 1 dated July 8, 2016; *see also* RCW 34.05.449.
[6] Signature cross-examined Mr. Eggen in lieu of calling him as a witness. *See* TR 568-569 and 576.

closing briefs were due on July 29, 2016. The Program requested a short continuance to August 1, 2016, which was granted by the Presiding Officer. The hearing record was closed on August 1, 2016.

1.11 September 28 2016, the Presiding Order issued the Initial Order which was served on the parties on September 29, 2016.

1.12 On October 20, 2016, Signature filed a Petition for Administrative Review.

1.13 On November 1, 2016, the Program and the Alliance filed a Joint Motion for Continuance in order to expand the time for their responses to the Signature's Petition. The Review Officer granted the motion and set a response date of November 23, 2016.

1.14 On November 23, 2016, the Program filed a Brief Opposing Petition for Administrative Review.

1.15 Also on November 23, 2016, the Alliance filed a Response to Signature Healthcare Service's Petition for Administrative Review.

II. FINDINGS OF FACT

2.1 A "certificate of need" means a written authorization for a person to implement a proposal for one or more undertakings. WAC 246-310-010(11). Certificates of need shall be issued or denied in accordance with the provisions of chapter 70.38 RCW and the rules of the Department of Health, chapter 246-310 WAC. RCW 70.38.115(1).

2.2 An applicant[7] for a CN to operate or build a psychiatric hospital must meet the criteria set forth in WAC 246-310-200. The criteria include a determination whether the proposed project: 1) is needed; 2) will foster containment of the costs of healthcare; 3) is financially feasible; and 4) will meet the criteria for structure and process of care. WAC 246-310-200(1). An applicant must also meet the criteria set forth in WAC 246-310-210 through 240. WAC 246-310-200(2). Failure to comply with any one of the criteria will result in denial of the application. An application may meet a majority of the WAC 246-310-200 criteria but will fail if it does not meet every element. The applicant must establish that its application meets all of the CN criteria.[8] It is not the Program's responsibility to prove or disprove whether the CN applicant's application meets the criteria.[9] *See* WAC 246-10-606.

2.3 An applicant "shall submit a certificate of need application in such form and manner and containing such information as the department has prescribed and published as necessary to such a certificate of need application." WAC 246-310-090(1)(a). To meet the WAC 246-310-200(1) and (2) criteria, the applicant completes

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[7] Under WAC 246-310-010(6), an applicant is: (a) any person proposing to engage in any undertaking subject to review under chapter 70.38 RCW; or (b) a person or individual with ten percent or greater financial interest in a partnership or corporation or other comparable legal entity engaging in an undertaking subject to review under chapter 70.38 RCW.

[8] By law, the Program has a limited time to evaluate a CN application (*see* RCW 70.38.115(7) and (8)). Given the time limitations, the Program relies on the applicant to provide full and accurate information to permit the Program to evaluate the application. The Program does not investigate the accuracy of the applicant's assertions for that reason.

[9] This is a continuing point of confusion in CN cases; once a party requests a hearing it is not an "appeal" of the Program's evaluation. Rather the applicant must prove to the Presiding Officer (and Review Officer if review is requested), based on the information in the Application Record, that the application meets all the CN criteria. *See DaVita v. Dept. of Health,* 137 Wash.App. 174, 184-186, 151 P.3d 1095 (2007); *see also* WAC 246-10-606. Of course, parties may address any issues the Program identifies in its evaluation. While the Presiding Officer considers the Program's evaluation and the parties' arguments about the evaluation, the Presiding Officer is not required to defer to it. *DaVita* at 182-183. The same reasoning in *DaVita* applies to the Review Officer's administrative review of the Initial Order.

the CN application form created by the Program. There is no form specifically tailored for psychiatric hospital applications. The form in use is the one created for acute care hospitals.

2.4 An incomplete CN application may be returned to the applicant. *See* WAC 246-310-090(2)(b). In circumstances where a concurrent review is being conducted, the practical effect of returning an incomplete application is requiring the applicant to start the CN application process over. In addition to paying another application fee, there is no guarantee sufficient need will exist for the CN applicant who is required re-start the CN analysis. This is because another successful CN applicant may obtain all of the existing need (in this case, the psychiatric hospital beds) in the planning area. The CN process does not normally exclude an incomplete applicant early on in the process because whether an applicant is incomplete is often a question of fact. The preferred practice is to evaluate concurrent applications together to ensure that all necessary findings of fact are addressed in the in the agency's decision as required under WAC 246-310-200.

2.5 Changes to an application *may* be considered an amendment. *See* RCW 70.38.115(11); WAC 246-310-100(1) (emphasis added). Such changes include:

(a) Addition of a new service or elimination of a service included in the application;

(b) Expansion or reduction of a service included in the original application;

(c) Increase in bed capacity;

(d) Change in the capital cost of the project or the method of financing the project;

(e) Significant change in the rationale used to justify the project; or

(f) Change in the applicant.

When considering a change in the capital cost of the project, the CN Program generally requires an amended application when the increase in the total capital expenditure exceeds 12 percent or $50,000, whichever is greater.[10]

2.6 A CN is valid for two years. RCW 70.38.125(1). One six-month extension may be granted if substantial and continuing progress is being made toward the commencement of the project. *Id.* A CN may be granted on a conditional basis. *See* RCW 70.38.115(4); WAC 246-310-490(3).

The Alliance's Application

2.7 The Alliance is a joint venture by MultiCare and Franciscan. Each party will have a 50 percent ownership in the Alliance project. AR 388, AR 393, AR 464 (Letter of Intent dated November 14, 2014), and AR 466 (Statement of Mutual Intent dated December 12, 2014). The Alliance applied to establish a 120-bed psychiatric hospital in Pierce County on the campus of MultiCare's existing Allenmore Hospital, 1901 South Union Avenue, Tacoma, Washington. The capital expenditure for the project is $40,642,925. AR 388. The Alliance anticipates the facility will become operational on January 1, 2018. *Id.* Under this timeline, the first year of operation will be 2018 and the third year of operation will be 2020. Dividing the total project cost by the number of beds results in a cost per bed of $338,691.04.

2.8 On January 8, 2015, the Program sent a screening letter to the Alliance requesting additional clarification regarding the Alliance's application. AR 1248-1251.

[10] *See* RCW 70.38.115(11). While this subsection refers to nursing home projects, the Program has used this measurement for other CN projects.

On February 23, 2015, the Alliance responded to the Program's screening letter, including a signed letter of intent verifying the participation of both MultiCare and Franciscan in the psychiatric hospital project. AR 1262-1269 (Exhibit 20).

2.9 On October 5, 2015, the Program issued a Pivotal Unresolved Issue[11] letter to the Alliance as authorized by WAC 246-310-160(2)(b). *See* AR 2427-2430. The Program requested the Alliance provide additional information and documents in support of its application. On November 19, 2015, the Alliance submitted its Pivotal Unresolved Issue response. AR 2523–2616. The Alliance's response included updated resolutions from the MultiCare and Franciscan board of directors. AR 2535 (Resolution of MultiCare Board of Directors, dated November 11, 2015); AR 2537 (Resolution of the Executive Committee of the Board of Directors of Franciscan, dated October 29, 2015); AR 2539 (Franciscan approval, dated December 18, 2014); AR 2541 (MultiCare Resolution of the Member of the Alliance, dated June 2, 2015); and AR 2543-2563 (unexecuted Member Agreement between MultiCare and Franciscan). The Alliance also provided an unexecuted draft real estate purchase and sale agreement, including condominium terms. AR 2565-2585.

Signature's Application

2.10 Signature proposed a 174-bed (153 adult beds and 21 adolescent beds) psychiatric facility for the Pierce County planning area. It provided an executed purchase and sales agreement for a parcel of land that totaled 4.9 acres in the Madison

[11] The term "pivotal unresolved issue" is not specifically defined. It is a mechanism for the Program to submit a written request for additional information following the completion of the public hearing or public comment period and extends the review period, *See* RCW 70.38.115(8). The pivotal unresolved issue written request is not considered *ex parte* contact under WAC 246-310-090(1).

Park site. AR 90-108 (Attachment 9). The site address is identified as 4100 South 19th Street, Tacoma, Washington. AR 15; AR 91. Signature's application stated that in the event its project is approved, the City of Tacoma will require a conditional use permit. AR 9; AR 15. If it received the requested CN, Signature anticipated the conditional use permit process would take six to seven months. *Id.* This assumes no appeals are filed. AR 120-121 (Attachment 12). The project will also require modification to an existing Wetland Permit or "have to keep additional development outside of a wetland buffer that crosses the southwest portion of the site." *Id. See also* AR 15.

2.11 Signature will construct the hospital in space leased from Tacoma Life Properties, LLC, a limited liability corporation owned by Dr. Soon K. Kim. The capital expenditure for the 174-bed psychiatric hospital project would be $42,565,368. AR 10. Signature anticipated the facility would become operational on January 1, 2018. Under this timeline, the first full year of operation is 2018 and the third full year of operation is 2020. Dividing the total project cost by the number of beds shows the cost per bed to be $244,628.55.[12]

2.12 On October 5, 2015, the Program issued a Pivotal Unresolved Issue letter to Signature as authorized under WAC 246-310-190(2)(b). *See* AR 2422–2425. The Program requested Signature provide additional information and documents in support of its application. On November 18, 2015, Signature provided its Pivotal Unresolved Issue response. AR 2435–2441. The response included copies of an email with Patricia Beard of the City of Tacoma Economic Development Office, dated November 3,

[12] If, as discussed later, Signature's project was limited to 153 beds, the cost per bed would increase to $278,205.02.

2014, in which Ms. Beard anticipated that Signature's project would take six to seven months to receive all of the land use approvals assuming there were no appeals. AR 2438-39. Signature also provided Dr. Soon Kim/Signature Health Services LLC's Statement of Cash and Liquid Assets, dated August 6, 2015. [13] This statement claimed Dr. Kim held $76.8 million in cash and liquid assets. AR 2441.

WAC 246-310-210 "Determination of Need

2.13 Under WAC 246-31-210(1), a CN applicant must demonstrate there is a need for the proposed services. Chapter 246-310 WAC does not specifically provide for a psychiatric bed forecasting method. RCW 70.38.115(5) and the State Health Plan[14] allow for discretion in selecting and applying evaluation methods to determine psychiatric bed need. The applicant examines what is the appropriate number of psychiatric beds needed per 100,000 people in the population. This figure is known as the use rate. Currently, the use rate is 27.25 beds per 100,000 people.[15] Need is calculated by multiplying the use rate times the anticipated population growth of the area. The anticipated need is then deducted from the known existing bed number. Given the size of hospital projects, the projection for need for a hospital project covers a longer period of time than other CN projects. Hospital need projections can measure

[13] As part of its application Signature provided an Organization Structure chart. AR 73 (Attachment 2). This chart represents an entire organizational structure, starting with Dr. Soon K. Kim and sets forth the interlocking limited liability corporations and their roles in the project.
[14] The forecasting methods and definitions contained in the 1987 Washington State Health Plan are traditionally used in calculating bed need. While the State Health Plan was "sunset" in 1989, the concepts and methodologies it contains remain a reliable tool for managing the growth of healthcare services such as psychiatric beds.
[15] This use rate figure represents the average use rate of the Northwest states (Alaska, Idaho, Montana, and Oregon). The use rate in the 1987 State Health Plan was 13 beds per 100,000 people. That use rate is now considered too low.

out at least six, and sometimes as many as 15 or 20, years into the future depending on the size of the project.

2.14 The Alliance calculated bed need using a 15-year planning horizon (2014-2029). AR 425-427; AR 2470-2471. The Alliance's 120-bed project did not include beds for adolescent patients. Using the medium population forecast from the Office of Financial Management released in 2012 (the last full year for which data was available during the evaluation), a 27.30 use rate per 100,000 people, and subtracting the current 23-bed psychiatric capacity in Pierce County, the Alliance projected need for 177.29 adult beds by 2029. AR 426-427 (Table 16); AR 2471. The Alliance's need calculation would support its 120-bed project.

2.15 Signature also calculated bed need using a 15-year planning horizon (2014-2029) as well as using a 20-year planning horizon (2014-2034). AR 26-29. Signature's 174-bed project included 153 adult beds and 21 adolescent beds.[16] Signature provided both adolescent and adult population estimates beginning with the 2014 application year and measuring bed need at six, seven, 10, 15, and 20 years. AR 26-29; AR 2468-2469. Signature calculated a total bed need using the Office of Financial Management medium population forecast released in May of 2012, the 27.25 use rate per 100,000 people, and the current 23-bed capacity. AR 27. Using these figures, Signature projected need for 198 psychiatric beds for people age 12 or older by 2029, and 208 beds by 2034. AR 29. Excluding adolescents, Signature's calculations

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[16] As detailed below, 30 adolescent beds were approved in the planning area after Signature submitted its application. Signature subsequently stated that although it offered to provide a 21-bed adolescent unit, it sought to provide a 174-bed psychiatric hospital whether or not adolescent beds were included. *See* Signature's Closing Brief, pages 6-7.

show a need for 174 adult beds by 2029, and 183 adult beds by 2034. Even without considering adolescent need, the need calculations for adult beds support Signature's project.

2.16 Adolescent bed need and adult bed need are calculated separately, as adolescent patients are not housed with adult patients. The Program performed separate adolescent and adult need calculations when evaluating Signature's need calculations. AR 2472-2473. However, in its evaluation the Program considered information that did not exist at the time Signature submitted its application. On April 4, 2015, the Washington State Legislature passed Second Substitute Senate Bill 6312 (2014 c 225 sec. 106) which amended RCW 70.38.111 to exempt psychiatric beds from certificate of need review when the beds are converted from existing acute care beds.[17] *See* AR 2467. On April 21, 2015, the Program issued CN #1543 to MultiCare to allow the conversion of 30 acute care licensed beds to psychiatric beds at its Tacoma General Hospital facility for the development and operation of a child/adolescent mental health service program.[18]

2.17 On April 22, 2015, the Program sent a supplemental screening letter to Signature asking the following:

> 1. Please explain the impact on your proposed project that the increase of 30 beds to provide child/adolescent mental health services by

[17] Subsection 106 of S2SSB read: "(10) To alleviate the need to board psychiatric patients in emergency departments, for fiscal year 2015 the department shall suspend the certificate of need requirement for a hospital licensed under chapter 70.41 RCW that changes the use of licensed beds to increase the number of beds to provide psychiatric services, including involuntary treatment services. A certificate of need exemption under this section shall be valid for two years." This subsection was renumbered to RCW 70.38.111(11) pursuant to Engrossed Second House Bill 2450 (chapter 31, Laws of 2016) effective June 28, 2016. The renumbering did not amend the language.
[18] Tacoma General Hospital is located in Pierce County, Washington.

MultiCare Tacoma General Hospital and 20 psychiatric beds by MultiCare Auburn Medical Center would have on our project. In other words, would the conversion of these beds to psychiatric beds impact your proposal?

2. If necessary, please make revisions to all applicable areas within the application.

AR 382-383.

Signature did not view the amendment to RCW 70.38.110(10), or MultiCare's bed conversion project, to affect its proposed 174-bed CN. Signature considered MultiCare's bed conversion as temporary (that is, for two years). Signature contended MultiCare's 30-bed conversion project should not be counted for need calculation purposes because Signature interpreted the RCW 70.38.111(10) exemption to apply only to adult care beds. *See* AR 2520-2522.

2.18 As currently written, the RCW 70.38.111(10) exemption does not limit its application to adult care beds. MultiCare's conversion of 30 acute care beds to adolescent psychiatric beds addresses the adolescent psychiatric bed need for the foreseeable future. *See* AR 2473 (Tables 13 and 14). In evaluating the Alliance and Signature applications, the foreseeable future means through 2029.

2.19 Based on the Application Record, the reliability of the underlying population and patient data used by the parties, the Review Officer finds that need exists for 176.8 adult psychiatric beds in Pierce County by 2029. AR 2472-2473 (Table 12). The Alliance proposes a 120-bed project. Dividing the $40,642,925 project cost by 120 beds shows a per bed cost of $338,691.04. Signature proposes either a 174-bed project (assuming all beds are used for adults) or a 153-bed project (that is 174 total

beds minus the 21 adolescent beds). Dividing the $42,565,368 project cost by 174 beds shows a per bed cost of $244,628.55. In the alternative, a 153-bed project shows a per bed cost of $278,205.02. Both the Alliance's project and either version of Signature's proposed project will meet the psychiatric bed need criteria in the Pierce County planning area under WAC 246-310-210(1).

2.20 Signature argues its project is superior to the Alliance's 120-bed project, as it more closely meets the projected 176.8 bed need in 2029.[19] This argument is less a need argument and more a consideration of which of the two applications is superior under WAC 246-310-240(1) because the need consideration primarily serves to determine how many, if any, beds are needed rather than who can best address that need. Providing more beds does not, in and of itself, create superiority. The total number of beds in a project is one factor for consideration. Need analysis also considers other factors, such as expected fill rate (how many beds are actually occupied at a given time) and the accuracy of the bed need calculations that are made 15 years into the future.[20] See TR[21] 236-238 (Fox). Alliance and Signature each explained their respective need calculations to allow a review of each project under WAC 246-310-210(1).

2.21 During the application process, Signature considered an "optimal solution," namely the approval of both Signature's and the Alliance's projects.[22]

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[19] *See* Signature's Opening Brief, pages 44-45.
[20] For example, one of the assumptions used in calculating need is that the planning area's population will consistently grow throughout the 15-year planning horizon. Like any assumption, it may not be true in this case.
[21] Transcript of Proceedings.
[22] *See* Signature's Opening Brief, pages 4-5, and 55-62; Signature's Closing Brief, page 4.

Signature reached this conclusion by calculating need on a 20-year forecast horizon, which is a forecast horizon that has been used in some past CN evaluations. *See* AR 425; AR 2249-2250. Signature contends using the 20-year horizon and calculating need using the total population figure (children, adolescents, and adults) is consistent with the American College of Emergency Physicians methodology approach. AR 135, 171-172. Using a 20-year horizon, total population approach, Signature calculated need for 251 beds by 2034. AR 1378. But Signature's total population figure includes adolescents and there is no need for adolescent psychiatric beds through at least 2029. *See* AR 2473 (Tables 13-14). Signature argues the benefits outweigh the potential costs of a bed surplus. In reaching this conclusion, Signature's alternative approach relies on the Division One Court of Appeals decision in *Providence Health & Services - Washington v. Department of Health*, 194 Wash. App. 849, 378 P.3d 249 (2016). Signature argues this approach would foster market competition, improve patient access, and provide patients with a choice of providers. Signature argues the Program failed to consider this alternative.[23] While Signature discussed this approach in the application and in its briefing, it rejected it as a potential alternative and did not specifically offer this approach as an option under its WAC 246-310-240(1) analysis, so Signature never seriously considered this alternative in its application. *See* AR 62-63; AR 2502-2503.

[23] *See* Signature's Closing Brief, page 4. Generally, an issue raised for the first time in a reply brief is too late to warrant consideration. *See Cowiche Canyon Conservancy v. Bruce Bosley*, 118 Wash.2d 801, 809, 828 P.2d 549 (1992). Given that there was some discussion of this argument in both the Application Record and by Signature's expert witness at hearing, it is appropriate to address the issue.

2.22 Signature's reliance on *Providence Health* holding does not support its two facility solution. In that case, the University of Washington applied for a CN to add 79 acute care beds to its Seattle facility even though the traditional numeric need methodology did not demonstrate need and other facilities in the planning area were underutilized. In determining the need for additional beds, the court held that the Program need not rely on the traditional numeric methodology in the State Health Plan but could rely on an alternative methodology, which included factors such as accessibility to underserved groups, expansion of programs with better results, and promotion of training programs, to indicate a need for additional beds. *Providence Health*, 194 Wash.App. at 862-864.

2.23 The *Providence Health* alternative approach does not apply here. There was a need for 147.5 psychiatric beds in 2014 and that need grows to 176.8 beds by 2029. While calculating greater numeric need, Signature has not addressed the unique factors considered in *Providence Health* but instead focused on in-migration (patients coming into the planning area) from Federal Way, Joint Base Lewis-McChord, and Western State Hospital.[24] Nor does the current situation require use of a 20-year planning horizon. The correct forecast horizon is 15 years because it reduces the potential for beds to be built before they are needed, thus remaining idle and unused for a long period of time. The need calculation does not support Signature's proposed 251-bed need alternative.

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[24] *See* Signature's Opening Brief, pages 55-57.

2.24 Under WAC 246-310-210(2), a CN applicant must prove it will provide services to all residents of the service area, including low-income, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups. The Alliance provided its draft admission and charity care policies. AR 507-546 (Exhibit 11: Financial Assistance Policy); AR 547-564 (Exhibit 12: Admission Policy); and AR 2476. The Alliance anticipates projected Medicare revenues of 26.6 percent and Medicaid revenues of 18.7 percent of its total hospital revenues. AR 2476. The Alliance projects its charity care percentages of 3.00 percent of total revenue or 5.49 percent of its adjusted revenue. AR 2477 (Table 16). The 3.00 percent of total revenue figure exceeds the Puget Sound regional average; the 5.49 percent of adjusted revenue is below the Puget Sound regional averages.

2.25 Signature is currently not a Pierce County provider. In support of its application Signature provided a copy of its draft admissions policy. AR 256-257 (Appendix 15) and AR 2474-2475. Signature's admission policy would allow the admission of patients at its psychiatric hospital without regard to race, color, religion, sex, and national origin. Signature anticipates Medicare revenues of 26.6 percent and Medicaid revenues of 18.7 percent of its total hospital revenues. Signature projects its charity care percentages of total revenue at 3.33 percent of total revenue or 5.97 percent of adjusted revenue. AR 2476 (Table 15). The 3.33 percent of total revenue figure exceeds the Puget Sound regional average; the 5.97 percent of adjusted revenue is below the Puget Sound regional average.

2.26 Alliance disputes the accuracy of Signature's charity care percentages, as Signature considers bad debt (services that were billed to the patient but cannot be collected) as part of its charity care figures.[25] Signature's expert acknowledges the general principle that bad debt cannot be considered as charity care, but claims the definition of bad debt has changed over time.[26] See TR 486 (McGuick). Signature submitted a proposed charity care policy with its application, which permitted a review of its charity care policy. *See* AR 258-260 (Attachment 16). As currently written, Signature's proposed draft charity care policy does not disqualify it under WAC 246-310-210(2) but will be considered under a superiority analysis.

2.27 Review of the admission policies, charity care policies, and Medicare eligibility certification and policies reveals both the Alliance and Signature meet the criterion under WAC 246-310-210(2).

<u>WAC 246-310-220 "Financial Feasibility"</u>

2.28 Under WAC 246-310-220, a CN applicant must prove its project is financially feasible. Specifically, the applicant must demonstrate that it can meet the capital and operating costs of the project; that the cost of the project will probably not result in an unreasonable impact on the costs for health services; and that the applicant can appropriately finance the project.

2.29 WAC 246-310-220(1) requires the applicant prove its project can meet its immediate and long-range capital and operating costs. The Department of Health's

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[25] *See* Alliance Post-Hearing Brief, pages 9-11.

[26] *But see* WAC 246-453-010 which defines charity care as "appropriate hospital-based medical services provided to indigent persons" whereas bad debt is defined as "uncollectible amounts, excluding contractual adjustments, arising from failure to pay by patients *whose care has not been classified as charity care*." (Emphasis added.)

Hospital and Patient Data Systems Office examines the applicant's pro forma statement and performs a financial ratio analysis.[27] The ratio analysis examines the applicant's immediate and long-term ability to finance the proposed project. The examination covers the first three years of operation.

2.30 The Alliance's 2018-2020 pro forma statement covers the first three years of its operation of the proposed 120-bed project. AR 570-574. The Alliance's projected revenues and expenses reveal the project would suffer a net loss in 2018, but would experience a net profit in years 2019 and 2020. The Department's Hospital and Patient Data Systems Office examined the current and projected debt ratios for the project.[28] AR 1353-1357; AR 2485. There was no long-term debt because the Alliance hospital does not yet exist. The Alliance's financial ratios were derived from the terms it provided for its proposal project. Richard Ordos (the Department of Health Hospital and Patient Data Systems evaluator) examined the financial strength of the Alliance partners (MultiCare and Franciscan). Given the financial strength of the MultiCare and Franciscan organizations, Mr. Ordos concluded the Alliance project possessed the necessary financial capacity to proceed with the project and could meet the financial feasibility and cost containment criteria. AR 1353-1354.

2.31 Signature's 2018-2020 pro forma statement covers the first three years of the operation of the proposed 174-bed project. AR 114-118 (Attachment 11).

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[27] While the Program's application form requires an applicant provide a pro forma statement as a part of its application, the term is not specifically defined in chapter 70.38 RCW or 246-310 WAC. "Pro forma" is used to describe accounting, financial, and other statements or conclusions based upon assumed or anticipated facts. *See* Black's Law Dictionary, Sixth Edition, page 1212 (1990).

[28] The ratios are: long-term debt to equity; current assets/current liabilities; assets funded by liabilities; operating expenses/operating revenues; and debt service coverage.

Signature's projected revenues and expenses reveal the project would suffer a net loss in 2018, but would experience a net profit in years 2019 and 2020. AR 115. The Department Hospital and Patient Data Systems Office examined the current and projected debt ratios for the project.[29] Signature has no long-term debt because the hospital does not yet exist. The Signature financial ratios were derived from the terms Signature provided for its proposed project. Richard Ordos examined Signature's financial ratios. AR 348-352. Based on that information Mr. Ordos determined that Signature's 174-bed project could meet the immediate and long-range capital expenditures and operating costs. AR 249-350; AR 2481-2483.

2.32 Signature submitted a second pro forma statement which addressed a 120-bed project.[30] AR 342-346 (Attachment 21). Normally, Signature would need to submit a third pro forma statement in support of a 153-bed proposal (the adult bed portion of its 174-bed application). However, Signature's $42,565,368 capital expenditure would enable both the 120-bed and the 174-bed projects to show a profit by year three. Because the 153-bed project was "bracketed" by two profitable projects, Signature reasoned that a 153-bed project would similarly meet the financially feasible criterion. TR 389-396. The Program conceded this point. TR 395-396. The Review Officer accepts the "bracketing" under the specific facts in this case.[31]

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[29] *Id.*

[30] The Hospital and Data Systems Office did not evaluate the 120-bed project.

[31] Nothing in this Final Order relieves applicants in other cases from providing a pro forma in any future certificate of need case. Applicants are required to prove that their application meets all of the relevant CN criteria. *See* WAC 246-10-606.

2.33 Based on the Application Record and the above analysis, both the Alliance and Signature meet the WAC 246-310-220(1) criterion.

2.34 Under WAC 246-310-220(2), an applicant must prove the proposed project's costs, including any construction costs, will probably not result in an unreasonable impact on the costs and charges for healthcare. This criterion can be broken down into two questions:

1) Will the project costs have an impact on the costs and charges for health services?
2) If there is an impact on the costs and charges for health services, is that impact a reasonable or an unreasonable one?

The Alliance

2.35 The Alliance's 120-bed facility in Pierce County would have a capital cost of $40,642,925. To show it met the WAC 246-310-220(2) criterion, the Alliance submitted the following documents:

(1) Letter of Intent Regarding Joint Venture;
(2) Letter of Zoning Conformance;
(3) Allenmore Property Deed;
(4) Contractor Letter; and
(5) Financial Commitment Letters.

See AR 392; AR 2487-2488. The Alliance would own and operate the hospital, which it would develop as a commercial condominium. The annual condominium dues would be $324,000. MultiCare would provide management services. *See* AR 2587-2588.

2.36 Signature questioned the accuracy of the Alliance's capital cost figure on several grounds. First, Signature contends the Alliance underreported its capital cost

figure, as the Alliance failed to specifically include the demolition costs (the removal of the old medical building on the proposed project site) in its capital cost figure. *See* AR 442 (Table 23: Estimated Capital Costs); AR 566 (Exhibit 13: Sellen Construction Cost Estimate). Dr. Frank Fox reviewed the Sellen Company construction cost estimate worksheets and one of the worksheets contained the information related to the demolition costs. TR 251 (Fox). Dr. Fox's review of the worksheet showed that approximately $800,000 was allotted for the demolition. Signature presented no evidence to contradict Dr. Fox's statement. The Review Officer finds Dr. Fox's testimony on the inclusion of the demolition costs to be credible. The Alliance's capital cost figure accurately includes the cost of the demolition of the medical office building.

2.37 Second, Signature contends the Alliance failed to provide sufficient documentation to show the Alliance held a sufficient interest in its proposed hospital project site.[32] Signature argues that Alliance failed to show site control, which requires control over the land on which the facility was located.[33] Signature argues MultiCare (one of the Alliance partners) either: (1) Did not properly convey this land to the Alliance under the draft real estate purchase and sales agreement (thereby evidencing that the Alliance did not have site control over the land); or (2) MultiCare did convey the land to the Alliance and the Alliance failed to include the cost of the land in the project's costs. Signature characterized the Alliance condominium agreement as a lease and

[32] Sufficient interest includes clear legal title for the proposed site (land and facility) or a lease for at least five years with options to renew for not less than a total of 20 years in the case of a psychiatric hospital.
[33] *See* Signature's Opening Brief, pages 31-36; Signature's Closing Brief, pages 17-25.

contends the condominium agreement/lease failed to show the Alliance had control over the facility for at least five years with options to renew for no less than 20 years.

2.38 Signature's arguments are not persuasive. The Alliance provided a statutory warranty deed dated December 18, 2004, showing that MultiCare (an Alliance partner) controlled the Allenmore Medical Center land in question. *See* AR 495-500 (Exhibit 8). The statutory warranty deed contained a legal description of the land in question. AR 498. MultiCare retains control over the land and it is not selling or gifting the land to Alliance for this project.[34]

2.39 The Alliance also submitted draft agreements to create a commercial condominium with two airspace condominium units on the Allenmore campus. Condominium A would consist of approximately 88,805 square feet and would include all improvements and fixtures constructed thereon as part of the Alliance's project. AR 2561; AR 2568. That the airspace condominium was the property being transferred, and not the land on which it sits, is evidenced by a description of the size of the property being conveyed (88,805 square feet – the footprint size of the Alliance's proposed four-story psychiatric hospital building). AR 414; AR 493. MultiCare will continue to own the land underneath the airspace condominium and the Alliance will pay $324,000 per year in condominium dues. AR 571; TR 99, TR 123 (Kohler); TR 275 (Fox). As there is no land being conveyed by sale or gift, there is no cost of land that must be included in the project's cost.

[34] Whether a sale or a gift, the price would constitute a capital cost. *See* RCW 70.38.025(2) and WAC 246-310-010(10) (definition of capital expenditure).

2.40 Signature relies on the language contained in the Alliance's draft real estate purchase and sales agreement (real estate agreement) in support of its argument that the MultiCare land should be included in the capital cost of the Alliance's project.[35] Paragraph 1.5 of the real estate agreement uses the word "land" within the definition of the term "property" while the term "project" is separately defined as the building. *See* AR 2566-2567. The Alliance disagrees.[36]

2.41 Although the terms "property" and "project" are separately defined, a full understanding of the Alliance's application requires a more careful reading of the entire real estate agreement. MultiCare is identified as the seller of the land depicted in the "property." As discussed in paragraph 2.39 above, the "property" and the "project" are both 88,805 square feet in size. The land is also described in relation to the condominium agreement. A careful reading shows the word "land" describes the location of the condominium (that is, the location of the project) rather than transferring the land beneath the condominium. Reading the real estate agreement, the management services agreement, the condominium agreement, and the statutory warranty deed together, it is clear that there is no "land" being sold or transferred as a result of the Alliance's project. Thus, the Alliance did not omit the cost of the land as Signature argues. There is no capital cost error in the capital cost of the Alliance project.

2.42 Signature further argues the Alliance failed to prove the site control requirement because it did not include a lease. This argument fails. The Alliance is not

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[35] *See* Signature's Closing Brief, pages 17-22.
[36] *See* Alliance's Post-Hearing Brief, pages 24-25; Alliance's Reply Brief, pages 12-13.

leasing the hospital building from MultiCare. Rather, the Alliance is building the hospital and will own it outright. TR 99 (Kohler). There is sufficient evidence in the Alliance's application (a statutory warranty deed showing MultiCare already owns the site; a draft purchase and sales agreement conveying to the Alliance the condominium airspace where the hospital will built; and draft condominium terms) to show the Alliance has site control. *See* AR 495-500; AR 2561-2563; AR 2564-2585. *See also* TR 99-101 (Kohler). Alliance meets the site control issue here.

Signature

2.43 Signature proposed its new 174-bed facility in Pierce County at a capital cost of $ 42,565,368. To show that it complied with the WAC 246-310-220(2) criterion, Signature submitted the following documents:

(1) Non-binding Estimate of Construction Costs;
(2) Documentation of Site Control;
(3) Purchase and Sales Agreement;
(4) Letter of Funding Commitment; and
(5) Land Use Documentation.

See AR 68; AR 2486-2487. Approval of Signature's project would require a condition to submit executed copies of documentation of the land use approval for the site. AR 2486.

2.44 Signature submitted an executed Commercial and Investment Real Estate Purchase and Sales agreement related to the project site. The agreement identified the location of the site, the purchase price, and outlined the roles between the purchaser of

the property (Signature Healthcare Services LLC) and the seller (Jemstone LLC). AR 90-108; AR 2486.

2.45 As with other Signature hospital construction projects, Dr. Kim will fund Signature's construction through his wholly owned real estate subsidiaries. In Signature's application, the real estate subsidiary (Tacoma Life Properties LLC) would lease the facility to the hospital (Tacoma Behavioral Healthcare Hospital LLC). AR 73. The draft agreement between the parties outlines the roles and responsibilities for each party.

2.46 The Alliance contends Signature does not show that it has sufficient site control.[37] The Alliance contends: (1) Signature is the applicant and the key subsidiaries (Tacoma Life Properties LLC and Tacoma Behavioral Healthcare Hospital LLC) do not currently exist; and (2) Signature did not show that it can use the site for the stated purpose, given the current zoning and need for environmental reviews.

2.47 The first issue is the existence of Signature's subsidiaries. As stated in Finding of Fact 2.45 above, Signature (the CN applicant) will create both a real estate subsidy (Tacoma Life Properties LLC) and a hospital (Tacoma Behavioral Healthcare Hospital LLC). All of the organizations flow from Dr. Kim's ownership interest. *See* AR 73. Although Signature's expert did not understand the intricacies of Signature's organizational structure (*see* TR 460 (McGuick)), chapter 70.38 RCW as currently written does not require an applicant to use a specific ownership model. A CN applicant must sufficiently describe the various facets of the project to enable a review of whether

[37] *See* Alliance Post-Hearing Brief, pages 11-16.

the project meets the CN criteria. Here Signature provided sufficient information to allow for a review of whether its project meets the CN requirements for ownership.[38]

2.48 The second issue relates to Signature's chosen project site. Signature contacted Pat Beard of the City of Tacoma Economic Development Division regarding a zoning reclassification of Signature's application site from the residential and commercial classification to an all commercial development classification that would permit Signature to construct its proposed hospital project. AR 120-121. Given the location and the need for mitigation (landscaping, high quality design, infrastructure upgrades), Ms. Beard anticipated it could take six to seven months to rezone the land to allow Signature to construct its hospital "assuming there are no appeals." *Id.* Signature's expert healthcare consultant accepted the six to seven month period as realistic. *See* AR 9; TR 436-438 (McGuick). The Alliance's land use expert characterized Ms. Beard's email as being a "very preliminary feasibility analysis." TR 182 (Halsan). He expressed several concerns that could extend the rezoning period beyond the six to seven month period to a much longer period, including neighbor opposition and neighborhood compatibility. TR 186; TR 196-198 (Halsan). Generally speaking, these types of issues can delay a project for months or even years. TR 198 (Halsan). The Alliance's expert also gave a range of cost to accomplish the zoning mitigation. TR 198-200 (Halsan). Neither Signature's expert nor its pro forma statement identified the cost to achieve the above-identified mitigation and rezoning necessary to comply with the land use requirements. *See* AR 115-118.

[38] Parties may submit drafts for review. By submitting drafts some issues may remain unanswered, which is why CN applications may be granted on a conditional basis. *See* RCW 70.38.115(4).

2.49 Bart Eggen is an Executive Director in the Department of Health's Office of Community Health Systems and reviews evaluations prepared by the CN Program. Mr. Eggen has no expertise as a land use planner. TR 598 (Eggen). Despite his lack of expertise as a land use planner, Mr. Eggen has derived general experience from his years of reviewing CN applications. Because Mr. Eggen believed Signature could eventually build and run a psychiatric hospital in Pierce County, the Program passed Signature on each CN criteria including this issue. TR 659 (Eggen). However, in a case like this where an applicant's project requires additional land use or zoning, the Program does not immediately issue a CN or a conditional CN to the applicant. This is significant because by first issuing the letter of intent, the Program enables the applicant to complete the land use/zoning issues without using up the two-year period provided to the applicant to commence the CN project. TR 598 (Eggen). Unlike Signature's project, Alliance's proposed site is currently zoned for hospital use. Assuming without finding Signature's mitigation costs are included in its capital costs, and assuming without finding it can complete the land use and zoning requirements within the six to seven month estimate, Signature's project would start six to seven months behind the Alliance's project.

2.50 Based on the Application Record and the above analysis, both Alliance and Signature can meet the WAC 246-310-220(2) criterion. However, the Alliance's project will provide patient access in a shorter period of time, given the minimum six to seven month delay for Signature to obtain the land use or zoning permits.

2.51 Under WAC 246-310-220(3), the applicant must prove it can appropriately finance its project.

The Alliance

2.52 The capital expenditure (construction and equipping the building; all construction and consultation fees; and Washington sales tax) associated with Alliance's project is $40,642,925. The Alliance's project will be funded by cash on hand from MultiCare and Franciscan (partners in the Alliance venture) and they provided financial commitment letters demonstrating their ability to fund the project. AR 568-569 (Exhibit 14); AR 2489-2490. To further demonstrate the project's financial soundness, the Alliance provided both current (2013) and historical (2011 and 2012) audited financial statements for MultiCare and Franciscan. AR 575-824 (Exhibit 16); AR 2489-2490.

2.53 Signature contends the Alliance cannot appropriately finance its project. Signature infers this from: (1) the Alliance qualifying for a five million dollar grant from the state; and (2) news articles indicating the Alliance will seek other sources of funding for the project. The Alliance did qualify for the five million dollar grant as a result of 2SSB 6312 but not within the snapshot in time (the time period under which the project is considered). The Alliance relied on the information and resources on hand during the relevant period. There is no evidence the Alliance partners (MultiCare and Franciscan) did not have the existing funds to finance the project as described in the Alliance's application.

2.54 Signature submitted copies of newspaper articles to suggest the Alliance was seeking funding in addition to or to replace the existing joint partner funding. The newspaper articles were written on May 3, 2016, and July 4, 2016, which is clearly after the Program's evaluation. The newspaper articles are outside the snapshot in time (the time period under which the project is considered), as the Program issued CN #1563 on February 1, 2016. Signature implies the right to a de novo review allows for the presentation of evidence that supports its case, even if that evidence did not exist when the snapshot in time was taken. *See University of Washington Medical Center v. Department of Health*, 164 Wash.2d 95, 103, 187 P.3d 243 (2008).

2.55 The Washington Supreme Court's decision in *University of Washington* held that the CN statutes and rules anticipated that the decision would be made quickly. Requiring the Presiding Officer to admit evidence after the snapshot in time undermines the statutory objective of expeditious decision making. *See University of Washington*, 164 Wash.2d at 104. The newspaper articles provided by Signature do not justify accepting evidence from outside the snapshot in time in this case. Even if they were considered, the information in the newspaper articles does not contradict the evidence that the Alliance partners (MultiCare and Franciscan) possessed sufficient monies to fund the project at the time of the CN application or beyond. It merely shows that the Alliance sought additional revenue from available sources to use in place of existing cash reserves. Signature's argument fails.

<u>Signature</u>

2.56 The capital expenditure (purchase of the land; construction and equipping the building; all construction and consultation fees; and Washington sales tax) associated with Signature's project is $42,565,368. Signature will receive initial capital for the project of $14,897,476 from Dr. Kim, which represents 35 percent of the total capital expenditure amount. Signature will borrow the remaining 65 percent of the capital expenditure amount through commercial banks loans. AR 110. Signature provided reference letters from three banks who would consider (but not guarantee) loaning money to complete Signature's project. AR 111-113 (Attachment 10).

2.57 The Alliance disputes that Signature has sufficient funding to enable it to construct its hospital project, as Signature's three bank letters do not specifically make formal commitments to lend money. *See* AR 111-113. Letters provided to Signature by the Pacific Western Bank and the Torrey Pines Bank state that the letters are not a commitment to lend. *See* AR 111 and 112. As written, the letters indicate: (1) the banks in question have previously financed multiple psychiatric hospital projects for Dr. Kim and Signature Healthcare; and (2) the banks conclude Dr. Kim and Signature Healthcare Services are sufficiently creditworthy. The letters provide sufficient proof the banks anticipate lending funds to Signature for its Tacoma project.

2.58 Richard Ordos of the Department of Health Hospital and Patient Data Systems Office considered the three bank letters in his review. Mr. Ordos found that Signature's letters show it had sufficient financial strength to obtain the remaining 65 percent loan necessary to finance the construction of the Tacoma facility. AR 351.

Therefore, the bank letters sufficiently prove Signature can obtain bank funding to complete its proposed Tacoma project.

2.59 Based on the Application Record and the above analysis, both the Alliance and Signature meet the WAC 246-310-220(3) criterion.

WAC 246-310-230 "Structure and Process of Care"

2.60 Under WAC 246-310-230, an applicant must prove it can provide for adequate staffing; appropriate organizational structure and support; conformity with licensing requirements; continuity of health care; and the provision of safe and adequate care.

WAC 246-310-230(1)

2.61 Under WAC 246-310-230(1), an applicant must prove it can adequately staff the CN project. The Alliance anticipates all 120 beds will become operational by January 2018. Under this timeline 2018 represents the first full year of operation and 2020 represents the third full year of operation. In projecting staffing levels, the Alliance projects a 68 percent occupancy rate in 2018, an 83 percent occupancy rate in 2019, and an 87 percent occupancy rate in 2020. AR 1259; AR 2493. The Alliance therefore needs sufficient staffing to provide care to those occupancy levels. The Alliance partners currently operate 11 hospitals (seven Franciscan hospitals; four MultiCare hospitals) in Washington and are both familiar and experienced in staff recruitment and retention. The Alliance will recruit the majority of staff from its existing MultiCare and Franciscan facilities in 2018.

2.62 Signature expects all 174 hospital beds will be operational by January 2018. Using this timeline, year one is 2018 and year three is 2020. Signature anticipates achieving an 18 percent occupancy rate in 2018, a 53 percent occupancy rate in 2019, and a 63 percent occupancy rate in 2020. AR 2491. Signature projects that its nursing, clinical, and administrative staff would increase over this three-year period to accommodate the increases in occupancy. Signature operated 13 psychiatric hospitals in several states (Arizona, California, Illinois, Nevada, and Texas) at the time it filed its CN application, which provides it with sufficient experience in recruiting and retaining staff.

2.63 The Alliance and Signature each question the other's staffing cost assumptions. This includes the number and type of staff employed (registered nursing or mental health workers) and the expenses related to the applicant's selected staffing models (salaries and benefits). For example, the Alliance used historical data from Pierce County and estimated benefit costs (28 percent of salaries). Signature assumes a lower estimated benefit cost (17 percent of salaries) based on a corporate-wide (more national) model. Comparing the Alliance (a not-for-profit corporation) and Signature (a for-profit corporation) staffing assumptions results in an "apples to oranges" comparison. Neither the Alliance nor the Signature staffing system is clearly superior to the other for that reason.

2.64 The parties also differ on the organizational structure they choose to follow. The Alliance follows an integrative behavioral health and physical healthcare model, which integrates the treatment of psychiatric patients with comorbidities (medical

conditions other than psychiatric). The Alliance supports this integrative mode by co-locating the psychiatric facility with the Tacoma MultiCare Allenmore Hospital (an acute care hospital). This allows for a seamless and rapid transition from psychiatric to physical medical care. Signature believes a freestanding facility is less sterile and can offer unique programs (such as ball fields, rope courses, and outside areas). Signature will have treatment plans in place to address a patient's comorbidity needs and transfer agreements with local emergency rooms to address transport to other facilities when needed to address a patient's medical needs. Both the Alliance and Signature will have rapid response teams to address medical emergencies for psychiatric patients.

2.65 A February 2011 project by the Robert Wood Johnson Foundation determined that in contrast to evidence for clinical collaborative care models, there was little research evidence comparing the effectiveness of different organizational approaches in delivering the supportive care. Under the Robert Wood Johnson Foundation study, either care model can be effective as an organizational structure when providing psychiatric care. *See* AR 1220-1232.

2.66 Based on the Application Record and the above analysis, the Alliance and Signature would both meet the WAC 246-310-230(1) criterion.

<u>WAC 246-310-230(2)</u>

2.67 Under WAC 246-310-230(2), an applicant must prove its proposed project will provide the necessary ancillary and support services (working relationships with existing community clinics and independent healthcare providers that provide outpatient support to psychiatric patients or clients and provide a continuity of care to those

patients/clients post-hospitalization) needed to support the project's health services (here psychiatric beds). The Alliance will support the 120-bed psychiatric hospital project by using existing MultiCare and Franciscan ancillary and support services. The Alliance previously established the ancillary and support services with the community clinics and independent providers in Pierce County. *See* AR 2173-2241 (Letters of Support provided during the public hearing).

2.68 Signature listed the common ancillary and support services necessary to operate a psychiatric hospital and indicated that it will directly provide many of these outpatient support services. Signature has contacted community provides and intends to create the necessary working relationships with the ancillary and support service provider to address the necessary continuity of care services. AR 55. However, Signature has not yet formally established these working relationships with the local area providers necessary to comply with this criterion and did not provide a timeline for how long it will take to establish the working relationships.

2.69 Based on the Application Record and the above analysis, both the Alliance and Signature can meet the WAC 246-310-230(2) criterion.

WAC 246-310-230(3)

2.70 Under WAC 246-310-230(3), the applicant must prove the project will meet all of the applicable licensing requirements, including any applicable Medicare and Medicaid program requirements. The Alliance hospital will be a new psychiatric hospital and does not have a history of Medicare certification or inspections by the Department of Health. MultiCare and Franciscan (the Alliance partners) currently provide health

care services in the state of Washington. Neither MultiCare nor Franciscan has any history of criminal convictions related to the operation of a healthcare facility, licensure revocation, or other sanctions. They have a history of compliance with Medicare and Medicaid requirements. AR 2496-2497. The Joint Commission is an independent, not-for-profit organization that accredits and certifies hospitals in the United States. Joint Commission accreditations and certifications are nationally recognized as a measure of quality. AR 2497. The Program reviewed the accreditation information on the Joint Commission website, which did not reveal any adverse licensing actions for the hospitals operated by either MultiCare or Franciscan. AR 2496-2497.

2.71 Signature is a new provider to the state of Washington and has no history of Department of Health or Medicare certifications or inspections in Washington State. Signature operates 13 psychiatric hospitals located in other states, 12 of which show a history of compliance with Medicare and Medicaid requirements.[39] These 12 facilities do not have adverse licensing actions based on survey responses received by the Program. *See* AR 2495-2496. The Joint Commission website provides access to that history. All of Signature's 13 out-of-state facilities have Joint Commission accreditation and 12 of the facilities have national patient safety and quality improvement goals measured on the website. *See* AR 1424-1539; AR 2496. Based on Signature's history of Medicare and Medicaid compliance at its out-of-state facilities, and based on Signature's accreditation with the Joint Commission, it is reasonable to infer that

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[39] One facility in Glendale, Arizona, was determined to be below the national average during its 2013 survey. AR 2496.

Signature's proposed Pierce County facility will comply with all Medicare and Medicaid program requirements.

2.72 The Alliance argues Signature and its owner have a reputation for misconduct at their facilities in other states (California and Illinois) as well as a documented history of substandard care. This misconduct includes findings at other Signature facilities of substandard patient care, sexual assaults by patients on other patients, and the failure to ensure patient safety. AR 1654-1656; AR 2498-2500. Signature acknowledged these substandard care issues and has taken steps to ensure they are not repeated. Signature notes not a single Signature hospital has ever lost any license or any federal, state, or Joint Commission accreditation despite these patient safety mistakes. *See* AR 2499-2500; *see also* TR 511-512 (Sherbun). The Joint Commission materials the Program reviewed indicate that Signature did not lose its accreditation. Each of Signature's hospitals has undergone at least one quality of care review by the relevant state licensing facility. Signature's past patient safety issues are concerning but, as an organization, Signature has made seemingly good faith attempts to correct them.

2.73 Based on the Application Record and the above analysis, the Alliance and Signature both meet the WAC 246-310-230(3) criterion.

<u>WAC 246-310-230(4)</u>

2.74 WAC 246-310-230(4) requires the applicant prove the proposed project will promote continuity in the provision of healthcare. This requires the applicant prove the proposed project will not result in an unwarranted fragmentation of services and will

have an appropriate relationship to the service area's existing health system. The Alliance anticipates its new psychiatric hospital will become operational in January of 2018. The Alliance is a joint MultiCare-Franciscan project and these facilities have already established working relationships with other Pierce County healthcare providers. *See* AR 2173-2241 (Letters of Support provided during the public hearing); AR 2497-2498. The Alliance's established working relationships and placement on the campus of an acute care hospital will guard against any unwarranted fragmentation of healthcare services.

2.75 Signature anticipates its 174-bed psychiatric hospital will become operational in January of 2018. However, as discussed above, this anticipated operational date will be delayed by at least six to seven months to allow Signature to complete the land use permitting and zoning process. Once completed, the facility is large enough to offer a broad array of patient care needs, including inpatient hospitalization and outpatient services. Offering these services on site will reduce the fragmentation of psychiatric or behavioral healthcare services in Pierce County. AR 2497. Given its experience operating 13 out-of-state hospitals, Signature further anticipates it will not be difficult to establish the necessary working relationships with other Washington facilities. Signature is working to meet with the existing Pierce County healthcare providers to develop the necessary working relationships. AR 55. Signature did not provide any timeline for establish the necessary working relationships.

2.76 Based on the Application Record and the above analysis, both the Alliance and Signature meet the WAC 246-310-230(4) criterion. The Alliance has

already established these relationships in Pierce County but there is no evidence Signature will not have such relationships in place prior to the hospital's anticipated date of operation.

WAC 246-310-230(5)

2.77 WAC 246-310-230(5) requires the applicant provide reasonable assurances that its proposed project will provide safe and adequate care services to the public. This includes showing the applicant will provide services in accordance with applicable state and federal laws, rules, and regulations. The Alliance partners (MultiCare and Franciscan) have a history of complying with Medicare and Medicaid requirements and Joint Commission certification. *See* Finding of Fact 2.70 above. The Alliance contends it will provide safe and adequate care services to the public.

2.78 Relying on the out-of-state facility information regarding its compliance with Medicare and Medicaid, and its certification for its out of state facilities with the Joint Commission, Signature contends that it will provide safe and adequate care services to the public. *See* Findings of Fact 2.71 and 2.72 above.

2.79 Based on the Application Record and the above analysis, the Alliance and Signature both meet the WAC 246-310-230(5) criterion.

WAC 246-310-240 "Cost Containment"

2.80 WAC 246-310-240 requires the applicant prove: (1) there are no superior alternatives available in terms of cost, efficiency, or effectiveness when compared to the project; (2) where the project involves construction, that the costs, scope, and methods of construction and energy conservation are reasonable; and (3) where the project

involves construction, that the project will not have an unreasonable impact on the healthcare costs and charges. In reviewing applications reference can be made to nationally recognized standards; standards developed by Washington State professional organizations; federal Medicare and Medicaid certification requirements; or state licensing requirements. Absent recognized standards the reviewer of the application (the CN Program or subsequently the Presiding Officer or Review Officer) can rely on the agency's experience and expertise. When a concurrent review is performed for multiple applications, the WAC 246-310-240(1) analysis looks at the totality of both applications to weigh all factors, and determine if one project is superior to the other application(s). WAC 246-310-240(2) and (3) criteria are reviewed as part of the superiority analysis.

2.81 Under WAC 246-310-240(1) the Review Officer first examines whether superior alternatives currently exist. There are currently only 23 adult psychiatric beds in Pierce County, with a need for 147.5 psychiatric beds in 2014. No superior alternative currently exists to the establishment of a new psychiatric bed facility.

2.82 Next, the Review Officer reviews the alternatives the applicants considered in their applications.

The Alliance

2.83 The Alliance examined five options: (1) converting existing inpatient acute care beds to psychiatric beds; (2) a joint venture to construct a 120-bed facility on the Allenmore hospital campus; (3) a 60-bed hospital on the Allenmore hospital campus; (4) a 150-bed hospital on the Allenmore hospital campus; or (5) not building any project.

AR 457-461; AR 2502-2503. The Alliance rejected the "no project" alternative given the need for psychiatric beds in Pierce County. The Alliance determined there was an insufficient supply of acute care hospital beds available to convert to psychiatric beds and thereby address the planning area need, so it also dismissed that option. Alliance focused on choosing one of the three alternatives involving new construction of a 150-bed, 120-bed facility, or 60-bed facility. The Alliance chose the 120-bed facility on the Allenmore hospital campus as the best alternative among these three choices. AR 458-461(Tables 26, 27, and 28); AR 2503. Although the projected need is higher, the Alliance's expert explained a 120-bed facility accounted for patient out-migration to other planning areas and the recent increase of beds in the surrounding planning areas. TR 307-311 (Fox).

2.84 Signature contends the Alliance incorrectly chose the 120-bed option, when the objective facts show that the Alliance's 150-bed option was the appropriate choice. Signature argues a 150-bed option is superior because a larger hospital: (1) reaches profitability in less time; (2) does not approach the critical occupancy rates in a short period of time; and (3) more closely meets the 176.8 bed need projected in 2029. The Program and the Alliance disagree.

2.85 The Alliance's 150-bed option is not the superior option here. The Alliance is a not-for-profit facility; profitability is not a consideration except to the extent the project must show profitability by the third year of operation. The project proposing the number of beds that more closely matches the bed need calculation is only one factor for consideration. The number of beds in a project is based on several additional

factors, including the bed utilization or fill rate (the occupancy rate of the patient beds), the accuracy of bed projections 15 years into the future, and what percentage of unmet need that a specific project or facility actually capture. The Alliance determined the 150-bed facility would more closely meet the projected number of beds needed in 2029, but it would be more costly to build and less efficient to operate, given that there would be a larger idle capacity during that period. TR 259 (Fox). The Alliance projected that some patients would leave Pierce County for their care, and out-migration is not accounted for in calculating the bed need. TR 307-308 (Fox). Projecting need for Pierce County residents was difficult given the recent increase in the number of new beds in the surrounding counties. TR 311 (Fox). These factors support Alliance's decision to choose a 120-bed facility.

Signature

2.86 Signature initially considered three options regarding the appropriate psychiatric bed hospital size: (1) a 174-bed psychiatric facility; (2) a 194-bed psychiatric facility; or (3) a 145-154 bed psychiatric hospital. AR 62. Signature later added a fourth alternative to build a 90-120 bed facility. *Id.* Signature preferred the 174-bed option, but offered the 90-120 bed option in part to demonstrate that it is financially feasible to build two separate facilities. *Id.* Signature ultimately rejected the 90-120 bed, 194-bed, and 145-154 bed facility alternatives in favor of the 174-bed option. AR 63-65.

2.87 The Program's issuance of CN #1543 to MultiCare for the adolescent 30-bed conversion project eliminated the need for additional adolescent beds in Pierce County. Therefore, the Program assumed Signature's project would then involve 153

beds (174 minus the 21 beds earmarked for adolescent patients). From a numerical need standpoint alone, either Alliance's 120-bed psychiatric facility or Signature's 153-bed facility could significantly address Pierce County's need for psychiatric beds. Neither the Alliance's 120-bed project nor Signature's 153-bed project would completely address the 176.8-bed need projected for 2029. As previously stated, the number of beds in a project is a factor but not a controlling factor.

2.88 There is not sufficient need in the 15-year planning horizon to support two psychiatric bed facilities even assuming Signature's lowest proposed bed number (90).

2.89 The next step is to compare the Alliance and Signature projects to each other to determine whether either project is a superior alternative in terms of cost, efficiency, or effectiveness. WAC 246-310-240(1); *see also* RCW 70.38.115(7). The analysis requires looking at the WAC 246-310-240(2) and (3) criterion first.

2.90 Under WAC 246-310-240(2), when a project requires construction, the project must be evaluated to determine: (a) if the costs, scope, and methods of construction and energy conservation are reasonable; and (b) that the project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.

WAC 246-310-240(2)(a)

2.91 Under WAC 246-310-240(2)(a), the Alliance provided assurances that its project will be constructed to meet both the Washington State Building Code and the Washington Energy Code. AR 461-462 and AR 2504-2505. The Alliance's application

shows the cost, scope, and method of construction and energy conservation are reasonable for a 120-bed facility.

2.92 Under WAC 246-310-240(2)(a), Signature has developed 12 hospitals and has opened two in the past year. AR 66; AR 2504. As a new facility, Signature's facility will be required to meet industry standards and Washington State licensing and construction review standards. It will also meet the Center for Medicare and Medicaid Services standards for construction. *Id.* Signature's application shows that the cost, scope, and method of construction and energy conservation are reasonable for a 153-bed facility.

WAC 246-310-240(2)(b)

2.93 Measuring whether a project can meet the WAC 246-310-240(2)(b) (the project will not have an unreasonable impact on the cost and charges to the public for providing healthcare) can be measured using the WAC 246-310-220(2) criterion. The Alliance met the WAC 246-310-220(2) criterion. *See* Findings of Fact 2.35 through 2.42, and 2.50. Signature met the WAC 246-310-220(2) criterion. *See* Findings of Fact 2.43 through 2.50. Neither the Alliance's project nor Signature's project will have an unreasonable impact on the costs and charges to the public.

2.94 Based on the Application Record and the above analysis, the Alliance and Signature both meet the WAC 246-310-240(2)(a) and (b) criteria. Given the Alliance's project is superior under the WAC 246-310-220(2), the Alliance's project is also superior under the WAC 246-310-240(2) criterion.

2.95 The WAC 246-310-240(3) criterion measures whether a 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. The Alliance proposes to finance its project using available reserves. Signature proposes to finance its project using available internal financing and cash loans. Neither the Alliance nor the Signature financing and delivery methods propose any innovations in project financing. For that reason, the WAC 246-310-240(3) criterion does not apply to either project.

2.96 The next step is to examine each of the CN applications to determine if either project is a superior alternative in terms of cost, efficiency, or effectiveness when compared to each other. See WAC 246-310-240(1); RCW 70.38.115(7). In its evaluation, the Program determined the Alliance's project to be superior to Signature's project for three reasons:

1. The existing inpatient medical and psychiatric services provided by MultiCare and Franciscan will enable the Alliance to more immediately develop relationships in the community to provide more efficient and effective development of the necessary inpatient medical and behavioral health support services;
2. The existing medical and psychiatric outpatient services provided by MultiCare and Franciscan will enable the Alliance to more immediately develop relationships that will promote continuity in the delivery of outpatient services; and

3. The location of the Alliance project on an existing hospital campus will promote more immediate development of the Alliance project and provide superior access to medical services over Signature's project.

See AR 2503-2504.

2.97 Signature argued the above three reasons are an incomplete superiority evaluation because a complete evaluation requires a review of the costs, efficiency and effectiveness under the "totality of the applications" standard upon objective evidence in the record. Signature identified five additional issues in its adjudicative proceeding request:

1. Non-compliance matters discovered by the Program should have resulted in the Alliance's application being returned or denied.
2. The Alliance failed to establish site control. Among other things, all materials provided by MultiCare are revocable and can be discretionarily modified.
3. The Alliance submitted incomplete organizational documents in response to the Pivotal Unresolved Issue information demand to determine if the financial pro forma was complete or reliable.
4. The Alliance's project should have either been removed from comparative review or denied because the application was incomplete, required an amendment, and was unreliable.
5. The Program based its decision on an incomplete, inaccurate, and irrelevant application of tie-breakers.

Request for Adjudicative Proceeding filed February 12, 2016, page 3.

2.98 Signature identified two additional issues in its request for an adjudicative proceeding: (1) When should an application be returned or denied prior to the evaluation process; and (2) when should an application be returned or denied prior to the concurrent review process?

2.99 Changes to an application *may* be considered an amendment. *See* WAC 246-310-100(1) (Emphasis added). Such changes include:

(a) The addition of a new service or elimination of a service included in the original application.

(b) The expansion or reduction of a service included in the original application.

(c) An increase in bed capacity.

(d) A change in the capital cost of the project or the method of financing the project.

(e) A significant change in the rationale used to justify the project.

(f) A change in the applicant.

2.100 Change of Application: Signature argues that Franciscan was not listed as an Alliance Board member in the Articles of Incorporation. This prompted the Program to declare a Pivotal Unresolved Issue. *See* Finding of Fact 2.9 above. The Alliance responded to the pivotal unresolved issue by submitting documents showing Franciscan to be a board member. AR 2524, AR 2539; AR 2541. Although it was required to submit documentation to show which Franciscan employee was on the

Alliance board, there is no question that the Alliance was a joint venture between MultiCare and Franciscan. *See* Finding of Fact 2.7 above. Thus, there was no change in the Alliance applicant, and there was no requirement for the Alliance to amend its CN application under WAC 246-310-100(1)(f) on this point.

2.101 Non-Compliance: Signature argues MultiCare filed incorporation papers on December 11, 2014, that identified itself as the sole member of the Alliance. Signature further argues that MultiCare's amendment of its governing documents to include joint venture partner Franciscan on June 2, 2015 was untimely. As stated in Finding of Fact 2.100 immediately above, there was no change in the applicant. While the Alliance needed to file additional documentation in response to the Pivotal Unresolved Issue request, both MultiCare and Franciscan were clearly identified by the Alliance as partners from the beginning of the application process. AR 386-389. The application must provide sufficient evidence to allow for the review of the application. RCW 38.70.125(4) permits for the conditional issuance of a CN. The production of conditional documentation will suffice, subject to the production of executed or completed documentation. The Alliance identified the two Alliance partners (MultiCare and Franciscan) and provided the necessary documentation showing each partner was commitment to the project.

2.102 Site Control: The Alliance established site control. *See* Findings of Fact 2.37 through 2.42 above. The Alliance met the site control issue as "prescribed as published" in WAC 246-310-090(1).

2.103 Tie-breaker Analysis: Signature argued that no objective tie-breaker analysis was performed when comparing the Alliance and Signature applications. Unlike the kidney dialysis regulation in WAC 246-310-288, there is no tie-breaker rule that applies in psychiatric hospital bed situations. The only "tie-breaker analysis" is a multi-step process to determine which project constitutes the superior or most favorable project. The tie-breaker analysis is an examination of which CN project best meets the four CN criteria. *See DaVita Healthcare Partners, Inc., v. Department of Health*, 192 Wash.App. 102, 115-116, 365 P.3d 1283 (2015). Based on a review of each project, the Review Officer finds:

A. Complete application. Both Signature and the Alliance each provided a complete CN application that would address the need for psychiatric beds in Pierce County. Neither application is superior based on this issue.

B. Number of beds. Signature's application would provide either a 153-bed or 174-bed facility. Alliance's application would provide a 120-bed facility. Neither application completely meets the identified 176.8 bed need by 2029 (the 15-year planning horizon). The need calculation is not an exact science because it does not include certain relevant factors such as occupancy rates and in/out migration. However, both applications significantly address the projected need. The fact that Signature would operate more beds weighs in Signature's favor.

C. Cost per bed. Dividing the total project cost by the number of beds provides a cost per bed for each project. The Alliance's cost per bed is $338,691 ($40,642,925 divided by 120 beds). Signature's cost per bed is $278,205 ($42,565,368

divided by 153 beds). The cost and size of each project is based on a number of factors that affect this cost per bed figure. These differences include the costs for expenses, salaries, wages, and benefits for staff.

A review of Signature's capital cost amount fails to show the cost for the expenses associated with the land-use and zoning issues related to the project. *See* Finding of Fact 2.48 above. Therefore, the cost per bed figure potentially, but not conclusively, falls in Signature's favor.

D. Commencement of project. Both the Alliance and Signature anticipated the commencement of their respective psychiatric hospital bed projects by January 2018. However, Signature's anticipated January 2018 commencement date did not factor in the minimum six to seven month delay arising from the need to obtain zoning permits. *See* Findings of Fact 2.48-2.50 above. Even if Signature could qualify its site based on the information received from the City of Tacoma, the six to seven month delay precludes Signature from commencing its CN project by January 2018. The Alliance's project location is currently zoned for hospital use. The primary intent of CN projects is to provide accessible health services while controlling costs. RCW 70.38.015; *see also Providence Health*, 194 Wash.2d at 853. The Alliance can more likely meet the January 2018 commencement date, which makes the Alliance project clearly superior on this point.

E. Geographic location. Another factor is the geographic location of the proposed facility. The Alliance's project is sited on MultiCare's Allenmore Hospital campus. Signature's proposed site is located less than one mile from the Alliance's

proposed site. This issue is aligned with the arguments raised by the parties that one practice model (free standing site versus a site incorporated with a hospital facility) is superior to the other. Based on the evidence presented, the Review Officer does not find any superiority regarding the choice of practice model used to provide psychiatric care presented by the parties. *See* Findings of Fact 2.63 through 2.64 above.

However, the geographic proximity of the proposed two project sites does not tell the entire story. The Alliance psychiatric bed project will be physically connected to the Allenmore acute care hospital facility. This connection will provide a time savings in the transfer process, which will benefit the patient by providing medical care faster. Signature's transfer process requires some form of transportation such as an ambulance. This transfer process does not have the ease of use and treatment time saving as the Alliance process. For this reason, the Alliance's project is superior on this issue.

F. Charity/low income care. A CN applicant must demonstrate that all residents of the service area will have access to the proposed health services. *See* WAC 246-310-210(2). To determine compliance with this rule, the Program requires an applicant to show, *inter alia*, they will provide a certain level of charity care. Signature asserted it will provide 2.67 percent of total revenue and 5.82 percent of adjusted revenue. AR 30; AR 2475-2476 (Table 15). However, a portion of that charity care will, in fact, consist of "bad debt" that was billed to patients but unsuccessfully collected. AR 2690; TR 485 (McGuirk). In addition, Signature intends to offer free care to patients

with incomes below 200 percent of the federal poverty level (FPL) and a sliding scale of costs for patients with incomes up to 350 percent of the FPL. AR 2681-2682.

The Alliance asserts it will provide charity care percentages of 3.00 percent of total revenue or 5.49 percent of its adjusted revenue. AR 2477 (Table 16). It will offer free care to patients with incomes up to 300 percent of the FPL, and will offer a sliding scale at income levels up to 500 percent of the FPL. Thus, the Alliance plans to offer financial assistance to a larger number of patients in the service area. The Alliance is superior on this issue.

2.104 Signature submitted a complete application, proposes beds that will significantly address need in the planning area, and (subject to the additional costs related to zoning) may be able to build those beds at a lower cost than the Alliance. The Alliance also submitted a complete application and proposes beds that will significantly address need in the planning area. In addition, its project will likely be completed at least six to seven months earlier, provides for seamless transition of patients to an acute care hospital, and will offer a higher level of charity care and financial assistance to indigent and low-income patients. The Alliance's project is, therefore, superior.

III. CONCLUSIONS OF LAW

3.1 The Secretary is authorized to designate a Review Officer to review initial orders and to enter final orders. RCW 43.70.740.

3.2 A Petition for Administrative Review must be filed within 21 days of service of the Initial Order. WAC 246-10-701.

3.3 Signature's Petition for Administrative Review was timely filed.

Certificate of Need

3.4 The Department of Health is authorized and directed to implement the certificate of need program. RCW 70.38.105(1). Establishment of a psychiatric hospital requires a certificate of need. RCW 70.38.105(4)(a). The applicant must show or establish that its application meets all the applicable criteria. WAC 246-10-606(2). An applicant "shall submit a certificate of need application in such form and manner and containing such information as the department has prescribed and published as necessary to such a certificate of need." WAC 246-310-090(1)(a). Admissible evidence in a certificate of need hearing is the kind of evidence on which reasonably prudent persons are accustomed to rely in the conduct of their affairs. RCW 34.05.452(1). The standard of proof is preponderance of the evidence. WAC 246-10-606.

3.5 The Presiding Officer (on delegated authority of the Secretary of Health) is the agency's fact finder and decision maker. *DaVita v. Department of Health,* 137 Wash.App. 174, 182, 151 P.3d 1095 (2007). The Presiding Officer engages in a *de novo* review of the record. *See University of Washington*, 164 Wash.2d at 103. The Presiding Officer may consider the Program's written evaluation in reaching a decision but is not required to defer to the Program. *DaVita*, 137 Wash.App. at 182-183.

3.6 In 2013, the Washington State Legislature amended the law to make the decisions of Presiding Officers initial, rather than final, orders. RCW 43.70.740. The

Review Officer shall exercise all the decision-making power that the Review Officer would have had to decide and enter the final order had she presided over the hearing. RCW 34.05.464(4).

3.7 In acting as the Department's final decision maker, the Review Officer reviewed the entire file including the application record, clerk's file, transcript of proceedings, and briefing submitted by the parties. The Review Officer applied the standards found in WAC 246-310-200 through 246-310-240 in evaluating the competing applications.

Certificate of Need Requirements

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

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

3.9 WAC 246-310-210 defines the "determination of need" in evaluating CN applications,[40] to wit:

> The determination of need for any project shall be based on the following criteria, except these criteria will not justify exceeding the limitation on increases of nursing home beds provided in WAC 246-310-810.
>
> (1) The population served or to be served has need for the project and other services and facilities of the type proposed are not or will not be sufficiently available or accessible to meet that need. The assessment of the conformance of a project with this criterion shall include, but need not be limited to, consideration of the following:
>
> . . .
>
> (b) In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities similar to those proposed;
>
> (2) All residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services. The assessment of the conformance of a project with this criterion shall include, but not be limited to, consideration as to whether the proposed services makes a contribution toward meeting the health-related needs of members of medically underserved groups which have traditionally experienced difficulties in obtaining equal access to health services, particularly those

[40] The sub-criteria set forth in 246-310-201(3), (4), (5), and (6) are not discussed in this decision as they are not relevant to the Alliance and Signature projects.

needs identified in the applicable regional health plan, annual implementation plan, and state health plan as deserving of priority. Such consideration shall include an assessment of the following:

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

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

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

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

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

The determination of financial feasibility of a project shall be based on the following criteria.

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

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

(3) The project can be appropriately financed.

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

A determination that a project fosters an acceptable or improved quality of health care shall be based on the following criteria.

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

(2) The proposed service(s) will have an appropriate relationship, including organizational relationship, to ancillary and support services, and ancillary and support services will be sufficient to support any health services included in the proposed project.

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

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

(5) There is reasonable assurance that the services to be provided through the proposed project will be provided in a manner that ensures safe and adequate care to the public to be served and in accord with applicable federal and state laws, rules, and regulations. The assessment of the conformance of a project to this criterion shall include but not be limited to consideration as to 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 healthcare facility, a revocation of a license to practice a health profession, or a decertification as a provider of services in the Medicare or Medicaid program because of failure to comply with applicable federal conditions of participation; or

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

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

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

3.13 Based on the above Findings of Fact and Conclusions of Law, the Review Officer determines that both the Alliance and Signature applications meet the CN criteria set forth in WAC 246-310-210, WAC 246-310-220, WAC 246-310-230, and WAC 246-310-240. Following a WAC 246-310-240(1) analysis, the Review Officer concludes that the Alliance application is superior to the Signature application.

The CN Evaluation as an "Initiating Document"

3.14 In challenging the Program's evaluation, Signature provided a specific statement of the laws and issues involved and the grounds for its appeal of the Program's evaluation.[41] Signature argues the Program's evaluation is an "initiating document" and the Program may only amend it by following the applicable procedural rules.[42] *See* TR 602-606; *see also* WAC 246-10-202 and WAC 246-10-203. Signature claims unless the Program amends the initiating document under the applicable procedural rules, it is restricted to those issues contained in the initial evaluation. WAC 246-10-203. Signature further argues that amending the document provides the applicant an opportunity to grant a continuance to allow the responding party to prepare a defense.[43]

3.15 Signature contends the issue is not the *de novo* standard of review, rather the issue is what claims can and cannot be considered in the *de novo* review.[44] Since it never raised any of its claims prior to the discovery or motions cutoff, Signature contends the Alliance is prohibited from doing so now. The Program and the Alliance disagree that they are restricted to issues in the "initiating document" as argued by Signature.[45]

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[41] *See* RCW 70.38.125(10) and WAC 246-310-610(1) and (2).
[42] "Initiating document" shall mean a written agency document which initiates action against a license holder or applicant for a license or recipient of benefits and which creates the right to an adjudicative proceeding. It may be entitled a statement of charges, notice of intent to deny, order, or by any other designation indicating the action or proposed action to be taken. WAC 246-10-102.
[43] Even if a CN evaluation is an "initiating document" it did not prohibit Signature or any party from requesting a continuance. *See* Prehearing Order No. 4: Order Denying Motion for Continuance of the Hearing Date, issued June 17, 2016; *see also* WAC 246-10-403(3) (continuances may be granted for good cause).
[44] *See* Signature's Closing Brief, pages 15-17.
[45] *See* Program's Post-Hearing Opening Brief, pages 6-7; Alliance's Reply Brief, page 5.

3.16 Signature's characterization of the CN evaluation as an "initiating document" is incorrect, as it conflates the CN procedure (a comparative review) with the Department of Health's disciplinary procedure (an adversarial proceeding). *See DaVita*, 137 Wash.App. 174. The Court's holding in *DaVita* is instructive here. The Division Two Court of Appeals explained that a comparative review is not an adversarial proceeding, but a competitive one. *DaVita,* 137 Wash.App. at 185. The burden of proof is not on the Program; it is upon each applicant to prove that its application meets the applicable criteria. The Review Officer must make factual findings on *all material issues,* including whether the applicant has met its burden. *Id.* (Emphasis added).

3.17 The CN application process is a detailed process, as the applicants and competitors (interested and affected parties) participate throughout the application process. They participate in the public hearing[46] and provide arguments in support or opposition of the applications. The applicants know what arguments or concerns exist throughout the application process. CN hearings do not resemble disciplinary proceedings, where one party may be unaware of the issues until that party receives the "initiating document." The Presiding Officer conducts a *de novo* review of the applications contained in the CN application record, considers all of the evidence, and then issues the agency's initial decision. *See Providence Health,* 194 Wash.App. at 857) (citing *DaVita*, 137 Wash.App. at 181)). If requested, the Review Officer then conducts a separate and distinct *de novo* review before issuing the final order. RCW

[46] *See* WAC 246-310-180.

34.05.464(4). The Review Officer may consider the Program's written analysis and the Initial Order but is not required to defer to either. The Review Officer finds Signature's argument to be both incorrect and unpersuasive.

Intervention in CN Adjudicative Proceedings

3.18 Signature further contends the Alliance did not request an adjudicative proceeding to contest the Program's evaluation, and RCW 70.38.115(10)(b) limits the Alliance's ability to intervene to the presentation of oral or written testimony or argument. The Presiding Officer may grant a petition for intervention at any time, upon a determination that the intervenor qualifies under any provision of law and the intervention is in the interest of justice and will not impair the orderly and prompt conduct of the hearing. *See* RCW 34.05.443(1); *see also St. Joseph Hospital and Health Care Center v. Department of Health*, 125 Wash.2d 733, 742, 887 P.2d 891 (1995) (competitors have standing in CN matters). Here the Presiding Officer signed an Order Granting Alliance's Petition to Intervene on April 11, 2016, giving the Alliance the right to intervene and fully participate as a party to the proceeding. Signature did not contest the intervention Order. Given this ruling, the Alliance's participation was not restricted in this matter to oral or written testimony or argument.

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IV. FINAL ORDER

Based on the foregoing, IT IS HEREBY **ORDERED**:

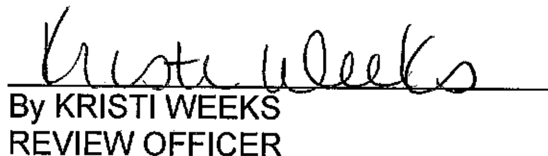
4.1 Alliance's CN application to establish a 120-bed adult psychiatric hospital at 1901 S. Union Avenue, Tacoma, Washington in the Pierce County planning area is **GRANTED**.

4.2 Signature's CN application to establish a 174-bed adult and adolescent psychiatric hospital at 4100 S. 19th Street, Tacoma, Washington in the Pierce County planning area is **DENIED**.

4.3 In the alternative, Signature's CN application to establish a 153-bed adult psychiatric hospital at 4100 S. 19th Street, Tacoma, Washington in the Pierce County planning area is **DENIED**.

Dated this 10th day of March, 2017

JOHN WIESMAN, DrPH, MPH
SECRETARY OF HEALTH



By KRISTI WEEKS
REVIEW OFFICER

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NOTICE TO PARTIES

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

Adjudicative Clerk Office
Adjudicative Service Unit
PO Box 47879
Olympia, WA 98504-7879

A copy must be sent to the other parties. 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

The petition must state the specific grounds upon which reconsideration is requested and the relief requested. WAC 246-10-704. The petition for reconsideration is considered denied twenty (20) days after the petition is filed if the Adjudicative Clerk Office has not responded to the petition or served written notice of the date by which action will be taken on the petition.

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

The Order remains in effect even if a petition for reconsideration or petition for judicial review is filed. "Filing" means actual receipt of the document by the Adjudicative Clerk Office. RCW 34.05.010(6). This Order was "served" upon you on the day it was deposited in the United States mail. RCW 34.05.010(19).

Final orders are public documents, and may be placed on the Department of Health's website and otherwise released as required by the Public Records Act, chapter 42.56 RCW.