COMMONWEALTH of VIRGINIA

Department of Health

M. NORMAN OLIVER, MD, MA
STATE HEALTH COMMISSIONER

PO BOX 2448
RICHMOND, VA 23218

TTY 7-1-1 OR
1-800-828-1120

November 6, 2019

Matthew Jenkins, Esquire
Hunton Andrews Kurth
Riverfront Plaza, East Tower
951 East Byrd Street
Richmond, Virginia 23219-4074

RE: CERTIFICATE OF PUBLIC NEED
(COPN or "Certificate")
No. VA-04682
(REQUEST No. VA-8426)
Bon Secours - St. Francis, Inc.
Chesterfield County, Planning District (PD) 15
Addition of 55 Hospital Beds

Dear Mr. Jenkins:

In accordance with Article 1.1 of Chapter 4 of Title 32.1 (§ 32.1-102.1 *et seq.*) of the Code of Virginia, I have reviewed the application captioned above and the record compiled in relation to the project proposed in that application. As required by Subsection B of Virginia Code § 32.1-102.3, I have considered all matters, listed therein, that must be taken into account in making a determination of public need.

I have received, reviewed and adopted the enclosed findings, conclusions and recommended decision of the adjudication officer who convened the informal fact-finding conference to discuss the application, and who reviewed the administrative record pertaining to the proposed project.

Based on my review of the project and on the recommended decision of the adjudication officer, I am approving the project proposed by Bon Secours - St. Francis Medical Center, Inc., (the "St. Francis Project"). The project merits approval and should result in issuance of a Certificate. It is necessary to meet a public need.

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

The reasons for my decision include the following:

(i) The St. Francis Project is consistent with the State Medical Facilities Plan (SMFP), or is in overall harmony or general agreement with the SMFP and public interests and purposes to which that plan is devoted;

(ii) The St. Francis Project is a reasonable, incremental response that addresses a public need, expressed as an institution-specific need, for additional acute care resources;

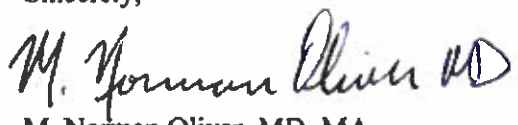
(iii) Approval of the St. Francis Project may reasonably be expected to have little, if any, negative effect on competition or the utilization of existing providers of inpatient services in PD 15;

(iv) The St. Francis Project would promote operational efficiency and provide for an increase in facility-based, clinical sophistication, and thereby can reasonably be expected to enhance beneficial competition; and

(v) The St. Francis Project enjoys strong community support.

While this letter announces an approval of an application, in an abundance of caution, I advise that, in accordance with Rule 2A:2 of the Rules of the Supreme Court of Virginia, any aggrieved party to an administrative proceeding choosing to appeal a case decision* shall file, within 30 days after service of the case decision, a signed notice of appeal with "the agency secretary." I would consider such a notice sufficiently filed if it were addressed and sent to the Office of the State Health Commissioner, and timely received by that office, at the James Madison Building, Thirteenth Floor, 109 Governor Street, Richmond, Virginia 23219. Under the Rule, when service of a decision is "accomplished by mail," three days are added to the 30-day period.

Sincerely,



M. Norman Oliver, MD, MA
State Health Commissioner

cc: Alexander Samuel, MD, MPH
Director, Chesterfield Health District

* In accordance with Va. Code § 2.2-4023, the signed original of these final agency case decisions "shall remain in the custody" of the Department, while the applicants are receiving a photocopy of the original case decision letter.

c (cont'd):

Vanessa MacLeod, Esq.
Assistant Attorney General
Deborah Waite
Virginia Health Information
Erik O. Bodin, III
Director, Division of
Certificate of Public Need
Douglas R. Harris, JD
Adjudication Officer

COPY

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HEALTH
MEDICAL CARE FACILITIES CERTIFICATE OF PUBLIC NEED

THIS CERTIFIES THAT Bon Secours - St. Francis Medical Center, is authorized to initiate the proposal as described herein.

NAME OF FACILITY: Bon Secours St. Francis Medical Center

LOCATION: 13710 St. Francis Boulevard, Midlothian, Virginia 23114

OWNERSHIP AND CONTROL: Bon Secours - St. Francis Medical Center.

SCOPE OF PROJECT: Addition of 55 beds (42 medical/surgical beds, nine (9) obstetrical beds and four (4) intensive care beds) in accordance with specifications and representations made during the course of review. The total authorized capital and financing costs of the project is $155,764,458. The project is scheduled to be completed by May 30, 2023. This certificate is issued with confirmation of an existing St. Francis hospital-wide charity care condition.

Pursuant to Chapter 4, Article 1:1 of Title 32.1, Sections 32.1-102.1 through 32.1-102.11, Code of Virginia (1950), as amended and the policies and procedures promulgated thereunder, this Medical Care Facilities Certificate of Public Need is issued contingent upon substantial and continuing progress towards implementation of the proposal within twelve (12) months from the date of issuance. A progress report shall be submitted to the State Health Commissioner within twelve (12) months from the date of issuance along with adequate assurance of completion within a reasonable time period. The Commissioner reserves the right not to renew this Certificate in the event the applicant fails to fulfill these conditions. This Certificate is non-transferable and is limited to the location, ownership, control and scope of the project shown herein.

Certificate Number: VA-04682

Date of Issuance: November 6, 2019

Expiration Date: November 5, 2020

M. Norman Oliver MD

M. Norman Oliver, MD, MA
State Health Commissioner

RECOMMENDATION
TO THE STATE HEALTH COMMISSIONER
FOLLOWING AN INFORMAL FACT FINDING
CONFERENCE ("IFFC")
REGARDING CERTIFICATE OF PUBLIC NEED
("COPN" or "Certificate")
REQUEST NUMBER VA-8426
Bon Secours St. Francis Medical Center, Inc. ("St. Francis")
Health Planning Region ("HPR") IV,
Planning District ("PD") 15, Chesterfield County
Add Fifty-Five (55) Acute Care Beds (the "St. Francis Project")

I. Introduction

The present document is a recommended decision. It is being submitted to the State Health Commissioner (hereinafter, the "Commissioner") for his review, consideration and adoption. This recommended decision, in response to an application, or a proposed project, follows an informal fact-finding conference ("IFFC") conducted in accordance with the Virginia Administrative Process Act (the "APA," Virginia Code § 2.2-4000 *et seq.)*[1] and reflects a review of the Virginia Department of Health's (the "Department's") administrative record regarding the application for a COPN, captioned above.

This document is an effort made by a hearing officer employed by the Department to provide the Commissioner means to inform the applicant "briefly and generally in writing of the factual or procedural basis" for a decision on the captioned application as called for in the APA, and primarily informed by the "criteria of need," or the statutory considerations of public need, set forth in Virginia Code § 32.1-102.3(B), and in accordance with the administrative procedures that supplement the APA that are contained in Virginia Code § 32.1-102.6.[2]

This recommended decision is an effort to follow applicable law by addressing all "criteria of need," or applicable statutory considerations of public need (through which the Commissioner must make determinations of public need), by concisely discussing the proposed project and by gauging the proposed project against the statutory considerations. It includes references to sufficient information and data, contained in the record compiled by the Department on this application, supportive of the recommendation made below.

II. Authority and Procedural History

Article 1 of Chapter 4 of Title 32.1 (§ 32.1-102.1 *et seq.)* of the Virginia Code (the "COPN law") addresses medical care facilities and provides that "[n]o person shall commence any project without first obtaining a [COPN] issued by the Commissioner." This article defines "project" to

[1] Specifically, Va. Code § 2.2-4019.

[2] Reflecting a need for economy and efficiency, the present document contains much of the substance found in a post-IFFC filing from the applicant, i.e., a closing submission styled as a proposed recommended decision.

include, in part, "[a]n increase in the total number of beds . . . in an existing medical care facility." In turn, "[m]edical care facility" is defined to include a "[g]eneral hospital[]."[3]

The application proposing the above-captioned project falls within these statutory definitions and the COPN law thereby applies to the St. Francis Project. The law requires its review to determine whether a public need exists for its authorization.

The presentation of this recommended decision follows an IFFC convened on June 27, 2019, in the City of Richmond, and conducted pursuant to controlling law. The St. Francis Project was the subject of the IFFC, at which the applicant appeared and was represented by legal counsel. The applicant was given the opportunity to present the merits of the St. Francis Project, and did so with evidence (including written and visual exhibits and the testimony of sworn witnesses) and argument. A transcript of the IFFC was created and made available to the applicant's counsel (for use in preparing post-IFFC filings on the project), to staff of the Department's Division of Certificate of Public Need ("DCOPN")[4] and to me on or about July 17, 2019. A date for the close of the administrative record was mutually devised.

A health facilities planning analyst from DCOPN attended the IFFC and presented that division's analysis and recommendation. The close of the administrative record on this application occurred on August 23, 2019.

III. Background, Findings of Fact and Conclusions of Law

The factual basis underlying the recommended decision made herein consists of evidence in the administrative record, including information contained in the application giving rise to this review, the DCOPN staff report, and IFFC-related submittals made by the applicant's counsel.[5]

I have reviewed the administrative record relating to the application.[6] By reference, I hereby incorporate the DCOPN staff report into the present document for the purpose of establishing facts and providing basic analysis that support or substantiate the evidentiary basis on which the present recommended decision rests, notwithstanding the degree to which the DCOPN staff report diverges from the present recommended decision.

My recommended decision, the basics of which appear at the end of the present document, may incorporate by reference identified portions of the DCOPN staff report in order to provide reliable conclusions and may rely upon it to demonstrate a full gauging of the project against the statutory considerations of public need, as they are customarily applied. Findings of fact include:

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[3] Va. Code § 32.1-102.3, and § 32.1-102.1 (definitions of "[p]roject," and [m]edical care facility").

[4] DCOPN is the work unit, or division, within the Department that is composed of the Commonwealth's professional facilities planning staff.

[5] The applicant's counsel supplied an Exhibit Book at the IFFC containing eleven (11) numbered exhibits and, in addition, supplied post-IFFC supplemental information in the form of two (2) supplemental exhibits.

[6] DCOPN supplied the administrative record (the "AR") to the applicants within the first several days following the June 27, 2019 IFFC. The AR contains Exhibits numbered 1 through 19.

1. Bon Secours - St. Francis Medical Center, Inc., is a not-for-profit Virginia stock corporation organized in 1999. Bon Secours - Richmond Health System, a not-for-profit Virginia nonstock corporation, holds 100 percent of the ownership interests in St. Francis.[7]

2. St. Francis has operated as a 130-bed acute care hospital in Chesterfield County, which is in PD 15, HPR IV, since it first opened to the public in 2005. Establishment of the hospital, pursuant to the relocation and replacement of Bon Secours Stuart Circle Hospital in the City of Richmond, was approved in 2003 pursuant to COPN No. VA-03713.[8]

3. In addition to its main hospital campus located at 13710 St. Francis Boulevard, St. Francis operates the Bon Secours Westchester Emergency Center at 601 Watkins Center Parkway, also in Chesterfield County, and has plans to develop a freestanding emergency department in the Chester area of Chesterfield County, to be known as the Bon Secours Chester Emergency Center. In May 2019, the Commissioner approved the expansion of St. Francis' CT services to the planned Chester facility (COPN No. VA-04656).[9]

4. In 2008, the Commissioner issued COPN No. VA-04178 to St. Francis, authorizing it to add 54 acute care beds to its bed complement based on a demonstrated institution-specific need for additional bed capacity. The case decision that authorized the issuance of the bed expansion COPN to St. Francis also authorized the issuance of COPN No. VA-04179 to West Creek Medical Center, Inc. ("West Creek"), an HCA entity, to establish a new 97-bed acute care hospital within PD 15 in Goochland County.[10]

5. West Creek appealed the issuance of the COPN No. VA-04178 to St. Francis under the APA. The Chesterfield Circuit Court determined West Creek did not have standing to appeal the Commissioner's approval of the bed expansion COPN to St. Francis. West Creek then appealed to the Virginia Court of Appeals, which in 2014 reversed the lower court's decision.[11] St. Francis ultimately relinquished COPN No. VA-04178 in 2015, providing witness testimony during the IFFC on the present COPN Request No. VA-8426 that it relinquished the original bed expansion COPN due to the substantial ongoing costs of litigation and uncertainties stemming from enactment of the Affordable

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[7] AR Record Ex. 5 (COPN Application) at Section I.

[8] AR Record Ex. 5 (COPN Application) at Section III.A. The Commissioner originally approved the establishment of St. Francis through the relocation and replacement of Stuart Circle Hospital in 1999. CJW Medical Center, an HCA entity that owns two hospitals south of the James River in PD 15, sought to establish "good cause" through filing of a petition, which the Commissioner denied. Pursuant to the APA, CJW Medical Center successfully appealed the Commissioner's denial of its petition, gaining status as a party to further administrative proceedings on remand. The Department's Adjudication Officer conducted the additional proceedings in 2002, following which the Commissioner again concluded there was a demonstrated public need for St. Francis and issued a new COPN for the hospital (COPN No. VA-03713).

[9] St. Francis IFFC Ex. 2 at 3; IFFC Tr. at 24-25 (Accashian).

[10] St. Francis IFFC Ex. 10. The COPN authorizing the establishment of West Creek Medical Center was conditioned on HCA's agreement to delicense and close 122 acute care beds at its Retreat Hospital, which is located in the City of Richmond and now is known as Retreat Doctors' Hospital.

[11] St. Francis IFFC Ex. 11.

Care Act (ACA) and the potential for the ACA to substantially impact the healthcare delivery system.[12] To date, HCA has not built its West Creek acute care hospital in Goochland.[13]

6. The St. Francis Project presently under review is substantially similar to the 2008 54-bed expansion project approved by the Commissioner. The project proposed by St. Francis today would expand the hospital's licensed by capacity by 55 acute care beds, including 42 medical/surgical, nine (9) obstetric and four (4) intensive care beds. The St. Francis Project entails a substantial capital improvement, i.e., the construction of two 2-story expansions to the hospital's existing critical care and patient towers and ancillary expansion and renovation to pharmacy, storage and dietary spaces as well as additional parking. In addition to increasing the hospital's licensed by capacity by 55 beds, the renovation and expansion also would accommodate a dedicated 10-bed observation unit.[14] The capital and financing costs of the project total $155.8 million.[15] Upon completion of the St. Francis Project, the hospital would have a total licensed bed complement of 185 acute care beds. St. Francis cites an institution-specific need to expand its bed capacity as the basis for its proposed expansion.

7. The administrative record reflects exceptionally strong public support for the St. Francis Project.[16]

8. A. The Proposed Projects in Relation to Specific Provisions of the Eight Statutory Considerations. Facts and conclusions[17] regarding the St. Francis Project and relating directly to the eight considerations[18] of public need, set forth and enumerated in subsection B of Virginia Code § 32.1-102.3,[19] as amended (the "statutory considerations"), appearing in bold type below, are set forth below in relation to each statutory consideration. Salient facts and conclusions about the project and relating to each statutory consideration include:

> **1. The extent to which the proposed service or facility will provide or increase access to needed services for residents of the area to be served, and the effects that the proposed service or facility will have on access to needed services in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.**
>
> Data and the SMFP's computational methodology reflect that PD 15 has a net need for

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[12] St. Francis IFFC Ex. 2 at 7; IFFC Tr. at 29-30 (Accashian).

[13] AR Ex. 5 (COPN Application) at Section IV.A.

[14] AR Ex. 5 (COPN Application) at Section III.A; St. Francis IFFC Ex. 2 at 5-6.

[15] AR Ex. 10 (Completeness Responses) at Section V.

[16] HCA Virginia submitted a letter objecting to the medical/surgical bed component of the St. Francis Project on August 21, 2019, two (2) days before the close of the administrative record. There is no other opposition to the St. Francis Project.

[17] Some statements and conclusions, appearing below and in direct relation to one statutory consideration, may carry significance and relevance in addressing one or more other statutory considerations.

[18] As set forth below, the statutory considerations are those set forth in statute *verbatim*, except that the first word of some discrete items have been capitalized, punctuation at the end of discrete items has been changed in a few instances for parallel treatment, and two usages of "and" has been removed.

[19] As amended, effective March 25, 2009. See Acts of Assembly, 2009, Chapter 175 (House Bill 1598).

additional intensive care beds[20] and a computational surplus of medical/surgical beds.[21, 22] St. Francis, however, cites an institution-specific need to expand its licensed bed capacity to address capacity constraints and ensure adequate access for its growing patient population. Despite ongoing, focused efforts to manage the demand for inpatient services on the St. Francis campus, including the 2011 establishment of its off-campus Westchester Emergency Center and significant expenditures on process improvement initiatives to maximize efficient throughput of patients, St. Francis maintains it remains capacity-constrained.[23] Absent an expansion of its licensed bed capacity as proposed, there do not appear to be any reasonable alternatives available to St. Francis to ensure that it remains available as an inpatient services resource for its service area population.[24]

St. Francis' service area population is growing. Its primary service area consists of sixteen zip codes, comprised largely of Chesterfield County as well as portions of Nottaway and Powhatan Counties and Colonia Heights. Its secondary service area is comprised of geographic regions to both the west and east of its primary service area.[25] Between 2018 and 2023, the combined service area population is projected to grow by 3.9 percent.[26] The senior population (aged 65+), which utilizes healthcare resources at a much greater rate, is expected to grow even more substantially, by 19.5 percent over the same time period.[27] This population growth can reasonably be expected to result in increased demand for inpatient services at St. Francis.

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[20] The DCOPN staff report identifies a net need for 67 intensive care beds in PD 15 under the calculation methodology set forth in 12 VAC 5-230-560. AR Ex. 17 (DCOPN Staff Report) at 15-17.

[21] The SMFP contains provisions for the establishment of obstetric services (12 VAC 5-230-900 through -930) but does not contain provisions for the expansion of obstetric services or a bed-need calculation methodology for determining the computational need for obstetric beds in a planning district.

[22] AR Ex. 17 (DCOPN Staff Report) at 14-16. As discussed herein, the DCOPN staff report identifies a computational surplus of 574 medical/surgical beds in PD 15 based on its calculation undertaken pursuant to 12 VAC 5-230-540. *Id.* at. 14. St. Francis in post-IFFC supplemental information identifies a computational surplus of 380 beds in PD 15 based on its calculation under the same SMFP provision. St. Francis Supplemental Ex. 1. St. Francis contends the discrepancy appears to be result of DCOPN's miscalculation of licensed adult medical/surgical beds and, in addition, their associated patient days. DCOPN included in its analysis Cumberland Hospital for Children and Adolescents (which maintains pediatric beds only), Vibra Hospital of Richmond (which is licensed as a long term acute care hospital (LTACH)), and West Creek Medical Center (which does not yet exist and is to be established through the relocation of bed capacity from Retreat Doctors' Hospital) and, in addition, appears to have overstated the medical/surgical bed capacity of certain of the acute care hospitals in PD 15 in Table 1 of its DCOPN staff report (e.g., Table 1 identifies Bon Secours Memorial Regional Medical Center as having 225 licensed medical/surgical beds when it actually is licensed for 185 medical/surgical beds, and identifies St. Francis, the applicant, as has having 130 medical/surgical beds when it actually is licensed for 93 medical/surgical beds). DCOPN further included in its analysis of medical/surgical bed need obstetric, intensive care and pediatric patient days across all PD 15 facilities. AR Ex. 17 (DCOPN Staff Report) at 13.

[23] IFFC Tr. at 31-36 (Accashian).

[24] "Bed capacity is really the only lever we have left to pull in terms of our ability to operate efficiently." *Id.* at 31 (Accashian).

[25] AR Ex. 5 at Section IV.B.1 and Exhibit IV.H.1.A; St. Francis IFFC Ex. 2 at 10.

[26] Notably, Chesterfield County, which comprises most of St. Francis' primary service area, is the largest locality in the Richmond Metropolitan Statistical Area (MSA), and the fourth largest county in the Commonwealth of Virginia. St. Francis states that the Chesterfield County population is projected to grow by 12% between 2010 and 2020, and by another 11% between 2020 and 2030. By 2030, the population is projected to reach 392,811. St. Francis IFFC Ex. 2 at 11-13; IFFC Tr. at 40-42 (Accashian).

[27] St. Francis IFFC Ex. 2 at 14; IFFC Tr. at 40-42 (Accashian).

No compelling or constructive argument involving access exists for restricting the reasonable addition of an incremental number of acute care beds at St. Francis as proposed.

2. The extent to which the project will meet the needs of the residents of the area to be served, as demonstrated by each of the following:

(i) The level of community support for the project demonstrated by citizens, businesses, and governmental leaders representing the area to be served;

DCOPN received a petition in support of the St. Francis Project containing more than 700 signatures, and in addition received more than 400 letters of support for the project.[28] The public hearing was well attended, with 68 individuals attending and indicating their support for the St. Francis Project.[29] No one who attended the public hearing spoke in opposition to, or otherwise indicated opposition to, the St. Francis Project, and DCOPN received no letters or other expressions of opposition to the project prior to the IFFC or within the several weeks thereafter. Late in the post-IFFC process, the PD 15 HCA Virginia hospitals stated their opposition to the project.

(ii) The availability of reasonable alternatives to the proposed service or facility that would meet the needs of the population in a less costly, more efficient, or more effective manner;

According to DCOPN, "the status quo is not a viable alternative to the proposed project."[30] I agree. DCOPN states that "St. Francis is currently operating over the threshold necessary to establish institutional need for intensive care beds."[31] St. Francis states that DCOPN concludes, however, St. Francis does not have sufficient occupancy to demonstrate an institutional need to expand its obstetric or medical/surgical bed complements, but simultaneously observes, "DCOPN has received numerous letters detailing the difficulties of St. Francis to accommodate additional patients at their facility with their current bed allotment, with patients often spending the night in the emergency room waiting for beds to become available. DCOPN additionally heard testimony from members of the community, staff, and volunteers at the facility corroborating these assertions."[32] Evidence provided in the form of witness testimony at IFFC further suggests that St. Francis is substantially capacity constrained and in my view demonstrates a compelling public need, expressed as an institution-specific need, for the full complement of beds proposed (42 medical/surgical, nine (9) obstetric, and four (4) intensive care). The demand for inpatient services expressed at St. Francis has exceeded St. Francis' current service capacity pursuant to an evaluation of the St. Francis Project under 12 VAC 5-230-80, as discussed in greater detail herein.

DCOPN also "suggests that reallocation of beds from within the Bon Secours Richmond Health System to St. Francis could be an alternative to the proposed project given the large surplus of medical/surgical beds in the planning district, provided that such reallocation does not result in a

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[28] AR Exhibit 17 (DCOPN Staff Report) at 6.

[29] *Id.*

[30] *Id.*

[31] *Id.*

[32] *Id.*

deficit of beds at the facility from which the beds are being reallocated."[33] I disagree and believe reallocation would be counterproductive.

According to the SMFP computational methodology, PD 15 does maintain a substantial surplus of licensed medical/surgical beds. DCOPN identifies a computational surplus of 574 medical/surgical beds, but in doing so appears to have miscalculated the number of existing licensed medical/surgical beds and patient days in PD 15.[34] St. Francis identifies a computational surplus of 380 medical/surgical beds, appearing to have corrected for the miscalculations in DCOPN's analysis.[35]

But regardless of the exact computational surplus of medical/surgical beds in PD 15, the surplus does not rest with Bon Secours Richmond Health System acute care hospitals. The four hospitals that comprise the Bon Secours Richmond Health System (Bon Secours Memorial Regional Medical Center, Bon Secours Richmond Community Hospital, Bon Secours St. Mary's Hospital and St. Francis) collectively are licensed for 588 medical/surgical beds, comprising 29.2% of the licensed medical/surgical beds in PD 15.[36] Bon Secours Richmond Health System hospitals staff almost all of their beds, with just three (3) of the 588 unstaffed (0.8%) at Bon Secours Richmond Community Hospital.[37] Similarly, VCU Medical Center, which is licensed for 437 medical/surgical beds, comprising 21.7% of the licensed medical/surgical beds in PD 15, staffs 100% of its licensed beds.[38] In contrast, HCA acute care hospitals in PD 15, which include Henrico Doctors' Hospital – Forest, Henrico Doctors' Hospital – Parham, Retreat Doctors' Hospital, Chippenham Medical Center, and Johnston-Willis Hospital, collectively are licensed for 986 medical/surgical beds (comprising 49.0% of the licensed/medical surgical beds in PD 15), but staff just 634.[39] Of the 355 unstaffed medical/surgical beds licensed to PD 15 acute care hospitals, 352 (99.2%) sit on the license of an HCA hospital.[40] While I have long held the view that beds are as much, if not more, a public resource than a proprietary asset,[41] no provision of the COPN law authorizes the Commissioner to compel a reallocation of licensed bed capacity between health systems to facilitate a demonstrated need for additional licensed beds at St. Francis.

Although Bon Secours Richmond Community Hospital's 2017 medical/surgical bed occupancy arguably suggests the hospital may maintain an excess complement of licensed beds,[42]

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[33] *Id.* at 7.

[34] *See* fn. 20 *supra*.

[35] St. Francis Supplemental Ex. 1.

[36] St. Francis IFFC Ex. 2 at 19.

[37] *Id.* at 17-21.

[38] *Id.* at 18-20.

[39] *Id.* at 17-20.

[40] *Id.* at 21.

[41] St. Francis IFFC Ex. 10 at Adjudication Officers' report, p. 13, fn. 45.

[42] *See* AR Ex. 17 (DCOPN Staff Report) at 2, Table 1. Table 1 is cited for purposes of generally observing Bon Secours Richmond Community Hospital's medical/surgical bed occupancy. I note, however, that Table 1 appears to overstate the hospital's licensed medical/surgical bed capacity by five beds. DCOPN identifies Richmond Community Hospital as having 64 licensed medical surgical beds whereas the applicant identifies the hospital as having 59 licensed medical/surgical beds. *See* St. Francis IFFC Ex. 2 at 17; St. Francis Supplemental Ex. 1.

relocation of beds from Richmond Community to St. Francis would be imprudent and inadvisable. Bon Secours Richmond Community Hospital plays an essential role in the health of the population it serves in the historically underserved East End of the City of Richmond and moving beds out of the facility to St. Francis in Chesterfield County would serve only to compromise Bon Secours Richmond Community Hospital's efforts to reinvigorate the community it serves.[43] Importantly, Bon Secours Richmond Community Hospital participates in the federal government's 340B drug pricing program and is a disproportional share hospital (DSH).[44] Participation in these programs, which is impacted in part by the hospital's licensed bed capacity, is an essential component of the hospital's ability to provide ongoing support and investment in the East End.[45]

(iii) Any recommendation or report of the regional health planning agency regarding an application for a certificate that is required to be submitted to the Commissioner pursuant to subsection B of § 32.1-102.6;

This statutory consideration is not applicable. No regional health planning agency serves HPR IV by submitting recommendations to the Commissioner addressing proposed projects within HPR IV.

(iv) Any costs and benefits of the project;

The total capital and financing costs for the St. Francis Project are $155,764,458. As DCOPN recognizes, "[t]he costs for the project are reasonable and consistent with previously approved projects to add new acute care beds through the expansion of existing towers."[46]

The benefits of the St. Francis Project are significant. In my report and recommendation to the Commissioner on St. Francis' 2008 COPN Request No. VA-7530 to expand its licensed bed capacity by 54 beds (adopted by the Commissioner in the issuance of COPN No. VA-04178), I observed that, "[a]llowing the addition of a reasonable contingent of med-surg beds at SFMC, along with the OB-bed addition, to be implemented in one fell swoop and in connection with the construction of two floors atop SFMC's hospital tower, appears generally prudent and appropriate."[47] My view remains unchanged for the substantially similar 55-bed project presently under review. St. Francis has demonstrated that it faces ongoing capacity constraints that can be remedied only thought the addition of licensed bed capacity.[48]

(v) The financial accessibility of the project to the residents of the area to be served, including indigent residents; and

Evidence in the administrative record indicates that St. Francis' inpatient services are financially accessible and will remain so if the St. Francis Project is approved. The Bon Secours

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[43] *See* IFFC Tr. at 59-74 (Quiriconi).

[44] *Id.* at 60, 73 (Quiriconi).

[45] *Id.* Bon Secours Richmond Health System's Chief Financial Officer identified a number of efforts undertaken by Bon Secours to reinvest in and reinvigorate the East End. *Id.* at 65-73 (Quiriconi).

[46] AR Ex. 17 (DCOPN Staff Report) at 8.

[47] St. Francis IFFC Ex. 10 at Adjudication Officer's report, p. 7.

[48] St. Francis is the second to the smallest hospital in PD 15 and is challenged to meet the increasing demands of a growing patient population with just 130 licensed beds. Even with the addition of the proposed 55 licensed beds, St. Francis will remain the second to the smallest in PD 15 with 185 beds. St. Francis IFFC Ex. 2 at 16.

Richmond Health System, of which St. Francis is a part, has well established policies and procedures for ensuring appropriate charity care. St. Francis is subject to a 3.0% hospital-wide charity care condition established in 2003 through a condition imposed on COPN No. VA-03713.

(vi) At the discretion of the Commissioner, any other factors as may be relevant to the determination of public need for a project.

In the 2003 case decision authorizing the establishment of St. Francis (COPN No. VA-03713), the Commissioner found that St. Francis would "inject an element of beneficial competition in PD 15 and address strong indications of market concentration, relating to two geographically-distinct areas of behavior within a larger economic market, thereby promising several benefits, including lower costs and prices, and greater accessibility to, quality of and efficiency in rendering health care services."[49] The utilization and occupancy data provided by the applicant and which serve as the basis for the proposed bed expansion confirm that St. Francis has provided beneficial competition to the community it serves in PD 15. The addition of the proposed 55 beds at St. Francis reasonably can be expected to alleviate the ongoing capacity constraints the facility faces in its current 130-bed configuration and enable St. Francis to continue to provide beneficial competition south of the James River in PD 15.[50]

3. The extent to which the application is consistent with the State Medical Facilities Plan.

The COPN law requires that "[a]ny decision to issue . . . a certificate shall be consistent with the most recent applicable provisions of the [SMFP] . . . ."[51] The SMFP, adopted as an amended regulation by the State Board of Health in 2009, and contained in the Virginia Administrative Code ("VAC") at 12 VAC 5-230-10 *et seq.*, includes several provisions applicable to a project proposing the addition of inpatient beds.

Driving Time Standards. The SMFP's driving time standard for inpatient beds provides that

> Inpatient beds should be within 30 minutes driving time one way under normal conditions of 95% of the population of a health planning district using a mapping software as determined by the commissioner.[52]

DCOPN concludes that medical/surgical beds and services are currently available within the driving times and to the required percentage of residents set forth in this standard. I find no reason to

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[49] St. Francis Supplemental Ex. 2 (Commissioner's 2003 case decision issuing COPN No. VA-03713) at Commissioner's case decision, p. 3.

[50] Monica Noether, a nationally-recognized health economist who testified on behalf of St. Francis during the 2002 administrative proceedings regarding the establishment of St. Francis, also testified on behalf of St. Francis on the proposed 55-bed expansion, observing "[t]he addition of 55 beds at St. Francis will allow it to compete more effectively by alleviating the capacity constraint that really – currently limits its ability to do that. And this will provide patients, particularly those who live south of the James River[,] with more choice for their hospital care." IFFC Tr. at 130 (Noether).

[51] Va. Code § 32.1-102.3.

[52] 12 VAC 5-230-520.

disagree, but note that in light of St. Francis' currently high bed occupancy rate, additional beds appear to be needed to ensure timely patient access to inpatient services at St. Francis.[53]

Need for new medical/surgical beds. DCOPN's calculations under the SMFP standard addressing the need for new medical/surgical beds reflect an excess of medical/surgical beds in PD 15.[54] Specifically, DCOPN identifies a total of 2,949 beds and a computational surplus of 574 medical/surgical beds in PD 15 based on its calculation undertaken pursuant to 12 VAC 5-230-540.[55] However, St. Francis argues that the surplus identified by DCOPN is overstated.[56]

St. Francis in post-IFFC supplemental information identifies a computational surplus of 380 medical/surgical beds in PD 15 based on its calculation under the same SMFP provision, apparently correcting for DCOPN's miscalculation of licensed medical/surgical beds in PD 15.[57] Furthermore, St. Francis observes, I believe appropriately, that the computational surplus does not rest within the Bon Secours Richmond Health System's complement of acute care hospitals. There are 2,011 licensed medical/surgical beds in PD 15.[58] 588 (29.2%) are licensed to Bon Secours Richmond acute care hospitals, 437 (21.7%) are licensed to VCU Medical Center, and 986 (49%) are licensed to HCA acute care hospitals.[59] Of the 2,011 licensed medical/surgical beds, 355 are unstaffed, with nearly all (352 of the 355, or 99.2 percent) sitting on the license of an HCA hospital.[60] When the PD 15 computational surplus of 380 medical/surgical beds identified by St. Francis is adjusted by the 355 unstaffed medical/surgical beds, the computational surplus is reduced to 25 medical/surgical beds.

Need for new intensive care beds. DCOPN identifies a need for 67 additional intensive care beds in PD 15 pursuant to the calculation methodology set forth in 12 VAC 5-230-560.[61] Although St. Francis' proposes to expand licensed bed capacity based on institution-specific need, the four (4) intensive care beds to be added as part of the St. Francis Project would reduce the need for intensive care beds in PD 15 to 63.

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[53] St. Francis IFFC Ex. 2 at 9; St. Francis IFFC Ex. 6 at 21-33.

[54] AR Ex. 17 (DCOPN Staff Report) at 12-14.

[55] *Id.* at 14.

[56] DCOPN included in its analysis Cumberland Hospital for Children and Adolescents (which maintains pediatric beds only), Vibra Hospital of Richmond (which is licensed as a long term acute care hospital (LTACH)), and West Creek Medical Center (which does not yet exist and is to be established through the relocation of bed capacity from Retreat Doctors' Hospital) and, in addition, appears to have overstated the medical/surgical bed capacity of certain of the acute care hospitals in PD 15 in Table 1 of its DCOPN staff report (e.g., Table 1 identifies Bon Secours Memorial Regional Medical Center has having 225 licensed medical/surgical beds when it actually is licensed for 185 medical/surgical beds, and identifies St. Francis, the applicant, as has having 130 medical/surgical beds when it actually is licensed for 93 medical/surgical beds). *Id.* at 2. DCOPN further included in its analysis of medical/surgical bed need obstetric, intensive care and pediatric patient days across all PD 15 facilities. AR Ex. 17 (DCOPN Staff Report) at 13.

[57] St. Francis Supplemental Ex. 1.

[58] Based on 2017 data publicly available from VHI. *See* St. Francis Supplemental Ex 1.

[59] St. Francis IFFC Ex. 2 at 19.

[60] *Id.* at 17-18, 21.

[61] AR Ex. 17 (DCOPN Staff Report) at 17.

Need for obstetric beds. The SMFP includes provisions for the establishment of obstetric services,[62] but does not include provisions addressing the expansion of licensed bed capacity within an existing obstetric service. St. Francis proposes to add nine (9) obstetrical beds to its existing complement based on institution-specific need. In fiscal year 2018, St. Francis' existing 21 obstetric beds exceeded 65% occupancy 245 days (67%) of the year.[63] Some 60 days during the year St. Francis had more obstetric patients admitted to the hospital than it had available obstetric beds, resulting in patients being boarded in the emergency department or labor, delivery and recovery beds.[64]

Institutional need. DCOPN identifies St. Francis' 114 medical/surgical and obstetric beds as having a combined occupancy rate of 76.4 percent in 2017, and its 16 intensive care beds has having an occupancy rate of 62.4 percent.[65] Accordingly, based on 2017 occupancy, St. Francis' medical/surgical and obstetric beds operated at 95.5 percent of the 80 percent occupancy standard for medical/surgical beds established by 12 VAC 5-230-530.A.2.a and 96.2 percent of the 65 percent occupancy standard for intensive care beds established by 12 VAC 5-230-530.A.2.b.[66] The applicant provides additional compelling evidence that such occupancy rates belie the true utilization of its inpatient beds, which is even higher than reflected by the SMFP calculation methodology.

First, St. Francis, like many other hospitals, is increasingly providing inpatient-level care to patients categorized by the Medicare program as "observation" patients. Observation patients are classified as outpatients by the Medicare program for reimbursement purposes, but receive inpatient services and may occupy a bed in the hospital for up to three (3) days without requiring an inpatient admission. For hospitals like St. Francis that do not have dedicated observation units, these observation patients occupy a licensed bed. Taking this patient population into consideration can have a material impact on bed utilization; in St. Francis' case, including observation patients in the analysis of its 2017 medical/surgical bed occupancy results in an average occupancy of 83.2 percent.[67]

Second, St. Francis' medical/surgical bed complement is distributed across several units designed and staffed specifically to meet the care needs of a particular patient population (i.e., medical vs. surgical) and to ensure, to the maximum extent possible, that patients admitted to the hospital for surgery and who are otherwise healthy are not exposed to sick patients suffering from infectious disease or other illness.[68] These dedicated units, and the need to avoid wherever possible the co-mingling of distinct patient populations, creates additional capacity constraints. The applicant has

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[62] 12 VAC 5-230-900 through -930.

[63] St. Francis IFFC Ex. 6 at 33.

[64] IFFC Tr. at 108 (Bachrodt).

[65] AR Ex. 17 (DCOPN Staff Report) at 7, Table 10.

[66] The 80% occupancy standard set forth in 12 VAC 5-230-530 applies to medical/surgical and pediatric beds. Although DCOPN includes obstetric beds in its analysis, the SMFP does not establish a bed occupancy rate for the expansion of an existing obstetric service. Provisions relevant to the establishment of an obstetric service are set forth in 12 VAC 5-230-900 through -930.

[67] IFFC Tr. at 36-38 (Accashian); St. Francis IFFC Ex. 2 at 9. The 83.2% occupancy rate is based on the conservative assumption that each observation patient remained in an inpatient bed for 24 hours. As noted by the applicant, patients may remain under observation status for up to three (3) days. Accordingly, 83.2% occupancy may understate the actual impact of observation patients on the occupancy rate of St. Francis' medical/surgical beds.

[68] Separation of surgical patients from medical patients admitted to the hospital with infectious disease or other illness appears to be a widely-accepted best practice. IFFC Tr. at 13-15 (counsel to the applicant's opening remarks); 102-04 (Bachrodt).

provided credible evidence demonstrating that its units regularly exceed their maximum capacity,[69] so much so that the hospital has not had any alternative other than to have its 4th floor surgical unit serve as an overflow unit for its 5th floor medical unit.[70]

St. Francis' high occupancy rate is sufficient to warrant the addition of the full proposed complement of medical/surgical, obstetric and intensive care beds pursuant to the SMFP's institutional need provision.[71]

Staffing. As an established hospital, St. Francis' inpatient services are and will be "under the direction or supervision of one or more qualified physicians."

Taken as a whole, the evidence in the administrative record establishes that the St. Francis Project is consistent with the applicable provisions of the SMFP, and specifically the institutional need provision thereof (12 VAC 5-230-80).

4. The extent to which the proposed service or facility fosters institutional competition that benefits the area to be served while improving access to essential health care services for all persons in the area to be served.

Among the reasons the Commissioner issued a COPN in 2003 for the establishment of St. Francis through the relocation and replacement of Bon Secours Stuart Circle Hospital was the promise of beneficial competition. Recognizing that the James River serves as the dividing line for two relatively distinct healthcare markets north and south of the James River in PD 15, the Commissioner based his decision in part on a determination that St. Francis would "inject an element of beneficial competition in PD 15 and address strong indications of market concentration, relating to two geographically-distinct areas of behavior within a larger economic market, thereby promising several benefits, including lower costs and prices, and greater accessibility to, quality of and efficiency in rendering health care services."[72]

By all indications, St. Francis has been successful, offering choice and providing beneficial competition for healthcare services south of the James River. Residents of St. Francis' service area are choosing to obtain healthcare services from St. Francis, so much so that utilization has resulted in

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[69] The applicant submitted evidence demonstrating that its progressive care unit, comprised of 21 beds, met or exceed 80% occupancy 341 days (93%) of the year in FY 2018, and that its 5th floor 36-bed medical unit met or exceeded 80% occupancy 261 days (72%) of the year in FY 2018. Its 4th floor 36-bed surgical unit, where volume is largely driven off of the dates surgeons and their patients schedule their surgical cases, experienced lower average occupancy (meeting or exceeding 80% occupancy 127 days (35%) of the year in FY 2018), but high occupancy on Mondays (83%), Tuesdays (84%) and Wednesdays (78%). St. Francis IFFC Ex. 6 at 21-22; IFFC Tr. at 101-105 (Bachrodt). Notably, these occupancy rates are based on analysis of inpatient data only, and do not include observation patients. IFFC Tr. at 105 (Bachrodt). On average, an additional 4.2 observation patients occupy a bed in St. Francis' 4th floor 36-bed unit, an additional 4.4 observation patients occupy a bed in St. Francis' 5th floor 36-bed unit, and an additional 1.5 observation patients occupy a bed in St. Francis' progressive care unit. *Id.* at 105-06 (Bachrodt); St. Francis IFFC Ex. 6 at 24.

[70] *Id.* at 103 (Bachrodt).

[71] 12 VAC 5-230-80.

[72] St. Francis Supplemental Ex. 2 (Commissioner's 2003 case decision issuing COPN No. VA-03713), at Commissioner's case decision, p. 2. *See also* IFFC Tr. at 128-29 (Noether).

substantial capacity constraints that can be resolved only through the addition of bed capacity.[73] Approval of the St. Francis Project will enable St. Francis to alleviate its capacity constraints and to compete more effectively, thereby enhancing access and patient choice for healthcare services south of the James River.[74]

5. The relationship of the project to the existing health care system of the area to be served, including the utilization and efficiency of existing services or facilities.

The St. Francis Project currently under review is substantially similar to a 54-bed expansion project proposed by St. Francis and approved by the Commissioner in 2008. In my report and recommendation to the Commissioner in 2008, I observed the then-proposed expansion was "relatively modest, comprising a request for 54 beds – equivalent to less than two percent of the total number of licensed beds in PD 15."[75] My view has not changed. St. Francis was then and is now "one of the smaller hospitals in PD 15 and is located in an overall area of the metropolitan region generally expected to experience continued and sustained growth."[76] Of the ten inpatient acute care hospitals presently in operation in PD 15, St. Francis is currently the second smallest.[77] It will remain in the second smallest acute care hospital in the planning district even following the addition of the proposed 55 beds.[78]

At 130 licensed beds, St. Francis appears to be undersized to meet the needs of its growing and aging service area population. In my report and recommendation to approve the 2008 project, I noted the original considerations relevant to determining the size of the hospital, specifically observing as follows:

> SFMC's current 130 acute-care bed contingent reflects an effort, circa 1999 (the date of its initial certification) and carried through 2005 (the date of its second, post-judicial-review certification), to size the then-proposed hospital according to (i) low utilization experienced by the increasingly-bypassed hospital it replaced – Bon Secours Stuart Circle Hospital – and (ii) a then-continuing belief that the general effects of managed care, as a healthcare management strategy, would act to continually suppress bed utilization and had broken a directly-proportional relationship between general population growth and increases in bed utilization. In recent years, several downsized-replacement hospitals have sought incremental increases in their bed complements. Populations have experienced some general aging. Such considerations may counsel effectively against a

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[73] St. Francis' CEO testified to the measures the hospital has undertaken to address its capacity constraints (*see, e.g.*, IFFC Tr. at 31-34, 49-51 (Accashian)), and described the proposed addition of bed capacity as "the only lever we have left to pull in terms of our ability to operate efficiently." *Id.* at 31.

[74] *See* IFFC Tr. at 130 (Noether) ("The addition of 55 beds at St. Francis will allow it to compete more effectively by alleviating the capacity constraint that really – currently limits its ability to do that.")

[75] St. Francis IFFC Ex. 10 at Adjudication Officer's Report, p. 6.

[76] *Id.* at 7.

[77] Bon Secours Richmond Community Hospital is the only acute care hospital with fewer licensed acute care beds than St. Francis. Bon Secours Richmond Community Hospital is licensed for 104 acute care beds. St. Francis IFFC Ex. 2 at 16.

[78] *Id.*; IFFC Tr. at 44 (Accashian).

parsimonious response to a generally reasonable request for an incremental increase in resourcing.[79]

These observations remain relevant in the current review.

6. The feasibility of the project, including the financial benefits of the project to the applicant, the cost of construction, the availability of financial and human resources, and the cost of capital.

The pro forma financial statements provided by the applicant indicates that St. Francis Project is feasible.[80] The costs of construction are reasonable in light of the scope of the project, and financial and human resources are available. The cost of capital, as that matter is conventionally understood under this statutory consideration, does not appear to present an issue.

7. The extent to which the project provides improvements or innovations in the financing and delivery of health services, as demonstrated by:

(i) The introduction of new technology that promotes quality, cost effectiveness, or both in the delivery of health care services;

Not applicable.

(ii) The potential for provision of services on an outpatient basis;

Not applicable.

(iii) Any cooperative efforts to meet regional health care needs; and

Not applicable.

(iv) At the discretion of the Commissioner, any other factors as may be appropriate.

No additional factors relating to the review of this project are remarkable or call for the exercise of the Commissioner's discretion in identifying or evaluating them in relation to the application as gauged under this item of the seventh statutory consideration.

8. In the case of a project proposed by or affecting a teaching hospital associated with a public institution of higher education or a medical school in the area to be serve (i) the unique research, training, and clinical mission of the teaching hospital or medical school, and (ii) any contribution the teaching hospital or medical school may provide in the delivery, innovation, and improvement of health care for citizens of the Commonwealth, including indigent or underserved populations.

Not applicable.

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[79] St. Francis IFFC Ex. 10 at Adjudication Officer's Report, p. 6-7, fn.18.

[80] AR Exhibit 17 (DCOPN Staff Report) at 21.

B. The Proposed Project in Relation to the Statutory Considerations and the COPN Law Generally. In relation to all eight statutory considerations, appearing in bold type above, and upon review of the administrative record compiled in relation to the proposed project (including the application, the transcript of the IFFC, the DCOPN staff report and the IFFC-related submittals of the applicant's counsel), I believe that sufficient data and information exist to substantiate the recommendation made below. Specifically, the administrative record presents, overall, a sufficient basis for approval of the St. Francis Project. Reference to the record is made, and reliance on administrative precedent, consistent with the APA,[81] is asserted.

I have explored all major issues pertinent to making public need determinations in relation to this project, giving evaluative attention to both the salient facts in the record and the pertinent considerations in the process of applying the COPN law in adjudicatory review of the St. Francis Project. I present this document and the following recommendation to the Commissioner, for his consideration in a public need determination, *i.e.*, a case decision on the project captioned at the head of this document, as called for by operation of the COPN law.

IV. Recommendation

The recommendation made herein follows a full review of the application and related documents seeking approval of the addition of 55 acute care beds at St. Francis. I have heard from counsel to the applicant, who have argued the applicant's position. I have closely considered the public analysis represented in the DCOPN staff report.

Based on my assessment, I conclude that the St. Francis Project merits approval. St. Francis should receive a Certificate authorizing the proposed project. The St. Francis project is necessary to meet a public need.

In addition to conclusions drawn throughout this document, specific reasons for my recommendations include:

(i) The St. Francis Project is consistent with the SMFP, or is in overall harmony or general agreement with the SMFP and public interests and purposes to which that plan is devoted;

(ii) The St. Francis Project is a reasonable, incremental response that addresses a public need, expressed as an institution-specific need, for additional acute care resources;

(iii) Approval of the St. Francis Project may reasonably be expected to have little, if any, negative effect on competition or the utilization of existing providers of inpatient services in PD 15;

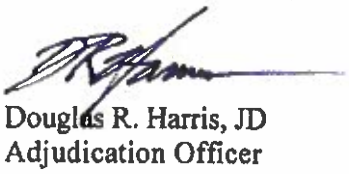
(iv) The St. Francis Project would promote operational efficiency and provide for an increase in facility-based, clinical sophistication, and thereby can reasonably be expected to enhance beneficial competition; and

[81] Specifically, see, Va. Code § 2.2-4019 (B).

(v) The St. Francis Project enjoys strong community support.

I further recommend that any certificate authorizing the St. Francis Project include a condition confirming the applicability of the existing St. Francis hospital-wide charity care condition.

Respectfully submitted,



October 29, 2019

Douglas R. Harris, JD
Adjudication Officer