

THE STATE OF SOUTH CAROLINA

In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
Ralph King Anderson III, Administrative Law Judge

Appellate Case No. 2014-000973
Case No. 2012-ALJ-07-0090-CC

Grand Strand Regional Medical Center, LLC Respondent,
v.

South Carolina Department of Health and
Environmental Control.....Respondent below.

Case No. 2012-ALJ-07-0091-CC

Grand Strand Regional Medical Center, LLC Respondent,
v.

South Carolina Department of Health and
Environmental Control and Carolina Regional Cancer Center, LLC ... Respondents below,

Of whom Carolina Regional Cancer Center, LLC is the Appellant.

RECORD ON APPEAL

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STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Grand Strand Regional Medical
Center, LLC,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control,

Respondent.

Docket No.: 12-ALJ-07-0090-CC

**AMENDED FINAL ORDER
AND DECISION**

Grand Strand Regional Medical
Center, LLC,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control and Carolinas
Regional Cancer Center,

Respondents.

Docket No.: 12-ALJ-07-0091-CC

(Consolidated)

Appearances:

For Petitioner Grand Strand: William R. Thomas, Esq. and Walter H. Cartin, Esq.

For Respondent CRCC: James G. Long III, Esq.; E. Wade Mullins, III, Esq.;
and Jennifer J. Hollingsworth, Esq.

For Respondent SC DHEC: Ashley C. Biggers, Esq.

STATEMENT OF THE CASE

The above-captioned matters come before the South Carolina Administrative Law Court (ALC or Court) upon the requests of Petitioner Grand Strand Regional Medical Center, LLC (Grand Strand) for a contested case hearing to review the decisions of Respondent South

FILED

APR - 4 2014

SOUTH CAROLINA LAW COURT

R000007

Carolina Department of Health and Environmental Control (DHEC or the Department) (1) to deny Grand Strand's Certificate of Need (CON) application for the addition of a linear accelerator and CT Simulator for a radiation therapy center at its hospital location in Myrtle Beach, South Carolina; and (2) to approve the CON application of Respondent Carolina Regional Cancer Center (CRCC) for an additional linear accelerator to expand its existing linear accelerator services to Conway, South Carolina.¹ CRCC moved to intervene in the matter pending between Grand Strand and the Department, which was granted in an Order dated May 4, 2012. Also, the cases were consolidated by a Consent Order also dated May 4, 2012. After timely notice to the parties, the Court conducted a hearing on the merits September 12, 2013 through September 24, 2013. On March 20, 2014, CRCC filed a Motion to Alter or Amend the Court's Final Order and Decision dated March 10, 2014. On March 28, 2014, Grand Strand filed a Memorandum in Opposition to CRCC Motion to Alter or Amend.² After careful consideration of the arguments made by both parties, the Court has amended its March 10, 2014 Order accordingly below.

The Department found the CON applications to be competing applications as defined by the CON Regulations. CRCC supports DHEC's finding that Grand Strand's and its CON applications are competing and that Grand Strand's application should be denied. Grand Strand, on the other hand, challenges the Department's finding that the CON applications are competing applications and argues in the alternative that even if the applications were competing, DHEC should have approved Grand Strand's application and denied CRCC's application because Grand Strand's application more fully complies with the South Carolina CON Act, its regulations, and the applicable South Carolina Health Plan (State Health Plan or Health Plan).

I find that Grand Strand's and CRCC's CON applications are not competing applications as defined by the applicable law and both applications satisfy the State Health Plan, the Project Review Criteria (PRC),³ and the purposes of the Certificate of Need Act. Furthermore, there is a

¹ Initially, an additional applicant and petitioner, North Strand Radiation Oncology Center (North Strand) filed a contested case challenging DHEC's denial of its CON application and the approval of CRCC's CON application, but North Strand withdrew from the contested case and was formally dismissed with prejudice on March 5, 2013.

² Grand Strand filed a hard copy and electronic copy of its Memorandum on March 28, but due to an error in the Court's emailing system, the electronic version that Grand Strand submitted was not discovered by the Court until March 31.

³ The PRC, consisting of 33 general criteria, including subcriteria, are set forth in 3 S.C. Code Ann. Reg. 61-15 § 802 (Supp. 2013). Each criterion will henceforth be referred to using PRC in place of the regulatory citation followed by the subsections. For example, 3 S.C. Code Ann. Reg. 61-15 § 802(2)(b) will be cited as PRC 2(b).

need for two additional linear accelerators in the Service Area⁴ under the 2012-2013 State Health Plan. In reaching this decision, this Court compared the CON applications to determine which application more fully complied with the requirements, goals, and purposes of the CON program, State Health Plan, PRC, and the regulations developed by the Department. Therefore, I conclude that both CRCC and Grand Strand should be granted CONs.

FINDINGS OF FACT

Having observed the witnesses and exhibits present at the hearing and closely passed upon their credibility, taking into consideration the burden of proof upon the parties, I make the following Findings of Fact by a preponderance of the evidence:

The Parties

Grand Strand, a for-profit subsidiary of Hospital Corporation of America (HCA),⁵ is a 269-bed tertiary-care hospital located in Myrtle Beach, South Carolina, that opened in 1978. Grand Strand is an accredited community cancer center by the Commission on Cancer of the American College of Surgeons.

CRCC is a freestanding radiation therapy provider currently operating three linear accelerators at one location in Myrtle Beach, South Carolina. CRCC's Myrtle Beach facility is located three miles from Grand Strand's campus. CRCC is a 100% subsidiary of Atlantic Urology Clinics, LLC (AUC), which is a 100% subsidiary of 21st Century Oncology of South Carolina, LLC, which is, in turn, a 100% subsidiary of Radiation Therapy Service, Inc. (21st Century).⁶ CRCC has been approved for, but has not been issued, a CON to relocate one of its three linear accelerators from its facility in Myrtle Beach, South Carolina, to a facility in Murrells Inlet, South Carolina, which is located in northern Georgetown County.

Applications at Issue

The applications at issue in this case are for the three-county Service Area. CRCC filed an application on March 10, 2011, to install a Varian TrueBeam linear accelerator (TrueBeam)

⁴ The Service Area consists of three counties comprised of: Horry, Georgetown, and Williamsburg Counties (Service Area).

⁵ HCA is the nation's largest provider of hospital services, based out of Nashville, TN, with approximately 174 hospitals. HCA operates about 40 linear accelerators across the country.

⁶ 21st Century is the largest provider of radiation therapy services in the United States. It operates approximately 100 radiation therapy centers in 16 U.S. States and approximately 30 additional centers in South America, employing over 125 radiation oncologists and more than 250 oncology-related physicians.

and a CT simulator⁷ at a new location in Conway, South Carolina to provide conventional, Intensity Modulated Radiation Therapy (IMRT), and Image-Guided Radiation Therapy (IGRT) radiotherapy services to treat cancer patients in the Service Area. Grand Strand subsequently filed an application on July 19, 2011, to install a Varian Clinac iX linear accelerator (Clinac iX) and a CT simulator on the campus of its hospital in Myrtle Beach, South Carolina to provide conventional, IMRT, and IGRT radiotherapy services to treat cancer patients in the Service Area.

Radiotherapy, or "radiation therapy," is a service covered by the State Health Plan. Radiation therapy is one of three major modalities to treat cancer, along with surgery and chemotherapy. Between 50% and 60% of all cancer patients receive radiation therapy as part of their cancer treatment. External beam radiation therapy is the most common form of radiation therapy, which focuses the beam of radiation to a precise treatment field with fewer side effects. IMRT and IGRT are types of external beam radiation therapy.

A linear accelerator delivers an external beam of radiation to the patient. It puts out high-energy radiation to reach the tumor, with the ability to rotate 360° around the patient to treat from any angle. Before radiation therapy begins, the treatment is planned using a CT scan with a CT Simulator, which identifies the tumor, and nearby vital structures to avoid. The doctor then uses the results of the CT scan to enter of coordinates for the radiation to enter the patient's body.

Though radiation therapy is used to treat many different types of cancer, it is most commonly used for breast cancer, prostate cancer, lung cancer, and metastatic cancer (where the cancer has spread from its primary site). Radiation therapy can be a palliative treatment (to provide pain relief) and/or a curative treatment (to cure the disease). The overwhelming majority of radiation therapy is delivered on an outpatient basis. The patient is typically treated once a day, five days per week, for a number of weeks. The number of radiation therapy treatments a patient will have depends on several factors, including the type of cancer, the stage of the cancer, and the size of the tumor. The average number of treatments for commonly seen cancers is typically thirty or more treatments for each patient, though some patients receive fewer treatments due to the location of the tumor or the advance stage of the disease.

⁷ A CT simulator stands for Computerized Tomography scanner and is used to identify tumors and surrounding tissue in order to plan the precise radiation therapy treatment.

Both Applicants (CRCC and Grand Strand) applied under the 2010-2011 State Health Plan, each projecting that its proposed linear accelerator will achieve more than 50% capacity (3,500 treatments) by the third year. The 2010-2011 State Health Plan sets forth the Plan standards for Radiotherapy. The 2010-2011 State Health Plan states that the "following project review criteria are considered to be the most important in evaluating [CON] applications for [radiation therapy] services: (a) Compliance with the Need Outlined in this Section of the Plan; (b) Community Need Documentation; (c) Distribution (Accessibility); (d) Projected Revenues; (e) Projected Expenses; (f) Financial Feasibility; and (g) Cost Containment." Additionally, the State Health Plan states that the "benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service."

The following standards from IX-5, -6 of the 2010-2011 State Health Plan are directly applicable to the CON applications in this case and are relevant to the ultimate decision:

- 1.⁸ The capacity of a conventional linear accelerator . . . is 7,000 treatments per year.
2. Linear accelerators providing IMRT or IGRT have a capacity of 5,000 treatments per year. A Facility must document that it is providing or will provide these specialized treatments in sufficient volume to justify why it should be held to this planning capacity.
* * *
6. New Radiotherapy services shall only be approved if the following conditions are met:
 - A. All existing units in the service area have performed at a combined use rate of 80 percent of capacity for the year immediately preceding the filing of the applicant's CON application; and
 - B. An applicant must project that the proposed service will perform a minimum number of treatments equal to 50 percent of capacity annually within three years of initiation of services, without reducing the utilization of the existing machines in the service area below the 80 percent threshold
7. Expansion of an existing service, whether the expansion occurs at the existing site or at an alternate location in the service area, shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for each of the past two years and can project a minimum use rate of 50 percent of capacity per year on the additional equipment within three years of its implementation.

⁸ Each of these numbers is a subsection under Chapter IX, Section 4 of the 2010-2011 State Health Plan.

8. The applicant shall project the utilization of the service and document referral sources for patients within its service area, including letters of support from physicians and health care facilities indicating a willingness to refer patients to the proposed service, with expected annual referral volumes.

* * *

Standards 6(A) and 6(B) apply to Grand Strand as a new provider, but not to CRCC, while Standard 7 applies to CRCC because its proposal is an expansion project.

Need for a Linear Accelerator in the Service Area

Grand Strand presented Dan Sullivan as a healthcare planning and finance consultant. Mr. Sullivan explained the need for the CON application and presented a review of the competing CON applications. Mr. Sullivan has worked on CON applications for three decades, concentrating on radiation therapy services for the past seven to eight years. He is very familiar with the Service Area in terms of the market for acute care and radiation therapy. He is also familiar with the applicable Health Plans and has been qualified as an expert in healthcare planning and finance in South Carolina and nearly a dozen other states. I find that Mr. Sullivan is a well-qualified and accomplished expert in healthcare planning and finance and will be basing these findings of fact on the analysis used by Mr. Sullivan unless otherwise indicated.

According to the 2010 U.S. Census data, Horry County has 269,291 people, the majority of the population in the Service Area, and four times the population of Georgetown County. Horry County has the fastest population growth in the Service Area, and there is a strong indication that the future demand for radiation therapy services would be greatest in Horry County since the fastest growing segment of society is the aged-65-and-older category, which has the highest incidence of cancer.

In the year immediately preceding the filing of its CON application, all existing units in the Service Area were performing well above the 80% threshold, as required by Standard 6(A) in the Health Plan.⁹ Generally, between 50% and 60% of all cancer patients will require radiation therapy. Grand Strand applied 55% to new cancer cases. Taking the cancer incidence rate and applying it to the age-specific component of population in each of the Service Area's three

⁹ The total percentage of utilization for the Service Area in 2010 was 110.3%.

counties, there would be 2,622 cancer cases by 2015, with 1,442 patients, or 55%, requiring radiation therapy.¹⁰ This represents a growth of 194 new cancer cases over the 2010 estimate.

At the time of the filing of the applications, the 2010-2011 State Health Plan was in effect. The 2010-2011 State Health Plan indicates that the four existing linear accelerators in the Service Area, three at CRCC and one affiliated with Georgetown Memorial Hospital (GMH), were operating at 80.5% of capacity, based on a total 2009 Service Area utilization of 20,918 "Total Area Treatments" with a "Planning Area Capacity" of 26,000 treatments. Since the DHEC Staff (Staff) made the decisions with respect to the two instant applications, the 2012-2013 State Health Plan took effect. The 2012-2013 Health Plan's linear accelerator standards and relative importance of Project Review Criteria are nearly identical to those in the 2010-2011 State Health Plan.¹¹ The 2012-2013 State Health Plan sets forth that there are five linear accelerators in the Service Area that were operating at 96.7% capacity in 2011, based on 31,902 "Total Area Treatments," with a "Planning Area Capacity" of 33,000 treatments. Moreover, the 2012-2013 State Health Plan indicates a "Need" in a column entitled "UNMET NEED?" Although the 2012-2013 State Health Plan identifies five linear accelerators in the Service Area, a footnote indicates that the Department included CRCC's approved, but not yet operational, Conway facility in the linear accelerator count, which is under review in this Contested Case. Thus, even with four operational linear accelerators, and one that has been approved, the 2012-2013 State Health Plan denotes that there is potentially an unmet need for another unit in the Service Area.

Grand Strand's Project

In its application, Grand Strand seeks to establish a new 9,519 square foot radiation therapy facility located within its main hospital in Myrtle Beach, South Carolina. Grand Strand applied to install a Varian Clinac iX linear accelerator at a cost of \$2.8 million.¹² The Clinac iX is very reliable; can perform all conventional cancer treatments including IMRT treatments and

¹⁰ Because of the twenty-one month time span between the decision date and the contested case hearing, the year 2015 is no longer a viable third year of operations. Presently, the third year of Grand Strand's operation would be 2017.

¹¹ The notable exception is that in the 2012-2013 Plan, Standard 8 does not require the applicant to provide expected annual referral volumes from physicians and health care facilities. However, that criterion was not an issue in this case.

¹² Since submitting this application, the cost of a True Beam linear accelerator has declined and, as a result, Grand Strand intends to seek a change in its application to install that linear accelerator if DHEC approves the change.

IGRT treatments; and is capable of delivering highly specialized treatments such as stereotactic radiation therapy, although stereotactic treatments comprise a small percentage of the overall number of treatments. CRCC operates a linear accelerator unit, the Varian 2300iX, that is very similar to the unit Grand Strand is proposing in its application. The project is estimated to cost approximately \$9.8 million.

Grand Strand is also accredited by the Commission on Cancer of the American College of Surgeons as a community cancer center and is the only hospital in the region that is accredited as such. Though Grand Strand has no direct experience providing radiation therapy, its parent company, HCA, operates 80 linear accelerators in 40 locations. Furthermore, if approved, Grand Strand intends to partner with Sarah Cannon Center, which is a comprehensive cancer center affiliated with HCA, located in Nashville, Tennessee. The Sarah Cannon Center will provide information, research, and analysis for clinical protocols surrounding the care of cancer patients.

Need for Grand Strand

Grand Strand is the Service Area's largest and most comprehensive tertiary care hospital. A "tertiary care hospital" provides higher-level services than those found in community hospitals, services such as open heart surgery, neurosurgery, and trauma services. Most tertiary care hospitals have at least one linear accelerator. In fact, Grand Strand is one of the only two hospitals in South Carolina operating above 50,000 patient days per year that does not offer radiation therapy services. In addition, Horry County is the only county in the state with more than 250,000 residents that lacks a hospital-based radiation therapy center.

Grand Strand seeks to develop a comprehensive cancer center where patients and their families can go to one facility to receive interdisciplinary cancer care, including radiation therapy. A comprehensive cancer treatment program promotes interdisciplinary care. Interdisciplinary cancer care involves multiple cancer specialists participating in the development of a treatment plan and care of a patient. The patient benefits from the interaction with the doctors caring for them. This personal interaction can assist the physician in planning the patient's treatment, thereby leading to more effective treatment. The best form of communication is face-to-face, though it is not always necessary and might be difficult for physicians, given time restraints. In addition, PET/CT services¹³ are a very important part of a

¹³ PET stands for Positron Emission Tomography and CT stands for Computerized Tomography; both used to reveal the presence or track the spread of cancer..

comprehensive cancer center. Grand Strand currently offers PET/CT services in a mobile setting at its South Strand location, and it anticipates that it would shift the PET/CT service to the main campus if approved for a radiation therapy center.

Adding a radiation therapy center to its campus in the context of a comprehensive cancer center will also allow Grand Strand to attract surgical and medical sub-specialists who provide cancer care, such as GYN oncologists, oncology surgeons, colorectal surgeons, and fellowship-trained breast surgeons. A hospital cannot establish a comprehensive cancer center without a radiation therapy program. Currently, patients residing in the Service Area must travel to the Medical University of South Carolina in Charleston, South Carolina to receive comprehensive cancer treatment.

Grand Strand proposes to locate its linear accelerator in the hospital because having a radiation therapy facility at the hospital would result in higher and better services available to the patients. Grand Strand proposes to treat both inpatients and outpatients at its facility, but acknowledges the vast majority will be outpatient treatments. Currently, there are no radiation therapy centers in the Service Area that are located within a hospital. Grand Strand's project will alleviate the inconvenient transfer of its inpatients who need radiation therapy out of the hospital via ambulance to an off-site radiation therapy center and then back to the hospital on multiple occasions during the hospital stay. The radiation therapy center will also be positioned proximate to Coastal Cancer Center, (Coastal), an active medical oncology group that consists of five medical oncologists practicing at several locations in the Service Area, including offices in Conway, Myrtle Beach, Loris, and near Waccamaw Hospital.

Grand Strand's Utilization

For 2017, Grand Strand can reasonably assume a 20% market share for Horry County as explained below. Grand Strand can reasonably assume a 1% market share for Georgetown because GMH, the radiation therapy provider located in Georgetown, has a distinct medical staff with local referral patterns. Because Williamsburg is even further from Grand Strand and nearer to the Medical University of South Carolina, Grand Strand can reasonably expect no more than a 1% market share from that area.

Grand Strand can reasonably assume a 20% market share for radiation therapy in Horry County by 2017 because Grand Strand's unit would be the fourth unit in the county, which theoretically lends itself to a 25% market share. Coastal's president, Dr. Lawrence Holt,

expressed that Coastal would be supportive of Grand Strand's project and represented that he thought some patients would choose Grand Strand for radiation therapy.¹⁴ However, CRCC has been operating in Horry County for three decades, so obtaining referrals will be a challenge for a new radiation therapy center. A substantial base of physician support is important to obtain sufficient utilization of the radiation services as required in the Health Plan. Therefore, in this instance, a 25% market share would not likely occur in Horry County because: (a) CRCC is an established provider with solid referral relationships in place; (b) CRCC has an affiliation with an existing urology practice, which means Grand Strand would not receive any urology referrals from that practice; and (c) Grand Strand would have to prove itself to the medical community by demonstrating good service and good outcomes.

In analyzing Grand Strand's potential utilization, it was important to quantify an average number of treatments per patient. Mr. Sullivan projected an average number of treatments of 21 per patient. I find that average to be reasonable under the facts of this case. Importantly, CRCC's actual experience prior to its acquisition by 21st Century on May 3, 2010, was 21 treatments per patient. AUC employs all the urologists who practice in Horry and parts of Georgetown County, and it is the only provider of urological services in the three-county Service Area.

Referrals for prostate issues made up the largest percentage by diagnosis mix and treatment diagnosis at CRCC for the years 2010, 2011, and 2012. While the standard number of IMRT treatments for prostate cancer patients is 40 to 45, some patients may receive up to 48 treatments. The vast majority of referrals from the AUC urologists will be to CRCC for prostate cancer patients. The number increases the average number of treatments per patient for CRCC and decreases the average number of treatments per patient for Grand Strand.

Using the 2015 data as a projection of Grand Strand's utilization in 2017, Grand Strand will likely treat 231 cancer patients at its center by 2015.¹⁵ Assuming an average of 21

¹⁴ Notably, Dr. Holt's support for Grand Strand did inversely suggest an over-utilization of Grand Strand's services. Despite CRCC's assertions to the contrary, Dr. Holt never committed that Coastal would send all, or even a substantial portion, of its patients to Grand Strand for radiation therapy services.

¹⁵ I find Mr. Sullivan's analysis to be sound, yet find slight discrepancies in his math. The Court projected the total number of cancer patient to be 231 in year 2015. That figure was derived utilizing the "Total Projected Grand Strand Radiotherapy Patients – Service Area" and adding 5% for "patient in-migration." See Joint Exhibit 2, p. 38. On the other hand, I did not find CRCC's draw-rate analysis as reliable as Grand Strand's for a number of reasons. First, it is not reasonable to assume that Grand Strand's penetration rate in the identified zip codes would be the same for radiation therapy as it would be for inpatient services given that Grand Strand, unlike CRCC, enjoys no

treatments per patient, based on CRCC's actual experience prior to its acquisition by 21st Century, Grand Strand will likely perform 4,851 treatments in 2015. With a capacity of 5,000 treatments, given its projection that 60% of treatments will be IMRT, Grand Strand's unit will be 97.02% utilized in year three, satisfying the first part of Standard 6-B in the State Health Plan, which requires a new unit to be operating at 50% capacity by the third year of operations.

At the Department's request, Mr. Sullivan also estimated the number of Grand Strand radiotherapy patients that it would serve by zip code. To accomplish this task, Mr. Sullivan developed a "draw rate" analysis in which he analyzed the origin of Grand Strand's inpatients with cancer by zip code and the population of those zip codes. By analyzing the origin of its inpatients with cancer by zip code and the population of those zip codes, the draw rate can be used to determine the reliance of a particular population on the particular service offered at the hospital. It can also be used to rank the zip codes served by Grand Strand, specifically for cancer patients, so as to determine primary and secondary service areas.¹⁶ Assuming reasonable market-share capture rates for both the primary and secondary service-area zip codes, the draw-rate analysis estimates that Grand Strand would treat 223 radiotherapy patients by year three of operations. Treatment of 223 patients would result in utilization 93.66% in year three.

In its B-11 analysis, Grand Strand addressed each of the nine Standards set forth in the 2010-2011 State Health Plan. Grand Strand addressed how it would staff the facility, which I find reasonable.¹⁷ Grand Strand will also deliver an estimated 3.3% of its radiation therapy center's gross revenue in the form of indigent care.

competitive advantage in radiation therapy. Also, CRCC's draw-rate analysis for Grand Strand does not take into account the fact that Grand Strand will not receive any urology referrals, which is a material percentage of the referral market.

¹⁶ I find a "draw rate" analysis to also be a reasonable and reliable method by which to estimate the number of radiotherapy patients Grand Strand would serve. On the other hand, I did not find CRCC's draw-rate analysis as reliable as Grand Strand's for a number of reasons. First, it is not reasonable to assume that Grand Strand's penetration rate in the identified zip codes would be the same for radiation therapy as it would be for inpatient services given that Grand Strand, unlike CRCC, enjoys no competitive advantage in radiation therapy. Also, CRCC's draw-rate analysis for Grand Strand does not take into account the fact that Grand Strand will not receive any urology referrals, which is a material percentage of the referral market.

¹⁷ Grand Strand, like CRCC, did not quantify expected referral volumes by physician because there is no practical way to project the referrals three years from opening. CRCC did provide current volumes from all referral sources. However, if a facility has not had a service in the past, and therefore has no historical basis for projecting referrals by physician, this standard becomes nearly impossible to satisfy. While Standard 8 in the 2010-2011 State Health Plan appears to require an annual referral volume projection by referral source, DHEC appears to have recognized the difficulty of making such a projection by referral source and removed the requirement from Standard 8 in the 2012-2013 State Health Plan that applicants document "expected annual referral volumes."

CRCC's Project

CRCC applied for a CON to establish a freestanding radiation therapy facility located in Conway, South Carolina on March 9, 2011, and it thus falls under the guidelines of the 2010-2011 State Health Plan. CRCC proposes to install a state-of-the-art TruBeam linear accelerator, which is considered to be superior to the Clinac iX. CRCC plans to use an existing site so its total project costs, including the cost of equipment, are \$5.1 million.

CRCC chose to locate its services in Conway using a facility that was previously constructed to house a linear accelerator. Nevertheless, I find the proposed facility to be underwhelming. Grand Strand's proposed facilities are far superior. The CRCC-Conway radiation therapy center would be in an older building that would require considerable renovation. Moreover, though the typical size of a 21st Century radiation therapy center is between 5,000 and 12,000 square feet, CRCC-Conway will only be 3,616 square feet.

Patients from the Conway and Loris areas drive an average of 45 minutes to the closer of the two Service Area cancer centers with linear accelerators. Though CRCC's Conway facility would reduce the average round-trip drive for a patient from the Conway and Loris areas, that drive time would be reduced by only an average of 20 minutes.

CRCC'S Utilization

CRCC operates three linear accelerators at its location in Myrtle Beach: a TomoTherapy linear accelerator, a 2300iX unit, and a 6EX unit. In 2012, CRCC performed 9,437 treatments on its Varian Clinac iX unit, which was more than any other unit. CRCC has been providing radiation therapy services in the Service Area for over 31 years and has earned the support of the provider community based on its long track record of providing quality cancer treatment services to the Service Area.

On May 3, 2010, CRCC was sold to AUC and 21st Century.¹⁸ AUC employs all the urologists who practice in Horry and parts of Georgetown County, and it is the only provider of urological services in the three-county Service Area. From 2009 to 2011, CRCC's treatment volumes increased by approximately 65%. When CRCC's treatment volumes are removed from statewide totals, treatment volumes statewide increased just 2.2% over that same time period.

¹⁸ 21st Century establishes group practices like AUC and pays employed physicians in the practice profits using an ancillary profit formula from revenues generated by their referrals to the affiliated radiation therapy center. The AUC-employed urologists have a financial relationship with CRCC by virtue of participating in an ancillary bonus pool. However, the AUC urologists are not contractually obligated to refer all of their cancer patients to CRCC.

Statewide, linear accelerator treatments actually decreased from 2010 to 2011, while CRCC's treatments increased from 20,946 treatments in 2010 to 25,709 treatments in 2011, an increase of 23%. In 2011, CRCC was the highest volume treatment provider in South Carolina.

Prior to CRCC's acquisition by AUC and 21st Century, the AUC urologists referral of prostate cancer patients to CRCC was limited because of a business dispute with CRCC's previous owner arising out of a CON challenge in which AUC was an applicant. CRCC had a significant increase in treatment volume after AUC was sold to 21st Century. The number of urologist referrals from AUC to CRCC increased from 39 in 2009 to 292 in 2010. The number of referrals in 2011 from AUC to CRCC increased to 406. In 2012, there were 886 patients who underwent treatment at CRCC. Of these 886 patients, AUC referred 263.

Referrals for prostate cancer made up the largest percentage by diagnosis mix and treatment at CRCC for the years 2010, 2011, and 2012. In 2012, 43.7% of all treatment diagnoses at CRCC were related to prostate cancer. IMRT is one of the procedures used for treatment of prostate cancer and is reimbursed at a higher rate. About 75% of CRCC's treatment volume comes from the higher reimbursed IMRT procedure. 28.4% of all revenues generated from CRCC radiation therapy treatments came from prostate cancer diagnoses.

CRCC addressed the applicable radiotherapy standards in the 2010-2011 State Health Plan. As mentioned above, Standards 6(A) and 6(B) do not apply to CRCC. Furthermore, CRCC identified the capacity of the existing units and found that the units collectively were operating at 102% of capacity as of 2010, with CRCC at 20,946 treatments on its 3 units, and GMH at 5,515 treatments on its unit. CRCC identified the target population and made reasonable projections for the Service Area, concluding that the Service Area would have 392,450 people in 2015. Twenty-two (22) percent of CRCC's patients originate from the Conway area, which has a population of 80,355 people. Finally, CRCC addressed Standards 8 and 9, although, like Grand Strand, CRCC did not project expected annual referral volumes by physicians. CRCC also set forth its staffing plan and financial *pro formas* and associated assumptions in the CON application, which I find reasonable.¹⁹

¹⁹ Although CRCC takes the position in this case that Grand Strand's project will adversely impact its operation due to the loss of Coastal referrals, CRCC never took the position with the DHEC staff at the project review meeting (PRM) or in follow-up written submission that Grand Strand's project would result in a substantial loss of Coastal referrals. See Brandt Tr. 1052:1-1053:5; Lewis Tr. 1340:25-1342:1; Tolbert Tr. 1834:13-1835:1-21-.

Approval of Both Projects

As addressed above, there is a need for two linear accelerators in this service area.²⁰ Nevertheless, even if there is a “need,” an applicant cannot receive a CON if approval of two linear accelerators in the service area would bring the use of the existing linear accelerator providers below the 80% threshold. CRCC and the Department assert that the approval of both applications will exceed the need for the services in the Service Area. I find that the evidence established otherwise. Both Grand Strand’s and CRCC’s CON applications can be approved without reducing the existing providers’ utilization below the 80% threshold.²¹

As required by Radiotherapy Standard 6-B, Grand Strand should not bring existing providers below the 80% threshold by the third year of operations based on growth in the market and Grand Strand’s projected utilization. Based on CRCC’s own growth projections, AUC is projected to refer 284 patients for treatment to CRCC in 2017, and the number of non-AUC patient referrals to CRCC is projected to increase to 669 in 2017. An estimated 11,360 treatments in the market in 2017 will not be available for capture by Grand Strand. Stated differently, nearly half of CRCC’s treatment volume is not at risk in 2017 because of CRCC’s relationship with AUC. Thus, Grand Strand would be competing for the remaining treatments against an existing provider with more capacity and potentially more locations.

CRCC projects that its new facility in Conway will have 5,499 treatments in 2017. If Grand Strand’s volume exceeds 5,525 treatments in 2017, also referred to as a “tipping point,” Grand Strand’s project would cause the existing providers to fall below the 80% threshold. However, as found above, Grand Strand would likely perform 4,851 based upon a 2015 projection, or the 5,168 treatments in 2017.²²

CRCC’s Projections

CRCC’s projects 7,500-8,000 treatments for Grand Strand in 2017 by creating five different adverse impact scenarios, four of which were premised on applying assumed market

²⁰ Also as addressed above, the parties chose the year 2017 as the third year of operations for the respective projects due to the time interval between the date of the Staff’s decision in this case and the date of the Contested Case.

²¹ CRCC never performed any financial-adverse-impact analysis with respect to the impact Grand Strand’s approval would have on CRCC if only one is approved or if both are approved.

²² CRCC’s expert projected that Grand Strand would perform 4,934 treatments in 2017 based upon Grand Strand’s 2015 projections. Since the Court found that the treatments performed by Grand Strand in 2015 would be 4,851, the Court added 4.76% to CRCC’s projection which is the percentage difference between 4,620 and 4,851.

shares for Grand Strand that differed from the market share assumed by Grand Strand in its CON application.²³ CRCC's analysis makes flawed assumptions about the market. In CRCC Scenarios 1-4, CRCC applied an inpatient acute market share, which was not proper. The inpatient market is much different from the outpatient radiation therapy market share in this instance because of the presence of entrenched competitors who have solid historical reputations. In Scenarios 1, 2, and 4, CRCC assumed that all 31,824 treatments were available for capture by Grand Strand, even though nearly half of CRCC's treatments are likely not available to Grand Strand because of CRCC's affiliation with AUC. Although inpatient market share and inpatient oncology market share are appropriate metrics to use in projecting market share for a new radiation therapy center, these would not be appropriate metrics in this instance for the primary reason that the Service Area urology referrals will likely not be captured by Grand Strand.²⁴

Furthermore, if Grand Strand were to achieve CRCC's projection of nearly 8,000 treatments by 2017, when compared to treatment volumes in 2011, Grand Strand would be operating at 153% of the average for the top five highest treatment volume providers and 165% of the average for single unit operators. This would be occurring in a market with a high-volume, entrenched provider. I do not find CRCC's projections to be realistic for a new provider in the Service Area.

Moreover, to show that the CON applications should be considered "competing," CRCC introduced its 2013 treatment data through July to show that the Service Area capacity at the end of 2013 would be below the 80% threshold, assuming five units are operating. CRCC took its treatment volume through July 2017 and compared it to the first seven months of 2012. Based on a 10.3% decline in the first seven months of 2013 over the same period for 2012, CRCC projected that its 2013 year-end utilization would be 20,450 treatments, or 10.3% lower than 2012. However, I do not find CRCC's analysis reliable.

²³ Mr. Tolbert created two separate Threshold Analyses based on the application of Grand Strand's market share to a projected Service Area volume of radiation therapy treatments for 2017. Both are similar in terms of the purported volume Grand Strand will capture from CRCC, but a later version includes a referral-shift analysis, an adjusted-market-share analysis, and an analysis based on Grand Strand's three-county inpatient oncology admission, which are discussed herein.

²⁴ While this Court has specifically found that inpatient market share can be used as a proxy to determine radiation therapy market share, the specific facts of that case, *Beaufort-Hilton Head Radiation Oncology Center v. S.C. Dep't of Health & Env'tl. Control*, 01-ALJ-07-0507-CC (Mar. 19, 2003 S.C.A.L.C), are quite distinct from the instant case where there are two providers in the Service Area, one of which has been operating for over 30 years and is currently owned by a major referral source whose employed physicians receive a financial benefit from referring to CRCC.

There is no evidence that the utilization during the first seven months of 2012 was representative of CRCC's typical treatment volume experience for the first seven months in any other year. CRCC assumed that GMH's volumes would be the same as in 2012, despite having no hard data to support that conclusion. CRCC's 2013 decrease is more likely due to less referrals from the urologists and, in particular, one urologist, who accounted for more than half of the decline, which could be a mere aberration. As such, concluding that the first seven months of 2013 is indicative of the rest of the year or future years is not reliable.²⁵

CRCC also claims that the CRCC-Myrtle Beach radiation therapy center volumes declined significantly from 2011 to 2012 due to a change in the Prostate-Specific Antigen (PSA) guidelines, which resulted in a decline in the number of prostate cancer patients referred to CRCC from AUC. However, a change in a guideline or protocol to screen for cancer does not validate that the actual rate of cancer will be impacted; rather, it suggest that the date the cancer is detected will be impacted. I find that the change in the PSA guidelines will not likely result in a significant decrease in treatment volumes in the Service Area or a decrease in referrals to CRCC.²⁶

CRCC's further assumed that Grand Strand's presence in 2017 would cause a significant shift in physician referrals from CRCC to Grand Strand and that Grand Strand would capture approximately 60% of the Coastal referrals in 2017. I do not find Mr. Tolbert's referral-shift analysis reliable. For instance, Mr. Tolbert never spoke to any physicians who referred patients for cancer treatment to CRCC, and he conceded that he did not have any idea of what the referral sources thought about CRCC. Also, Mr. Tolbert's analysis is based in part on one or two thirty-minute phone calls with Ms. Price and Dr. Francke, both of whom are CRCC employees strongly opposed to Grand Strand's project.²⁷ The low-volume physician referrers, which accounted for 127 patients to CRCC in 2012, were never discussed with Ms. Price or Dr. Francke. Furthermore, although Coastal indicated strong support for Grand Strand's project, the three

²⁵ Mr. Tolbert, in fact, testified that it is preferable to use a full year's data when projecting utilization because of the uncertainty of what can occur in the remaining part of the year.

²⁶ Even though CRCC experienced a volume decrease in 2012 over 2011, nine months into 2012, CRCC's plan was to apply for the additional linear accelerator that would be shown as needed in the 2012-2013 Health Plan, despite knowledge of the change in the PSA screening protocols.

²⁷ Dr. Francke is the Medical Director and staff radiation oncologist at CRCC, and Ms. Price is the Administrative Director.

Coastal physicians who service the Conway area supported CRCC's project.²⁸ CRCC's Medical Director, Dr. Francke, admitted that he has not had an indication from any of the Coastal physicians that they would cease referring to CRCC if both projects are approved. Grand Strand's location would offer no travel time advantage to a significant number of patients who would originate from the area around Murrells Inlet, where two CON applications for radiation therapy centers have been approved. In sum, patient and physician preference for a particular provider depends on many factors, including where the patient resides. Mr. Tolbert's analysis did not sufficiently account for these preferences. Therefore, I find that CRCC's referral-shift analysis is not predictive of Grand Strand's utilization in 2017.

Finally, CRCC's health planning expert did not give any effect to outmigration in preparing his projections. Based on CRCC's projection of new cancer cases in 2017, an additional 6,300 treatments may be performed on patients who leave the Service Area for treatment. The creation of a comprehensive cancer program could reverse at least a portion of the outmigration, which would further mitigate any potential adverse impact on the existing providers in the Service Area.

Other Project Review Criteria

I find that both applications meet the Project Review Criteria to receive a CON. I address this compliance more specifically below.

Community Need Documentation (PRC 2(a)-(c), (e))

As addressed above, Grand Strand seeks to develop a comprehensive cancer center. A comprehensive cancer center can reduce the fragmented nature of cancer treatment, which can be particularly difficult for elderly patients. A more comprehensive setting has the benefit of reducing travel and facilitates consultation between separate providers such as radiologists and radiation oncologists.

There are also advantages in terms of cost, patient care, and convenience with respect to inpatient based radiation therapy offered in a comprehensive cancer treatment setting. An inpatient who can be treated without transport out of the hospital on an ambulance gurney is

²⁸ According to CRCC's 2013 volumes, through May, Dr. Holt was responsible for 30 treatment plans at CRCC. The three medical oncologists whose support for CRCC-Conway was critical—Drs. Cody, Karpenko and Goldberg—were responsible for a combined 100 treatment plans at CRCC through May 2013, and all three provided letters of support for the CRCC-Conway project.

more comfortable because the patient does not have to be strapped-in, as they would in an ambulance. Further, there is a significant cost associated with ambulance transport.

Although infrequent, there are times when patients cannot be transported out of the hospital for radiation therapy treatment, such as when the patient is in an intensive care unit on a ventilator. Dr. Collins testified that he treats several patients a year who are in life-threatening circumstances and cannot be transferred out of the hospital for necessary and critical radiation therapy. An in-hospital radiation therapy program would be of great benefit to these patients.

Distribution (Accessibility) (PRC 3(a)-(c), (e)-(f))

Both CRCC and Grand Strand have documented the means by which a person will have access to their services. CRCC's project improves travel time for patients who reside in the Loris and Conway areas. Additionally, Grand Strand's project is not an unnecessary duplication of services because patients will now have ready access to in-hospital radiation therapy and comprehensive cancer treatment. Currently, the closest comprehensive cancer treatment is approximately 100 miles away, thus requiring patients who desire comprehensive cancer treatment or in-hospital radiation therapy services to drive significant distances to reach either. Grand Strand's project location also allows for the delivery of necessary support services because within the hospital there is a much wider array of support services immediately available to patients, such as radiology, surgical services, and physical therapy.

Record of the Applicant (PRC 13(a)-(b))

Both applicants also have demonstrated the ability to obtain the necessary capital financing for their respective projects. CRCC has been successfully providing radiation therapy services in the Service Area for over 30 years and is supported by 21st Century. Likewise, Grand Strand is affiliated with its parent organization, HCA, and has demonstrated an ability to develop new services into successful programs.

Acceptability (4(a))

Both applicants have demonstrated a significant level of community and provider support for their respective projects to demonstrate that both will be well-utilized.

Distribution (22)

Both projects improve the distribution of health services in the Service Area based on the findings above.

Financial Feasibility (15)

Both CRCC and Grand Strand projected positive net income for their respective projects in all three years of operations, which indicates both the immediate and long-term financial feasibility of the projects. CRCC contends that Grand Strand's *pro formas* indicate that the project might not be financially viable because Grand Strand's internal rate of return and the returns on investment (ROI) for the project were lower than what CRCC's expert would expect. However, given its healthy bottom line, Grand Strand can afford to sustain potential losses in the first three years of operations, even under CRCC's "breakeven" analysis.²⁹

While Grand Strand's *pro forma* contains some errors, when they are corrected, the revenues are understated and the project would still show a profitable bottom line. Grand Strand expects its annual treatment volumes to increase as the market continues to grow and Grand Strand's reputation as a radiation therapy provider improves. I find that Grand Strand's application *pro forma* is a conservative estimate of the project's financial performance.

Cost Containment (16(a)-(c))

Both CRCC and Grand Strand addressed cost containment, identified methods of funding, and demonstrated the feasibility of the funding option. Moreover, Grand Strand does not expect to raise its patient charges to subsidize the cost of the radiation therapy project. Grand Strand's in-hospital radiation therapy center would also alleviate charges associated with transporting patients to and from a freestanding facility. Because the project is self-sustaining, I find that the project will not affect Grand Strand's costs or charges.

CRCC contends that Grand Strand's project will represent higher costs to the healthcare system.³⁰ While Grand Strand's reimbursement from governmental sources like Medicare and Medicaid will be higher than CRCC's, I find that Grand Strand's project will promote cost

²⁹ I decline to rely on CRCC's analysis in which it determined that for a freestanding radiation therapy center to "break even," it would need to operate at 4,500 treatments annually. Mr. Lewis admitted that he never performed a breakeven analysis for a hospital-based radiation therapy center. Grand Strand's project will be a hospital-based facility that, unlike a freestanding facility, is not going to duplicate all of the overhead expenses that a freestanding center would if they were beginning operations; and hospitals have a different revenue profile with a different breakeven point.

³⁰ While CRCC did not discuss the impact of the radiation therapy center project on Grand Strand's patient charges generally, CRCC suggested that Grand Strand expects to receive \$5,000 per radiation treatment from non-governmental payors. There is no credible evidence in the record to suggest that Grand Strand would get \$5,000 per treatment as CRCC suggests. In fact, Grand Strand's charges per procedure are set forth in its CON application, and it estimates it will receive in actual dollars approximately 32% of the charges. The highest listed charge for a radiation therapy treatment plan is \$4,239. On that charge, Grand Strand expects to receive \$1,356.

containment, particularly with private insurance companies, in the Service Area. Both CRCC and Grand Strand are relying on receiving a significant portion of revenues from non-governmental payors, such as PPOs.³¹ However, there is currently no real price competition in Horry County as it relates to radiation therapy services, because there is only one provider.³²

Over the past several years, there has been concern in the radiation therapy industry that urologists who have a financial interest in radiation therapy centers may direct patients to more expensive radiation therapy as opposed to alternative, less expensive, types of cancer treatment. AUC urologists have a financial interest in the operations of CRCC, which appears to promote referrals to CRCC. When CRCC was sold to 21st Century, it had a significant increase in treatment volume, most of which came from the AUC urologists. Grand Strand's project would provide an alternative treatment setting where there are no financial incentives to referring physicians who may over-utilize costly radiation therapy treatments.³³ Therefore, I find that the approval of both projects will further promote cost containment in the Service Area.³⁴

Projected Revenues/Projected Expenses (6(a), 7)

Grand Strand included its chargemaster for radiation therapy services and represented that it estimated the actual dollars reimbursed on those charges to be approximately 32%. CRCC contends Grand Strand's charges will be higher than its own charges for patients insured by governmental programs, which Grand Strand conceded. However, CRCC did not address whether Grand Strand's project costs were inconsistent with those experienced by similar providers offering a similar level and scope of service. For instance, CRCC's Murrells Inlet

³¹ A PPO, or preferred provider organization, is an insurance plan that contracts with providers like hospitals and physicians. In exchange for making them preferred or in-network providers, those providers offer a discount to the insured that is under the PPO plan. It is a different form of insurance where rates are negotiated between the insurance company and the providers. Examples of PPOs would be Blue Cross/ Blue Shield, Aetna, CIGNA, and Humana.

³² CRCC contends that competition is not referenced in the PRC or the purposes of the CON Act. While not directly referenced therein, competition enhances the negotiating power of payors and the choices and quality that may be available for the residents of South Carolina, all of which are related closely to the purposes of CON Act.

³³ Despite the 10,000 treatment increase at CRCC from 2009 to 2011, the Staff did not perform any research or analysis on the issue of the AUC urologists having a financial interest in a radiation therapy center. Even though Grand Strand raised the issue of CRCC's monopoly of radiation therapy services in Horry County and the effect that would have on rates for third-party payors, the Staff did not consider this factor when making its decision on the project generally and with respect to cost containment specifically.

³⁴ While AUC's financial relationship with CRCC is concerning, given the findings above, because CRCC's project costs are significantly lower than those of newly built radiation therapy centers, I find that its project satisfies the PRC for cost containment.

facility, which was also approved by the Staff, is proposed to be nearly 7,000 square feet with a total project cost of approximately \$8 million. Grand Strand's project cost of \$9.7 million is reasonable when compared to other recently approved radiation therapy projects.

I find that both projects can be completed in a reasonable amount of time given their respective scope of construction and services.³⁵

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, I conclude the following as a matter of law:

The ALC has jurisdiction over this matter pursuant to S.C. Const. art. I, § 22; S.C. Code Ann. §§ 1-23-320, -600(B), 44-1-60(F), and 44-7-210(E); 3 S.C. Code Ann. Regs. 61-15; and Rule 11 of the South Carolina Administrative Law Court Rules (SCALCR). Grand Strand timely filed its request for a contested case hearing regarding DHEC's decisions. *See* 3 S.C. Code Ann. Regs. 61-15 § 401. Because CRCC is an existing provider of radiation therapy services in the service area, it is an "affected person" for the purposes of participating in a contested case related to DHEC's decisions appealed by Grand Strand. *See* S.C. Code Ann. § 44-7-130(1) (2002); 3 S.C. Code Ann. Regs. 61-15 § 103(1).

A contested case hearing conducted before this Court in a CON matter is a trial *de novo*, in which "the whole case is tried as if no trial whatsoever had been had in the first instance," and the administrative law judge conducting the hearing is the sole finder of fact, who "must make sufficiently detailed findings supporting the denial or grant of a permit application." *Marlboro Park Hosp. v. S.C. Dep't of Health & Envtl. Control*, 358 S.C. 573, 579, 595 S.E.2d 851, 854 (Ct. App. 2004) (quoting *Blizzard v. Miller*, 306 S.C. 373, 412 S.E.2d 406 (1991) and *Converse Power Corp. v. S.C. Dep't of Health & Envtl. Control*, 350 S.C. 39, 564 S.E.2d 341 (Ct. App. 2002)). The weight and credibility assigned to evidence presented at the hearing of a matter is within the province of the trier of fact. *S.C. Cable Television Ass'n v. S. Bell Tel. & Tel. Co.*, 308 S.C. 216, 222, 417 S.E.2d 586, 589 (1992). The trier of fact may also give an expert's testimony the weight he or she determines it deserves. *Florence County Dep't of Soc. Servs. v. Ward*, 310 S.C. 69, 425 S.E.2d 61 (Ct. App. 1992) and may accept the testimony of one expert over that of another. *S.C. Cable Television Ass'n, supra*.

³⁵ Though CRCC's project is estimated to cost \$5.1 million, the evidence reflected that CRCC might have plans to move its radiation therapy facility to another location in Conway where the AUC-employed urologists own property. This could mean additional project costs associated with the same unit. However, the Staff would have to approve any such future relocation, which is not an issue before this Court.

Finally, the CON Act states that the “the Administrative Law Court . . . shall consider the South Carolina Health Plan in place at the time the application was filed and may consider the current South Carolina Health Plan when making its decision.” S.C. Code Ann. § 44-7-225 (Supp. 2013).

Regulatory Framework

This matter arises under the regulatory program by which the State of South Carolina issues CONs for the development of health care facilities and services in this State. The regulatory scheme consists of the State Certification of Need and Health Facility Licensure Act (CON Act), S.C. Code Ann. § 44-7-110 *et seq.* (2002 & Supp. 2013); the regulations promulgated thereunder: 3 S.C. Code Ann. Regs. 61-15 (Supp. 2013); and a State Health Plan, which is revised at least biannually. The purposes of the CON Act, and thus the regulatory program itself, are to “promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure high quality services are provided in health facilities in this State.” *See* S.C. Code Ann. § 44-7-120 (2002).

In determining whether to grant or deny an application for a CON, the Department evaluates the proposed project under the review criteria found in the CON regulations and under the policies and standards set forth in the applicable State Health Plan. S.C. Code Ann. § 44-7-210(B) (Supp. 2013). Pursuant to the CON Act, the Department may not issue a CON to an applicant “unless the application complies with the South Carolina Health Plan, Project Review Criteria, and other regulations.” *Id.*; *see also MRI at Belfair, LLC v. S.C. Dep’t of Health and Envtl. Control*, 379 S.C. 1, 9, 664 S.E.2d 471, 475 (2008) (holding that compliance with the State Health Plan and the PRC were independent requirements for approval of a CON). The Department can refuse to issue a CON based on PRC and other regulations identified by the Department even if an application complies with the State Health Plan. Section 44-7-210(B). But no project can be approved unless it is consistent with the State Health Plan. 3 S.C. Code Ann. Regs. 61-15 § 307(1). Where the CON applications are considered competing, “the [D]epartment shall award a [CON], if appropriate, on the basis of which, if any, most fully complies with the requirements, goals, and purposes of [the CON Act] and the State Health Plan, Project Review Criteria, and the regulations adopted by the department.” Section 44-7-210(B).

The PRC set forth in Regulation 61-15 include thirty-three separate criteria that fall into five general categories: (1) criteria related to the need for the proposed project; (2) criteria related to the economic considerations of the project; (3) criteria related to the project's impact on the resources of the health care system; (4) criteria related to the suitability of the site of the project; and (5) criteria related to certain special circumstances, such as the project's ability to serve medically underserved groups. *See* 3 S.C. Code Ann. Regs. 61-15 §§ 801(1), 802.

As required by the CON Act, the State Health Plan contains the following statistics, standards, and findings with regard to the various facilities and services regulated by the CON Act:

(1) an inventory of existing health care facilities, beds, specified health services, and equipment; (2) projections of need for additional health care facilities, beds, health services, and equipment; (3) standards for distribution of health care facilities, beds, specified health services, and equipment including scope of services to be provided, utilization, and occupancy rates, travel time, regionalization, other factors relating to proper placement of services, and proper planning of health care facilities; and (4) a general statement as to the project review criteria considered most important in evaluating Certificate of Need applications for each type of facility, service, and equipment, including a finding as to whether the benefits of improved accessibility to each such type of facility, service, and equipment may outweigh the adverse affects caused by the duplication of any existing facility, service, or equipment.

S.C. Code Ann. § 44-7-180(B). The State Health Plan section applicable to the establishment of either applicant's linear accelerator project is found in Chapter IX, beginning at page IX-1. The Standards applicable to the projects begin at page IX-5.

The CON Regulations require that:

On the basis of staff review of the record established by the Department, including but not limited to, the application, comments from affected persons and other persons concerning the application, data, studies, literature and other information available to the Department, the staff of the Department shall make a proposed decision to grant or deny the Certificate of Need.

3 S.C. Code Ann. Regs. 61-15 § 308 (Supp. 2013).

Question of Competing Applications

As a threshold matter, the Court must first decide whether the CON applications are competing. The CON Act prohibits the issuance of multiple CONs if two or more CON applications are competing. S.C. Code Ann. § 44-7-210(B). Therefore, if the two CON applications at issue in these contested cases are competing applications, only one CON

application can be approved. CRCC concurs with the Department's finding that the applications are competing applications, while Grand Strand contends that the applications are not competing applications and both can be approved.

Under the CON Act, "competing applicants" are defined as follows:

[T]wo or more . . . health care facilities . . . who apply for Certificates of Need to provide similar services or facilities in the same service area within a time frame as established by departmental regulations and whose applications, if approved, would exceed the need for services or facilities.

S.C. Code Ann. § 44-7-130(5); *see also* 3 S.C. Code Ann. Regs. 61-15 § 103(6). Therefore, to be deemed competing CON applications, two or more CON applications must satisfy four elements:

- (a) The CON applications must be filed within the time period established by the regulations;
- (b) The CON applications must be for same or similar services or facilities;
- (c) The projects must be located in the same service area; and
- (d) The approval of both CON applications must exceed the need for the services or facilities.

S.C. Code Ann. § 44-7-130(5); *see also, e.g., Spartanburg Reg'l Med. Ctr. v. Oncology and Hematology Assocs. of S.C., LLC*, 387 S.C. 79, 90, 690 S.E.2d 783, 789 (2010). It is undisputed that the two CON applications at issue in this case meet the first three elements of the definition of competing applications: *i.e.*, the CON applications were filed within the time period established in the Regulations, the CON applications are for the similar services/facilities, and each proposed project will be located in the same service area. Therefore, the issue for the Court is whether the approval of both CON applications will exceed the need for the services, which is a fact-intensive inquiry dependent upon the evidence submitted by the parties. *Spartanburg Reg'l Med. Ctr.*, 387 S.C. at 91, 690 S.E.2d at 789.

The Court must first resolve whether the approval of Grand Strand's project would bring the existing linear accelerator providers below the 80% threshold if both projects are approved. Grand Strand, as Petitioner and moving party, bears the burden of establishing by a preponderance of the evidence that approval of both applications for linear accelerator services would not exceed the need for the services in the service area. *See* S.C. Code Ann. § 44-7-210(E) (Supp. 2012); *Anon. v. State Bd. of Med. Exam'rs*, 329 S.C. 371, 375, 496 S.E.2d 17, 19 (1998). CRCC and the Department assert that the approval of both applications will exceed the

need for the services in the Service Area. Grand Strand argues that approval of both applications will not exceed the need for services in the Service Area. Based on the following, I find that the approval of both projects would not exceed the need for the services or facilities in the Service Area and are thus not competing.

In making this determination, I choose to consider the 2012-2013 State Health Plan. It indicates that *in 2011 all of the linear accelerator units in the Service Area, plus one that had been approved but was not operational*, were operating at 96.7% of capacity, well above the 80% threshold, such that there was a “need” identified in the Service Area for another linear accelerator in addition to CRCC’s approved project. The Staff’s decision was made on December 28, 2011, based on CRCC’s *projected* 22,419 treatments for 2011, as stated in its CON application that was filed in March 2011. CRCC’s *actual* 2011 utilization, also set forth in the current State Health Plan, was 25,709 treatments, higher than any other radiation therapy provider in South Carolina. The 2012-2013 State Health Plan thus validates Grand Strand’s position taken during the CON review process that the Service Area could support two new linear accelerators in 2011. Moreover, due to the twenty-one (21) month time span between the Staff’s decision and the Contested Case hearing, the likely third year of operations shifted from 2015 to 2017 with respect to determining the 80% threshold analysis set forth in Radiotherapy Standard 6(B) of the Health Plan. *See Spartanburg Reg’l Med. Ctr.*, 387 S.C. at 86, 690 S.E.2d at 787 (indicating that the competing applicants changed their third year projections at the contested case hearing from what was originally proposed in their applications).

Grand Strand’s radiation therapy treatment volumes and projections in its CON application are reasonable and reliable. Grand Strand’s 2017 threshold analysis is more reliable than CRCC’s because, unlike Grand Strand’s analysis, CRCC fails to properly account for the unavailability of the AUC referrals, it fails to assign any weight to CRCC’s status as an entrenched provider, and it speculates about Grand Strand’s effect on CRCC’s future referral patterns. Even when Grand Strand assumes capturing more than one third of the available market in 2017, GMH is operating at 7,165 treatments and CRCC is operating at 19,934 treatments. Thus, the estimated 2017 utilization in the Service Area indicates that if this Court approves both applications, existing providers operating in the Service Area will not fall below the 80% threshold, the adverse impact on existing providers will be minimal, and all providers will be well-utilized.

While it is appropriate to give due consideration to the Staff's utilization of its specialized knowledge and expertise in the application of the CON Act and CON regulations, I find the testimony of Grand Strand's health planning and finance expert more reliable than the testimonies of the Staff reviewer and CRCC's similarly qualified expert. Consequently, based on the foregoing facts, I conclude by a preponderance of the evidence that the approval of a sixth linear accelerator, to be located at Grand Strand, would not bring existing operators below the 80% threshold. Given the robust estimated 2017 utilization of all existing and proposed radiation therapy providers in the Service Area, the approval of both applications would not exceed the need for services in the Service Area.³⁶

Approval of Both Projects

Since the applications do not exceed the need for facilities and services in the Service Area, and therefore are not competing, I must determine whether each applicant's project can be approved under the CON Act, its regulations, and the State Health Plan. 3 S.C. Code Ann. Regs. 61-15 § 307(1).

A project does not have to satisfy every project review criterion in order to be approved, but no project may be approved unless it is consistent with the State Health Plan. Nevertheless, a project may be denied if the Department determines that the project does not sufficiently meet one or more of the criteria. *Id.* § 801(3). Here, the approval of both projects furthers each of the goals articulated in the CON Act. By approving these projects, the Service Area, and particularly Horry County, will have an additional provider that will foster cost containment by providing private insurance companies leverage in negotiating rates for services. While services are duplicated, the facilities are not because Grand Strand is offering an in-hospital radiation therapy center, which is not currently available in the Service Area. Grand Strand's project will foster the development of a comprehensive cancer center, which is not currently available in the Service Area. The establishment of both Grand Strand's and CRCC's project will best serve the public's need by providing an inpatient option, comprehensive cancer services, and a facility in Conway, which currently lacks local radiation therapy services. The linear accelerator units proposed by Grand Strand and CRCC in their CON applications are both reasonable and

³⁶ CRCC's VP of Finance Operations testified that even if both CON applications are approved, CRCC will still build its facility in Conway.

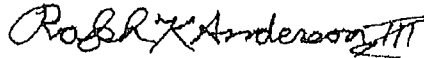
adequate for the proposed radiation therapy services.³⁷ Indeed, both applicants have proven that they will offer high quality radiation therapy services.

I conclude that both applications at issue are consistent with the requirements of the CON Act, its regulations, including the PRC, and the State Health Plan.³⁸

ORDER

IT IS THEREFORE ORDERED that a Certificate of Need for CRCC's proposed project for a radiation therapy center in Conway, South Carolina and a Certificate of Need for Grand Strand's proposed project for a radiation therapy center in Myrtle Beach, South Carolina are **APPROVED**. The Department shall issue a Certificate of Need for each of the proposed projects.

AND IT IS SO ORDERED.



Ralph King Anderson, III
Chief-Administrative Law Judge

April 4, 2014
Columbia, South Carolina

³⁷ If Grand Strand chooses to upgrade its linear accelerator unit following the issuance of a CON, it will need to request permission from the Staff pursuant to 3 S.C. Code Ann. Reg. 61-15 § 605 (Supp. 2013). Because I have found that the linear accelerator proposed by Grand Strand in its Application complies with the applicable PRC, I do not find that Grand Strand's intention to upgrade its unit due to a decrease in price constitutes a substantial change at this time requiring remand of its application to the Staff.

³⁸ Grand Strand has taken the position that while both projects can be approved, if only one can be approved, its project is superior. In light of my decision in this case that determination is unnecessary. Nevertheless, based upon the evidence, I agree with Grand Strand that its project more fully complies with the applicable requirements. As set forth in my Findings of Fact above, Grand Strand's project stands apart from CRCC's because it will offer access to comprehensive cancer treatment and in-hospital radiation therapy services in a Service Area where none currently exist. Grand Strand's project will also offer an alternative to radiation therapy services where the referral sources may be financially rewarded. Non-governmental payors like PPOs will have the ability to negotiate rates in Horry County. While Grand Strand's project costs more than CRCC's, the access it affords to the citizens of the Service Area, the vast majority of whom live in Horry County, outweighs any assertion of duplication or adverse impact due to its location in close proximity to CRCC's facility in Myrtle Beach. However, because I have found that both projects can be approved without exceeding the need for facilities and services, and both projects comply with the CON Act, the Health Plan standards, and applicable PRC, I decline to approve only Grand Strand's Application.

CERTIFICATE OF SERVICE

I, E. Harvin Belser Fair, hereby certify that I have this date served this Order upon all parties to this cause by depositing a copy hereof in the United States mail, postage paid, in the Interagency Mail Service, or by electronic mail, to the address provided by the party(ies) and/or their attorney(s).

E. Harvin Belser Fair

E. Harvin Belser Fair
Judicial Law Clerk

April 4, 2014
Columbia, South Carolina

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Grand Strand Regional Medical Center, LLC,	)	Docket No.: 12-ALJ-07-0090-CC
	)	
Petitioner,	)	
	)	
vs.	)	
	)	RECONSIDERATION ORDER
South Carolina Department of Health and Environmental Control,	)	
	)	
Respondent.	)	

Grand Strand Regional Medical Center, LLC,	)	Docket No.: 12-ALJ-07-0091-CC.
	)	
Petitioner,	)	
	)	
vs.	)	
	)	(Consolidated)
South Carolina Department of Health and Environmental Control and Carolinas Regional Cancer Center,	)	
	)	
Respondents.	)	

This matter comes before the South Carolina Administrative Law Court (ALC or Court) pursuant to Respondent Carolina Regional Cancer Center's (CRCC) Motion to Alter or Amend the Court's Final Order and Decision dated March 10, 2014 (Final Order), in which it found that CRCC and Grand Strand Regional Medical Center, LLC (Grand Strand) were not competing and should both be granted a Certificate of Need (CON) for radiotherapy centers in Horry County. On March 28, 2014,¹ Grand Strand filed a Memorandum in Opposition to CRCC's Motion to Alter or Amend. After careful consideration of the arguments submitted, I find that a few of CRCC's arguments warrant reconsideration and clarification of the original Order. Accordingly,

¹ Grand Strand filed a hard copy and electronic copy of its Memorandum on March 28, but due to an error in the Court's emailing system, the electronic version that Grand Strand submitted was not discovered by the Court until March 31.

FILED

APR - 4 2014

SOUTH CAROLINA ADMINISTRATIVE LAW COURT

I am issuing an Amended Final Order and Decision (Amended Final Order) that will reflect the changes made upon reconsideration. The remaining arguments will be addressed below.

DISCUSSION

Remand of Grand Strand's CON Application

CRCC argues that Grand Strand's CON Application should have been remanded back to the South Carolina Department of Health and Environmental Control (DHEC or Department). CRCC contends that the Court erred in "weighing the project review criteria itself and approving Grand Strand's CON application, even though DHEC only compared the applications and never made an initial decision on whether Grand Strand's application could be independently approved." CRCC is correct that DHEC did not make an initial decision on whether Grand Strand's application could be independently approved. However, this fact does not prevent this Court from deciding whether to approve both applicants' CON applications without remanding the matter back to DHEC.

In *Spartanburg Reg'l Med. Ctr. v. Oncology and Hematology Assocs. of S.C., LLC*, 387 S.C. 79, 690 S.E.2d 783 (2010), DHEC found that two applicants were competing and granted a CON to one applicant and denied the other's application. The ALC agreed with DHEC's decision to grant the one applicant a CON, but disagreed with DHEC's denial of the other CON application. Rather, the ALC found that the two applicants were not competing and that both applications were consistent with the applicable State Health Plan.² The South Carolina Supreme Court held that the ALC's conclusion that the two applications were not competing was legally correct. The Court not only found sufficient factual evidence in the record to support the ALC's finding, but also interpreted S.C. Code Ann. § 44-7-130(5) (2002) (the definition of "competing applicants") as plainly meaning: "If granting both applications would not exceed the need, then the applications are not competing and both may be granted (provided all other relevant criteria are met)." The Court then noted approvingly that the ALC "specifically found that both [applicants] met the relevant project criteria." The Court thus did not impose some obligation on the ALC to remand the case back to the Department when it finds that the applicants are not competing for consideration of whether the previously denied applicant

² It is noteworthy that when the *Spartanburg Reg'l* case was decided, the appeal went from the ALC to the DHEC board for review (the Department Board had appellate review under the old system). The Board affirmed the ALC's decision to grant both CON applications.

independently meets the project review criteria. Rather, the Court approved of the same actions taken by the ALC in that case that the ALC took in this case. Therefore, this Court rejects CRCC's argument that Grand Strand's CON Application should be remanded to DHEC.³

Further, CRCC cites *S.C. Dep't of Health & Envtl. Control v. Armstrong*, 293 S.C. 209, 359 S.E.2d 302 (Ct. App. 1987) in support of its remand argument. However, *Armstrong* involved a dispute between a restaurant owner and DHEC over a permit to operate a restaurant. After inspecting the restaurant, DHEC informed the restaurant owner that the premises did not comply with DHEC regulations. When the restaurateur failed to cease operating his restaurant, DHEC issued "an administrative order directing [the restaurateur] to cease and desist operation of his restaurant." *Id.* at 211, 359 S.E.2d at 303. The actual permit in *Armstrong*, which would be analogous to the issuance of a CON in this case, "was neither issued nor denied" by DHEC. *Id.* Rather, the issue was whether to enforce the DHEC administrative order it issued *before* rendering *any* permitting decision. The Court of Appeals held that the trial judge had "displaced the administrative" process by taking action in the case. *Id.* at 215, 359 S.E.2d at 304. The *Armstrong* case has no effect on this case. Here, the Department engaged in a lengthy review process and then made an official—albeit erroneous—agency decision that gave rise to this contested case proceeding. In *Armstrong*, there was no such agency decision made. Therefore, the Court will not rely on *Armstrong*.

Finally, the ALC conducts a *de novo* review of the Department's decision in CON cases. South Carolina Code Ann. § 44-7-210 governs CON contested case review procedures, and it expressly defines the scope of reviewable issues in CON contested cases:

The *issues* considered at the contested case hearing considering a certificate of need are limited to those *presented to or considered during the staff review*.

S.C. Code Ann. § 44-7-210(E) (emphasis added). The ALC thus may consider *any issue* "presented to" the Department during staff review. The Department does not have to rule on or decide every facet or alternative nuance of an issue. The Department does not have to pass upon

³ The Court also rejects CRCC's other, collateral arguments on this subject, as all of those arguments (except the one regarding Footnote 11) could have been made in *Spartanburg Reg'l* yet would have failed based on the Supreme Court's reasoning in that case. And as to Footnote 11, the Court agrees with CRCC that if Grand Strand decides to purchase a True Beam linear accelerator instead of the one in its application, then Grand Strand will have to get approval from DHEC. However, Grand Strand has not yet sought to procure a True Beam, regardless of its intentions.

every conceivable portion or implication of an issue. So long as the issue is presented to or considered by the Department, the ALC may hear it.

In this case, three applicants originally submitted linear accelerator CON applications to the Department. The basic issues presented to the Department involved whether the CON applications complied with the State Health Plan and Regulations. Once these issues were properly before the ALC, the ALC conducted a *de novo* review. In *Marlboro Park v. S.C. Dept. of Health & Envt'l Control*, 358 S.C. 573, 595 S.E.2d 851 (Ct. App. 2004), the Department Board⁴ adopted a narrow view of this Court's authority that is similar to the restrictions that CRCC seeks to impose here. Looking to the plain language of section 44-7-210(E), Judge Kittredge, writing for the Court, stated:

A trial *de novo* is one in which "the whole case is tried *as if no trial whatsoever had been had in the first instance*. Moreover, when reviewing a contested case on appeal, "[t]he ALJ, as the fact-finder, must make sufficiently detailed findings supporting the denial [or grant] of a permit application." "Detailed findings enable [an appellate court] to determine whether such findings are supported by the evidence. . . ." Here, because the ALJ was conducting a *de novo* hearing, we find that he properly considered the evidence presented in his pursuit to make sufficiently detailed findings of fact for subsequent review.

Id. at 579, 595 S.E.2d at 854 (emphasis added) (internal citations omitted).

Therefore, clearly this Court conducts a *de novo* review of the issues presented to or considered by the Department staff during the review period.

Footnote 37

CRCC argues that footnote 37 in the Court's Final Order should be deleted, because a discussion of how the Court would have alternatively ruled (i.e., had the Court found the applications competing) was irrelevant in light of the Court's decision that the applications were not competing. CRCC also argues that the Court's statements in footnote 37 contradict the statement in footnote 34, in which the Court declined to consider certain facts since the Court found that the applications were not competing. CRCC also contends that the findings in footnote 37 ignore DHEC's analysis and the analysis of CRCC's expert. Finally, CRCC argues that footnote 37 "has no practical effect" and is "advisory."

⁴ The *Marlboro Park* case was decided prior to the effective date of Act 387. (2006 S.C. Acts 387, eff. July 1, 2006.). Act 387 changed the order of the CON review process. Nevertheless, Act 387 does not affect the operation of section 44-7-210(E), nor does it affect the holding in *Marlboro Park*.

As an initial matter, the Court has amended footnote 34 (35 in the Amended Final Order) as follows in order to clarify what the Court had intended to convey. Moreover, if this Court were to find that the applications were competing, consideration of a potential move of the Conway facility to another location would be of little probative value in evaluating CCRC's application. As stated in the Final Order, the Staff would have to approve any such future relocation. That issue was not before this Court and would involve consideration of many facts that were not in this record. Therefore, in concluding in footnote 37 that Grand Strand's project more fully complies with the applicable CON requirement, the potential relocation of CCRC's Conway facility was not a consideration. And as the finder of fact, the Court is free to reject evidence. *See S.C. Dep't of Transp. v. M & T Enters. of Mt. Pleasant, LLC*, 379 S.C. 645, 668 n.12, 667 S.E.2d 7, 20 n.12 (Ct. App. 2008) (noting that a finder of fact is "free to accept or reject any or all of a witness' testimony, including that of an expert witness.").

The Court also notes that its comment in footnote 37 was hardly "summarily" stated. The Court provided specific grounds for why it would have found that Grand Strand better-complied had it found the two applications to be competing. And again, as the finder of fact, the Court is "free to accept or reject any or all of a witness' testimony, including that of an expert witness." *S.C. Dep't of Transp., supra*. Thus, the fact that the Court would have rejected certain facts from DHEC's analysis or from CRCC's expert's analysis is within the Court's province as the finder of fact.

Finally, whether or not the applications were competing, the Court ultimately was asked to render a decision as to whether Grand Strand should be granted a CON. Thus, the issue before the Court was not abstract or theoretical. It was an actual, concrete controversy affecting the rights of a party to the litigation. The question was not hypothetical, but was squarely before the Court, forming, in part, the basis of Grand Strand's prayer for relief. Moreover, the practical effect of footnote 37 is simply to demonstrate that Grand Strand would have received the CON regardless of whether the Court found its and CRCC's CON Applications to be competing. Offering alternative grounds for a determination – in this case, granting Grand Strand a CON – does not make the footnote advisory. *See e.g., Myatt v. RHBT Fin. Corp.*, 370 S.C. 391, 397 n.3, 635 S.E.2d 545, 548 n.3 (Ct. App. 2006) (noting that there was no need to address the trial court's additional sustaining grounds because it affirmed the trial court's initial ground for granting summary judgment); and *I'On, L.L.C. v. Town of Mt. Pleasant*, 338 S.C. 406, 420, 526

S.E.2d 716, 723 (2000) (holding that an appellate court has discretion to address any additional sustaining grounds). Therefore, the Court declines to delete footnote 37.

Consideration of the 2012-2013 State Health Plan

CRCC argues that the Court overlooked S.C. Code Ann. Regs. 61-15 § 504 (Supp. 2013) when considering the 2012-2013 State Health Plan. Specifically, CRCC emphasizes the following language in that regulation:

Should a new plan be adopted during any phase of the review or appeals process, the applicant shall have the option of withdrawing the application and resubmitting under the newly adopted plan or continuing the review or appeal process under the plan in use when the application was submitted.

Id. Here, the Court's references to the 2012-2013 State Health Plan simply make note that the 2012-2013 State Health Plan *supports* the Court's other factual findings. The 2012-2013 State Health Plan is not referenced as the primary basis for the Court's decision.

Furthermore, South Carolina Code Annotated section 44-7-225 states that the "department, the Administrative Law Court, and the Court of Appeals shall consider the South Carolina Health Plan in place at the time the application was filed and may consider the current South Carolina Health Plan when making its decision." This statute tells the Court that it *must* "consider" the State Health Plan in place at the time the application is filed. Using the same language, it also gives the Court *permissive authority* to "consider" the State Health Plan in place at the time the Court renders a decision. Thus, section 44-7-225 establishes that this Court has the authority to "consider" the 2012-2013 State Health Plan in the same manner that it would "consider" the State Health Plan in place at the time the applications were filed.

Regulation 504 merely addresses the option that a CON applicant has to file a new application under a new plan if a new plan is adopted after the applicant filed its original plan. This has no bearing on the option afforded to this Court (or to the Court of Appeals for that matter) under S.C. Code Ann. § 44-7-225 (Supp. 2013) to consider the current Health Plan when making its decision.⁵ And even if DHEC promulgated Regulation 61-15 § 504 to narrow the scope of its review power granted by the statute, the Department does not have the power to divest this Court or the Court of Appeals of review powers granted by the enabling statute, Section 44-7-225. *See Young v. S.C. Dep't of Highways and Public Transp.*, 287 S.C. 108, 113,

⁵ The Court declines to consider the "apparent purposes of Regulation 61-15 § 504" as set forth by CRCC.

336 S.E.2d 879, 882 (Ct. App. 1985) (“An administrative regulation is valid so long as it is reasonably related to the purpose of the enabling legislation.”).

Therefore, the Court rejects CRCC’s application of Regulation 61-15 § 504.

Shifting of Burden of Proof to CRCC

CRCC asserts that this Court shifted the burden of proof from Grand Strand to CRCC. CRCC charges this Court with having “overlooked the dearth of evidence provided by Grand Strand” and “focused instead on the perceived weaknesses in CRCC’s evidence and expert testimony.”

However, as mentioned above, as the trier of fact, this Court has the discretion to determine what amount of weight to give to the evidence, and may accept or reject evidence presented. See *State v. Dorce*, 320 S.C. 480, 482, 465 S.E.2d 772, 773 (Ct. App. 1995) (“The trial judge was presented with contradicting testimony, and it was within his province, as the trier of fact, to weigh the credibility of the evidence presented to determine which witnesses he deemed credible.”); *Moore v. Benson*, 390 S.C. 153, 164, 700 S.E.2d 273, 279 (Ct. App. 2010) (“[T]he fact finder [] was free to accept or reject the testimony.”). Therefore, the Court was free to reject CRCC’s evidence in favor of Grand Strand’s.

Moreover, the Court’s mention of weaknesses in CRCC’s evidence is perfectly proper as part of this Court’s “credibility determinations,” just as the ALC made in its order in *Spartanburg Reg’l Med. Ctr.*, *supra*. Indeed, the Supreme Court in that case found that credibility determinations were among several other factors – including findings of fact, conclusions of law, and legal analysis – that made the ALC opinion “far from conclusory.” This Court not only set forth the respective methods of determining market share, but also set forth its reasoning for its decision to accept one method and reject the other. Therefore, an appellate court would be able to review this Court’s decision and state, as the Supreme Court did regarding the ALC’s order in *Spartanburg Reg’l Med. Ctr.*, *supra*, that it “need not speculate about why the ALC reached the decision it did because the written order makes the reasons manifest.” Just because the Court does not share CRCC’s opinion about the credibility of Grand Strand’s draw-

rate analysis does not make its decision reversible error. Indeed, the Court would naturally expect CRCC to disagree with a decision that adopts the findings and reasoning of its adversary.⁶

Overlooked or Misapprehended Key Facts

Having carefully considered the alleged misapprehensions or overlooked facts enumerated in CRCC's Motion, the Court, as the trier of fact, considered all of the relevant evidence, rejected that which was not probative, and attributed more weight to some evidence than other evidence. However, the Court agrees with CRCC as to one factual error: the Court stated the following on page 14 of its Final Order: "Grand Strand estimated that there will be 13,205 treatments in the market in 2017 that will not be available for capture by Grand Strand." However, the number of treatments that will be unavailable to Grand Strand in 2017 should have been 11,360. This correction will be reflected in the Court's forthcoming Amended Final Order. Aside from that oversight, the Court rejects the remainder of CRCC's contention that the Court overlooked or misapprehended key facts.

Though the Court need not specifically respond to any of the other allegations brought by CRCC, the Court will provide the following observations seriatim in response to CRCC's allegations (note: the order of the observations will correspond to the order of the allegations):

- **CRCC Bullet #1 – Mr. Sullivan's experience.** The Court has not overstated Mr. Sullivan's experience. There is evidence in the trial transcript that supports the finding that Mr. Sullivan is an accomplished and well-qualified health planning expert with significant knowledge of the market. (Sullivan Trial Tr. 610:3-617:6). Moreover, CRCC never challenged Mr. Sullivan's qualifications or experience with respect to his work on linear accelerator CON applications. The transcript is replete with evidence documenting Mr. Sullivan's work on Grand Strand's CON, the project review meeting, his challenge of CRCC's application, and his work on his draw-rate analysis. (Sullivan Trial Tr. 618:1- 622:4; 622:23-623:2, 629:1-631:1, 681:4-683:16, 685:3-687:21, 772:2-777:7; Joint Ex. #2, Pet. Ex. #16, 24).
- **CRCC Bullet #2 – Grand Strand's Provision of Comprehensive Care.** The evidence supports the findings regarding Grand Strand's intention to provide comprehensive cancer services. Grand Strand's radiation therapy center is equipped to provide chemotherapy services. (Joint Ex. #2 at 125, 129; White Tr. 89:13-90:6; Collins Tr. 607:22-608:21). While Grand Strand acknowledged that

⁶ CRCC references in footnote 2 of its Motion the fact that inpatient market share was previously accepted by the ALC as a proxy for market share, citing *Beaufort-Hilton Head Radiation Oncology Center v. S.C. Dep't of Health & Envtl. Control*, 01-ALJ-07-0507-CC (Mar. 19, 2003 S.C.A.L.C). However, this Court has already addressed this point in footnote 23 of its Final Order and stands by what it said therein.

Dr. Holt will continue to perform chemotherapy as he has done in the past, Grand Strand's CEO indicated that he expected Grand Strand to perform some chemotherapy treatment and planned to do so in the future. (White Trial Tr. 90:7-19). Although CRCC states that Grand Strand will not house PET/CT at the hospital, Mr. White testified that Grand Strand would shift PET/CT services to the main campus if it is approved for a linear accelerator. (White Tr. 254:13-255:1; 283:22-284:6). Moreover, Grand Strand's witnesses never testified that some form of interdisciplinary care was not presently occurring at Grand Strand during tumor boards. Rather, Grand Strand's witnesses testified that patients will be able to go to one location to receive all of their cancer needs, and comprehensive care promotes interdisciplinary care. (White Tr. 85:23-86:8; Collins Tr. 551:16-18). Grand Strand also stressed that establishing a comprehensive cancer center would allow it to recruit surgical and medical sub-specialists who provide cancer care, such as GYN oncologists, oncology surgeons, colorectal surgeons, and fellowship-trained breast surgeons. (White Tr. 87:24-88:20, 90:20-91:22; Sullivan Tr. 646:22-648:7).

- **CRCC Bullet #3 – Grand Strand's 20% market share assumption.** The Court did not overlook Grand Strand's overall market share in its primary and secondary service areas. Rather, the Court notes found that Grand Strand's overall market share was not an appropriate metric to use in this instance because of the presence of an entrenched competitor who has a solid historical reputation. The Court noted on page 9 of the Final Order the reasons why Grand Strand's assumption of 20% for linear accelerator market share in the third year of operations was reasonable. With respect to Grand Strand's internal calculations, the Court is well aware of Grand Strand's "what if" analysis and considered the testimony of its CFO Robert Grace and the testimony of its expert, Mr. Sullivan, and found the "what if" analysis to be unreliable. (Grace Tr. 413:22-415:2, 417:24-418:4, 451:24-452:19, 465:13-22; Sullivan Tr. 783:24-785:5).

- **CRCC Bullet #4 – Dr. Holt's Letter of Support.** While Dr. Holt did not provide a letter of support to CRCC, there was no evidence in the transcript that CRCC ever asked for one. The Court also notes in footnote 27 in the Final Order (28 in the Amended Final Order) that Dr. Holt was responsible for only 30 treatment plans at CRCC in 2013, while the three medical oncologists whose support for CRCC-Conway was critical—Drs. Cody, Karpenko and Goldberg—were responsible for a combined 100 treatment plans at CRCC through May 2013, and all three provided letters of support for CRCC-Conway project. According to CRCC, Drs. Cody, Karpenko and Goldberg were the CCC physicians whose support it really needed. (Lewis Tr. 1342:2-1343:23; Pet. Ex. #50; Joint Ex. 1A at 228-30). Moreover, both applicants received hundreds of support letters for their respective projects. (Joint Ex. #1 at 638-641; Joint Ex. #1-A at 1-240; Joint Ex. #2 at 868-74). Lastly, as noted on page 17 of the Final Order, CRCC's Medical Director, Dr. Francke, admitted that he has not had an indication from any of the Coastal physicians that they would cease referring to CRCC if both projects are approved.

• **CRCC Bullet #5 – CRCC’s Draw Rate Analysis.** In this bullet point, CRCC misstates the facts. First, CRCC’s draw-rate analysis is set forth in CRCC Exhibit 13, not CRCC Exhibit 12. There is no indication that CRCC’s expert backed out urology referrals in his draw-rate analysis. In fact, using the likely number of treatments per patient, CRCC’s draw-rate analysis indicates that Grand Strand will not bring CRCC below the 80% threshold. Furthermore, I disagree with CRCC’s analysis in Exhibit 12 that it removed “the urology patients when calculating Grand Strand’s market share.” In that analysis, CRCC took Grand Strand’s *inpatient* admissions and carved out certain special services for which Grand Strand was a primary provider in the Service Area, such as cardiovascular services, *urological surgery*, and medical urology cases. (Resp. Ex. #12 at 12906; Tolbert Tr. 2000:22-2001:9) (emphasis added). CRCC could have simply carved out the actual AUC referrals/treatments to CRCC from the threshold analyses, as did Grand Strand. In fact, several CRCC documents show the exact percentage of prostate cancer treatments and the exact number of AUC referrals under treatment at CRCC in 2012. (Tolbert Tr. 2002:8-2003:24; Pet. Ex. #52 at CRCC 72; Resp. Ex. #10).

• **CRCC Bullet #6 – CRCC’s Facility.** While the Court noted in the Final Decision that CRCC’s proposed facility was “underwhelming,” the Court also noted that both projects will promote cost containment, and the introduction of Grand Strand’s radiation therapy center in the market will promote cost containment through price competition and by providing an alternative treatment setting where there are no financial incentives to refer. Nevertheless, CRCC’s Conway facility would not be comparable to even its other facilities in the area.

• **CRCC Bullet #7 – Drive Time.** CRCC asserts that the Court “downplayed the 20-minute reduction in drive time that CRCC’s Conway facility would afford to the average patient.” However, the finding that the savings were only 20 minutes was made in context of both projects. The nearest comprehensive cancer center, which Grand Strand is proposing to develop, is located in Charleston, South Carolina, 100 miles away.

• **CRCC Bullet #8 – Adverse Impact to CRCC.** Footnote 18 states, “CRCC never took the position with the Staff at the PRM or in follow-up written submission that Grand Strand’s project would result in a substantial loss of CCC referrals.” That finding is not the same as stating that “CRCC never argued to DHEC that Grand Strand’s project would adversely impact its operation,” as CRCC states in its Motion. The Court addressed CRCC’s adverse-impact analyses at length in the Final Order, and there is evidence supporting the Court’s determination as to any adverse impact that CRCC will incur as a result of the approval of Grand Strand’s project.

• **CRCC Bullet #9 – Volume of Unavailable Treatments.** The Court has already addressed this allegation, agreeing with CRCC, and has corrected the

volume number of unavailable treatments in the forthcoming Amended Final Order accordingly.

- **CRCC Bullet #10 – CRCC’s Current Utilization Data.** The Court considered the evidence presented by both sides with respect to CRCC’s declining utilization, and concluded that CRCC’s 2013 decrease in the first seven months of the year was an aberration due to one urologist referring far less patients than his urologist partners. The Court also was swayed by the testimony of Mr. Tolbert who testified that it is preferable to use a full year of data when projecting utilization because of the uncertainty of what can occur in the remaining part of the year, which would have been five full months. (Tolbert Tr. 1828:16-1829:5, 2005:13-2006:13). Moreover, the Court also recognized that even though CRCC experienced a volume decrease in 2012 over 2011, nine months into 2012, CRCC’s plan was to apply for the additional linear accelerator that would be shown as needed in the 2012-2013 Health Plan, despite knowledge of a change in the urology cancer screening protocols, which purportedly would lead to less urology cancer detection. (Pet. Ex. #74 at Tolb. 1353-54; Lewis Tr. 1338:19-1340:18; Francke Tr. 1543:14-17). Finally, the Court noted that a change in the protocol merely changes when the cancer will be detected, not if it will be detected.

- **CRCC Bullet #11 – Mr. Tolbert’s Referral Analysis.** The Court does not find Mr. Tolbert’s “referral analysis” to be conservative. He overstated the number of referrals that Grand Strand is likely to receive. Furthermore, Mr. Tolbert’s analysis was based in part on one or two thirty-minute phone calls with Ms. Price and Dr. Francke, both of whom are CRCC employees strongly opposed to Grand Strand’s project. During these conversations, they discussed where the higher volume referral sources might refer patients if Grand Strand were present in the market. (Tolbert Tr. 1943:10-1944:6; 1950:7-1951:2). The low-volume physician referrers, which accounted for 127 patient referrals to CRCC in 2012, were never discussed with Ms. Price or Dr. Francke. (Tolbert Tr. 1951:24-1952:11). Mr. Tolbert also assumed that 40% of these patients, or 51 patients, would be redirected to Grand Strand, which is the equivalent of over 1,000 treatments. (Resp. Ex. #10).

To the contrary, the evidence supports Grand Strand’s assertion. While a “referral analysis” was considered by Mr. Sullivan, he correctly determined that such an analysis would not be reliable. (Sullivan Tr. 2111:8-2113:17). Although not included in the Final Order, the Court heard convincing expert testimony from Grand Strand that CRCC provided no reasonable basis to assign a 40-40-20% split to Grand Strand, CRCC and GMH, respectively, to the low-volume referral physicians who may not have a nexus to the area and who have historically referred patients to CRCC. (Sullivan Tr. 2111:8-2112:12; Resp. Ex. #10). Of 275 CCC patient referrals to CRCC in 2012, 152 resided in Myrtle Beach, North Myrtle Beach, and the Murrells Inlet area. Mr. Tolbert assumed that 75% of these patients would be redirected to Grand Strand, even though CRCC’s practice manager, Ms. Price, testified that Grand Strand’s location would offer no travel

time advantage to patients and a significant number of patients would originate from the area around Murrells Inlet, where two CON applications for radiation therapy centers have been approved. (Tolbert Tr. 1966:7-1970:10; Resp. Ex. #10 at Tolb. 12844). Ultimately, Mr. Tolbert concluded that only *two* out of the 128 non-AUC physicians would continue to send 100% of their patients to CRCC. (Tolbert Tr. 1705:6-15; Resp. Ex. 11 at Tolb. 12895).

- **CRCC Bullet #12 – Grand Strand’s Project and Duplication.** The Court correctly determined that Grand Strand’s project would not unnecessarily duplicate services. The Court found that currently, there is neither a comprehensive cancer center nor an in-hospital radiation therapy center located in the service area. The nearest such facilities require cancer patients to travel long distances for inpatient and comprehensive cancer treatment. As there was a need for two CONs in the service area, the duplication was not unnecessary.

- **CRCC Bullet #13 – Competition and Cost Containment.** CRCC has no competition in Horry County and therefore CRCC has an advantage when negotiating prices with third party PPO payors. When there is a single provider in a geographic area, the provider has the ability to raise prices in a way that would not be possible in a market with competition. (Sullivan Reb. Tr. 2082:14-24). Moreover, the “cost containment” The Project Review Criteria (PRN) in the CON regulation requires more than just consideration of cost of the service. Grand Strand addressed cost containment and identified methods of funding and demonstrated the feasibility of the funding option. (Joint Ex. #1 at 670, 674; Resp. Ex. #6 at Tolb. 12927). CRCC did not challenge this portion of Grand Strand’s cost-containment analysis. PRN 16(c) also requires that “[t]he impact of the project upon the applicant’s cost to provide services and the applicant’s patient charges” be reasonable. 3 S.C. Code Ann. Regs. 61-15 § 802(16)(c) (Supp. 2013). CRCC did not directly address the impact that Grand Strand’s project would have on Grand Strand’s cost to provide services and on its patient charges. The evidence also reflected that an in-hospital radiation therapy center would alleviate charges associated with transporting patients to and from a freestanding facility up to three times during a hospital stay. (Sullivan Reb. Tr. 2073:19-2074:7).

- **CRCC Bullet #14 – AUC Referrals to CRCC.** CRCC asserts that the lack of referrals on a “nasty relationship” between the urologists and the prior owner of CRCC, explains why the AUC urologists began referring significant number of patients to CRCC when they become financially affiliated with CRCC. However, the evidence in the record also suggests that the increase referrals could be related to other factors. The evidence included findings by the United States General Accounting Office, showing that limited specialty groups, primarily urologists who self-refer, substantially increased the percentage of their prostate cancer patients they referred for IMRT treatment after they began to self-refer. Among all providers who referred a Medicare beneficiary diagnosed with prostate cancer in 2009, those that self-referred *were 53 percent more likely to refer their*

patients for IMRT and less likely to refer them for other, less costly treatments, like prostatectomy or brachytherapy. The study suggests that financial incentives for self-referring providers, specifically those in limited specialty groups like urology practices, were likely a major factor driving the increase in the percentage of prostate cancer patients referred for IMRT. (Sullivan Tr. 741:14-747:4). Moreover, a strategy that 21st Century utilizes to build volume is to establish a group practice like AUC and pay employed physicians in the practice profits using an ancillary profit formula from revenues generated by their referrals to the affiliated radiation therapy center. (Lewis Tr. 1239:5-17). The AUC-employed urologists have a financial relationship with CRCC by virtue of participating in an ancillary bonus pool. (Lewis Tr. 1237:1-6).

- **CRCC Bullet #15 – DHEC Factors.** CRCC asserts that this Court misapprehended the factors that DHEC was supposed to consider when comparing the projects. The Court did not assert “that DHEC Staff failed to consider CRCC’s monopoly of radiation therapy services in Horry County.” Rather, the Court noted that DHEC failed to consider that issue. In terms of comparing the projects, the Court found that the CON applications were not competing, and thus a comparison of the projects by each PRC was not necessary to find that both projects could be approved. Furthermore, CRCC focuses too greatly on the word “monopoly” in footnote 32 (33 in the Amended Final Order), rather than to the highly relevant reference in footnote 32 to “cost containment.” As discussed above, the fact that CRCC has no competition in the market allows it to set the price for services because payors have virtually no leverage. That issue is relevant.

- **CRCC Bullet #16 – CRCC Adverse Impact Model.** CRCC asserts that “this Court ignored that the adverse impact model used by CRCC’s expert was initially raised by Grand Strand’s expert in his deposition.” The Court did not ignore the fact that the adverse-impact model used by CRCC’s expert, referenced as the “referral analysis,” was initially raised by Mr. Sullivan in his deposition. Rather, the Court agreed with Grand Strand’s expert that such an analysis would not be reliable because it was mostly based on speculation. (Sullivan Tr. 2111:8 – 2113:17).

- **CRCC Bullet #17 – Applications Not Competing.** CRCC claims that every adverse-impact scenario presented to the Court, except for the pre-discovery projections contained in Grand Strand’s CON application, indicated that the approval of both applications would reduce the existing units below the 80% threshold. This statement is not correct. In fact, using Mr. Tolbert’s own 2017 treatment projection, Grand Strand presented three different adverse-impact scenarios premised on the capture of the available treatments at different market share rates — 25%, 30%, and 35%. Each of these adverse-impact scenarios showed that even at a 35% capture rate, all of the existing units in the service area would be operating above the 80% threshold. (Pet. Ex. #39, 40, 41). Furthermore, applying the correct number of likely linear accelerator treatments (21) to

CRCC's draw-rate analysis would result in a treatment volume at Grand Strand below CRCC's "tipping point," which means all units would be operating above 80% in the year 2017. Finally, the evidence in the record indicates that Mr. Tolbert's adverse-impact analyses were not reliable. At least one showed that Grand Strand would be the highest-volume single-unit provider in the entire state after three years of operation, despite the heavily entrenched competition. (Joint Ex. #5 at IX-9). Even Mr. Tolbert admitted that the scenario was "farfetched." (Tolbert Tr. 1997:1-1999:12; Resp. Ex. #12 at Tolb. 12904).

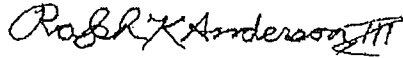
ORDER

IT IS THEREFORE ORDERED that CRCC's Motion to Alter or Amend is **GRANTED IN PART AND DENIED IN PART**, in keeping with this Order.

IT IS FURTHER ORDERED that all additional factual findings in this Order are incorporated into the Amended Final Order as findings of fact.

IT IS FURTHER ORDERED that all additional legal conclusions in this Order are incorporated into the Amended Final Order as conclusions of law.

AND IT IS SO ORDERED.



Ralph King Anderson, III
Chief Administrative Law Judge

April 4, 2014
Columbia, South Carolina

CERTIFICATE OF SERVICE

I, E. Harvin Belser Fair, hereby certify that I have this date served this Order upon all parties to this cause by depositing a copy hereof in the United States mail, postage paid, in the Interagency Mail Service, or by electronic mail, to the address provided by the party(ies) and/or their attorney(s).

E. Harvin Belser Fair

E. Harvin Belser Fair
Judicial Law Clerk

April 4, 2014
Columbia, South Carolina

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Grand Strand Regional Medical)
Center, LLC,)
)
Petitioner,)
)
vs.)
)
South Carolina Department of Health and)
Environmental Control,)
)
Respondent.)
_____)

Docket No.: 2012-ALJ-07-0090-CC

FINAL ORDER AND DECISION

Grand Strand Regional Medical)
Center, LLC,)
)
Petitioner,)
)
vs.)
)
South Carolina Department of Health and)
Environmental Control and Carolinas)
Regional Cancer Center,)
)
Respondents.)
_____)

Docket No.: 2012-ALJ-07-0091-CC

(Consolidated)

FILED

March 10, 2014

SC ADMIN. LAW COURT

Appearances:

For Petitioner Grand Strand: William R. Thomas, Esq. and Walter H. Cartin, Esq.

For Respondent CRCC: James G. Long III, Esq.; E. Wade Mullins, III, Esq.;
and Jennifer J. Hollingsworth, Esq.

For Respondent SC DHEC: Ashley C. Biggers, Esq.

STATEMENT OF THE CASE

The above-captioned matters come before the South Carolina Administrative Law Court (ALC or Court) upon the requests of Petitioner Grand Strand Regional Medical Center, LLC (Grand Strand) for a contested case hearing to review the decisions of Respondent South Carolina Department of Health and Environmental Control (DHEC or the Department) (1) to

deny Grand Strand's Certificate of Need (CON) application for the addition of a linear accelerator and CT Simulator for a radiation therapy center at its hospital location in Myrtle Beach, South Carolina; and (2) to approve the CON application of Respondent Carolina Regional Cancer Center (CRCC) for an additional linear accelerator to expand its existing linear accelerator services to Conway, South Carolina.¹ CRCC moved to intervene in the matter pending between Grand Strand and the Department, which was granted in an Order dated May 4, 2012. Also, the cases were consolidated by a Consent Order also dated May 4, 2012. After timely notice to the parties, the Court conducted a hearing on the merits September 12, 2013 through September 24, 2013.

The Department found the CON applications to be competing applications as defined by the CON Regulations. CRCC supports DHEC's finding that Grand Strand's and its CON applications are competing and that Grand Strand's application should be denied. Grand Strand, on the other hand, challenges the Department's finding that the CON applications are competing applications and argues in the alternative that even if the applications were competing, DHEC should have approved Grand Strand's application and denied CRCC's application because Grand Strand's application more fully complies with the South Carolina CON Act, its regulations, and the applicable South Carolina Health Plan (State Health Plan or Health Plan).

I find that Grand Strand's and CRCC's CON applications are not competing applications as defined by the applicable law and both applications satisfy the State Health Plan, the Project Review Criteria (PRC),² and the purposes of the Certificate of Need Act. Furthermore, there is a need for two additional linear accelerators in the Service Area³ under the 2012-2013 State Health Plan. In reaching this decision, this Court compared the CON applications to determine which application more fully complied with the requirements, goals, and purposes of the CON program, State Health Plan, PRC, and the regulations developed by the Department. Therefore, I conclude that both CRCC and Grand Strand should be granted CONs.

¹ Initially, an additional applicant and petitioner, North Strand Radiation Oncology Center (North Strand) filed a contested case challenging DHEC's denial of its CON application and the approval of CRCC's CON application, but North Strand withdrew from the contested case and was formally dismissed with prejudice on March 5, 2013.

² The PRC, consisting of 33 general criteria, including subcriteria, are set forth in 3 S.C. Code Ann. Reg. 61-15 § 802 (Supp. 2013). Each criterion will henceforth be referred to using PRC in place of the regulatory citation followed by the subsections. For example, 3 S.C. Code Ann. Reg. 61-15 § 802(2)(b) will be cited as PRC 2(b).

³ The Service Area consists of three counties comprised of: Horry, Georgetown, and Williamsburg Counties (Service Area).

FINDINGS OF FACT

Having observed the witnesses and exhibits present at the hearing and closely passed upon their credibility, taking into consideration the burden of proof upon the parties, I make the following Findings of Fact by a preponderance of the evidence:

The Parties

Grand Strand, a for-profit subsidiary of Hospital Corporation of America (HCA),⁴ is a 269-bed tertiary-care hospital located in Myrtle Beach, South Carolina, that opened in 1978. Grand Strand is an accredited community cancer center by the Commission on Cancer of the American College of Surgeons.

CRCC is a freestanding radiation therapy provider currently operating three linear accelerators at one location in Myrtle Beach, South Carolina. CRCC's Myrtle Beach facility is located three miles from Grand Strand's campus. CRCC is a 100% subsidiary of Atlantic Urology Clinics, LLC (AUC), which is a 100% subsidiary of 21st Century Oncology of South Carolina, LLC, which is, in turn, a 100% subsidiary of Radiation Therapy Service, Inc. (21st Century).⁵ CRCC has been approved for, but has not been issued, a CON to relocate one of its three linear accelerators from its facility in Myrtle Beach, South Carolina, to a facility in Murrells Inlet, South Carolina, which is located in northern Georgetown County.

Applications at Issue

The applications at issue in this case are for the three-county Service Area. CRCC filed an application on March 10, 2011, to install a Varian TrueBeam linear accelerator (TrueBeam) and a CT simulator⁶ at a new location in Conway, South Carolina to provide conventional, Intensity Modulated Radiation Therapy (IMRT), and Image-Guided Radiation Therapy (IGRT) radiotherapy services to treat cancer patients in the Service Area. Grand Strand subsequently filed an application on July 19, 2011, to install a Varian Clinac iX linear accelerator (Clinac iX) and a CT simulator on the campus of its hospital in Myrtle Beach, South Carolina to provide conventional, IMRT, and IGRT radiotherapy services to treat cancer patients in the Service Area.

⁴ HCA is the nation's largest provider of hospital services, based out of Nashville, TN, with approximately 174 hospitals. HCA operates about 40 linear accelerators across the country.

⁵ 21st Century is the largest provider of radiation therapy services in the United States. It operates approximately 100 radiation therapy centers in 16 U.S. States and approximately 30 additional centers in South America, employing over 125 radiation oncologists and more than 250 oncology-related physicians.

⁶ A CT simulator stands for Computerized Tomography scanner and is used to identify tumors and surrounding tissue in order to plan the precise radiation therapy treatment.

Radiotherapy, or “radiation therapy,” is a service covered by the State Health Plan. Radiation therapy is one of three major modalities to treat cancer, along with surgery and chemotherapy. Between 50% and 60% of all cancer patients receive radiation therapy as part of their cancer treatment. External beam radiation therapy is the most common form of radiation therapy, which focuses the beam of radiation to a precise treatment field with fewer side effects. IMRT and IGRT are types of external beam radiation therapy.

A linear accelerator delivers an external beam of radiation to the patient. It puts out high-energy radiation to reach the tumor, with the ability to rotate 360° around the patient to treat from any angle. Before radiation therapy begins, the treatment is planned using a CT scan with a CT Simulator, which identifies the tumor, and nearby vital structures to avoid. The doctor then uses the results of the CT scan to enter coordinates for the radiation to enter the patient’s body.

Though radiation therapy is used to treat many different types of cancer, it is most commonly used for breast cancer, prostate cancer, lung cancer, and metastatic cancer (where the cancer has spread from its primary site). Radiation therapy can be a palliative treatment (to provide pain relief) and/or a curative treatment (to cure the disease). The overwhelming majority of radiation therapy is delivered on an outpatient basis. The patient is typically treated once a day, five days per week, for a number of weeks. The number of radiation therapy treatments a patient will have depends on several factors, including the type of cancer, the stage of the cancer, and the size of the tumor. The average number of treatments for commonly seen cancers is typically thirty or more treatments for each patient, though some patients receive fewer treatments due to the location of the tumor or the advance stage of the disease.

Both Applicants (CRCC and Grand Strand) applied under the 2010-2011 State Health Plan, each projecting that its proposed linear accelerator will achieve more than 50% capacity (3,500 treatments) by the third year. The 2010-2011 State Health Plan sets forth the Plan standards for Radiotherapy. The 2010-2011 State Health Plan states that the “following project review criteria are considered to be the most important in evaluating [CON] applications for [radiation therapy] services: (a) Compliance with the Need Outlined in this Section of the Plan; (b) Community Need Documentation; (c) Distribution (Accessibility); (d) Projected Revenues; (e) Projected Expenses; (f) Financial Feasibility; and (g) Cost Containment.” Additionally, the

State Health Plan states that the “benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.”

The following standards from IX-5, -6 of the 2010-2011 State Health Plan are directly applicable to the CON applications in this case and are relevant to the ultimate decision:

- 1.⁷ The capacity of a conventional linear accelerator . . . is 7,000 treatments per year.
2. Linear accelerators providing IMRT or IGRT have a capacity of 5,000 treatments per year. A Facility must document that it is providing or will provide these specialized treatments in sufficient volume to justify why it should be held to this planning capacity.
* * *
6. New Radiotherapy services shall only be approved if the following conditions are met:
 - A. All existing units in the service area have performed at a combined use rate of 80 percent of capacity for the year immediately preceding the filing of the applicant’s CON application; and
 - B. An applicant must project that the proposed service will perform a minimum number of treatments equal to 50 percent of capacity annually within three years of initiation of services, without reducing the utilization of the existing machines in the service area below the 80 percent threshold
7. Expansion of an existing service, whether the expansion occurs at the existing site or at an alternate location in the service area, shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for each of the past two years and can project a minimum use rate of 50 percent of capacity per year on the additional equipment within three years of its implementation.
8. The applicant shall project the utilization of the service and document referral sources for patients within its service area, including letters of support from physicians and health care facilities indicating a willingness to refer patients to the proposed service, with expected annual referral volumes.
* * *

Standards 6(A) and 6(B) apply to Grand Strand as a new provider, but not to CRCC, while Standard 7 applies to CRCC because its proposal is an expansion project.

Need for a Linear Accelerator in the Service Area

Grand Strand presented Dan Sullivan as a healthcare planning and finance consultant. Mr. Sullivan explained the need for the CON application and presented a review of the

⁷ Each of these numbers is a subsection under Chapter IX, Section 4 of the 2010-2011 State Health Plan.

competing CON applications. Mr. Sullivan has worked on CON applications for three decades, concentrating on radiation therapy services for the past seven to eight years. He is very familiar with the Service Area in terms of the market for acute care and radiation therapy. He is also familiar with the applicable Health Plans and has been qualified as an expert in healthcare planning and finance in South Carolina and nearly a dozen other states. I find that Mr. Sullivan is a well-qualified and accomplished expert in healthcare planning and finance and will be basing these findings of fact on the analysis used by Mr. Sullivan unless otherwise indicated.

According to the 2010 U.S. Census data, Horry County has 269,291 people, the majority of the population in the Service Area, and four times the population of Georgetown County. Horry County has the fastest population growth in the Service Area, and there is a strong indication that the future demand for radiation therapy services would be greatest in Horry County since the fastest growing segment of society is the aged-65-and-older category, which has the highest incidence of cancer.

In the year immediately preceding the filing of its CON application, all existing units in the Service Area were performing well above the 80% threshold, as required by Standard 6(A) in the Health Plan.⁸ Generally, between 50% and 60% of all cancer patients will require radiation therapy. Grand Strand applied 55% to new cancer cases. Taking the cancer incidence rate and applying it to the age-specific component of population in each of the Service Area's three counties, there would be 2,622 cancer cases by 2015, with 1,442 patients, or 55%, requiring radiation therapy.⁹ This represents a growth of 194 new cancer cases over the 2010 estimate.

At the time of the filing of the applications, the 2010-2011 State Health Plan was in effect. The 2010-2011 State Health Plan indicates that the four existing linear accelerators in the Service Area, three at CRCC and one affiliated with Georgetown Memorial Hospital (GMH), were operating at 80.5% of capacity, based on a total 2009 Service Area utilization of 20,918 "Total Area Treatments" with a "Planning Area Capacity" of 26,000 treatments. Since the DHEC Staff (Staff) made the decisions with respect to the two instant applications, the 2012-2013 State Health Plan took effect. The 2012-2013 Health Plan's linear accelerator standards and relative importance of Project Review Criteria are nearly identical to those in the 2010-2011

⁸ The total percentage of utilization for the Service Area in 2010 was 110.3%.

⁹ Because of the twenty-one month time span between the decision date and the contested case hearing, the year 2015 is no longer a viable third year of operations. Presently, the third year of Grand Strand's operation would be 2017.

State Health Plan.¹⁰ The 2012-2013 State Health Plan sets forth that there are five linear accelerators in the Service Area that were operating at 96.7% capacity in 2011, based on 31,902 "Total Area Treatments," with a "Planning Area Capacity" of 33,000 treatments. Moreover, the 2012-2013 State Health Plan indicates a "Need" in a column entitled "UNMET NEED?" Although the 2012-2013 State Health Plan identifies five linear accelerators in the Service Area, a footnote indicates that the Department included CRCC's approved, but not yet operational, Conway facility in the linear accelerator count, which is under review in this Contested Case. Thus, even with four operational linear accelerators, and one that has been approved, the 2012-2013 State Health Plan denotes that there is potentially an unmet need for another unit in the Service Area.

Grand Strand's Project

In its application, Grand Strand seeks to establish a new 9,519 square foot radiation therapy facility located within its main hospital in Myrtle Beach, South Carolina. Grand Strand applied to install a Varian Clinac iX linear accelerator at a cost of \$2.8 million.¹¹ The Clinac iX is very reliable; can perform all conventional cancer treatments including IMRT treatments and IGRT treatments; and is capable of delivering highly specialized treatments such as stereotactic radiation therapy, although stereotactic treatments comprise a small percentage of the overall number of treatments. CRCC operates a linear accelerator unit, the Varian 2300iX, that is very similar to the unit Grand Strand is proposing in its application. The project is estimated to cost approximately \$9.8 million.

Grand Strand is also accredited by the Commission on Cancer of the American College of Surgeons as a community cancer center and is the only hospital in the region that is accredited as such. Though Grand Strand has no direct experience providing radiation therapy, its parent company, HCA, operates 80 linear accelerators in 40 locations. Furthermore, if approved, Grand Strand intends to partner with Sarah Cannon Center, which is a comprehensive cancer center affiliated with HCA, located in Nashville, Tennessee. The Sarah Cannon Center will provide information, research, and analysis for clinical protocols surrounding the care of cancer patients.

¹⁰ The notable exception is that in the 2012-2013 Plan, Standard 8 does not require the applicant to provide expected annual referral volumes from physicians and health care facilities. However, that criterion was not an issue in this case.

¹¹ Since submitting this application, the cost of a True Beam linear accelerator has declined and, as a result, Grand Strand intends to seek a change in its application to install that linear accelerator if DHEC approves the change.

Need for Grand Strand

Grand Strand is the Service Area's largest and most comprehensive tertiary care hospital. A "tertiary care hospital" provides higher-level services than those found in community hospitals, services such as open heart surgery, neurosurgery, and trauma services. Most tertiary care hospitals have at least one linear accelerator. In fact, Grand Strand is one of the only two hospitals in South Carolina operating above 50,000 patient days per year that does not offer radiation therapy services. In addition, Horry County is the only county in the state with more than 250,000 residents that lacks a hospital-based radiation therapy center.

Grand Strand seeks to develop a comprehensive cancer center where patients and their families can go to one facility to receive interdisciplinary cancer care, including radiation therapy. A comprehensive cancer treatment program promotes interdisciplinary care. Interdisciplinary cancer care involves multiple cancer specialists participating in the development of a treatment plan and care of a patient. The patient benefits from the interaction with the doctors caring for them. This personal interaction can assist the physician in planning the patient's treatment, thereby leading to more effective treatment. The best form of communication is face-to-face, though it is not always necessary and might be difficult for physicians, given time restraints. In addition, PET/CT services¹² are a very important part of a comprehensive cancer center. Grand Strand currently offers PET/CT services in a mobile setting at its South Strand location, and it anticipates that it would shift the PET/CT service to the main campus if approved for a radiation therapy center.

Adding a radiation therapy center to its campus in the context of a comprehensive cancer center will also allow Grand Strand to attract surgical and medical sub-specialists who provide cancer care, such as GYN oncologists, oncology surgeons, colorectal surgeons, and fellowship-trained breast surgeons. A hospital cannot establish a comprehensive cancer center without a radiation therapy program. Currently, patients residing in the Service Area must travel to the Medical University of South Carolina in Charleston, South Carolina to receive comprehensive cancer treatment.

Grand Strand proposes to locate its linear accelerator in the hospital because having a radiation therapy facility at the hospital would result in higher and better services available to the

¹² PET stands for Positron Emission Tomography and CT stands for Computerized Tomograph; both used to reveal the presence or track the spread of cancer..

patients. Grand Strand proposes to treat both inpatients and outpatients at its facility, but acknowledges the vast majority will be outpatient treatments. Currently, there are no radiation therapy centers in the Service Area that are located within a hospital. Grand Strand's project will alleviate the inconvenient transfer of its inpatients who need radiation therapy out of the hospital via ambulance to an off-site radiation therapy center and then back to the hospital on multiple occasions during the hospital stay. The radiation therapy center will also be positioned proximate to Coastal Cancer Center, (Coastal), an active medical oncology group that consists of five medical oncologists practicing at several locations in the Service Area, including offices in Conway, Myrtle Beach, Loris, and near Waccamaw Hospital.

Grand Strand's Utilization

For 2017, Grand Strand can reasonably assume a 20% market share for Horry County as explained below. Grand Strand can reasonably assume a 1% market share for Georgetown because GMH, the radiation therapy provider located in Georgetown, has a distinct medical staff with local referral patterns. Because Williamsburg is even further from Grand Strand and nearer to the Medical University of South Carolina, Grand Strand can reasonably expect no more than a 1% market share from that area.

Grand Strand can reasonably assume a 20% market share for radiation therapy in Horry County by 2017 because Grand Strand's unit would be the fourth unit in the county, which theoretically lends itself to a 25% market share. Coastal's president, Dr. Lawrence Holt, expressed that Coastal would be supportive of Grand Strand's project and represented that he thought some patients would choose Grand Strand for radiation therapy.¹³ However, CRCC has been operating in Horry County for three decades, so obtaining referrals will be a challenge for a new radiation therapy center. A substantial base of physician support is important to obtain sufficient utilization of the radiation services as required in the Health Plan. Therefore, in this instance, a 25% market share would not likely occur in Horry County because: (a) CRCC is an established provider with solid referral relationships in place; (b) CRCC has an affiliation with an existing urology practice, which means Grand Strand would not receive any urology referrals from that practice; and (c) Grand Strand would have to prove itself to the medical community by demonstrating good service and good outcomes.

¹³ Notably, Dr. Holt's support for Grand Strand did inversely suggest an over-utilization of Grand Strand's services. Despite CRCC's assertions to the contrary, Dr. Holt never committed that Coastal would send all, or even a substantial portion, of its patients to Grand Strand for radiation therapy services.

In analyzing Grand Strand's potential utilization, it was important to quantify an average number of treatments per patient. Mr. Sullivan projected an average number of treatments of 21 per patient. I find that average to be reasonable under the facts of this case. Importantly, CRCC's actual experience prior to its acquisition by 21st Century on May 3, 2010, was 21 treatments per patient. AUC employs all the urologists who practice in Horry and parts of Georgetown County, and it is the only provider of urological services in the three-county Service Area.

Referrals for prostate issues made up the largest percentage by diagnosis mix and treatment diagnosis at CRCC for the years 2010, 2011, and 2012. While the standard number of IMRT treatments for prostate cancer patients is 40 to 45, some patients may receive up to 48 treatments. The vast majority of referrals from the AUC urologists will be to CRCC for prostate cancer patients. The number increases the average number of treatments per patient for CRCC and decreases the average number of treatments per patient for Grand Strand.

Using the 2015 data as a projection of Grand Strand's utilization in 2017, Grand Strand will likely treat 231 cancer patients at its center by 2015.¹⁴ Assuming an average of 21 treatments per patient, based on CRCC's actual experience prior to its acquisition by 21st Century, Grand Strand will likely perform 4,851 treatments in 2015. With a capacity of 5,000 treatments, given its projection that 60% of treatments will be IMRT, Grand Strand's unit will be 97.02% utilized in year three, satisfying the first part of Standard 6-B in the State Health Plan, which requires a new unit to be operating at 50% capacity by the third year of operations.

At the Department's request, Mr. Sullivan also estimated the number of Grand Strand radiotherapy patients that it would serve by zip code. To accomplish this task, Mr. Sullivan developed a "draw rate" analysis in which he analyzed the origin of Grand Strand's inpatients with cancer by zip code and the population of those zip codes. By analyzing the origin of its inpatients with cancer by zip code and the population of those zip codes, the draw rate can be

¹⁴ I find Mr. Sullivan's analysis to be sound, yet find slight discrepancies in his math. The Court projected the total number of cancer patient to be 231 in year 2015. That figure was derived utilizing the "Total Projected Grand Strand Radiotherapy Patients – Service Area" and adding 5% for "patient in-migration." See Joint Exhibit 2, p. 38. On the other hand, I did not find CRCC's draw-rate analysis as reliable as Grand Strand's for a number of reasons. First, it is not reasonable to assume that Grand Strand's penetration rate in the identified zip codes would be the same for radiation therapy as it would be for inpatient services given that Grand Strand, unlike CRCC, enjoys no competitive advantage in radiation therapy. Also, CRCC's draw-rate analysis for Grand Strand does not take into account the fact that Grand Strand will not receive any urology referrals, which is a material percentage of the referral market.

used to determine the reliance of a particular population on the particular service offered at the hospital. It can also be used to rank the zip codes served by Grand Strand, specifically for cancer patients, so as to determine primary and secondary service areas.¹⁵ Assuming reasonable market-share capture rates for both the primary and secondary service-area zip codes, the draw-rate analysis estimates that Grand Strand would treat 223 radiotherapy patients by year three of operations. Treatment of 223 patients would result in utilization 93.66% in year three.

In its B-11 analysis, Grand Strand addressed each of the nine Standards set forth in the 2010-2011 State Health Plan. Grand Strand addressed how it would staff the facility, which I find reasonable.¹⁶ Grand Strand will also deliver an estimated 3.3% of its radiation therapy center's gross revenue in the form of indigent care.

CRCC's Project

CRCC applied for a CON to establish a freestanding radiation therapy facility located in Conway, South Carolina on March 9, 2011, and it thus falls under the guidelines of the 2010-2011 State Health Plan. CRCC proposes to install a state-of-the-art TruBeam linear accelerator, which is considered to be superior to the Clinac iX. CRCC plans to use an existing site so its total project costs, including the cost of equipment, are \$5.1 million.

CRCC chose to locate its services in Conway using a facility that was previously constructed to house a linear accelerator. Nevertheless, I find the proposed facility to be underwhelming. Grand Strand's proposed facilities are far superior. The CRCC-Conway radiation therapy center would be in an older building that would require considerable renovation. Moreover, though the typical size of a 21st Century radiation therapy center is between 5,000 and 12,000 square feet, CRCC-Conway will only be 3,616 square feet.

¹⁵ I find a "draw rate" analysis to also be a reasonable and reliable method by which to estimate the number of radiotherapy patients Grand Strand would serve. On the other hand, I did not find CRCC's draw-rate analysis as reliable as Grand Strand's for a number of reasons. First, it is not reasonable to assume that Grand Strand's penetration rate in the identified zip codes would be the same for radiation therapy as it would be for inpatient services given that Grand Strand, unlike CRCC, enjoys no competitive advantage in radiation therapy. Also, CRCC's draw-rate analysis for Grand Strand does not take into account the fact that Grand Strand will not receive any urology referrals, which is a material percentage of the referral market.

¹⁶ Grand Strand, like CRCC, did not quantify expected referral volumes by physician because there is no practical way to project the referrals three years from opening. CRCC did provide current volumes from all referral sources. However, if a facility has not had a service in the past, and therefore has no historical basis for projecting referrals by physician, this standard becomes nearly impossible to satisfy. While Standard 8 in the 2010-2011 State Health Plan appears to require an annual referral volume projection by referral source, DHEC appears to have recognized the difficulty of making such a projection by referral source and removed the requirement from Standard 8 in the 2012-2013 State Health Plan that applicants document "expected annual referral volumes."

Patients from the Conway and Loris areas drive an average of 45 minutes to the closer of the two Service Area cancer centers with linear accelerators. Though CRCC's Conway facility would reduce the average round-trip drive for a patient from the Conway and Loris areas, that drive time would be reduced by only an average of 20 minutes.

CRCC'S Utilization

CRCC operates three linear accelerators at its location in Myrtle Beach: a TomoTherapy linear accelerator, a 2300iX unit, and a 6EX unit. In 2012, CRCC performed 9,437 treatments on its Varian Clinac iX unit, which was more than any other unit. CRCC has been providing radiation therapy services in the Service Area for over 31 years and has earned the support of the provider community based on its long track record of providing quality cancer treatment services to the Service Area.

On May 3, 2010, CRCC was sold to AUC and 21st Century.¹⁷ AUC employs all the urologists who practice in Horry and parts of Georgetown County, and it is the only provider of urological services in the three-county Service Area. From 2009 to 2011, CRCC's treatment volumes increased by approximately 65%. When CRCC's treatment volumes are removed from statewide totals, treatment volumes statewide increased just 2.2% over that same time period. Statewide, linear accelerator treatments actually decreased from 2010 to 2011, while CRCC's treatments increased from 20,946 treatments in 2010 to 25,709 treatments in 2011, an increase of 23%. In 2011, CRCC was the highest volume treatment provider in South Carolina.

Prior to CRCC's acquisition by AUC and 21st Century, the AUC urologists referral of prostate cancer patients to CRCC was limited because of a business dispute with CRCC's previous owner arising out of a CON challenge in which AUC was an applicant. CRCC had a significant increase in treatment volume after AUC was sold to 21st Century. The number of urologist referrals from AUC to CRCC increased from 39 in 2009 to 292 in 2010. The number of referrals in 2011 from AUC to CRCC increased to 406. In 2012, there were 886 patients who underwent treatment at CRCC. Of these 886 patients, AUC referred 263.

Referrals for prostate cancer made up the largest percentage by diagnosis mix and treatment at CRCC for the years 2010, 2011, and 2012. In 2012, 43.7% of all treatment

¹⁷ 21st Century establishes group practices like AUC and pays employed physicians in the practice profits using an ancillary profit formula from revenues generated by their referrals to the affiliated radiation therapy center. The AUC-employed urologists have a financial relationship with CRCC by virtue of participating in an ancillary bonus pool. However, the AUC urologists are not contractually obligated to refer all of their cancer patients to CRCC.

diagnoses at CRCC were related to prostate cancer. IMRT is one of the procedures used for treatment of prostate cancer and is reimbursed at a higher rate. About 75% of CRCC's treatment volume comes from the higher reimbursed IMRT procedure. 28.4% of all revenues generated from CRCC radiation therapy treatments came from prostate cancer diagnoses.

CRCC addressed the applicable radiotherapy standards in the 2010-2011 State Health Plan. As mentioned above, Standards 6(A) and 6(B) do not apply to CRCC. Furthermore, CRCC identified the capacity of the existing units and found that the units collectively were operating at 102% of capacity as of 2010, with CRCC at 20,946 treatments on its 3 units, and GMH at 5,515 treatments on its unit. CRCC identified the target population and made reasonable projections for the Service Area, concluding that the Service Area would have 392,450 people in 2015. Twenty-two (22) percent of CRCC's patients originate from the Conway area, which has a population of 80,355 people. Finally, CRCC addressed Standards 8 and 9, although, like Grand Strand, CRCC did not project expected annual referral volumes by physicians. CRCC also set forth its staffing plan and financial *pro formas* and associated assumptions in the CON application, which I find reasonable.¹⁸

Approval of Both Projects

As addressed above, there is a need for two linear accelerators in this service area.¹⁹ Nevertheless, even if there is a "need," an applicant cannot receive a CON if approval of two linear accelerators in the service area would bring the use of the existing linear accelerator providers below the 80% threshold. CRCC and the Department assert that the approval of both applications will exceed the need for the services in the Service Area. I find that the evidence established otherwise. Both Grand Strand's and CRCC's CON applications can be approved without reducing the existing providers' utilization below the 80% threshold.²⁰

As required by Radiotherapy Standard 6-B, Grand Strand should not bring existing providers below the 80% threshold by the third year of operations based on growth in the market

¹⁸ Although CRCC takes the position in this case that Grand Strand's project will adversely impact its operation due to the loss of Coastal referrals, CRCC never took the position with the DHEC staff at the project review meeting (PRM) or in follow-up written submission that Grand Strand's project would result in a substantial loss of Coastal referrals. See Brandt Tr. 1052:1-1053:5; Lewis Tr. 1340:25-1342:1; Tolbert Tr. 1834:13-1835:1-21.

¹⁹ Also as addressed above, the parties chose the year 2017 as the third year of operations for the respective projects due to the time interval between the date of the Staff's decision in this case and the date of the Contested Case.

²⁰ CRCC never performed any financial-adverse-impact analysis with respect to the impact Grand Strand's approval would have on CRCC if only one is approved or if both are approved.

and Grand Strand's projected utilization. Based on CRCC's own growth projections, AUC is projected to refer 284 patients for treatment to CRCC in 2017, and the number of non-AUC patient referrals to CRCC is projected to increase to 669 in 2017. An estimated 13,205 treatments in the market in 2017 will not be available for capture by Grand Strand. Stated differently, nearly half of CRCC's treatment volume is not at risk in 2017 because of CRCC's relationship with AUC. Thus, Grand Strand would be competing for the remaining treatments against an existing provider with more capacity and potentially more locations.

CRCC projects that its new facility in Conway will have 5,499 treatments in 2017. If Grand Strand's volume exceeds 5,525 treatments in 2017, also referred to as a "tipping point," Grand Strand's project would cause the existing providers to fall below the 80% threshold. However, as found above, Grand Strand would likely perform 4,851 based upon a 2015 projection, or the 5,168 treatments in 2017.²¹

CRCC's Projections

CRCC's projects 7,500-8,000 treatments for Grand Strand in 2017 by creating five different adverse impact scenarios, four of which were premised on applying assumed market shares for Grand Strand that differed from the market share assumed by Grand Strand in its CON application.²² CRCC's analysis makes flawed assumptions about the market. In CRCC Scenarios 1-4, CRCC applied an inpatient acute market share, which was not proper. The inpatient market is much different from the outpatient radiation therapy market share in this instance because of the presence of entrenched competitors who have solid historical reputations. In Scenarios 1, 2, and 4, CRCC assumed that all 31,824 treatments were available for capture by Grand Strand, even though nearly half of CRCC's treatments are likely not available to Grand Strand because of CRCC's affiliation with AUC. Although inpatient market share and inpatient oncology market share are appropriate metrics to use in projecting market share for a new

²¹ CRCC's expert projected that Grand Strand would perform 4,934 treatments in 2017 based upon Grand Strand's 2015 projections. Since the Court found that the treatments performed by Grand Strand in 2015 would be 4,851, the Court added 4.76% to CRCC's projection which is the percentage difference between 4,620 and 4,851.

²² Mr. Tolbert created two separate Threshold Analyses based on the application of Grand Strand's market share to a projected Service Area volume of radiation therapy treatments for 2017. Both are similar in terms of the purported volume Grand Strand will capture from CRCC, but a later version includes a referral-shift analysis, an adjusted-market-share analysis, and an analysis based on Grand Strand's three-county inpatient oncology admission, which are discussed herein.

radiation therapy center, these would not be appropriate metrics in this instance for the primary reason that the Service Area urology referrals will likely not be captured by Grand Strand.²³

Furthermore, if Grand Strand were to achieve CRCC's projection of nearly 8,000 treatments by 2017, when compared to treatment volumes in 2011, Grand Strand would be operating at 153% of the average for the top five highest treatment volume providers and 165% of the average for single unit operators. This would be occurring in a market with a high-volume, entrenched provider. I do not find CRCC's projections to be realistic for a new provider in the Service Area.

Moreover, to show that the CON applications should be considered "competing," CRCC introduced its 2013 treatment data through July to show that the Service Area capacity at the end of 2013 would be below the 80% threshold, assuming five units are operating. CRCC took its treatment volume through July 2017 and compared it to the first seven months of 2012. Based on a 10.3% decline in the first seven months of 2013 over the same period for 2012, CRCC projected that its 2013 year-end utilization would be 20,450 treatments, or 10.3% lower than 2012. However, I do not find CRCC's analysis reliable.

There is no evidence that the utilization during the first seven months of 2012 was representative of CRCC's typical treatment volume experience for the first seven months in any other year. CRCC assumed that GMH's volumes would be the same as in 2012, despite having no hard data to support that conclusion. CRCC's 2013 decrease is more likely due to less referrals from the urologists and, in particular, one urologist, who accounted for more than half of the decline, which could be a mere aberration. As such, concluding that the first seven months of 2013 is indicative of the rest of the year or future years is not reliable.²⁴

CRCC also claims that the CRCC-Myrtle Beach radiation therapy center volumes declined significantly from 2011 to 2012 due to a change in the Prostate-Specific Antigen (PSA) guidelines, which resulted in a decline in the number of prostate cancer patients referred to

²³ While this Court has specifically found that inpatient market share can be used as a proxy to determine radiation therapy market share, the specific facts of that case, *Beaufort-Hilton Head Radiation Oncology Center v. S.C. Dep't of Health & Envtl. Control*, 01-ALJ-07-0507-CC (Mar. 19, 2003 S.C.A.L.C), are quite distinct from the instant case where there are two providers in the Service Area, one of which has been operating for over 30 years and is currently owned by a major referral source whose employed physicians receive a financial benefit from referring to CRCC.

²⁴ Mr. Tolbert, in fact, testified that it is preferable to use a full year's data when projecting utilization because of the uncertainty of what can occur in the remaining part of the year.

CRCC from AUC. However, a change in a guideline or protocol to screen for cancer does not validate that the actual rate of cancer will be impacted; rather, it suggest that the date the cancer is detected will be impacted. I find that the change in the PSA guidelines will not likely result in a significant decrease in treatment volumes in the Service Area or a decrease in referrals to CRCC.²⁵

CRCC's further assumed that Grand Strand's presence in 2017 would cause a significant shift in physician referrals from CRCC to Grand Strand and that Grand Strand would capture approximately 60% of the Coastal referrals in 2017. I do not find Mr. Tolbert's referral-shift analysis reliable. For instance, Mr. Tolbert never spoke to any physicians who referred patients for cancer treatment to CRCC, and he conceded that he did not have any idea of what the referral sources thought about CRCC. Also, Mr. Tolbert's analysis is based in part on one or two thirty-minute phone calls with Ms. Price and Dr. Francke, both of whom are CRCC employees strongly opposed to Grand Strand's project.²⁶ The low-volume physician referrers, which accounted for 127 patients to CRCC in 2012, were never discussed with Ms. Price or Dr. Francke. Furthermore, although Coastal indicated strong support for Grand Strand's project, the three Coastal physicians who service the Conway area supported CRCC's project.²⁷ CRCC's Medical Director, Dr. Francke, admitted that he has not had an indication from any of the Coastal physicians that they would cease referring to CRCC if both projects are approved. Grand Strand's location would offer no travel time advantage to a significant number of patients who would originate from the area around Murrells Inlet, where two CON applications for radiation therapy centers have been approved. In sum, patient and physician preference for a particular provider depends on many factors, including where the patient resides. Mr. Tolbert's analysis did not sufficiently account for these preferences. Therefore, I find that CRCC's referral-shift analysis is not predictive of Grand Strand's utilization in 2017.

²⁵ Even though CRCC experienced a volume decrease in 2012 over 2011, nine months into 2012, CRCC's plan was to apply for the additional linear accelerator that would be shown as needed in the 2012-2013 Health Plan, despite knowledge of the change in the PSA screening protocols.

²⁶ Dr. Francke is the Medical Director and staff radiation oncologist at CRCC, and Ms. Price is the Administrative Director.

²⁷ According to CRCC's 2013 volumes, through May, Dr. Holt was responsible for 30 treatment plans at CRCC. The three medical oncologists whose support for CRCC-Conway was critical—Drs. Cody, Karpenko and Goldberg—were responsible for a combined 100 treatment plans at CRCC through May 2013, and all three provided letters of support for the CRCC-Conway project.

Finally, CRCC's health planning expert did not give any effect to outmigration in preparing his projections. Based on CRCC's projection of new cancer cases in 2017, an additional 6,300 treatments may be performed on patients who leave the Service Area for treatment. The creation of a comprehensive cancer program could reverse at least a portion of the outmigration, which would further mitigate any potential adverse impact on the existing providers in the Service Area.

Other Project Review Criteria

I find that both applications meet the Project Review Criteria to receive a CON. I address this compliance more specifically below.

Community Need Documentation (PRC 2(a)-(c), (e))

As addressed above, Grand Strand seeks to develop a comprehensive cancer center. A comprehensive cancer center can reduce the fragmented nature of cancer treatment, which can be particularly difficult for elderly patients. A more comprehensive setting has the benefit of reducing travel and facilitates consultation between separate providers such as radiologists and radiation oncologists.

There are also advantages in terms of cost, patient care, and convenience with respect to inpatient based radiation therapy offered in a comprehensive cancer treatment setting. An inpatient who can be treated without transport out of the hospital on an ambulance gurney is more comfortable because the patient does not have to be strapped-in, as they would in an ambulance. Further, there is a significant cost associated with ambulance transport.

Although infrequent, there are times when patients cannot be transported out of the hospital for radiation therapy treatment, such as when the patient is in an intensive care unit on a ventilator. Dr. Collins testified that he treats several patients a year who are in life-threatening circumstances and cannot be transferred out of the hospital for necessary and critical radiation therapy. An in-hospital radiation therapy program would be of great benefit to these patients.

Distribution (Accessibility) (PRC 3(a)-(c), (e)-(f))

Both CRCC and Grand Strand have documented the means by which a person will have access to their services. CRCC's project improves travel time for patients who reside in the Loris and Conway areas. Additionally, Grand Strand's project is not an unnecessary duplication of services because patients will now have ready access to in-hospital radiation therapy and comprehensive cancer treatment. Currently, the closest comprehensive cancer treatment is

approximately 100 miles away, thus requiring patients who desire comprehensive cancer treatment or in-hospital radiation therapy services to drive significant distances to reach either. Grand Strand's project location also allows for the delivery of necessary support services because within the hospital there is a much wider array of support services immediately available to patients, such as radiology, surgical services, and physical therapy.

Record of the Applicant (PRC 13(a)-(b))

Both applicants also have demonstrated the ability to obtain the necessary capital financing for their respective projects. CRCC has been successfully providing radiation therapy services in the Service Area for over 30 years and is supported by 21st Century. Likewise, Grand Strand is affiliated with its parent organization, HCA, and has demonstrated an ability to develop new services into successful programs.

Acceptability (4(a))

Both applicants have demonstrated a significant level of community and provider support for their respective projects to demonstrate that both will be well-utilized.

Distribution (22)

Both projects improve the distribution of health services in the Service Area based on the findings above.

Financial Feasibility (15)

Both CRCC and Grand Strand projected positive net income for their respective projects in all three years of operations, which indicates both the immediate and long-term financial feasibility of the projects. CRCC contends that Grand Strand's *pro formas* indicate that the project might not be financially viable because Grand Strand's internal rate of return and the returns on investment (ROI) for the project were lower than what CRCC's expert would expect. However, given its healthy bottom line, Grand Strand can afford to sustain potential losses in the first three years of operations, even under CRCC's "breakeven" analysis.²⁸

While Grand Strand's *pro forma* contains some errors, when they are corrected, the revenues are understated and the project would still show a profitable bottom line. Grand Strand

²⁸ I decline to rely on CRCC's analysis in which it determined that for a freestanding radiation therapy center to "break even," it would need to operate at 4,500 treatments annually. Mr. Lewis admitted that he never performed a breakeven analysis for a hospital-based radiation therapy center. Grand Strand's project will be a hospital-based facility that, unlike a freestanding facility, is not going to duplicate all of the overhead expenses that a freestanding center would if they were beginning operations; and hospitals have a different revenue profile with a different breakeven point.

expects its annual treatment volumes to increase as the market continues to grow and Grand Strand's reputation as a radiation therapy provider improves. I find that Grand Strand's application *pro forma* is a conservative estimate of the project's financial performance.

Cost Containment (16(a)-(c))

Both CRCC and Grand Strand addressed cost containment, identified methods of funding, and demonstrated the feasibility of the funding option. Moreover, Grand Strand does not expect to raise its patient charges to subsidize the cost of the radiation therapy project. Grand Strand's in-hospital radiation therapy center would also alleviate charges associated with transporting patients to and from a freestanding facility. Because the project is self-sustaining, I find that the project will not affect Grand Strand's costs or charges.

CRCC contends that Grand Strand's project will represent higher costs to the healthcare system.²⁹ While Grand Strand's reimbursement from governmental sources like Medicare and Medicaid will be higher than CRCC's, I find that Grand Strand's project will promote cost containment, particularly with private insurance companies, in the Service Area. Both CRCC and Grand Strand are relying on receiving a significant portion of revenues from non-governmental payors, such as PPOs.³⁰ However, there is currently no real price competition in Horry County as it relates to radiation therapy services, because there is only one provider.³¹

Over the past several years, there has been concern in the radiation therapy industry that urologists who have a financial interest in radiation therapy centers may direct patients to more expensive radiation therapy as opposed to alternative, less expensive, types of cancer treatment. AUC urologists have a financial interest in the operations of CRCC, which appears to promote referrals to CRCC. When CRCC was sold to 21st Century, it had a significant increase in

²⁹ While CRCC did not discuss the impact of the radiation therapy center project on Grand Strand's patient charges generally, CRCC suggested that Grand Strand expects to receive \$5,000 per radiation treatment from non-governmental payors. There is no credible evidence in the record to suggest that Grand Strand would get \$5,000 per treatment as CRCC suggests. In fact, Grand Strand's charges per procedure are set forth in its CON application, and it estimates it will receive in actual dollars approximately 32% of the charges. The highest listed charge for a radiation therapy treatment plan is \$4,239. On that charge, Grand Strand expects to receive \$1,356.

³⁰ A PPO, or preferred provider organization, is an insurance plan that contracts with providers like hospitals and physicians. In exchange for making them preferred or in-network providers, those providers offer a discount to the insured that is under the PPO plan. It is a different form of insurance where rates are negotiated between the insurance company and the providers. Examples of PPOs would be Blue Cross/ Blue Shield, Aetna, CIGNA, and Humana.

³¹ CRCC contends that competition is not referenced in the PRC or the purposes of the CON Act. While not directly referenced therein, competition enhances the negotiating power of payors and the choices and quality that may be available for the residents of South Carolina, all of which are related closely to the purposes of CON Act.

treatment volume, most of which came from the AUC urologists. Grand Strand's project would provide an alternative treatment setting where there are no financial incentives to referring physicians who may over-utilize costly radiation therapy treatments.³² Therefore, I find that the approval of both projects will further promote cost containment in the Service Area.³³

Projected Revenues/Projected Expenses (6(a), 7)

Grand Strand included its chargemaster for radiation therapy services and represented that it estimated the actual dollars reimbursed on those charges to be approximately 32%. CRCC contends Grand Strand's charges will be higher than its own charges for patients insured by governmental programs, which Grand Strand conceded. However, CRCC did not address whether Grand Strand's project costs were inconsistent with those experienced by similar providers offering a similar level and scope of service. For instance, CRCC's Murrells Inlet facility, which was also approved by the Staff, is proposed to be nearly 7,000 square feet with a total project cost of approximately \$8 million. Grand Strand's project cost of \$9.7 million is reasonable when compared to other recently approved radiation therapy projects.

I find that both projects can be completed in a reasonable amount of time given their respective scope of construction and services.³⁴

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, I conclude the following as a matter of law:

The ALC has jurisdiction over this matter pursuant to S.C. Const. art. I, § 22; S.C. Code Ann. §§ 1-23-320, -600(B), 44-1-60(F), and 44-7-210(E); 3 S.C. Code Ann. Regs. 61-15; and Rule 11 of the South Carolina Administrative Law Court Rules (SCALCR). Grand Strand timely filed its request for a contested case hearing regarding DHEC's decisions. *See* 3 S.C.

³² Despite the 10,000 treatment increase at CRCC from 2009 to 2011, the Staff did not perform any research or analysis on the issue of the AUC urologists having a financial interest in a radiation therapy center. Even though Grand Strand raised the issue of CRCC's monopoly of radiation therapy services in Horry County and the effect that would have on rates for third-party payors, the Staff did not consider this factor when making its decision on the project generally and with respect to cost containment specifically.

³³ While AUC's financial relationship with CRCC is concerning, given the findings above, because CRCC's project costs are significantly lower than those of newly built radiation therapy centers, I find that its project satisfies the PRC for cost containment.

³⁴ Though CRCC's project is estimated to cost \$5.1 million, the evidence reflected that CRCC might have plans to move its radiation therapy facility to another location in Conway where the AUC-employed urologists own property. This could mean additional project costs associated with the same unit. However, I do not consider this potential move and the potential of higher project costs for CRCC, given that I have decided that the applications are not competing. Moreover, the Staff would have to approve any such future relocation.

Code Ann. Regs. 61-15 § 401. Because CRCC is an existing provider of radiation therapy services in the service area, it is an “affected person” for the purposes of participating in a contested case related to DHEC’s decisions appealed by Grand Strand. *See* S.C. Code Ann. § 44-7-130(1) (2002); 3 S.C. Code Ann. Regs. 61-15 § 103(1).

A contested case hearing conducted before this Court in a CON matter is a trial *de novo*, in which “the whole case is tried as if no trial whatsoever had been had in the first instance,” and the administrative law judge conducting the hearing is the sole finder of fact, who “must make sufficiently detailed findings supporting the denial or grant of a permit application.” *Marlboro Park Hosp. v. S.C. Dep’t of Health & Envtl. Control*, 358 S.C. 573, 579, 595 S.E.2d 851, 854 (Ct. App. 2004) (quoting *Blizzard v. Miller*, 306 S.C. 373, 412 S.E.2d 406 (1991) and *Converse Power Corp. v. S.C. Dep’t of Health & Envtl. Control*, 350 S.C. 39, 564 S.E.2d 341 (Ct. App. 2002)). The weight and credibility assigned to evidence presented at the hearing of a matter is within the province of the trier of fact. *S.C. Cable Television Ass’n v. S. Bell Tel. & Tel. Co.*, 308 S.C. 216, 222, 417 S.E.2d 586, 589 (1992). The trier of fact may also give an expert’s testimony the weight he or she determines it deserves. *Florence County Dep’t of Soc. Servs. v. Ward*, 310 S.C. 69, 425 S.E.2d 61 (Ct. App. 1992) and may accept the testimony of one expert over that of another. *S.C. Cable Television Ass’n, supra*.

Finally, the CON Act states that the “the Administrative Law Court . . . shall consider the South Carolina Health Plan in place at the time the application was filed and may consider the current South Carolina Health Plan when making its decision.” S.C. Code Ann. § 44-7-225 (Supp. 2013).

Regulatory Framework

This matter arises under the regulatory program by which the State of South Carolina issues CONs for the development of health care facilities and services in this State. The regulatory scheme consists of the State Certification of Need and Health Facility Licensure Act (CON Act), S.C. Code Ann. § 44-7-110 *et seq.* (2002 & Supp. 2013); the regulations promulgated thereunder: 3 S.C. Code Ann. Regs. 61-15 (Supp. 2013); and a State Health Plan, which is revised at least biannually. The purposes of the CON Act, and thus the regulatory program itself, are to “promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best

serve public needs, and ensure high quality services are provided in health facilities in this State.” See S.C. Code Ann. § 44-7-120 (2002).

In determining whether to grant or deny an application for a CON, the Department evaluates the proposed project under the review criteria found in the CON regulations and under the policies and standards set forth in the applicable State Health Plan. S.C. Code Ann. § 44-7-210(B) (Supp. 2013). Pursuant to the CON Act, the Department may not issue a CON to an applicant “unless the application complies with the South Carolina Health Plan, Project Review Criteria, and other regulations.” *Id.*; see also *MRI at Belfair, LLC v. S.C. Dep’t of Health and Envtl. Control*, 379 S.C. 1, 9, 664 S.E.2d 471, 475 (2008) (holding that compliance with the State Health Plan and the PRC were independent requirements for approval of a CON). The Department can refuse to issue a CON based on PRC and other regulations identified by the Department even if an application complies with the State Health Plan. Section 44-7-210(B). But no project can be approved unless it is consistent with the State Health Plan. 3 S.C. Code Ann. Regs. 61-15 § 307(1). Where the CON applications are considered competing, “the [D]epartment shall award a [CON], if appropriate, on the basis of which, if any, most fully complies with the requirements, goals, and purposes of [the CON Act] and the State Health Plan, Project Review Criteria, and the regulations adopted by the department.” Section 44-7-210(B).

The PRC set forth in Regulation 61-15 include thirty-three separate criteria that fall into five general categories: (1) criteria related to the need for the proposed project; (2) criteria related to the economic considerations of the project; (3) criteria related to the project’s impact on the resources of the health care system; (4) criteria related to the suitability of the site of the project; and (5) criteria related to certain special circumstances, such as the project’s ability to serve medically underserved groups. See 3 S.C. Code Ann. Regs. 61-15 §§ 801(1), 802.

As required by the CON Act, the State Health Plan contains the following statistics, standards, and findings with regard to the various facilities and services regulated by the CON Act:

- (1) an inventory of existing health care facilities, beds, specified health services, and equipment; (2) projections of need for additional health care facilities, beds, health services, and equipment; (3) standards for distribution of health care facilities, beds, specified health services, and equipment including scope of services to be provided, utilization, and occupancy rates, travel time, regionalization, other factors relating to proper placement of services, and proper planning of health care facilities; and (4) a general statement as to the project

review criteria considered most important in evaluating Certificate of Need applications for each type of facility, service, and equipment, including a finding as to whether the benefits of improved accessibility to each such type of facility, service, and equipment may outweigh the adverse affects caused by the duplication of any existing facility, service, or equipment.

S.C. Code Ann. § 44-7-180(B). The State Health Plan section applicable to the establishment of either applicant's linear accelerator project is found in Chapter IX, beginning at page IX-1. The Standards applicable to the projects begin at page IX-5.

The CON Regulations require that:

On the basis of staff review of the record established by the Department, including but not limited to, the application, comments from affected persons and other persons concerning the application, data, studies, literature and other information available to the Department, the staff of the Department shall make a proposed decision to grant or deny the Certificate of Need.

3 S.C. Code Ann. Regs. 61-15 § 308 (Supp. 2013).

Question of Competing Applications

As a threshold matter, the Court must first decide whether the CON applications are competing. The CON Act prohibits the issuance of multiple CONs if two or more CON applications are competing. S.C. Code Ann. § 44-7-210(B). Therefore, if the two CON applications at issue in these contested cases are competing applications, only one CON application can be approved. CRCC concurs with the Department's finding that the applications are competing applications, while Grand Strand contends that the applications are not competing applications and both can be approved.

Under the CON Act, "competing applicants" are defined as follows:

[T]wo or more . . . health care facilities . . . who apply for Certificates of Need to provide similar services or facilities in the same service area within a time frame as established by departmental regulations and whose applications, if approved, would exceed the need for services or facilities.

S.C. Code Ann. § 44-7-130(5); *see also* 3 S.C. Code Ann. Regs. 61-15 § 103(6). Therefore, to be deemed competing CON applications, two or more CON applications must satisfy four elements:

- (a) The CON applications must be filed within the time period established by the regulations;
- (b) The CON applications must be for same or similar services or facilities;
- (c) The projects must be located in the same service area; and

- (d) The approval of both CON applications must exceed the need for the services or facilities.

S.C. Code Ann. § 44-7-130(5); *see also, e.g., Spartanburg Reg'l Med. Ctr. v. Oncology and Hematology Assocs. of S.C., LLC*, 387 S.C. 79, 90, 690 S.E.2d 783, 789 (2010). It is undisputed that the two CON applications at issue in this case meet the first three elements of the definition of competing applications: *i.e.*, the CON applications were filed within the time period established in the Regulations, the CON applications are for the similar services/facilities, and each proposed project will be located in the same service area. Therefore, the issue for the Court is whether the approval of both CON applications will exceed the need for the services, which is a fact-intensive inquiry dependent upon the evidence submitted by the parties. *Spartanburg Reg'l Med. Ctr.*, 387 S.C. at 91, 690 S.E.2d at 789.

The Court must first resolve whether the approval of Grand Strand's project would bring the existing linear accelerator providers below the 80% threshold if both projects are approved. Grand Strand, as Petitioner and moving party, bears the burden of establishing by a preponderance of the evidence that approval of both applications for linear accelerator services would not exceed the need for the services in the service area. *See* S.C. Code Ann. § 44-7-210(E) (Supp. 2012); *Anon. v. State Bd. of Med. Exam'rs*, 329 S.C. 371, 375, 496 S.E.2d 17, 19 (1998). CRCC and the Department assert that the approval of both applications will exceed the need for the services in the Service Area. Grand Strand argues that approval of both applications will not exceed the need for services in the Service Area. Based on the following, I find that the approval of both projects would not exceed the need for the services or facilities in the Service Area and are thus not competing.

In making this determination, I choose to consider the 2012-2013 State Health Plan. It indicates that *in 2011 all of the linear accelerator units in the Service Area, plus one that had been approved but was not operational*, were operating at 96.7% of capacity, well above the 80% threshold, such that there was a "need" identified in the Service Area for another linear accelerator in addition to CRCC's approved project. The Staff's decision was made on December 28, 2011, based on CRCC's *projected* 22,419 treatments for 2011, as stated in its CON application that was filed in March 2011. CRCC's *actual* 2011 utilization, also set forth in the current State Health Plan, was 25,709 treatments, higher than any other radiation therapy provider in South Carolina. The 2012-2013 State Health Plan thus validates Grand Strand's position taken during the CON review process that the Service Area could support two new

linear accelerators in 2011. Moreover, due to the twenty-one (21) month time span between the Staff's decision and the Contested Case hearing, the likely third year of operations shifted from 2015 to 2017 with respect to determining the 80% threshold analysis set forth in Radiotherapy Standard 6(B) of the Health Plan. See *Spartanburg Reg'l Med. Ctr.*, 387 S.C. at 86, 690 S.E.2d at 787 (indicating that the competing applicants changed their third year projections at the contested case hearing from what was originally proposed in their applications).

Grand Strand's radiation therapy treatment volumes and projections in its CON application are reasonable and reliable. Grand Strand's 2017 threshold analysis is more reliable than CRCC's because, unlike Grand Strand's analysis, CRCC fails to properly account for the unavailability of the AUC referrals, it fails to assign any weight to CRCC's status as an entrenched provider, and it speculates about Grand Strand's effect on CRCC's future referral patterns. Even when Grand Strand assumes capturing more than one third of the available market in 2017, GMH is operating at 7,165 treatments and CRCC is operating at 19,934 treatments. Thus, the estimated 2017 utilization in the Service Area indicates that if this Court approves both applications, existing providers operating in the Service Area will not fall below the 80% threshold, the adverse impact on existing providers will be minimal, and all providers will be well-utilized.

While it is appropriate to give due consideration to the Staff's utilization of its specialized knowledge and expertise in the application of the CON Act and CON regulations, I find the testimony of Grand Strand's health planning and finance expert more reliable than the testimonies of the Staff reviewer and CRCC's similarly qualified expert. Consequently, based on the foregoing facts, I conclude by a preponderance of the evidence that the approval of a sixth linear accelerator, to be located at Grand Strand, would not bring existing operators below the 80% threshold. Given the robust estimated 2017 utilization of all existing and proposed radiation therapy providers in the Service Area, the approval of both applications would not exceed the need for services in the Service Area.³⁵

Approval of Both Projects

Since the applications do not exceed the need for facilities and services in the Service Area, and therefore are not competing, I must determine whether each applicant's project can be

³⁵ CRCC's VP of Finance Operations testified that even if both CON applications are approved, CRCC will still build its facility in Conway.

approved under the CON Act, its regulations, and the State Health Plan. 3 S.C. Code Ann. Regs. 61-15 § 307(1).

A project does not have to satisfy every project review criterion in order to be approved, but no project may be approved unless it is consistent with the State Health Plan. Nevertheless, a project may be denied if the Department determines that the project does not sufficiently meet one or more of the criteria. *Id.* § 801(3). Here, the approval of both projects furthers each of the goals articulated in the CON Act. By approving these projects, the Service Area, and particularly Horry County, will have an additional provider that will foster cost containment by providing private insurance companies leverage in negotiating rates for services. While services are duplicated, the facilities are not because Grand Strand is offering an in-hospital radiation therapy center, which is not currently available in the Service Area. Grand Strand's project will foster the development of a comprehensive cancer center, which is not currently available in the Service Area. The establishment of both Grand Strand's and CRCC's project will best serve the public's need by providing an inpatient option, comprehensive cancer services, and a facility in Conway, which currently lacks local radiation therapy services. The linear accelerator units proposed by Grand Strand and CRCC in their CON applications are both reasonable and adequate for the proposed radiation therapy services.³⁶ Indeed, both applicants have proven that they will offer high quality radiation therapy services.

I conclude that both applications at issue are consistent with the requirements of the CON Act, its regulations, including the PRC, and the State Health Plan.³⁷

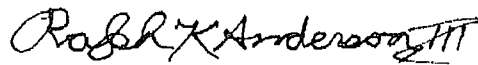
³⁶ If Grand Strand chooses to upgrade its linear accelerator unit following the issuance of a CON, it will need to request permission from the Staff pursuant to 3 S.C. Code Ann. Reg. 61-15 § 605 (Supp. 2013). Because I have found that the linear accelerator proposed by Grand Strand in its Application complies with the applicable PRC, I do not find that Grand Strand's intention to upgrade its unit due to a decrease in price constitutes a substantial change at this time requiring remand of its application to the Staff.

³⁷ Grand Strand has taken the position that while both projects can be approved, if only one can be approved, its project is superior. In light of my decision in this case that determination is unnecessary. Nevertheless, based upon the evidence, I agree with Grand Strand that its project more fully complies with the applicable requirements. As set forth in my Findings of Fact above, Grand Strand's project stands apart from CRCC's because it will offer access to comprehensive cancer treatment and in-hospital radiation therapy services in a Service Area where none currently exist. Grand Strand's project will also offer an alternative to radiation therapy services where the referral sources may be financially rewarded. Non-governmental payors like PPOs will have the ability to negotiate rates in Horry County. While Grand Strand's project costs more than CRCC's, the access it affords to the citizens of the Service Area, the vast majority of whom live in Horry County, outweighs any assertion of duplication or adverse impact due to its location in close proximity to CRCC's facility in Myrtle Beach. However, because I have found that both projects can be approved without exceeding the need for facilities and services, and both projects comply with the CON Act, the Health Plan standards, and applicable PRC, I decline to approve only Grand Strand's Application.

ORDER

IT IS THEREFORE ORDERED that a Certificate of Need for CRCC's proposed project for a radiation therapy center in Conway, South Carolina and a Certificate of Need for Grand Strand's proposed project for a radiation therapy center in Myrtle Beach, South Carolina are **APPROVED**. The Department shall issue a Certificate of Need for each of the proposed projects.

AND IT IS SO ORDERED.

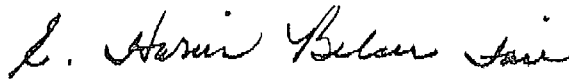


Ralph King Anderson, III
Chief Administrative Law Judge

March 10, 2014
Columbia, South Carolina

CERTIFICATE OF SERVICE

I, E. Harvin Belser Fair, hereby certify that I have this date served this Order upon all parties to this cause by depositing a copy hereof in the United States mail, postage paid, in the Interagency Mail Service, or by electronic mail, to the address provided by the party(ies) and/or their attorney(s).



E. Harvin Belser Fair
Judicial Law Clerk

March 10, 2014
Columbia, South Carolina

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Grand Strand Regional Medical)
Center, LLC,)
)
Petitioner,)
)
vs.)
)
South Carolina Department of Health and)
Environmental Control,)
)
Respondent.)
_____)

Docket No.: 2012-ALJ-07-0090-CC

FILED

ORDER

June 28, 2013

SC ADMIN. LAW COURT

Grand Strand Regional Medical)
Center, LLC,)
)
Petitioner,)
)
vs.)
)
South Carolina Department of Health and)
Environmental Control and Carolinas)
Regional Cancer Center,)
)
Respondents.)
_____)

Docket No.: 2012-ALJ-07-0091-CC

This matter comes before the South Carolina Administrative Law Court (ALC or Court) on Petitioner Grand Strand Regional Medical Center, LLC's (Grand Strand or Petitioner) Motion for Partial Summary Judgment, pursuant to Rule 56 of the South Carolina Rules of Civil Procedure (SCRCP) and Rule 68 of the Rules of Procedure for the ALC (SCALCR), against Respondents Carolina Regional Cancer Center (CRCC) and the South Carolina Department of Health and Human Services (Department or DHEC). Petitioner argues that contrary to DHEC's determination, Petitioner and CRCC are not, as a matter of law, "competing" Certificate of Need (CON) applicants.

BACKGROUND

The dispute in this case arises under the *State Certificate of Need and Health Facility Licensure Act*, S.C. Code Ann. § 44-7-110, *et seq.* (2002 & Supp. 2012) ("CON Act"). S.C.

Code Ann. § 44-7-140 (2002). The purpose of the CON Act is to promote cost containment, to prevent the unnecessary duplication of health care facilities and services in the state, to guide the establishment of health facilities and services in such a way as will best serve public needs, and to ensure that high quality services are provided in health facilities in the state. S.C. Code Ann. § 44-7-120 (2002). “To achieve these purposes, [the CON Act] requires: (1) the issuance of a Certificate of Need before undertaking a project prescribed by this article; (2) adoption of procedures and criteria for submittal of an application and appropriate review before issuance of a Certificate of Need; (3) preparation and publication of a State Health Plan; and (4) the licensure of facilities rendering medical, nursing, and other health care.” *Id.*

“The department may not issue a Certificate of Need unless an application complies with the State Health Plan, Project Review Criteria, and other regulations.” S.C. Code Ann. § 44-7-120(C) (2002). “A project does not have to satisfy every criterion in order to be approved. S.C. Code Ann. Regs. 61-15 § 801(3) (Supp. 2012). However, no CON application can be approved unless it complies with the Health Plan. S.C. Code Ann. § 44-7-210(B); *see also* S.C. Code Ann. Regs. 61-15 § 802(1) (“The proposal shall not be approved unless it is in compliance with the South Carolina Health Plan.”) The South Carolina Health Plan (Health Plan) is thus essential in the consideration of a CON application. Adopted at least once every two years, its purpose is to outline the need for health facilities and services in the State. *See* S.C. Code Ann. § 44-7-180(B). The determination of whether a particular facility or service is needed depends upon the projection of need set forth in the Health Plan. S.C. Code Ann. § 44-7-210(B); S.C. Code Ann. Regs. 61-15 § 802(1) (Supp. 2012). Regulation 61-15, *Certification of Need for Health Facilities and Services*, also governs review of CON applications. It contains the project review criteria that may be relevant in review of a CON application.

The *2010-2011 Plan* states that “[n]ew Radiotherapy services shall only be approved if the following conditions are met: A. All existing units in the service area have performed at a combined use rate of 80 percent of capacity for the year immediately preceding the filing of the applicant’s CON application” and “B. An applicant must project that the proposed service will perform a minimum number of treatments equal to 50 percent of capacity annually within three

years of initiation of services, without reducing the utilization of the existing machines in the service area below the 80 percent threshold.”¹

In this case, DHEC received three (3) CON applications, filed under the *2010-2011 South Carolina Health Plan (2010-2011 Plan)*, for megavoltage radiotherapy services in the tri-county service area of Georgetown, Horry, and Williamsburg Counties (Service Area). The *2010-2011 Plan*, which became effective November 12, 2010, showed a need for one additional linear accelerator in the Service Area. North Strand Radiation Oncology Center’s (North Strand), CRCC, and Grand Strand all applied for a linear accelerator in the Service Area. Of the three applicants, only CRCC was an existing provider of radiotherapy services in the Service Area; and it sought to expand its existing service by establishing a new location in an existing medical office building in Conway and installing a linear accelerator therein. This linear accelerator would be its fourth in the Service Area.² Grand Strand proposed to install a Varian Clinac iX Linear Accelerator and a CT simulator, which would allow Grand Strand to provide conventional radiotherapy services, as well as IMRT and IGRT services. When Grand Strand filed its CON application for a linear accelerator, it projected a sufficient need in the Service Area to support two new linear accelerators.

“Competing applicants” is defined as “two or more persons or health care facilities ... who apply for certificates of need to provide similar services or facilities in the same service area within a time frame as established by departmental regulations and whose applications, if approved, would exceed the need for services or facilities.” S.C. Code Ann. § 44-7-130(5) (2002).

The Department determined that approving Grand Strand’s CON application would result in an adverse impact to another linear accelerator project operated by the Francis B. Ford Cancer Center, which sought to move its existing linear accelerator to a new location in the Service Area. The Department also decided that approving more than one linear accelerator would exceed the need for radiotherapy services in the Service Area and would have an unjustifiably

¹ Expansion of an existing service has different conditions. See *2010-2011 Plan*, IX-5 to 6, ¶ 7. Also, the language in the *2012-2013 Plan* regarding the approval of Radiotherapy services and for an expansion of an existing service is identical to that contained within the *2010-2011 Plan*. See *2012-2013 Plan*, IX-6, ¶¶ 6-7.

² Currently, the Francis B. Ford Cancer Center is the only other radiation therapy provider in the Service Area, which is located in the City of Georgetown, approximately 20 miles from the Horry County line. Seeking radiation therapy at the Ford Cancer Center in Georgetown was not found to be a viable option for Horry County residents who have to receive 25-35 radiotherapy treatments over the course of 5-6 weeks.

adverse impact on other providers in the Service Area. Therefore, the Department concluded that CRCC and Grand Strand were “competing applicants.”

“In the case of competing applications, the department shall award a Certificate of Need, if appropriate, on the basis of which, if any, most fully complies with the requirements, goals, and purposes of [Title 44, Chapter 7, Article 3] and the State Health Plan, Project Review Criteria, and the regulations adopted by the department.” S.C. Code Ann. § 44-7-210(B) (Supp. 2012).

The Department’s staff compared the applications and concluded that CRCC’s application most fully complied with relevant project review criteria, Plan standards for radiotherapy, and the purposes of the CON Act. Therefore, by letter dated December 28, 2011, the Department notified the applicants of its decision to grant CRCC’s application and denied both North Strand and Grand Strand’s CON applications. Following the issuance of the Department’s decision, North Strand and Grand Strand submitted requests for final review by the DHEC Board. The Board declined to hold a final review conference, thus rendering the staff’s decision as the final agency decision. Grand Strand and North Strand then filed requests for contested case hearings with this Court to review the Department’s decisions.³

STANDARD OF REVIEW

Pursuant to Rule 56(c), SCRCP, summary judgment shall be granted “if the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.” “In determining whether any triable issues of fact exist, the court must view the evidence and all reasonable inferences that may be drawn from the evidence in the light most favorable to the nonmoving part[ies].” *Ray v. Austin*, 388 S.C. 605, 611, 698 S.E.2d 208, 211 (2010) (internal citations omitted). Because summary judgment is a drastic remedy, it should be “cautiously invoked so that a litigant will not be improperly deprived of trial on disputed factual issues.” *Cunningham ex rel. Grice v. Helping Hands, Inc.*, 352 S.C. 485 491, 575 S.E.2d 549, 552 (2003). “[T]he non-moving part[ies are] only required to submit a mere scintilla of evidence in order to withstand a motion for summary judgment.” *Hancock v. Mid-South Mgmt. Co.*, 381 S.C. 326, 330, 673 S.E.2d 801, 802 (2009). “Summary judgment is not

³ Pursuant to the Order Dismissing North Strand Radiation Oncology with Prejudice, this Court subsequently dismissed North Strand from this action.

appropriate where further inquiry into the facts of the case is desirable to clarify the application of the law.” *Gadson v. Hembree*, 364 S.C. 316, 320, 613 S.E.2d 533, 535 (2005). “Even when there is no dispute as to evidentiary facts, but only as to the conclusions or inferences to be drawn from them, summary judgment should be denied.” *Miller v. Blumenthal Mills, Inc.*, 365 S.C. 204, 220, 616 S.E.2d 722, 729 (Ct. App. 2005).

DISCUSSION

Grand Strand argues that both Grand Strand and CRCC’s CON applications can, as a matter of law, be approved without exceeding the need for radiotherapy services in the Service Area, and that Grand Strand is therefore not a competing applicant with CRCC. Grand Strand bases this argument on the fact that pursuant to S.C. Code Ann. § 44-7-225 (Supp. 2012), this Court may consider the current South Carolina Health Plan in addition to the Plan in place at the time the CON application was filed in making its decision to approve or deny CON applications, and that according to the *2012-2013 South Carolina Plan*, there exists an unmet need for an additional linear accelerator in the Service Area.

Consideration of the 2010-2011 and 2012-2013 Health Plans

DHEC, in its Memorandum in Opposition to Grand Strand’s Motion for Summary Judgment, contends that applying the *2012-2013 South Carolina Health Plan* to declare Grand Strand and CRCC as non-competing applicants “would deprive affected parties from the Service Area from being able to apply for radiotherapy services under the *2012-2013 Plan* and/or oppose Grand Strand’s effort to be awarded a CON for radiotherapy services under the *2012-2013 [South Carolina Health] Plan*.” DHEC also mentions that both S.C. Code Ann. § 44-7-225 and S.C. Code Ann. Regs. 61-15 § 504 (Supp. 2012) require consideration of the South Carolina Health Plan in effect at the time the application is submitted, and therefore the *2010-2011 South Carolina Health Plan* must be considered in the making a decision concerning the two applications. CRCC, in its Memorandum in Opposition, likewise argues that this Court “*must* consider the [South Carolina Health] Plan in place at the time of the CON applicant’s filing.” (emphasis in original). CRCC even chides Grand Strand for “gloss[ing] or avoid[ing] th[is] mandate in the CON Act.” CRCC also quotes Reg. 61-15 § 504, emphasizing much of its language.

Section 44-7-225 states: “The department, the Administrative Law Court, and the Court of Appeals shall consider the South Carolina Health Plan in place at the time the application was

filed and may consider the current South Carolina Health Plan when making its decision.” Reg. 61-15 § 504 states:

All decisions on Certificate of Need applications shall be made based on the currently approved South Carolina Health Plan in effect at the time such application is accepted. Should a new plan be adopted during any phase of the review or appeals process, the applicant shall have the option of withdrawing the application and resubmitting under the newly adopted plan or continuing the review or appeal process under the plan in use when the application was submitted. In cases where applications are withdrawn and resubmitted under the newly adopted South Carolina Health Plan within forty-five (45) calendar days of the date of withdrawal, no additional filing fee shall be required.

It is clear from Section 44-7-225, and both DHEC and CRCC acknowledge, that it is “permissible” for this Court to consider the current Plan, i.e. the *2012-2013 South Carolina Health Plan*, when making its decision. DHEC states this fact as part of a statement of Grand Strand’s argument but fails to explain the language of 44-7-225 in relation to Reg. 61-15 § 504. CRCC actually states the language from Section 44-7-225 but then proceeds to do the same thing that it chided Grand Strand for, but in the inverse, by shifting the focus from the permissive language in Section 44-7-225 and instead focusing on the mandatory language therein and on the language in Reg. 61-15 § 504. After comparing the language in Section 44-7-225 and Reg. 61-15 § 504, the Court finds that the two provisions conflict.

Clearly, the Court must consider the Health Plan in effect at the time such application is accepted. Nevertheless, though that consideration is obligatory it cannot be construed as exclusive. Section 44-7-225 clearly grants the “Department, ALC, or Court of Appeals” the authority to also consider the current South Carolina Health Plan in addition to the Plan in place at the time the application was filed when making its decision. To the extent that Reg. 61-15 § 504 contradicts Section 44-7-225, the regulation is invalid. *See S.C. Coastal Conservation League v. S.C. Dep’t of Health and Envtl. Control*, 390 S.C. 418, 429, 702 S.E.2d 246, 252 (2010) (internal citation omitted) (“Although a regulation has the force of law, it must fall when it alters or adds to a statute.”). The control of Section 44-7-225 over Reg. 61-15 § 504 is especially evident in this case given the fact that Section 44-7-225 was enacted **after** Reg. 61-15 § 504 was promulgated.⁴ Thus, while it is certain that the Court must consider the Health Plan in existence at the time of the filing of the CON application – the *2010-2011 South*

⁴ Section 44-7-225 became effective July 1, 2010. The language of Reg. 61-15 § 504 at that time was the same as it is now, except that “State Health Plan” was changed to “South Carolina Health Plan” where mentioned.

Carolina Health Plan in this case – the Court may consider both the 2010-2011 and 2012-2013 *South Carolina Health Plans* if the Court deems it appropriate to do so.⁵ Whether the Court finds it appropriate to consider the current South Carolina Health Plan in addition to the one for 2010-2011 is a determination that the Court will make following a contested case hearing to review DHEC's decisions to approve CRCC's CON application and deny Grand Strand's CON application. Furthermore, DHEC's concern about the affected parties from the Service Area being rendered unable "to apply for radiotherapy services under the 2012-2013 Plan and/or oppose Grand Strand's effort to be awarded a CON for radiotherapy services under the 2012-2013 Plan" is questionable. Nevertheless, in light of the clear authority of this Court to consider the current plan in reaching its decision, a factual resolution of this matter may assist this Court in resolving the issue. *See Evening Post Pub. Co. v. Berkeley County Sch. Dist.*, 392 S.C. 76, 83, 708 S.E.2d 745, 749 (2011) ("Summary judgment is not appropriate where further inquiry into the facts of the case is desirable to clarify the application of the law.").

Genuine Issue of Material Fact Concerning Need

CRCC argues that there is a genuine issue of material fact as to whether approval of both applications would exceed the need for the services claimed by Grand Strand. It argues that the only evidence Grand Strand has presented as to this question has been the enactment of the 2012-2013 Plan, which alone does not satisfy Grand Strand's burden of proving, as a matter of law, that approval of its application would not exceed the need for its proposed services and/or facilities. I agree.

According to the definition of "competing applicants" pursuant to S.C. Code Ann. § 44-7-130(5) (2002) and S.C. Code Ann. Regs. 61-15 § 103(6) (Supp. 2012), for two CON applications to be considered competing applications, all of the following four requirements must be met:

- (1) The applications must be filed within the time period prescribed in the statute and regulation;
- (2) The applications must be for similar services or facilities;
- (3) The applications must be servicing the same service area; and

⁵ CRCC's contends that if this Court were to consider both South Carolina Health Plans and find that approval of both CRCC's and Grand Strand's CON applications would not exceed the need, that this Court would violate the CON Act and Regulations by ignoring the South Carolina Health Plan under which the two applications were filed. However, to do so would not ignore the first Health Plan. Section 44-7-225 allows for the two Health Plans to be considered together, even though the first Health Plan must always be considered.

- (4) The applications, if approved, must exceed the need for the services or facilities.⁶

Thus far, Grand Strand has merely presented the *2012-2013 Plan*, which only projects that there is availability in the Service Area for a new linear accelerator. But this availability does not answer the question of whether the way in which Grand Strand would provide its services with the new linear accelerator would satisfy the conditions for approval of new Radiotherapy services under either of the Health Plans at issue. Grand Strand argues that its satisfaction of the approval requirements is a factual determination that must be determined at the hearing and that it is separate from the question of whether Grand Strand and CRCC are competing CON applicants. I agree that Grand Strand's satisfaction of the approval requirements is a factual determination to be resolved at the hearing, but so is the determination of whether Grand Strand and CRCC are competitors.

The Court has already decided that it must make a factual determination as to whether it should exercise its discretion to consider the *2012-2013 Plan* in addition to the one for 2010-2011. Grand Strand's argument as to why it is a non-competitor with CRCC is based on an assumption that the *2012-2013 Plan* applies – a determination that this Court has yet to make. Specifically, Grand Strand argues that the *2012-2013 Plan* reflects a need for an additional linear accelerator, and therefore it would not exceed the need for both CRCC's and Grand Strand's CON applications to be approved. The Court certainly **may** consider the *2012-2013 Plan* in this case (in addition to the one for 2010-2011) pursuant to S.C. Code Ann. 44-7-225. But to rule that Grand Strand is a non-competitor with CRCC as a matter of law under Grand Strand's argument would necessarily require this Court to consider and apply the *2012-2013 Plan*, which this Court will not do without first receiving undisputed factual justification from Grand Strand.

Furthermore, requiring a factual determination to resolve whether the approval of two CON applications would exceed the need for the services and/or facilities comports with the South Carolina Supreme Court's decision in *Spartanburg Reg'l Med. Ctr. v. Oncology and Hematology Assoc. of S.C., LLC*, 387 S.C. 79, 690 S.E.2d 783 (2010), in which the Court stated:

The ALC found that granting both CON applications would not exceed the need, and therefore, the applications were not competing. From a factual perspective, there is abundant evidence in the record to support this based on

⁶ None of the parties argue that Grand Strand has not satisfied the first three requirements. Therefore, the fourth requirement is the object of the Court's focus here.

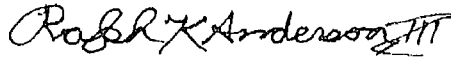
CCC's data projections. Moreover, it is hard to interpret the plain language of section 44-7-130(5) any other way than the manner in which the ALC interpreted it: If granting both applications would not exceed the need, then the applications are not competing and both may be granted (provided all other relevant criteria are met). See *Brown v. S.C. Dep't of Health and Envtl. Control*, 348 S.C. 507, 515, 560 S.E.2d 410, 414 (2002) ("Where the terms of the statute are clear, the court must apply those terms according to their literal meaning.").

(emphasis added). Though Grand Strand correctly points out that *Spartanburg* was litigated and decided prior to the enactment of Section 44-7-225, this has no bearing on the Court's application of this case. For the reasons stated above, the *2010-2011* and *2012-2013 Plans* cannot establish as a matter of law that need would not be exceeded in the Service Area.⁷

ORDER

IT IS THEREFORE ORDERED that the Grand Strand's Motion for Partial Summary Judgment is **DENIED**.

AND IT IS SO ORDERED.



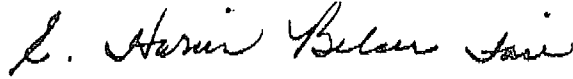
Ralph King Anderson, III
Chief Administrative Law Judge

June 28, 2013
Columbia, South Carolina

⁷ CRCC also argued that for the Court to render an opinion in this case would be to render an "advisory opinion." The Court dismisses that argument.

CERTIFICATE OF SERVICE

I, E. Harvin Belser Fair, hereby certify that I have this date served this Order upon all parties to this cause by depositing a copy hereof in the United States mail, postage paid, in the Interagency Mail Service, or by electronic mail, to the address provided by the party(ies) and/or their attorney(s).



E. Harvin Belser Fair
Judicial Law Clerk

June 28, 2013
Columbia, South Carolina

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Grand Strand Regional Medical Center,)
LLC,)
)
Petitioner,)
)
vs.)
)
South Carolina Department of Health and)
Environmental Control,)
)
Respondent.)
_____)

Docket No. 12-ALJ-07-0090-CC

**ORDER DISMISSING NORTH
STRAND RADIATION ONCOLOGY
CENTER WITH PREJUDICE**

Grand Strand Regional Medical Center,)
LLC)
)
Petitioner,)
)
vs.)
)
South Carolina Department of Health and)
Environmental Control and Carolinas)
Regional Cancer Center,)
)
Respondents.)
_____)

Docket No. 12-ALJ-07-0091-CC

North Strand Radiation Oncology Center,)
)
Petitioner,)
)
vs.)
)
South Carolina Department of Health and)
Environmental Control,)
)
Respondent.)
_____)

Docket No. 12-ALJ-07-0098-CC

FILED

March 5, 2013

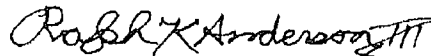
SC ADMIN. LAW COURT

North Strand Radiation Oncology Center,	)	
	)	Docket No. 12-ALJ-07-0099-CC
Petitioner,	)	
	)	
vs.	)	
	)	
South Carolina Department of Health and	)	
Environmental Control and Carolinas	)	
Regional Cancer Center,	)	
	)	
Respondents.	)	
_____	)	

North Strand Radiation Oncology Center (North Strand), by letter dated February 26, 2013, withdrew its requests for contested hearings filed on March 13, 2012, which were consolidated into the above-referenced cases, and consented to its dismissal from these cases with prejudice. Accordingly,

IT IS THEREFORE ORDERED that North Strand Radiation Oncology Center is hereby dismissed with prejudice as a Petitioner in Docket No. 12-ALJ-07-0098-CC and 12-ALJ-07-099-CC, and as an intervenor in Docket No. 12-ALJ-07-0090-CC and 12-ALJH-07-0091-CC.

AND IT IS SO ORDERED.

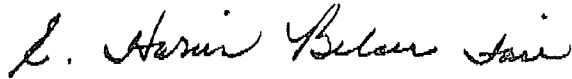


Ralph King Anderson, III
Chief Administrative Law Judge

March 5, 2013
Columbia, South Carolina

CERTIFICATE OF SERVICE

I, E. Harvin Belser Fair, hereby certify that I have this date served this Order upon all parties to this cause by depositing a copy hereof in the United States mail, postage paid, in the Interagency Mail Service, or by electronic mail, to the address provided by the party(ies) and/or their attorney(s).



E. Harvin Belser Fair
Judicial Law Clerk

March 5, 2013
Columbia, South Carolina

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Grand Strand Regional Cancer Center, LLC,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control,

Respondent.

Docket No.: 2012-ALJ-07-0090-CC

Grand Strand Regional Medical Center, LLC,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control and Carolina Regional
Cancer Center,

Respondents.

Docket No.: 2012-ALJ-07-0091-CC

North Strand Radiation Oncology Center,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control,

Respondent.

Docket No.: 2012-ALJ-07-0098-CC

North Strand Radiation Oncology Center,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control and Carolina Regional
Cancer Center,

Respondents.

Docket No.: 2012-ALJ-07-0099-CC

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SC ADMIN. LAW COURT

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CONSENT ORDER OF CONSOLIDATION

All four of the above-captioned contested case proceedings involve three applications for the establishment of a linear accelerator in Horry County, South Carolina. On December 28, 2011, the Respondent South Carolina Department of Health and Environmental Control (“DHEC” or “Department”) approved a Certificate of Need (“CON”) application filed by Carolina Regional Cancer Center (“CRCC”) to add a linear accelerator to a proposed location in Conway, South Carolina, while simultaneously denying two CON applications to add services to Horry County by Petitioners Grand Strand Regional Medical Center, LLC (“Grand Strand”) and North Strand Radiation Oncology Center (“North Strand”).

On March 14, 2012, Grand Strand filed two separate contested case proceedings challenging the Department’s decisions to grant a CON to CRCC and denial of its application. In the case captioned Grand Strand Regional Medical Center, LLC v. South Carolina Department of Health and Environmental Control, Docket No.: 12-ALJ-07-0090-CC, Grand Strand did not name CRCC as a party. In the case captioned Grand Strand Regional Medical Center, LLC v. South Carolina Department of Health and Environmental Control and Carolina Regional Cancer Center, Docket No.: 12-ALJ-07-0091-CC, CRCC was included as a party.

Also on March 14, 2012, North Strand filed two separate contested case proceedings challenging the Department’s decisions to grant a CON to CRCC and denial of its application. In the case captioned North Strand Radiation Oncology Center v. South Carolina Department of Health and Environmental Control, Docket No.: 12-ALJ-07-0098-CC, North Strand did not name CRCC as a party. In the case captioned North Strand Radiation Oncology Center v. South Carolina Department of Health and Environmental Control and Carolina Regional Cancer Center, Docket No.: 12-ALJ-07-0099-CC, CRCC was included as a party.

The parties to each of four proceedings have since agreed to the intervention of all parties

into all pending matters, thus North Strand and CRCC have obtained consent to intervene in Grand Strand actions bearing Docket Nos. 12-ALJ-07-0090-CC and 12-ALJ-07-0091-CC, and Grand Strand and CRCC have obtained consent to intervene in the North Strand actions bearing Docket Nos. 12-ALJ-07-0098-CC and 12-ALJ-07-0099-CC.

Rule 19(D), RPALC, requires consolidation of proceedings where the matters involve the same or substantially similar evidence. All four of these proceedings involve the same or substantially similar decisions of the Department as the applications are to provide the substantially similar services and were reviewed together by the Department, and will involve the same or substantially similar issues related to the approval or denial of linear accelerators and the issue of competing applications. The notion of consolidation is intended for just this scenario and will promote judicial economy to the greatest extent.

Based on the consent of the parties and a review of the file, I find that the actions entitled Grand Strand Regional Medical Center, LLC v. South Carolina Department of Health and Environmental Control, Docket No.: 12-ALJ-07-0090-CC; Grand Strand Regional Medical Center, LLC v. South Carolina Department of Health and Environmental Control and Carolina Regional Cancer Center, Docket No.: 12-ALJ-07-0091-CC; North Strand Radiation Oncology Center v. South Carolina Department of Health and Environmental Control, Docket No.: 12-ALJ-07-0098-CC; and North Strand Radiation Oncology Center v. South Carolina Department of Health and Environmental Control and Carolina Regional Cancer Center, Docket No.: 12-ALJ-07-0099-CC, are hereby consolidated for both discovery and trial purposes.

IT IS SO ORDERED.

May 4, 2012
Columbia, South Carolina

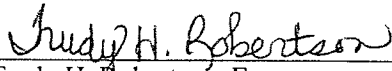

Ralph King Anderson, III
Administrative Law Court Judge

CERTIFICATE OF SERVICE

This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, in the United States mail, postage paid, or in the Interagency Mail Service addressed to the party(ies) or their attorney(s).

This 4th day of May, 2012.
By: L. Martin Nelson III
Judicial Law Clerk

WE CONSENT:



Trudy H. Robertson, Esq.

Donald B. Meyer, Esq.

Moore & Van Allen

Suite 300

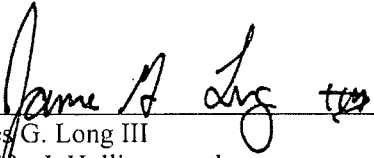
40 Calhoun Street

Post Office Box 22828

Charleston, South Carolina 29413

Attorneys for North Strand Radiation
Oncology Center

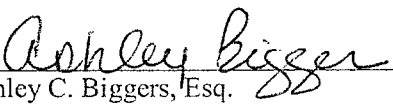
WE CONSENT:


James G. Long III
Jennifer J. Hollingsworth
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1230 Main Street, Suite 700 (29201)
Post Office Drawer 2426
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E. Wade Mullins III
BRUNER POWELL
1735 St. Julian Place, Suite 200
P.O. Box 61110 (29260-1110)
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Attorneys for Respondent
Carolina Regional Cancer Center

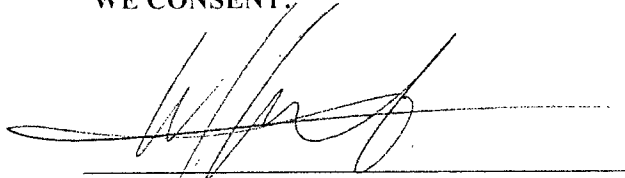
WE CONSENT:



Ashley C. Biggers, Esq.
Kristin L. Pawlowski, Esq.
South Carolina Department of Health and
Environmental Control
2600 Bull Street
Columbia, South Carolina 29201

Attorneys for Respondent S.C. Dept. of
Health and Env'tl. Control

WE CONSENT:

A handwritten signature in dark ink, appearing to be 'W. R. Thomas', is written over a horizontal line.

William R. Thomas, Esq.
Walter H. Cartin, Esq.
Parker Poe Adams & Bernstein, LLP
1201 Main Street, Suite 1450
P.O. Box 1509
Columbia, South Carolina 29202

*Attorneys for Grand Strand
Regional Medical Center, LLC*

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Grand Strand Regional Medical Center, LLC,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control and Carolina Regional
Cancer Center,

Respondents.

Docket No.: 2012-ALJ-07-0091-CC

PREHEARING STATEMENT

Pursuant to the April 4, 2012 Order for Prehearing Statements, Respondent Carolina Regional Cancer Center ("CRCC") respectfully submits the following Prehearing Statement:

1. The nature of this proceeding.

This action arises from the December 28, 2011 decision of the Respondent South Carolina Department of Health and Environmental Control ("DHEC" or "Department") to approve a Certificate of Need ("CON") application filed by CRCC to add a linear accelerator in Horry County to a proposed location in Conway, South Carolina, while simultaneously denying two competing CON applications to add services to Horry County – Petitioner Grand Strand Regional Medical Center, LLC ("Grand Strand") and North Strand Radiation Oncology Center ("North Strand"). This action was filed by Grand Strand. North Strand has filed two separate contested case proceedings related to this same decision, Docket Nos. 2012-ALJ-07-0098-CC and 2012-ALJ-07-0099-CC.

All three applicants sought to provide radiation therapy services in Horry County, South Carolina. The Department correctly determined that the three applications were competing under Regulation 61-15 and the CON Act because the approval of more than one linear

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accelerator would exceed the need for services in the service area. *See* 24A S.C. Code Ann. Regs. 61-15 § 103(6); *see also* 44-7-130(5). The Department correctly approved the CRCC application because it most fully complied with the CON Act, State Health Plan, project review criteria, and regulations. *See* 24A S.C. Code Ann. Regs. 61-15 § 307(2).

The decisions of the Department to approve the CON application filed by CRCC and deny the CON applications of Grand Strand and North Strand was correct.

2. Statutory provisions conferring subject matter jurisdiction to the agency and other applicable statutes and regulations.

The Court has jurisdiction over this matter under the South Carolina Administrative Procedures Act, S.C. Code Ann. §§ 1-23-310, *et seq.*; the State Certificate of Need and Health Facility Licensure Act, S.C. Code Ann. §§ 44-7-110, *et seq.* (“CON Act”); the Certificate of Need for Health Facilities and Services Regulations, 24A S.C. Code Ann. Regs. 61-15, *et seq.* (“CON Regulations”); and the Rules of Procedure for the Administrative Law Court. Under the CON Act, the Department is the agency charged with administering the CON program. S.C. Code Ann. § 44-7-140. CRCC serves patients residing in the service area of Georgetown, Horry, and Williamsburg Counties. CRCC is an affected person and has standing to defend its interests in this case. *See id.* at § 44-7-130(1).

3. The issues presented for determination, including any claims or defenses expected to be raised.

As evidenced by its Request for Contested Case, Grand Strand seeks to reverse the decision of the Department to approve the application of CRCC. In the contested case proceeding filed solely against the Department simultaneously with this filing, Grand Strand also seeks to reverse DHEC’s decision to deny its application to establish services in Myrtle Beach,

South Carolina. CRCC supports the decisions of the Department on the grounds that the applications are competing under the CON Act and Regulations and that CRCC's application most fully complies with all applicable laws, regulations, and rules.

CRCC further believes that regardless of the competing application analysis, Grand Strand's application was properly denied because it fails to satisfy the CON Act, Regulations, State Health Plan, and project review criteria.

4. The action requested of the Court and a detailed statement of the law which supports the requested action, including statutory and/or case citations.

CRCC respectfully requests that the Court affirm the decision of the Department in all respects: the approval of CRCC's application and the denial of the applications of Grand Strand and North Strand in the parallel proceeding. Where the petitioner cannot show by a preponderance of the evidence that DHEC erred in its decisions, this Court must affirm the Department and deny the petitioner's requested relief. *See e.g., Amisub of S.C., Inc. d/b/a Piedmont Med. Ctr. v. S.C. Dept. of Health and Envtl. Control*, Docket No. 2010-ALJ-07-0767-CC, 2011 WL 7119244 (Sept. 13, 2011).

5. A brief summary of the facts to be presented at the hearing.

Without waiving and reserving its right to present detailed factual and expert evidence to the Court, CRCC submits the following brief factual summary:

Under the *2010-2011 State Health Plan*, the four inventoried linear accelerators in the Georgetown/Horry/Williamsburg service area were operating at 80.5% capacity. CRCC currently operates three linear accelerators at its location at 4708 Oleander Drive, Myrtle Beach, in Horry County, South Carolina. Two units are conventional linear accelerators and the third is a TomoTherapy unit. In furtherance of its mission to support quality cancer care services to the

residents of the service area, CRCC identified Conway as an area with need for greater accessibility to linear accelerator services. In the year prior to filing its application on March 10, 2011, CRCC operated its existing equipment above capacity.

On March 9, 2011 and July 19, 2011, North Strand and Grand Strand respectively filed CON applications to establish new linear accelerator services in the service area. North Strand proposed to establish a new service in Little River, South Carolina, through a joint venture between McLeod Regional Medical Center and Loris Health Services, Inc. Grand Strand proposed to establish radiation therapy services as an attachment to its main hospital in Myrtle Beach.

Upon review of the three applications, the Department correctly concluded that the applications were competing under S.C. Code Ann § 44-7-130(5) and 24A S.C. Code Ann. Regs. 61-15 § 103(6). DHEC staff then analyzed which applicant most fully complied with the requirements and goals of the CON program and correctly concluded CRCC's application should be granted and the applications of North Strand and Grand Strand denied. CRCC supports the decisions of the Department and requests the Court affirm the Department and order the issuance of CRCC's CON to expand its linear accelerator services to Conway, South Carolina.

6. A summary of any motions expected to be raised at the hearing and the appropriate authority underlying the motion.

CRCC will file a Motion to Intervene in the proceeding filed by Grand Strand simultaneous with this matter but directed solely at the Department. CRCC also anticipates filing a Motion to Consolidate these matters with the parallel proceedings filed by North Strand challenging the same decisions of the Department. CRCC does not presently anticipate any other pre-trial motions other than a Consent Scheduling Order, but reserves its right to file a

dispositive motion in the event it is determined to be appropriate under the facts and law of the case.

7. A list of proposed witnesses and exhibits.

- (a) Patrick Franke, M.D., CRCC
- (b) Todd E. Williams, M.D., CRCC
- (c) Patricia Price, Regional Administrator, CRCC
- (d) Phil Clayton, CEO, Conway Medical Center

*CRCC reserves its right to name additional witnesses.

Subject to and without waiving its right to identify documents produced by any party to these proceedings, and to introduce documents gathered during the discovery process, CRCC identifies the following documents as potential exhibits at the trial of these matters:

- (a) The Department's Record for the CRCC Application;
- (b) The Department's Record for the Grand Strand Application;
- (c) The Department's Record for the North Strand Application;
- (d) *The 2010-2011 State Health Plan*
- (e) Any other relevant evidence produced during discovery by any party.

8. A statement regarding the necessity for discovery, if any.

CRCC believes that expanded discovery pursuant to the South Carolina Rules of Civil Procedure will be necessary in this case.

9. The estimated length of the hearing.

Assuming that the multiple proceedings related to the Department's decisions on December 28, 2011, are consolidated, CRCC estimates the trial of this matter would take fifteen (15) trial days.

10. Any dates in the next ninety (90) days when you will not be available for a hearing.

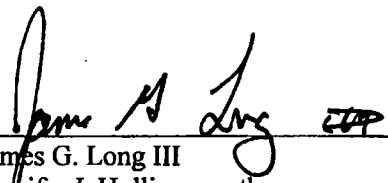
CRCC anticipates conferring with counsel for Grand Strand, North Strand and the Department to enter an agreeable Consent Scheduling Order to allow for the orderly progression of this case. Notwithstanding that intention, counsel for CRCC is not available May 10 to May 16, 2012 and July 11 to July 27, 2012.

11. An email address where you can be reached.

James G. Long, III at JLong@NexsenPruet.com

E. Wade Mullins, III at WMullins@BrunerPowell.com

Jennifer J. Hollingsworth at JHollingsworth@NexsenPruet.com



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E. Wade Mullins III
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1735 St. Julian Place, Suite 200
P.O. Box 61110 (29260-1110)
Columbia, SC 29204

Attorneys for Respondent
Carolina Regional Cancer Center

April 18, 2012
Columbia, South Carolina

CERTIFICATE OF SERVICE

This is to certify that the foregoing **Prehearing Statement** of Carolina Regional Cancer Center, LLC has been served upon counsel of record by hand delivery this 19th day of April, 2012, addressed as shown below.

William R. Thomas, Esquire
Parker Poe Adams
1201 Main Street, Suite 1400
Columbia, SC 29201

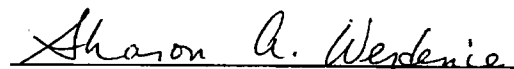
*Attorneys for Grand Strand Regional
Medical Center, LLC*

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South Carolina Department of Health
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Environmental Control*

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*Attorneys for Respondent Carolina
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Sharon A. Werdenie
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SC ADMIN. LAW COURT



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willthomas@parkerpoe.com

Charleston, SC
Charlotte, NC
Columbia, SC
Myrtle Beach, SC
Raleigh, NC
Spartanburg, SC

May 23, 2013

RECEIVED

MAY 23 2013

VIA HAND DELIVERY

The Honorable Ralph King Anderson, III
Chief Administrative Law Judge
Administrative Law Court
Edgar A. Brown Building
1205 Pendleton Street
Columbia, South Carolina 29201

NEXSEN PRUET, LLC

Re: Grand Strand Regional Medical Center, LLC vs. SC DHEC, Docket #12-ALJ-07-0090-CC
Grand Strand Regional Medical Center, LLC vs. SC DHEC and Carolina Regional Cancer
Center, LLC, Docket #12-ALJ-07-0091-CC
LLC, Docket #12-ALJ-07-0099-CC

Dear Judge Anderson:

Enclosed for filing please find the original and one copy of Grand Strand Regional Medical Center, LLC's Motion for Partial Summary Judgment and Memorandum of Law in Support, along with our firm's check in the amount of \$50.00. Please return a clocked-in copy to our courier. By copy of this letter, we are serving all counsel of record.

With kindest regards, I am

Sincerely,

William R. Thomas

WRT/rat
Enclosure

cc: Ashley C. Biggers, Esquire (w/enclosure)
Vito Wicevic, Esquire (w/enclosure)
James G. Long, III, Esquire (w/enclosure)
Jennifer J. Hollingsworth, Esquire (w/enclosure)
E. Wade Mullins, III, Esquire (w/enclosure)

PPAB 2039177v1

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**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Grand Strand Regional Medical Center, LLC,
Petitioner,

vs.

South Carolina Department of Health and
Environmental Control,
Respondent.

Docket No.: 2012-ALJ-07-0090-CC

Grand Strand Regional Medical Center, LLC,
Petitioner,

vs.

South Carolina Department of Health and
Environmental Control and Carolina Regional
Cancer Center,
Respondents.

Docket No.: 2012-ALJ-07-0091-CC

**GRAND STRAND REGIONAL MEDICAL CENTER, LLC'S MOTION FOR PARTIAL
SUMMARY JUDGMENT & MEMORANDUM OF LAW IN SUPPORT**

Grand Strand Regional Medical Center, LLC ("Grand Strand"), acting by and through its undersigned attorneys, moves this Court, pursuant to Rule 56 of the South Carolina Rules of Civil Procedure and Rule 68 of the Rules of Procedure for the Administrative Law Court, for partial summary judgment against Carolina Regional Cancer Center ("CRCC") and the South Carolina Department of Health and Environmental Control ("Department" or "DHEC") on the grounds that, as a matter of law, Grand Strand and CRCC are not "competing" Certificate of Need ("CON") applicants and the Department erred in concluding otherwise. In support of its Motion, Grand Strand shows unto the Court as follows:

BACKGROUND

These cases involve Grand Strand's and CRCC's respective CON Applications for the addition of linear accelerators in the service area encompassing Horry, Williamsburg, and Georgetown Counties ("Service Area").¹

A. Grand Strand's & CRCC's CON applications

Grand Strand is a 269 bed acute care hospital located in Myrtle Beach, South Carolina. Grand Strand is accredited by the American College of Surgeons as a Community Hospital Cancer Program. As such, Grand Strand provides a full spectrum of diagnostic and treatment services, either directly or through referral to other providers. (Grand Strand DHEC Record, at p. 23, attached as **Exhibit A**) Grand Strand is the largest healthcare provider in the Service Area.

Grand Strand currently coordinates care for cancer patients with Coastal Cancer Center, which has a number of offices throughout the Service Area. (*Id.*) Coastal Cancer Center's medical oncologists provide chemotherapy, hormonal therapy, targeted therapy, stem cell transplantation, biological therapy, as well as alternative medicine treatments to Grand Strand's patients. (*Id.*) Coastal Cancer Center's oncologists perform cancer treatment surgeries at Grand Strand. However, neither Grand Strand nor Coastal Cancer Center provide radiation therapy services directly, and patients requiring radiation therapy are referred to CRCC or other providers. (*Id.* at 24.)

On July 11, 2011, Grand Strand filed its CON application to establish a radiation therapy center on its main hospital campus. Grand Strand proposed to install a Varian Clinac iX Linear

¹ North Strand Radiation Oncology Center ("North Strand") also filed a CON Application for the addition of a linear accelerator in Horry County. The Department denied North Strand's CON application. After the Department Board declined final review, North Strand requested a contested case hearing before this Court. This Court consolidated North Strand's contested case with the above-referenced cases and allowed North Strand to intervene in the contested cases filed by CRCC and Grand Strand. Pursuant to the Order Dismissing North Strand Radiation Oncology With Prejudice, dated March 5, 2013, the Court dismissed North Strand from this action.

Accelerator and a CT simulator, which would allow Grand Strand to provide conventional radiotherapy services, as well as IMRT and IGRT services.

Grand Strand filed its CON application under the *2010-2011 South Carolina Health Plan* (“*2010-2011 Plan*”). The *2010-2011 Plan* showed a need for one additional linear accelerator in the Service Area. (*2010-2011 Plan*, at IX-8 – IX-10, attached as **Exhibit B**.) Based on a projected growth of 194 radiation therapy patients in the Service Area between 2010 and 2015, Grand Strand projected that the “approval of Grand Strand’s radiotherapy center will not result in either of the existing radiotherapy programs in the service area falling below a utilization rate of 80%,” and that “Grand Strand’s program should have a *de minimus* effect on Georgetown Memorial Hospital’s program” (**Exhibit A**, at pp. 34-35.) Further, in filings to the Department, Grand Strand’s expert argued that there was sufficient need in the Service Area to support *two* new linear accelerators. (**Exhibit A**, at pp. 1014 (“The historical and projected utilization of existing providers in the service area, however, refutes [CRCC’s claim that only one additional linear accelerator is needed] and demonstrates that two additional linear accelerators could be readily supported.”).) Grand Strand’s CON application showed that Grand Strand complied fully with each and every project review criteria.

Based on the need outlined in the *2010-2011 Plan*, CRCC also filed a CON application for the addition of a linear accelerator, which CRCC proposed to locate in Conway, South Carolina. CRCC has a near monopoly² on the provision of radiation therapy services in Horry County, which comprises over 70% of the population in the Service Area. (**Exhibit A**, at p. 28.) When CRCC filed its CON application on March 10, 2011, it was already operating three linear

² Currently, the Francis B. Ford Cancer Center is the only other radiation therapy provider in the Service Area, which is located in the City of Georgetown, approximately 20 miles from the Horry County line. Seeking radiation therapy at the Ford Cancer Center in Georgetown is not a viable option for Horry County residents who have to receive 25-35 radiotherapy treatments over the course of 5-6 weeks.

accelerators in the Service Area. If approved, CRCC would maintain its near monopoly in the Service Area, leaving third party payors with virtually no leverage in negotiating payment rates for radiotherapy services.

B. The Department's Decision

On December 28, 2011, the Department (1) concluded that Grand Strand and CRCC were “competing applicants,” (2) approved CRCC’s CON application, and (3) denied Grand Strand’s CON application. (Exhibit A, at pp. 925–45.) Although Grand Strand challenges all three Department determinations, this motion for partial summary judgment pertains only to the Department’s conclusion that CRCC’s and Grand Strand’s applications are “competing.”

In its analysis, the Department noted that CRCC “experienced significant growth in utilization during 2010” and that the “total treatments at CRCC grew 34.2% from 2009 to 2010 alone.” (*Id.* at p. 941.) The Department found that “CRCC is operating 12 hour shifts to meet the current demand since they are operating well over capacity.” (*Id.* at 942.) Notwithstanding, CRCC’s “significant growth” and pressing capacity constraints, the Department concluded that approving Grand Strand’s CON application would result in an adverse impact to another linear accelerator project in which the Francis B. Ford Cancer Center sought to move an *existing* linear accelerator to a new location in the Service Area. Completely disregarding Grand Strand’s expert’s opinion that the Service Area could support two new linear accelerators, as well as the incontrovertible data showing a dramatic rise in the need for radiotherapy therapy services, the Department decided that approving more than one linear accelerator would exceed the need for radiotherapy services in the Service Area. Therefore, the Department concluded that CRCC and Grand Strand were “competing applicants.” Because the Department errantly concluded that

CRCC's and Grand Strand's applications were competing, the Department approved only CRCC's CON application.

C. The 2012-2103 South Carolina Health Plan

Less than a year after the Department concluded that the applications were competing, the *2012-2013 South Carolina Health Plan* ("*2012-2013 Plan*") became effective. The new *Plan* contains linear accelerator need calculation standards that are virtually identical to the *2011-2012 Plan*. The *2012-2013 Plan* states that "[n]ew Radiotherapy services shall only be approved if the following conditions are met: A. All existing units in the service area have performed at a combined use rate of 80 percent of capacity for the year immediately preceding the filing of the applicant's CON application" and "B. An applicant must project that the proposed service will perform a minimum number of treatments equal to 50 percent of capacity annually within three years of initiation of services, without reducing the utilization of the existing machines in the service area below the 80 percent threshold." (*2012-2013 Plan*, at IX-6, attached as **Exhibit C.**)

In the *2012-2013 Plan*, the Department itself calculates whether there is an unmet "need" for new radiotherapy services in the Service Area. The Department's calculation of need takes into account any approved CON applications, including CRCC's. In the *2012-2013 Plan*, the Department concluded that there was, in fact, an unmet need in the Service Area for another linear accelerator. (**Exhibit C.** at IX-8.) Put plainly, the *2012-2013 Plan* states that there is an unmet need for another linear accelerator in the Service Area, even after taking into account CRCC's newly approved linear accelerator. (*Id.*)

* * *

On January 12, 2013, Grand Strand requested that the DHEC Board conduct final review conferences regarding the Department's decisions (1) to approve CRCC's CON application, and

(2) to deny Grand Strand's CON application. Following denial of those requests for final review conferences, Grand Strand timely filed requests for contested case hearings to review both decisions.

STANDARD OF REVIEW

Rule 56(c), SCRCP allows a party to move for summary judgment "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." If the moving party has provided the necessary support, "an adverse party may not rest upon the mere allegations or denials of his pleading, but his response . . . must set forth specific facts showing that there is a genuine issue for trial. If he does not so respond, summary judgment, if appropriate, shall be entered against him." Rule 56(e), SCRCP. Grand Strand can demonstrate that there is no genuine issue of material fact to be decided by this Court on the "competing applicants" issue and that, as a matter of law, Grand Strand is entitled to partial summary judgment.

ARGUMENT

Grand Strand and CRCC's CON applications are not "competing" within the meaning of the CON Act and its Regulations. The CON Act sets forth the following definition of "competing applicants":

"Competing applicants" means two or more persons or health care facilities as defined in this article who apply for Certificates of Need to provide similar services or facilities in the same service area within a time frame as established by departmental regulations and whose applications, if approved, would exceed the need for services or facilities.

S.C. Code Ann. § 44-7-130(5) (emphasis added). South Carolina Regulation 61-15 further explains the meaning of "competing applicants":

Competing applicants means two or more persons and/or health care facilities . . . who apply for Certificates of Need to provide similar services and/or facilities in the same service area and whose applications if approved would exceed the need for this facility or service. An application shall be considered competing if it is received by the Department not later than fifteen (15) days after a Notice of Affected Persons is published in the State Register for one or more applications for similar services and/or facilities in the same service area. All applications received by the Department within fifteen (15) days of publication of the Notice of Affected Persons in the State Register for the first application(s) will be considered to be competing. Any applications received by the Department later than the fifteenth day following publication of the Notice of Affected Persons in the State Register for the first application(s) will not be considered to be competing with the(se) application(s).

S.C. Code Ann. Regs. 61-15, § 103(6) (emphasis added).

If two or more applicants are “competing applicants,” then the Department may only grant a CON to the one applicant that the Department determines “most fully complies with the requirements, goals, and purposes of the Certificate of Need program, State Health Plan, project review criteria, and any regulations developed by the Department.” *Id.* at § 307(2); *accord* S.C. Code Ann. § 44-7-210(C). If, however, the CON applications do not satisfy each and every facet of the “competing applicants” definition, then the CON applications are *not* competing and this Court may approve more than one CON application. *See, e.g., Spartanburg Reg’l Med. Center v. Oncology & Hematology Assocs. of S.C. LLC*, 387 S.C. 79, 690 S.E.2d 783 (2010) (determining that DHEC erred in concluding that two con applications for the addition of linear accelerators in upstate South Carolina were competing applications, and affirming a lower court’s determination that both con applications should be approved).

In this case, several elements of the “competing applicants” test are met. Both CRCC and Grand Strand applied to add linear accelerators, and there is no dispute that the CON applications were filed within the “competing applicants” time frame outlined in Regulation 61-15, § 103(6).

The only remaining issue—and the issue Grand Strand now addresses—is whether the “applications if approved would exceed the need for [radiotherapy] service[s]” in the Service Area. *See* S.C. Code Ann. Regs. 61-15 § 103(6). Grand Strand asserts that, as a matter of law, both Grand Strand and CRCC’s CON applications can be approved without exceeding the need for radiotherapy services in the Service Area.

On this issue, however, the Department concluded to the contrary:

Staff has determined the applications are competing. CRCC, GSRMC, and NSROC each applied for a CON to provide radiation therapy services in Horry, Georgetown, and Williamsburg Counties and the need for radiation therapy services in the defined services area will be exceeded if more than one application is approved.

(Dec. 28, 2011, Department Ltr. to Grand Strand, at p. 917.) The Department’s determination is plainly at odds with the *2012-2013 Plan*, in which the Department indicated there is an unmet need for an additional linear accelerator in the Service Area.

The *State Health Plan* is an important piece of the CON regulatory structure. It is so important that the Department “*may not* issue a [CON] unless an application complies with the State Health Plan” S.C. Code Ann. § 44-7-210(C) (emphasis added). The regulations implementing the CON Act confirm the importance of the *State Health Plan*: “The proposal *shall not* be approved unless it is in compliance with the State Health Plan.” S.C. Code Ann. Regs § 61-15, § 802(1) (emphasis added). The South Carolina Supreme Court has been clear in confirming the importance of the *State Health Plan*, holding that a CON applicant must show that its project complies with *State Health Plan* standards. *See MRI at Belfair, LLC v. S.C. Dept. of Health & Envtl. Control*, 379 S.C. 1, 9, 664 S.E.2d 471, 475 (2008).

As a key piece of the regulatory structure, and as a document developed by the Department pursuant to a statutory mandate, the *2012-2013 Plan* is entitled to deference and

should be given significant weight by reviewing courts. *S.C. Coastal Conservation League v. S.C. Dep't of Health & Envtl. Control*, 363 S.C. 67, 75, 610 S.E.2d 482, 486 (2005) (“Courts defer to the relevant administrative agency's decisions with respect to its own regulations unless there is a compelling reason to differ.”); *see also Brown v. Bi-Lo, Inc.*, 354 S.C. 436, 440, 581 S.E.2d 836, 838 (2003) (“We recognize the Court generally gives deference to an administrative agency's interpretation of an applicable statute or its own regulation.”).

Moreover, the CON Act expressly states that the “department, the Administrative Law Court, and the Court of Appeals shall consider the South Carolina Health Plan in place at the time the application was filed and may consider the current South Carolina Health Plan when making its decision.” S.C. Code Ann. § 44-7-225. Because the *2012-2013 Plan* establishes that this Court can approve both CRCC’s and Grand Strand’s CON applications without exceeding the need for services in the Service Area, Grand Strand and CRCC are not “competing applicants.”

This Court’s review of the Department’s decision is *de novo*. *Marlboro Park Hosp. v. S.C. Dept. of Health & Envt’l Control*, 358 S.C. 573, 579, 595 S.E.2d 851, 854 (Ct. App. 2004). Accordingly, this Court can—and should—disregard the Department’s competing applicants determination and find that the applications are not competing. *See Spartanburg Reg’l Med. Center v. Oncology & Hematology Assocs. of S.C. LLC*, 387 S.C. 79, 91, 690 S.E.2d 783, 789 (2010). The Parties should then proceed to a trial, so that this Court can determine whether Grand Strand’s and CRCC’s CON applications comply with the relevant project review criteria.

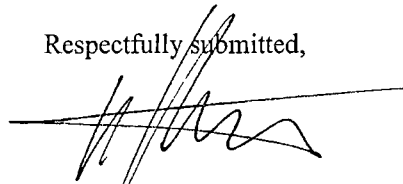
The Parties will likely begin conducting depositions in June 2013. If this Court rules in accordance with the *2012-2013 Plan* and finds that CRCC and Grand Strand are not “competing applicants,” the Court will narrow the issues for trial and the Parties can streamline their

discovery efforts. As such, Grand Strand asks that the Court consider and rule upon its Motion at the earliest opportunity.

CONCLUSION

Because the *2012-2013 Plan* establishes that there is an unmet need for an additional linear accelerator in the Service Area, Grand Strand respectfully requests that this Court issue an order finding that, as a matter of law, Grand Strand and CRCC are not "competing applicants" within the meaning of the CON Act and its regulations.

Respectfully submitted,



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Walter H. Cartin
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Post Office Box 1509
Columbia, South Carolina 29202
(803) 255-8000
(803) 255-8017 (facsimile)

*Attorneys for Grand Strand
Regional Medical Center, LLC*

May 23, 2013
Columbia, South Carolina

CERTIFICATE OF SERVICE

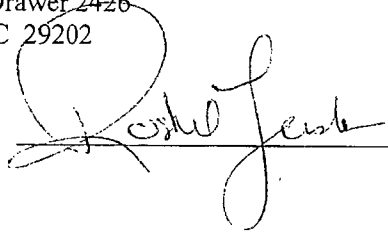
The undersigned hereby certifies that on May 23, 2013, s/he served the foregoing *Grand Strand Regional Medical Center, LLC's Motion for Partial Summary Judgment & Memorandum of Law in Support* on all parties of record as follows:

Via Hand Delivery

Ashley C. Biggers, Esquire
Vito Wicevic, Esquire
SC Department of Health & Environmental Control
2600 Bull Street
Columbia, SC 29201

Via Hand Delivery

James G. Long III, Esquire
Jennifer J. Hollingsworth, Esquire
Nexsen Pruet, LLC
1230 Main Street, Suite 700
Post Office Drawer 2426
Columbia, SC 29202



Columbia, South Carolina

EXHIBIT A

**GRAND STRAND REGIONAL MEDICAL CENTER
MYRTLE BEACH, SOUTH CAROLINA**

**CERTIFICATE OF NEED APPLICATION
FOR THE
ADDITION OF A LINEAR ACCELERATOR
AND CT SIMULATOR**

Submitted To:

**South Carolina Department of Health and
Environmental Control
Division of Certification of Need
1777 St. Julian Place
Columbia, South Carolina 29201**

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- B. An applicant must project that the proposed service will perform a minimum number of treatments equal to 50 percent of capacity annually within three years of initiation of services, without reducing the utilization of the existing machines in the service area below the 80 percent threshold. If the new equipment is a specialized radiotherapy unit as described in Standards 2, 3 or 4 above, then the applicant may propose an annual capacity based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in CON application calculations, as well as future capacity calculations, for that applicant. The applicant must document where the potential patients for this new service will come from and where they are currently being served, to include the expected shift in patient volume from existing providers.

Grand Strand's proposed radiotherapy service will perform a number of treatments by the third year of operation that exceeds 50% of its annual capacity. As a starting point, Grand Strand proposes to acquire a Varian Clinac iX, which will have capability of performing both IMRT and IGRT. As a consequence, the capacity of the proposed linear accelerator will be 5,000 treatments annually.

Grand Strand is currently accredited by the American College of Surgeons as a Community Hospital Cancer Program, which indicates that the facility provides a full range of diagnostic and treatment services for cancer patients, either directly or through referral, and that the members of its medical staff are board certified in the major medical specialties. In 2010, Grand Strand served 4,860 patients with either a primary or secondary diagnosis of cancer. (Source: Grand Strand Internal 2010 data). It is the largest provider of health care services in the three-county area and the most logical location for the needed radiotherapy unit.

Grand Strand coordinates care for cancer patients with the medical oncologists of the Coastal Cancer Center, which has offices in Myrtle Beach, Loris, Conway, and Murrell's Inlet in South Carolina, as well as Supply, North Carolina. Among the services Coastal Cancer Center provides are:

- Chemotherapy
- Hormonal therapy
- Targeted therapy
- Stem cell transplantation
- Biological therapy
- Complementary and alternative medicine

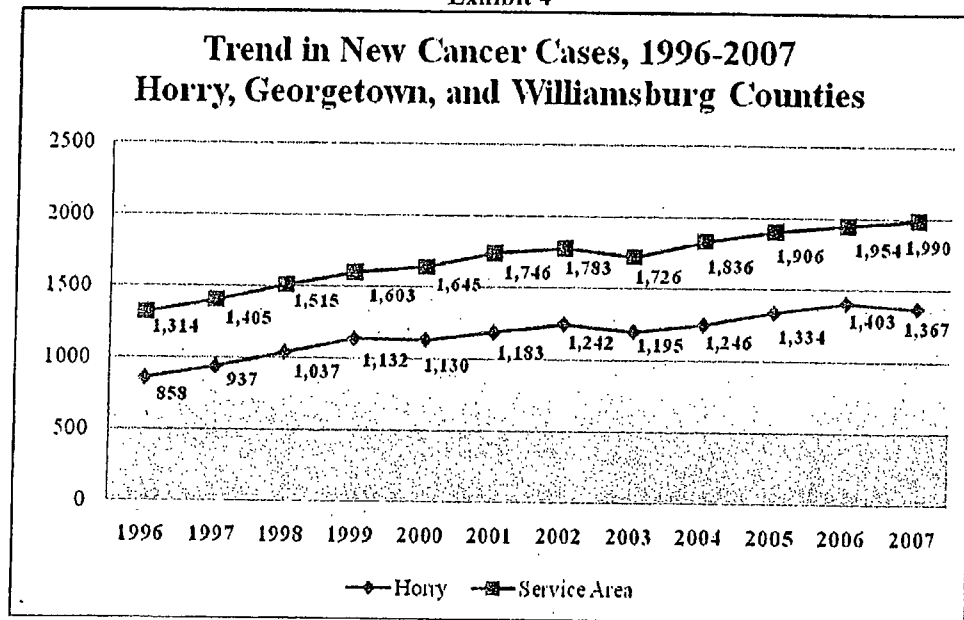
Coastal Cancer Center's principal office is located next to the Grand Strand campus. Cancer patients requiring surgery are usually referred to physicians practicing at Grand Strand. The one service that is not available at Coastal Cancer Center or Grand Strand is

radiation therapy. Currently, patients requiring radiation therapy are referred to CCRC or other providers.

Cancer treatment can be most effective when delivered in a comprehensive setting that permits cancer patients to minimize travel and provides for efficient and effective consultation and coordination among care providers. With the addition of radiotherapy services to a new facility located on Grand Strand's campus, in close proximity to Coastal Cancer Center, there will be a comprehensive cancer setting in Horry County for the first time. Radiation oncologists and medical oncologists will be practicing in close proximity, which will facilitate enhanced treatment planning for patients.

Both Horry County and the three-county service area have seen significant growth in new cancer cases between 1996 and 2007, the most recent year for which data are available from the South Carolina Central Cancer Registry. Horry County's new cancer cases grew by 4.3% annually over this period while the service area grew at 3.8% annually. Significantly, Horry County residents represented 69% of the new cancer patients in the service area in 2007. These trends are presented in Exhibit 4.

Exhibit 4



The age-adjusted cancer incidence rates in the three-county area are presented in Exhibit 5. Georgetown County's age-adjusted incidence rate is somewhat higher than the South

SCORS has not produced recent population projections by age cohort. Data were obtained from Claritas to determine trends in population growth by age cohort in the service area. These projections are presented in Exhibit 10. The Claritas projections closely approximate the SCORS projections. In 2010, the Claritas estimate is only 0.5% higher than the SCORS estimate for the service area. In 2015, Claritas' projection is only 2.3% higher than SCORS's projection. The Claritas projections indicate that the population age 65 and older is projected to increase by 3.8% annually (or 20.7% over the five-year period) in the service area and by 4.3% annually (or 23.6% over the five-year period) in Horry County. The incidence of cancer, and the resulting need for radiotherapy services, is significantly higher among the elderly population than for younger age groups.

Exhibit 10
Grand Strand's Radiotherapy Service Area
Estimated and Projected Population by Age Cohort

2010

County	Under 15	15-44	45-64	65+	Total
Georgetown	11,273	22,330	16,820	10,973	61,396
Horry	48,965	104,291	68,603	47,091	268,950
Williamsburg	6,035	13,496	9,275	6,091	34,897
Total Service Area	66,273	140,117	94,698	64,155	365,243

2011

County	Under 15	15-44	45-64	65+	Total
Georgetown	11,357	22,403	16,788	11,282	61,829
Horry	50,493	105,780	70,154	49,133	275,560
Williamsburg	5,994	13,341	9,141	6,190	34,665
Total Service Area	67,866	141,541	96,115	66,615	372,137

2012

County	Under 15	15-44	45-64	65+	Total
Georgetown	11,442	22,475	16,756	11,600	62,272
Horry	52,069	107,290	71,739	51,264	282,363
Williamsburg	5,954	13,187	9,008	6,290	34,439
Total Service Area	69,498	142,980	97,553	69,169	379,200

Exhibit 14
Grand Strand's Radiotherapy Program
Projected Utilization

	2013	2014	2015
Projected Service Area Patients Requiring Radiotherapy			
Horry	1,008	1,043	1,081
Williamsburg	106	107	107
Georgetown	246	250	254
Projected Grand Strand Radiotherapy Market Share			
Horry	15%	18%	20%
Williamsburg	1%	1%	1%
Georgetown	1%	1%	1%
GSRMC Projected Radiotherapy Patients - Horry County			
Horry	151	188	216
Williamsburg	1	1	1
Georgetown	2	2	3
Total Projected Grand Strand Radiotherapy Patients - Service Area	154	191	220
Percent In-migration	5%	5%	5%
Total Projected Grand Strand Radiotherapy Patients	162	201	232
Expected Treatments per Patient	21	21	21
GSRMC Projected Radiotherapy Treatments	3,234	4,011	4,620
GSRMC Capacity (Treatments)	5,000	5,000	5,000
GSRMC Utilization Rate	64.7%	80.2%	92.4%

Impact on Existing Providers

The approval of Grand Strand's radiotherapy center will not result in either of the existing radiotherapy programs in the service area falling below a utilization rate of 80%. Grand Strand's program should have a *de minimus* effect on Georgetown Memorial

Hospital's program since each program will get its largest number of patients from different counties and will have different referral sources. Some patients will be redirected from the CRCC as a result of this project. Given the projected growth of 194 new radiation therapy patients in the service area between 2010 and 2015 and the fact that Grand Strand projects to serve 220 patients in 2015, the net decrease in CRCC's utilization will be small. Assuming that CCRC were to lose 26 radiotherapy patients in 2015, this would result in a loss of 546 treatments. Based on CCRC's 2010 treatments, with a potential reduction of 546 treatments resulting from the opening of Grand Strand's program, CCRC would still operate at 107.4% of capacity. As a result, both existing programs in the service area should continue to operate at a utilization rate well above 80% after the Grand Strand program becomes operational.

7. **Expansion of an existing service, whether the expansion occurs at the existing site or at an alternate location in the service area, shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for each of the past two years and can project a minimum use rate of 50 percent of capacity per year on the additional equipment within three years of its implementation. If the additional equipment is a specialized radiotherapy unit as described in either Standards 2, 3 or 4 above, then the existing provider may propose an annual capacity for that additional equipment, based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in CON application calculations, as well as future capacity calculations, for that applicant.**

Not applicable. Grand Strand does not have an existing radiation therapy service.

8. **The applicant shall project the utilization of the service and document referral sources for patients within its service area, including letters of support from physicians and health care facilities indicating a willingness to refer patients to the proposed service, with expected annual referral volumes.**

The projection methodology was described in detail in response to Criterion 6B. These projections are supported by letters from a number of physicians practicing in the service area which are included in this application.

9. **The applicant must affirm the following:**

- A. **All treatments provided will be under the control of a board certified or board eligible radiation oncologist;**

Grand Strand will appoint a medical director for the radiation therapy center who is board certified or board eligible in radiation oncology.



C. Earl Hunter, Commissioner

Promoting and protecting the health of the public and the environment.

CERTIFIED MAIL 91 7199 9991 7030 0506 9361

December 28, 2011

Doug White, CEO
Grand Strand Regional Medical Center
809 82nd Parkway
Myrtle Beach, SC 29572

RE: Grand Strand Regional Medical Center
Myrtle Beach, South Carolina

Dear Mr. White:

It is the decision of this Department that a Certificate of Need application submitted by Grand Strand Regional Medical Center for the construction for the establishment of a new radiation therapy service in a center attached to the main hospital be denied.

The Department timely received three (3) Certificate of Need applications proposing to provide radiation therapy services in the radiotherapy service area comprised of Horry, Georgetown and Williamsburg Counties. Carolina Regional Cancer Center ("CRCC") proposed to expand their existing Myrtle Beach radiation therapy service location, whereas both North Strand Radiation Oncology Center ("NSROC") and Grand Strand Regional Medical Center ("GSRMC") proposed to establish a new service. Individually, the Department has determined all applications comply with the 2010-2011 South Carolina Health Plan. However, collectively, there are issues with exceeding the service area need. (See Analysis).

Section 103.6 of Regulation 61-15 "Certification of Need for Health Facilities and Services" defines "Competing applicants" as "two or more persons and/or health care facilities as defined in this regulation who apply for Certificates of Need to provide similar services and/or facilities in the same service area and whose applications if approved would exceed the need for this facility or service." Staff have determined that approval of more than one linear accelerator would exceed the need projected for this service area in the South Carolina Health Plan.

Therefore, Section 307.2 requires that "in the case of competing applications, the Department shall award a Certificate of Need, if appropriate, on the basis of which, if any, most fully complies with the requirements, goals, and purposes of the Certificate of Need program, State Health Plan, project review criteria, and any regulations developed by the Department." Staff concludes CRCC-Conway would better comply with the purpose of CON, with its funding from cash balances, lowest project cost, to include linear accelerator cost (cost containment), rapid ramp up time with advanced equipment in a more economically disadvantaged area (guide the establishment of health facilities and services which will best serve the public's needs), location in Conway (prevent unnecessary duplication) and extensive experience (ensure high quality

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

Health Regulation

2600 Bull Street • Columbia, SC 29201 • www.scdhec.gov

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Mr. White
December 28, 2011
Page 2

services). The SC Health Plan and project review criteria are addressed in the attached analysis. Adverse impact of GSRMC was considered. Staff determined approval of the GSRMC application could have substantial negative impact upon the approved, but appealed, relocated Francis B. Ford Cancer Center as well as the existing CRCC-Myrtle Beach. (See Analysis).

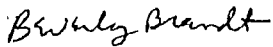
The decision is based upon the written findings contained in the attached Analysis and upon the following conclusions:

1. The applicant has documented the need for the proposed project within the application and the project will increase accessibility and availability of oncology services for residents of Horry County and surrounding areas;
2. The applicant's record is one of successful operation with adequate management experience;
3. Support, documented opposition and adverse effects on other facilities were considered; and,
4. The project appears to be financially feasible and cost effective based on the information available.

The findings pursuant to Section 501, Regulation No. 61-15, Certification of Need for Health Facilities and Services are not applicable to this project.

A copy of the Notice of Appeals Procedure is enclosed for your convenience. If you have any questions, please feel free to contact us at (803) 545-4200.

Sincerely,



Beverly Brandt, Chief
Bureau of Health Facilities and Services Development

Enclosures: Notice of Appeal Procedure
Analysis

cc: Patricia Price, CRCC
Wade Mullins, Esquire, Bruner Powell
Sam Tolbert, Strategic Directions
Dan Westbrook, Esquire, Nelson Mullins
Arnold Green, NSROC
Don Meyer, Moore & Van Allen
Will Thomas, Esquire, Parker Poe

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Notice of Appeal Procedure
Pursuant to S.C. Code Section 44-1-60

1. This decision of the S.C. Department of Health and Environmental Control (Department) becomes the final agency decision 15 calendar days after notice of the decision has been mailed or otherwise sent to the applicant, permittee, licensee and affected persons who have requested in writing to be notified, unless a written request for final review accompanied by a filing fee in the amount of \$100 is filed with the Department by the applicant, permittee, licensee, or affected person.
2. An applicant, permittee, licensee, or affected person who wishes to appeal this decision must file a timely written request for final review with the Clerk of the Board at the following address or by facsimile at 803-898-3393. A filing fee in the amount of \$100 made payable to SC DHEC must also be received by the Clerk within the time allowed for filing a request for final review. However, if a request for final review is filed by facsimile, the filing fee may be mailed to the Clerk of the Board if the envelope is postmarked within the time allowed for filing a request for final review.

Clerk of the Board
SC DHEC
2600 Bull Street
Columbia, SC 29201
3. In order to be timely, a request for final review must be received by the Clerk of the Board within 15 calendar days after notice of the decision has been mailed or otherwise sent to persons entitled to receive notice. If the 15th day occurs on a weekend or State holiday, the request is due to be received by the Clerk of the Board on the next working day. The request for final review must be received by the Clerk of the Board by 5:00 p.m. on the date it is due. A request for final review will be returned to the requestor if the filing fee is not received on time as described above.
4. The request for final review should include the following:
 - a. the grounds on which the Department's decision is challenged and the specific changes sought in the decision
 - b. a statement of any significant issues or factors the Board should consider in deciding whether to conduct a final review conference
 - c. a copy of the Department's decision for which review is requested
5. If a timely request for final review is filed with the Clerk of the Board, the Clerk will provide additional information regarding procedures. If the Board declines in writing to schedule a final review conference, the Department's decision becomes the final agency decision and an applicant, permittee, licensee, or affected person may request a contested case hearing before the Administrative Law Court within 30 calendar days after notice is mailed that the Board declined to hold a final review conference.

The above information is provided as a courtesy; parties are responsible for complying with all applicable legal requirements.

January 7, 2011

000927

R000127

Horry County Linear Accelerator Analysis

Summaries from the November 15, 2011 Project Review Meeting are incorporated by reference.

Background Information

Project Timeline. North Strand Radiation Oncology Center ("NSROC" or "North Strand") and Grand Strand Regional Medical Center ("GSRMC" or "Grand Strand") propose to establish a new service, whereas Carolina Regional Cancer Center ("CRCC") proposes to expand from their existing Myrtle Beach location. The Certificate of Need ("CON") application for NSROC was received on March 9, 2011. The facility is proposed to be located on the campus of Seacoast Medical Center in Little River as a non-profit joint venture between McLeod Regional Medical Center ("MRMC") and Loris Health Services, Inc. ("LHS"). The application for CRCC was received on March 10, 2011 and is proposed to be a facility near the campus of Conway Medical Center, to be named CRCC-Conway. The application for GSRMC, proposed to be a radiation therapy service attached to the main hospital in Myrtle Beach, was received on July 19, 2011. The GSRMC application was the last application to be "deemed complete" with Notification of Affected Persons published in the State Register on October 28, 2011. A Project Review Meeting was held on November 15, 2011.

Regulations. According to Section 101 of Regulation 61-15 "Certification of Need for Health Facilities and Services," the purpose of the Certificate of Need ("CON") program is to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State.

Section 103.6 of R. 61-15 defines "Competing applicants" as "two or more persons and/or health care facilities as defined in this regulation who apply for Certificates of Need to provide similar services and/or facilities in the same service area and whose applications if approved would exceed the need for this facility or service." All three providers filed CON application for a new linear accelerator ("linac"). Based on this definition, staff analyzed to determine if the need would be exceeded if more than one applicant was approved since all three applicants proposed to provide similar services and/or facilities in the same service area. Staff also evaluated compliance with the South Carolina Health Plan ("Plan"), the regulations, project review criteria and the purpose of CON.

Section 307.2 states that "in the case of competing applications, the Department shall award a Certificate of Need, if appropriate, on the basis of which, if any, most fully complies with the requirements, goals, and purposes of the Certificate of Need program, State Health Plan, project review criteria, and any regulations developed by the Department."

Service Area. Within Megavoltage Radiation Therapy Services, the Plan establishes different treatment capacities for different types of linacs. The Plan also has different standards that distinguish between a new service versus expansion of an existing service. As previously stated, NSROC and GSRMC propose to establish a new service, and CRCC-Conway proposes to be the expansion of an existing location.

2010-2011 South Carolina Health Plan. The following are excerpts from the Standards for Megavoltage Radiotherapy (with staff emphasis):

1. The capacity of a conventional linear accelerator, either with or without EPID, is 7,000 treatments per year.
2. Linear accelerators providing IMRT or IGRT have a capacity of 5,000 treatments per year. A facility must document that it is providing or will provide these specialized treatments in sufficient volume to justify why it should be held to this planning capacity.
6. New Radiotherapy services shall only be approved if the following conditions are met:
 - A. All existing units in the service area have performed at a combined use rate of 80 percent of capacity for the year immediately preceding the filing of the applicant's CON application; and
 - B. An applicant must project that the proposed service will perform a minimum number of treatments equal to 50 percent of capacity annually within three years of initiation of services, without reducing the utilization of the existing machines in the service area below the 80 percent threshold. If the new equipment is a specialized radiotherapy unit as described in Standards 2, 3 or 4 above, then the applicant may propose an annual capacity based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in CON application calculations, as well as future capacity calculations, for that applicant. The applicant must document where the potential patients for this new service will come from and where they are currently being served, to include the expected shift in patient volume from existing providers. (Note: Standards 3 and 4 are not applicable to these projects as Standard 3 applies to units with stereotactic capability and Standard 4 applies to stereotactic only units).
7. Expansion of an existing service, whether the expansion occurs at the existing site or at an alternate location in the service area, shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for each of the past two years and can project a minimum use rate of 50 percent of capacity per year on the additional equipment within three years of its implementation. If the additional equipment is a specialized radiotherapy unit as described in either Standards 2, 3 or 4 above, then the existing provider may propose an annual capacity for that additional equipment, based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in CON application calculations, as well as future capacity calculations, for that applicant.
8. The applicant shall project the utilization of the service and document referral sources for patients within its service area, including letters of support from physicians and health care facilities indicating a willingness to refer patients to the proposed service, with expected annual referral volumes.

Target Population / Service Area DHEC defines megavoltage radiotherapy service areas for the state. The service area for the applications under review consists of Georgetown, Horry, and Williamsburg Counties.

The following table presents the SC State Demographer's population projections for the service area and the state:

County	7/1/2009 Estimates	7/1/2010 Projection	7/1/2011 Projection	7/1/2012 Projection	7/1/2013 Projection	7/1/2014 Projection	7/1/2015 Projection
Georgetown	60,700	62,610	63,310	64,030	64,720	65,430	66,130
Horry	263,870	265,360	270,500	275,650	280,790	285,930	291,080
Williamsburg	34,450	35,370	35,350	35,320	35,300	35,270	35,240
Total for Service Area	359,020	363,340	369,160	375,000	380,810	386,630	392,450
South Carolina	4,561,240	4,549,150	4,596,170	4,643,230	4,690,500	4,737,670	4,784,700

Past Utilization of Existing Facilities. There are currently two providers of radiation therapy services in the service area: CRCC and Francis B. Ford Cancer Treatment Center located operated by Georgetown Memorial Hospital ("GMH") in Georgetown, SC.

The following table presents the service area linear accelerator utilization since 2005:

Radiation Treatments	2005	2006	2007	2008	2009	2010
CRCC	15,770	14,032	13,107	14,335	15,613	20,946
GMH	4,217	5,416	5,466	5,903	5,305	5,515
Region Total	19,987	19,448	18,573	20,238	20,918	26,461
Statewide	229,721	236,181	253,349	261,462	264,116	269,016

The treatment capacity for CRCC's three units is 19,000 treatments. CRCC operates one linear accelerator (Tomotherapy) which has a capacity of 5,000 treatments per year and two standard linear accelerators (Varian) having a capacity of 7,000 treatments per year each. The GMH Francis B. Ford linear accelerator has a capacity of 7,000 treatments. Therefore, the total capacity for the service area is 26,000 treatments. For 2009, the service area utilization was 80.5% of capacity and for 2010, the utilization was 101.8% of capacity. Francis B. Ford operated at 75.8% of capacity in 2009 and 78.9% of capacity in 2010. For 2009, the CRCC utilization was 82.2% of capacity and for 2010, the utilization was 110.2% of capacity.

Based on this data, the above Criteria 6A and 7 have been met. In fact, based upon the data, under Criterion 6A, both Grand Strand and North Strand could have applied as a new facility in 2010, but did not. Much analysis has been done regarding the adverse impact, to include as a component of Criterion 6B ("without reducing the utilization of the existing machines in the service area below the 80 percent threshold") and projecting the minimum use rate of 50% of capacity per year within three years.

Project Review Criteria

1. Compliance with the South Carolina Health Plan

Section 801.3 from R.61-15 states "A project does not have to satisfy every criterion in order to be approved, but no project may be approved unless it is consistent with the State Health Plan. A project may be denied if the Department determines that the project does not sufficiently meet one or more of the criteria."

Community Need Documentation – 2a, 2b, 2c, 2e

2a. The target population should be clearly identified as to the size, location, distribution, and socioeconomic status (if applicable).

2b. Projections of anticipated population changes should be reasonable and based upon accepted demographic or statistical methodologies, with assumptions and methodologies clearly presented in the application. The applicant must use population statistics consistent with those generated by the State Demographer, State Budget and Control Board.

2c. The proposed project should provide services that meet an identified (documented) need of the target population. The assumptions and methods used to determine the level of need should be specified in the application and based on a reasonable approach as judged by the reviewing

body. Any deviation from the population projection used in the State Health Plan should be explained.

2e. Current and/or projected utilization should be sufficient to justify the expansion or implementation of the proposed service.

Distribution (Accessibility) – 3a, 3b, 3c, 3e, 3f

3a. Duplication and modernization of services must be justified. Unnecessary duplication of services and unnecessary modernization of services will not be approved.

3b. The proposed service should be located so that it may serve medically underserved areas (or an underserved population segment) and should not unnecessarily duplicate existing services or facilities in the proposed service area.

3c. The location of the proposed service should allow for the delivery of necessary support services in an acceptable period of time and at a reasonable cost.

3e. The applicant must document the means by which a person will have access to its services (e.g. outpatient services, admission by house staff, admission by personal physician).

3f. The applicant should address the extent to which all residents of the area, and in particular low income persons, racial and ethnic minorities, women, the elderly, handicapped persons, and other medically underserved groups, are likely to have access to those services being proposed.

Record of the Applicant – 13a, 13b

13a. The applicant's record should be one of successful operation with adequate management experience.

13b. The applicant should have a demonstrated ability to obtain necessary capital financing.

2. Acceptability – 4a

4a. The proposal and applicant should have the support of "affected persons" (including local providers and the target population). The lack of opposition should not be considered support for the purposes of these criteria. Staff will also consider, 4b, which states: Where documented opposition exists to a proposal, such opposition will be considered along with the application.

Distribution – 22

22. The existing distribution of the health service(s) should be identified and the effect of the proposed project upon that distribution should be carefully considered to functionally balance the distribution to the target population.

Adverse Effects on Other Facilities – 23a

23a. The impact on the current and projected occupancy rates or use rates of existing facilities and services should be weighed against the increased accessibility offered by the proposed services.

3. Financial Feasibility – 15

15. The applicant must have projected both the immediate and long-term financial feasibility of the proposal. Such projection should be reasonable and based upon accepted accounting procedures.

Cost Containment – 16a, 16c

16a. The applicant should have identified and sought alternative sources and/or methods of funding and demonstrated that the method chosen was the most feasible option.

16c. The impact of the project upon the applicant's cost to provide services and the applicant's patient charges should be reasonable. The impact of the project upon the cost and charges of other providers of similar services should be considered if the data are available.

Projected Revenue/Projected Expenses – 6a, 7

6a. The proposed charges should be comparable to those charges established by other facilities for similar services within the service area or state. The applicant should document how the proposed charges were calculated.

7. Projections of construction costs, start-up costs, operating costs, debt service, depreciation, manpower costs, etc. should be consistent with those experienced by similar facilities offering a similar level and scope of services (with proper consideration given to such factors as inflation, cost of capital, etc.).

North Strand Radiation Oncology Center

Total Project Cost = \$9,522,745

Linear Accelerator: Varian Clinac iX (\$2,811,534)

Facility = 5,500 square feet

It is noted that a letter of May 24, 2011 from Arnold Green, President, Loris Health Services, Inc., states that one of the members of NSROC has changed from Loris Community Hospital District to a non-profit affiliated corporation, Loris Health Services, Inc. However, during the November 15 Project Review Meeting, NSROC indicated Loris Community Hospital District as a partner in the joint venture without explanation.

1. Compliance with the South Carolina Health Plan- Standards for Radiotherapy

North Strand addressed all standards. Letters indicated support from physicians (including six from Coastal Cancer Center and five from Southern Medical Associates) and healthcare facilities (Loris Community Hospital) for the project, but North Strand did not provide documentation by any physician or group of a willingness to refer patients to the proposed service, with expected annual referral volumes as required by Standard 8. Dr. Lawrence Holt, Jr. with Coastal Cancer Center, the physician group that also provided letters of support for the other two applicants, stated in a letter of November 29, 2011 they want to reaffirm their support for the project and intend to establish physician offices and chemotherapy services on the campus of Seacoast Medical Center in order to demonstrate their willingness to work with NSROC. However, the letter did not specifically state a willingness to refer patients. North Strand indicated during project review that they expect to receive referrals from a broad range of physicians, including the medical staffs of Loris and McLeod and the physicians of Coastal Cancer Center. The referrals from McLeod were not explained or quantified. Staff questions the likely number of referrals from a facility 80 miles away in another service area. It is questionable that Criterion 8 was met. See also Community Need Documentation and Adverse Impact.

Community Need Documentation – 2a, 2b, 2c, 2e

The applicant clearly identified the target population. NSROC's proposed service area includes the following ZIP Codes: 29511, 29526, 29544, 29545, 29566, 29568, 29569, 29581, and

29582, which are located within northeastern Horry County. NSROC also stated Northern Horry County as the target population they will serve. Population projections were clearly presented.

Exhibit 3 presents LHS's ZIP Code specific patient origin for patients who received a cancer diagnosis in Fiscal Year 2009. This exhibit shows LHS rendered healthcare services to 1,154 patients from NSROC's expected service area, during the period, which is less than other applicants. Another 508 cancer patients were served by LHS from the immediately adjacent areas of North Carolina, which is a notable portion of LHS's total cancer patients.

Exhibit 3
Loris Healthcare Cancer Patient Origin
FY 2009

<u>Zip Code</u>	<u>Total Patients</u>	<u>Percent of Total</u>	<u>Cumulative Percent</u>
29569	415	21.6%	21.6%
29566	227	11.8%	33.4%
29568	168	8.7%	42.1%
29582	130	6.8%	48.9%
29526	75	3.9%	52.8%
29581	51	2.7%	55.4%
29545	50	2.6%	58.0%
29511	29	1.5%	59.5%
29544	9	0.5%	60.0%
<i>SC Service Area</i>	<i>1,154</i>		
28463	203	10.6%	70.6%
28467	188	9.8%	80.3%
28468	40	2.1%	82.4%
28431	29	1.5%	83.9%
28472	28	1.5%	85.4%
28469	20	1.0%	86.4%
<i>Adjacent NC ZIPs</i>	<i>508</i>		
All Other SC	112	5.8%	92.3%
All Other NC	91	4.7%	97.0%
All Other	58	3.0%	100.0%
Total	1,923		

Source: Loris Internal Data

In addition, staff notes that of the 1,154 patients LHS rendered service to with a cancer diagnosis in FY2009, only 6.8% (130 patients) were from the North Myrtle Beach ZIP code and 3.9% (75 patients) from the Conway ZIP code. There were 508 cancer patients, or 26.5%, originating from NC, but out of state utilization cannot be used to demonstrate need. While Loris accounted for 21.6% of patients (415), Little River only accounted for 11.8%.

NSROC cited geographic distance and travel time as barriers. They state there is no direct provider in NSROC's proposed service area, mention residents from Little River, North Myrtle Beach and Loris, but do acknowledge radiation therapy services currently provided by CRCC and GMH. Data from CRCC indicates 22% of their patients originate from North Myrtle Beach, with 6% from the Loris area. Staff do not concur with NSROC's conclusion that residents do not

have reasonable access to radiation therapy services because of such remote locations and high traffic congestion roads. NSROC provided a chart with the closest providers of radiation therapy services to NSROC's proposed service area and indicated CRCC to be 16.4 miles away. Furthermore, North Strand classifies CRCC as being in Southern Horry County, but staff does not concur with this classification. The proposed North Strand location is shown to be 20.6 miles from Loris, with the CRCC-Conway location at 24.9 miles – a distance that is not appreciably greater. Conway, the area with the greatest population in the North Strand service area, is twice as distant at 22 miles, from NSROC than CRCC-Conway.

NSROC cited a drive time study that indicated a "portion of eastern Horry County" is currently outside of a 30-minute driving range to CRCC and considers the area to be underserved. These areas appear to include towns such as Longs, Worshams Ferry and Little River. Furthermore, North Strand cites travel impediments such as motor vehicle accidents, poor weather conditions, road construction, and special events, but staff maintain these could occur in any part of the service area.

North Strand provided travel time and traffic count data. But counters near all proposed locations, including the site for each applicant, indicated substantially higher counts during "tourist season." Staff concludes the study over emphasizes the alleged negative ramifications of the CRCC's proposed location.

North Strand stated that the northern Horry County area where they propose to locate is the fastest growing community in the Grand Strand and the population base in the service area is sufficiently large enough to justify this service (Exhibit 5, Project Review Summary). However, staff notes that Conway (ZIP code 29526) is the area of the highest population concentration followed by North Myrtle Beach (ZIP code 29582). It is noted that CRCC is currently serving this population with a patient origin of 22% for the Conway area and 22% for North Myrtle Beach. Staff feels it is not logical for North Strand's service area to encompass Conway and North Myrtle Beach, but not Myrtle Beach, as that area currently accounts for 20% of the CRCC patient origin.

Of the 1,154 patients LHS rendered service to with a cancer diagnosis in FY2009, only 6.8% (130 patients) were from North Myrtle Beach ZIP code and 3.9% (5 patients) from the Conway ZIP code. There were 508 LHS cancer patients, or 26.5%, originating from identified NC ZIP codes, but out of state utilization cannot be used to demonstrate need. Staff notes that Grand Strand had 4,860 patients with a primary or secondary cancer diagnosis in 2010 as opposed to North Strand's 1,154 patients in 2009. The Loris ZIP code accounted for 21.6% of LHS patients, 11.8% from Little River and 8.7% from Longs. Forty percent of patients originated from outside of the proposed service area, including over 30% from North Carolina when including "other NC."

For FY2010, LHS referred 637 cancer patients for radiation therapy, which is around 55% of patients diagnosed with cancer. Of these cases, 414 were from the service area (65%), 183 were from NC (29%) and 28 were "Other SC", 12 were "Other." Even though North Strand continues to project 29% of all cancer patients to originate from North Carolina, they projected 85% of radiation therapy patients to originate from the service area and around 10% from NC, which appears to be inconsistent.

North Strand assumes 25 visits (treatments) per patient and indicated in its project review presentation that "a course of treatment may mean up to 30 treatments per patient." North Strand projects being at 6,377 treatments or 127.5% of capacity by Year 3. This is substantially higher

than the 5,100 treatments projected by CRCC, a current provider, and 4,620 by Grand Strand, for Year 3. Staff is concerned the North Strand projections are neither reasonable nor achievable. North Strand indicated CRCC would maintain a utilization rate of over 80%, but did not specifically address the quantity.

North Strand expects to achieve its projected utilization (4,042 treatments in 2013, 5,797 in 2014 and 6,482 in 2015) largely due to the "benefit of the availability of McLeod Regional Medical Center's experience with operating a radiation therapy program." Staff does not argue this is of benefit, but feels the projections are unrealistically high and unachievable. Thus, compliance with the "50 percent of capacity" portion of Standard 6B is questionable. NSROC's project review presentation also stated the projections were based upon "McLeod's experience operating similar equipment" but did not provide details. Success of the project could be limited by the fact that MRMC is 80 miles away and the proposed location in Little River is adjacent to a recently opened small community hospital (Seacoast Medical Center) with only 50 beds and limited services.

Distribution (Accessibility) – 3a, 3b, 3c, 3e, 3f

North Strand claims to be the only applicant applying to serve the medically underserved area of northern Horry County and is not proposing to be located near existing providers. However, their proposed location is only 16 miles from the current Myrtle Beach location of CRCC. While North Strand considered actual cancer referral data from Coastal Cancer Center, it is noted that their physicians provided letters of support for the other two applicants.

North Strand is correct in stating there are no radiation therapy providers in northern Horry County, but clearly this area is currently being served by CRCC. Again, North Myrtle Beach is being served geographically by CRCC and their proposed Conway location will provide geographical access to these areas as well as the population center on Conway. While the CRCC-Conway and Grand Strand projects are not in northern Horry County, staff believes a location in Conway would better increase accessibility to these more rural areas. Furthermore, according to the travel time and distance data provided by North Strand, the rural areas of Nichols and Green Sea are approximately the same distance from CRCC-Conway as from NSROC, accounting for 5% of NSROC's proposed service area population as projected for 2015. The NSROC location in Little River is considerably closer to Little River and Longs (22.5% of 2015 population projection) than CRCC-Conway, but much further away from Aynor, Conway and Galivant's Ferry (41.5% of 2015 population projection). The remaining areas are North Myrtle Beach and Loris (20.6 miles from NSROC and 24.9 miles from CRCC-Conway). Note that this data is limited by the fact that it appears to pick a point in each ZIP code area and it would be useful to view the ZIP code map geographically. NSROC also cites tourist seasonal congestion reported on certain traffic counters, but the count for all project locations increased substantially during the July period when traffic was the heaviest as expected.

North Strand compares demographics between the Conway and Loris areas. While Loris has a higher rate of poverty, the rates are both substantially less than that of Myrtle Beach or North Myrtle Beach.

During project review, North Strand presented many testimonials from patients, one of whom mentioned traveling more than once daily to receive treatments. Project representatives admitted this occurs rarely and did not further quantify this occurrence. North Strand again mentioned in their November 28, 2011 correspondence that "NSROC will eliminate the need for northern

Horry County patients to travel long distances sometimes multiple times daily to receive treatments at different locations" but provided no data to support this statement.

North Strand will offer access to support services to accommodate the needs of their patients and has documented means by which a person will have access to its services.

Staff concludes all applicants demonstrate financial accessibility. The following table compares projected payor sources and financial accessibility among the applicants:

	CRCC	GSRMC	NSROC
Medicare	53.6%	51.8%	31.0%
Medicaid	3.3%	6.1%	11.0%
Self pay	1.6%	3.3%	6.4%
Charity Care	\$326,215	\$151,000	\$629,942
Charity Care % of Gross Revenue	2.5%	3.3%	5.4%

Record of the Applicant – 13a, 13b

North Strand expects to benefit from the availability of McLeod Regional Medical Center's experience with operating a radiation therapy program. Loris Healthcare System and MRMC have had a 15 year history of collaboration. As of January 12, 2012, McLeod will be the owner of the Loris Healthcare System. MRMC has extensive experience in providing radiation therapy.

2. Acceptability – 4a

North Strand received approximately 50 letters of support from patients, physicians and community leaders, which were substantially less letters of support than for Grand Strand or CRCC. Opposition to the project by Grand Strand and CRCC was considered. Dr. Lawrence Holt, Jr. with Coastal Cancer Center, the physician group that also provided letters of support for the other two applicants, stated in a letter of November 29, 2011 they want to reaffirm their support for the project and intend to establish physician offices and chemotherapy services on the campus of Seacoast Medical Center in order to demonstrate their willingness to work with NSROC.

Distribution – 22

The existing distribution and the effect of the proposed project upon that distribution was identified. See Community Need Documentation and Distribution (Accessibility)

Adverse Effects on Other Facilities – 23a

North Strand alleges no adverse impact upon "any other planning area providers." However there will be an adverse impact upon CRCC as their 2010 patient origin data indicates 22% from the Conway area, 22% from the North Myrtle Beach area and 6% from the Loris area.

3. Financial Feasibility – 15

The proposed project appears to be financially feasible and will realize a negative balance during the first year of operation, a slight profit during the second year and a modest profit during the third year. As previously indicated, McLeod Health will be purchasing LHS, but the financial impact of this purchase was not disclosed. However, the utilization projections, thus the financial projections, are questionable (See Community Need Documentation).

The CFOs for both LHS and McLeod Health confirmed availability of funds for the proposed project. The project will be funded through equal capital contributions from NSROC's two members, McLeod Regional Medical Center ("MRMC") and Loris Health Services, Inc., each having 50% ownership. Loris Healthcare System ("LHS") and MRMC expect to contribute a total of up to \$4,761,373 towards the capital funds needed to implement the project, and contribute additional money to provide start up working capital. LHS and MRMC will finance the capital cost from existing cash reserves.

Cost Containment – 16a, 16c

North Strand addressed cost containment and identified methods and availability of funding. The impact of the applicant's cost to provide services was documented.

Projected Revenue/Projected Expenses – 6a, 7

Proposed charges and cost projections appear to be reasonable. However, the utilization projections, thus the financial projections, are questionable (See Community Need Documentation).

Grand Strand Regional Medical Center

Total Project Cost = \$9,788,625
Linear Accelerator: Varian Clinac iX (\$2,812,533)
Facility = 9,519 square feet

1. Compliance with the South Carolina Health Plan

Grand Strand addressed all of the standards in the Plan. In a letter of November 16, 2011, Daniel Sullivan of the Sullivan Consulting Group responded to the staff request to provide information from Standard 8. Many letters expressed a willingness to refer, but did not quantify referral volumes. Mr. Sullivan stated most physician specialties do not refer patients directly to radiation therapy centers, but typically a primary care physician or a general surgeon, upon diagnosing cancer in a patient, would refer the patient to a medical oncologist to determine the most appropriate type of treatment. Six oncologists from Coastal Cancer Center provided letters of support.

Community Need Documentation – 2a, 2b, 2c, 2e

The applicant clearly identified the target population. Grand Strand is in the three-county service area that includes Georgetown, Horry, and Williamsburg Counties. Population projections were clearly presented. Grand Strand stated that for radiotherapy services, Horry County would be the primary service area and Georgetown and Williamsburg Counties would be the secondary service area.

When calculating existing utilization, it is noted that Grand Strand repeatedly assigns GMH a capacity of 5,000 treatments, but the facility has stated their capacity is 7,000 treatments and this capacity is reflected in the Plan.

According to 2008 DHEC data, there were 2,391 new cancer cases in the service area. Based on internal data, Grand Strand had 4,860 patients with a primary or secondary cancer diagnosis, currently referring them to CRCC or other providers. Grand Strand states they coordinate care for cancer patients with the medical oncologists of the Coastal Cancer Center. The oncologists also refer cancer patients requiring surgery to Grand Strand.

Grand Strand projects to capture 20% of Horry County patients (216 patients) plus 5% immigration (12 cases) for a total of 232 patients. They claim they will only be taking 26 patients (546 treatments) from CRCC in 2015. However, staff projects the impact will be greater. Based upon 55% of cancer patients requiring radiotherapy, Grand Strand projects the service area to have 1,249 radiotherapy cases in 2010 and 1,442 cases in 2015, resulting in an increase of 194 patients, which includes 173 Horry County patients. In order to achieve the projected 232 patients, Grand Strand would have to capture 100% of the additional 173 patients plus 43 CRCC patients to total 216 Horry County patients. Therefore, the impact upon CRCC of losing 26 patients does not appear to be accurate. Even at the higher number of patients taken from CRCC, it does not appear to decrease CRCC below 80% of capacity.

Grand Strand stated in a November 16, 2011 letter from Daniel Sullivan that a notable exception to the typical referral pattern is the case of the urologists in Horry County, most of which belong to the Atlantic Urology group that owns CRCC. Mr. Sullivan expects nearly 100% of these urological referrals to go to CRCC and this was considered in Grand Strand's utilization projections, though they were not quantified.

Distribution (Accessibility) – 3a, 3b, 3c, 3e, 3f

The staff concurs cancer treatment can be most effective when delivered in a comprehensive setting. However, GSRMC does not propose any inpatient treatments according to their pro forma. Staff concurs it is advantageous to have radiation oncologists and medical oncologists practicing in close proximity. Both Grand Strand and the main office for CRCC are both located within a few miles of Coastal Cancer Center, the primary referral source in that area for cancer treatment.

CRCC maintains that Conway Regional Medical Center and Loris Community Hospital will not refer patients for radiation therapy to Grand Strand. This is a reasonable concern and could limit accessibility. It is noted these facilities did not provide letters of support for Grand Strand.

The project will not increase geographic access since CRCC is currently located in Myrtle Beach in close proximity to Grand Strand. The Grand Strand project could provide greater access to inpatients at the hospital in need of cancer treatment services; however, their pro formas indicate no income from inpatients for this project.

Grand Strand will offer access to support services to accommodate the needs of their patients and has documented means by which a person will have access to its services.

Staff concludes all applicants demonstrate financial accessibility. The following table compares projected payor sources and financial accessibility among the applicants:

	CRCC	GSRMC	NSROC
Medicare	53.6%	51.8%	31.0%
Medicaid	3.3%	6.1%	11.0%
Self pay	1.6%	3.3%	6.4%
Charity Care	\$326,215	\$151,000	\$629,942
Charity Care % of Gross Revenue	2.5%	3.3%	5.4%

Record of the Applicant – 13a, 13b

Grand Strand has been providing health care services to the residents of Horry County since it opened in 1978. Services range from a Level III Trauma Center to the open-heart surgery program opened in June of 1995. Grand Strand is currently accredited by the American College of Surgeons as a Community Hospital Cancer Program. It is the service area's largest and most comprehensive tertiary care hospital. Grand Strand is a subsidiary of Hospital Corporation of America, Inc. (HCA), that provides a broad resource base of administrative and technical expertise in hospital operations.

2. Acceptability – 4a

Grand Strand has garnered significant support for this project, with over 240 letters of support. There were approximately 100 letters of support from physicians, 4 letters from elected officials and around 140 community letters. The majority of the community letters were from H2U members. H2U or Health to You, promotes living a healthy lifestyle and offers memberships through Grand Strand for health and wellness information, discounts, invitations to hospital sponsored activities, etc. Strand Orthopaedic Consultants supported this project as well as the CRCC project. Staff from Coastal Cancer Center supported this as well as the other two projects.

Staff considered opposition to the project. CRCC, North Strand and Georgetown Hospital System ("GHS") filed as affected persons opposing this project. See Adverse Effects.

Distribution – 22

The existing distribution and the effect of the proposed project upon that distribution was identified. See Community Need Documentation and Distribution (Accessibility)

Adverse Effects on Other Facilities – 23a

In the November 16, 2011 letter from Daniel Sullivan of Sullivan Consulting Group, Inc., a statement was made regarding Coastal Cancer Center that these physicians "serve a high percentage of the cancer patients in Horry County, and because Coastal's main office is next to the GSRMC campus and many of its patients receive chemotherapy treatment at the main office, it is reasonable to conclude that a significant percentage of Coastal's patients from the service area will choose GSRMC for radiation treatment." Mr. Sullivan did not quantify the percentage or number of patients, but "significant percentage" implies a sizeable impact upon the existing provider, CRCC, and Grand Strand projects serving 223 radiation therapy patients in the third year of operation.

Staff concludes there is adverse impact with this project and the approved relocation of the Francis B. Ford Cancer Treatment Center. A review of the proposed service area in the Francis B. Ford CON application indicates that there are six (6) overlapping ZIP codes with the Francis B. Ford project and the Grand Strand primary service area. The 6 ZIP codes account for 36.6% of the 2009 Francis B. Ford cancer patient origin and 48.2% of Grand Strand's 2010 inpatient discharges.

3. Financial Feasibility – 15

GSRMC proposes to fund the project from capital funds provided by HCA, which will be derived through internally generated and borrowed funds that are included in HCA's cash reserves. Grand Strand is owned by Healthtrust, Inc. – The Hospital Company, that is in turn, owned by HCA Inc.

Cost Containment – 16a, 16c

GSRMC addressed cost containment and identified methods of funding and demonstrated feasibility of this option. The impact of the applicant's cost to provide services was documented. GSRMC's project costs and patient charges appear to be reasonable.

Projected Revenue/Projected Expenses – 6a, 7

Proposed charges and cost projections appear to be reasonable.

Carolina Regional Cancer Center - Conway

Total Project Cost = \$9,522,745

Linear Accelerator: Varian TrueBeam (\$2,413,894)

Facility = 3,616 square feet

1. Compliance with the South Carolina Health Plan

CRCC demonstrated compliance with all standards in the Plan. A listing of patient referrals by referring physician for the previous 12 months was provided (November 2010 through October 2011). For a total unique patient count of 1,000 patients, 360 patients, or 36% of the total, were from Atlantic Urology. Coastal Cancer Center ("CCC") physicians accounted for 263 or 26.3% of referred patients. It is noted that three of the letters, from CCC physicians specifically mentioned a willingness to refer patients as required by Standard 8. Even though "expected annual referral volumes" were not provided, current volumes were provided from all referral sources. In their response to Item B-10, CRCC stated that 98% of its patients are from physician referrals, mostly from an attending physician.

2. Community Need Documentation – 2a, 2b, 2c, 2e

The applicant clearly identified the target population. CRCC treats patients from Georgetown, Horry, and Williamsburg Counties and considers the region to be its service area. Population projections were clearly presented.

Zip codes were grouped into six market areas based on geography and the following table summarizes the percent of CRCC patients from each area and the 2015 population projection

provided by Nielsen/Claritas.

Table 8 – Patient Origin in Service Area

Area	CRCC Patient Origin	2015 Population Projection*
Conway Area	22%	80,355
Georgetown Area & Williamsburg County	1%	72,415
Loris Area	6%	24,588
Murrells Inlet Area	29%	100,778
Myrtle Beach Area	20%	71,438
North Myrtle Beach Area	22%	53,310
Total	100%	402,884

The percentages are based on 495 patients from within the service area during the last six months of 2010. CRCC treated 571 total patients during this time period with 76 of those patients coming from locations outside of the three-county service area (22 from other locations in SC, 44 from NC, and 10 from other locations).

More than 22% of CRCC's patients live in the Conway area while 6% live in the Loris area. Combined, these two areas account for more than 28% of CRCC's patient volume. These patients would be served by a cancer treatment center in Conway, SC.

Projected Utilization. CRCC is proposing the expansion of an existing service based on its current patient volume and the unmet need in the Conway-Loris area. The following table projects the number of linear accelerator radiation treatments with two CRCC locations in the service area:

Table 10

Radiation Treatments	2009	2010	2011	2012	2013	2014
CRCC-Myrtle Beach	15,613	20,946	22,419	18,258	18,717	19,185
CRCC-Conway	NA	NA	NA	4,854	4,976	5,100
Total Treatments	15,613	20,946	22,419	23,112	23,693	24,285
Change over prev. year		34.2%	7.0%	3.1%	2.5%	2.5%

CRCC has experienced significant growth in utilization during 2010. The total treatments at CRCC grew 34.2% from 2009 to 2010 alone. To calculate projected utilization, a more conservative growth rate of 2.5% was applied. This is in contrast to the substantial growth experienced in 2010, which is attributed to the purchase of the facility by 21st Century Oncology. As previously shown, approximately 28% of CRCC's patients come from Conway and Loris area. CRCC conservatively expects that 75% of their patients from the Conway and Loris area will utilize the proposed linear accelerator located in Conway (i.e. 21% of their current patients will utilize CRCC-Conway).

Distribution (Accessibility) – 3a, 3b, 3c, 3e, 3f

This project projects the quickest implementation time with approximately six months, taking advantage of the existing vault, which will facilitate accessibility. This project will also improve the geographic accessibility for patients in the service area, especially those in the Conway and Loris areas. It is noted that the Conway area has a lower socio-economic status and the proposed site is more accessible to rural portions of the service area. North Strand promotes the accessibility of its site, but staff feels the sites are equally accessible and further notes that the

distance between Loris and Conway is approximately the same distance as Loris and Little River, the proposed site for NSROC. The Conway site is centrally located; serving more inland residents and accessible to rural residents.

Currently CRCC is operating 12 hour shifts to meet the current demand since they are operating well over capacity. Placing an additional accelerator in an area that currently accounts for 28% of patients will relieve capacity constraints.

Staff notes that the proposed Varian Trilogy True Beam system is more advanced than the iX systems proposed by the other applicants. Specifications for the unit include a higher dose rate, image guidance during treatment and is faster and more precise. Information from the manufacturer, Varian, supports the True Beam as being a more advanced system.

CRCC stated they will offer access to support services to accommodate the needs of their patients. CRCC adequately documented means by which a person will have access to its services (See Compliance with the SC Health Plan).

The following table presents the total amounts of indigent care provided by CRCC:

	2008	2009	2010
Gross Charges	\$35,959,784	\$36,978,776	\$46,520,118
Indigent Care	\$990,254	\$771,022	\$1,237,664
As % of Gross	2.8%	2.1%	2.7%

Projected:

	2011	2012	2013	2014
Gross Charges	\$59,574,787	\$61,417,306	\$62,952,739	\$64,526,557
Indigent Care	\$1,470,051	\$1,515,516	\$1,553,404	\$1,592,239
As % of Gross	2.5%	2.5%	2.5%	2.5%

The following table compares projected payor sources and financial accessibility among the applicants for each respective project, which indicates all applicants demonstrate financial accessibility:

	CRCC	GSRMC	NSROC
Medicare	53.6%	51.8%	31.0%
Medicaid	3.3%	6.1%	11.0%
Self pay	1.6%	3.3%	6.4%
Charity Care	\$326,215	\$151,000	\$629,942
Charity Care % of Gross Revenue	2.5%	3.3%	5.4%

Record of the Applicant – 13a, 13b

CRCC has provided radiation therapy services in the region for three decades. The center is accredited by the American College of Radiology (ACR), which has very high standards of compliance regarding radiological services. CRCC's current equipment appears focused on state of the art technology as evidenced by the tomotherapy unit and a recently replaced linear accelerator. CRCC has a 38 member team and has access to clinical trials.

3. Acceptability – 4a

CRCC has demonstrated strong support for this project, with over 100 letters of support. There were approximately 76 letters of support from medical providers, including 18 from Conway Medical Center. Strand Orthopaedic Consultants supported this project as well as the Grand Strand project. Staff from Coastal Cancer Center supported this as well as the other two projects. The community letters of support included over a dozen political letters (City of Conway, Town of Surfside Beach, etc.) and around 12 other community letters, such as from Agape Hospice and Mercy Care Hospice.

Staff considered opposition to the project. Grand Strand, North Strand and Georgetown Hospital System ("GHS") filed as affected persons opposing this project. See Adverse Impact.

Distribution – 22

The existing distribution and the effect of the proposed project upon that distribution was identified. See Community Need Documentation and Distribution (Accessibility).

Adverse Effects on Other Facilities – 23a

GHS contends that approval would significantly impact the recently approved Murrells Inlet projects with CRCC-Conway being 13 miles from the proposed relocation of Francis B. Ford. GHS mentions lack of need and significant adverse impact, but did not provide any data to support these claims. GHS feels approval of a linear accelerator in proximity to the recently approved projects without first allowing these providers to implement their projects would not constitute sound health planning. GHS claims the relocation was based on proving increased access to the majority of GHS patients who live in northern Georgetown and Horry Counties. Allowing another provider to enter the market would jeopardize the financial viability of their project. Staff notes that CRCC considered its Conway project within its Murrells Inlet application. Both projects are currently under appeal in the Administrative Law Court and staff is unsure at this time if or when the projects will be implemented. CRCC proposes to serve an existing market as the patient origin data indicated 22% of their patients are from the Conway area and only 1% are from the Georgetown area and Williamsburg County, areas proposed to be served by Francis B. Ford. CRCC also predicted a conservative growth rate of 2.5%.

4. Financial Feasibility – 15 (See also Cost Containment)

The pro formas show a profit during all years submitted – 2012 through 2015. Staff requested a breakdown showing the Murrells Inlet project, which is shown below:

2012				2013			
Myrtle Beach	Conway	Murrells Inlet	Combined	Myrtle Beach	Conway	Murrells Inlet	Combined
Gross Charges	\$48,519,672	\$12,897,834	\$-	\$61,417,306	\$37,142,116	\$13,220,075	\$12,590,548
Net Charges	\$17,655,993	\$4,693,365	\$-	\$22,349,368	\$13,514,933	\$4,810,699	\$4,581,618
Total Operating Expenses	\$7,791,255	\$2,736,630	\$-	\$10,527,785	\$7,168,178	\$2,807,597	\$3,310,133
Income Before Income Taxes	\$9,776,863	\$1,933,476	\$-	\$11,710,339	\$6,261,014	\$1,979,703	\$1,249,200
Net Income	\$6,012,771	\$1,189,088	\$-	\$7,201,859	\$3,850,524	\$1,217,517	\$758,258
Treatment Volume	18,258	4,854	23,112	13,978	4,978	4,739	23,693
2014				2015			
Myrtle Beach	Conway	Murrells Inlet	Combined	Myrtle Beach	Conway	Murrells Inlet	Combined
Gross Charges	\$38,070,689	\$13,550,577	\$12,096,311	\$64,528,557	\$39,022,438	\$13,889,341	\$13,227,944
Net Charges	\$13,550,577	\$4,693,365	\$-	\$18,243,942	\$13,514,933	\$4,810,699	\$4,581,618
Total Operating Expenses	\$7,791,255	\$2,736,630	\$-	\$10,527,785	\$7,168,178	\$2,807,597	\$3,310,133
Income Before Income Taxes	\$9,776,863	\$1,933,476	\$-	\$11,710,339	\$6,261,014	\$1,979,703	\$1,249,200
Net Income	\$6,012,771	\$1,189,088	\$-	\$7,201,859	\$3,850,524	\$1,217,517	\$758,258
Treatment Volume	18,258	4,854	23,112	13,978	4,978	4,739	23,693

Net Charges	\$13,853,669	\$4,930,967	\$4,698,158	\$23,480,794	\$14,200,010	\$5,054,241	\$4,813,562	\$24,067,813
Total Operating Expenses	\$7,294,845	\$2,852,050	\$3,349,334	\$13,496,229	\$7,403,779	\$2,897,495	\$3,389,365	\$13,690,039
Income Before Income Taxes	\$6,491,439	\$2,054,932	\$1,323,902	\$9,870,353	\$6,727,181	\$2,132,182	\$1,400,784	\$10,260,107
Net Income	\$3,992,235	\$1,263,783	\$814,249	\$8,070,287	\$4,137,204	\$1,311,280	\$881,482	\$8,309,966
Treatment Volume	14,328	5,100	4,857	24,285	14,687	5,227	4,970	24,892

With an existing lease already in place for a specialty-built medical building with a radiation therapy vault and shielded area for a CT simulator, CRCC can have the new center and linear accelerator giving treatments within a matter of months from the receipt of the CON. Staff notes that North Strand claims the CRCC building is inadequately designed and does not promote operational efficiency. Staff concludes the building is much smaller without extra space for a conference room, etc., but 21st Century possesses much experience and should be able to make the very conservative design work. CRCC appears to have budgeted substantial funds to renovate the building.

Cost Containment – 16a, 16c

CRCC adequately addressed cost containment. They identified methods of funding and demonstrated the method chosen as the most feasible option. Radiation Therapy Services, Inc. (RTSI) indicates that they plan to finance the project with existing operating reserves but may lease the linear accelerator or choose to finance some of the costs through borrowing arrangements with lenders. They stated that CRCC and RTSI have the resources and credit rating to fully finance the project. RTSI has at its disposal cash from operations in excess of \$23 million as of March 31, 2011. Patient charges were also indicated to be reasonable.

The applicant also provided the following to demonstrate cost containment: use of existing building; least total project cost, substantially lower than the other projects; shorter time-frame to bring their new linear accelerator online; large discounts on equipment and medical supplies available due to being a subsidiary of one of the nation's largest providers of radiation therapy services; economies of scale by the sharing of administrative support, computer systems, etc.; state of the art Varian TrueBeam System; clinical, operational, management and financial resources from 21st Century Oncology/Radiation Therapy Services, Inc.

Projected Revenue/Projected Expenses – 6a, 7

Pro formas were also submitted without the Murrells Inlet location (prior to its approval). Proposed charges and cost projections appear to be reasonable.

Conclusion

Staff has determined the applications are competing. CRCC, GSRMC, and NSROC each applied for a CON to provide radiation therapy services in Horry, Georgetown, and Williamsburg Counties and the need for radiation therapy services in the defined services area will be exceeded if more than one application is approved. Additionally, Staff believes that approval of more than one of these CON applications will have an adverse impact on other providers in the service area, and that this negative impact exceeds the benefits of improved accessibility.

The project proposed by CRCC best meets project review criteria, standards in the Plan and the purpose of CON. Therefore, staff has concluded that a CON should be awarded to CRCC-Conway.

Even though the Grand Strand project contributes to the continuum of care for current oncology services, it does not substantially improve accessibility since the location is in the vicinity of the CRCC Myrtle Beach location. The overlapping service area ZIP codes for patient origin are significant with the approved Francis B. Ford Cancer Center relocation. This can also be seen as unnecessary duplication. The location also does not improve access to Conway, an area of rapid growth. North Strand's project is not located in an area of rapid growth, if North Myrtle Beach is not considered. This area is also well served by CRCC's existing office. The utilization projections for North Strand appeared to be unrealistic. This project with the least support and did not provide adequate referral documentation.

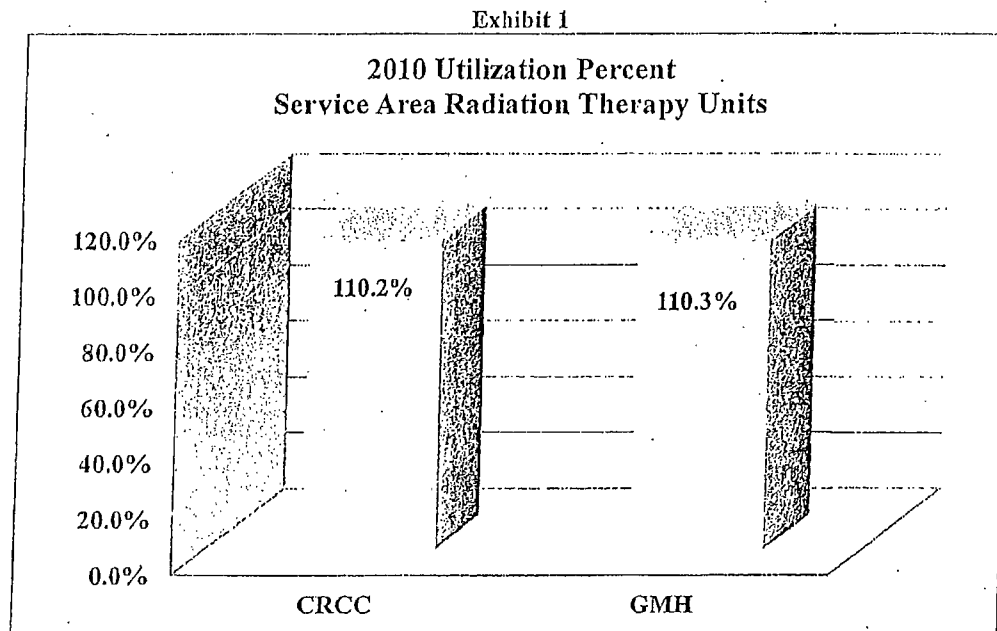
Staff recognizes the strong support received by Grand Strand and the fact that it is one of two hospitals of its size (besides Providence with its cardiology focus) without a radiation therapy program. Staff believes the projected utilization could have substantial adverse impact upon the existing CRCC location as evidenced in the statement by Grand Strand's consultant indicating "it is reasonable to conclude that a significant percentage of Coastal Cancer Center's patients from the service area will choose GSRMC for radiation treatment." Staff concurs with some concerns expressed by GHS over the fact that the Murrells Inlet linear accelerator projects have not been completed due to ongoing litigation. However, CRCC is currently operating significantly over capacity. Staff concludes it is prudent to consider that there are two other service area radiation therapy projects tied up in appeal and approving one project, particularly an expansion project, would better comply with the purpose of CON, with its funding from cash balances, lowest project cost, to include linear accelerator cost (cost containment), rapid ramp up time with advanced equipment in a more disadvantaged area (guide establishment best serving the public's needs), location in Conway (no unnecessary duplication) and extensive experience (high quality services).

As will be demonstrated in the following discussion, GSRMC's project can best address the need for additional radiation therapy services in the service area.

1. Number of Units Needed

CRCC argued at the Project Review Meeting that only one additional linear accelerator is needed in the Georgetown/Horry/Williamsburg service area, but without any analytical support. The historical and projected utilization of existing providers in the service area, however, refutes this claim and demonstrates that two additional linear accelerators could be readily supported.

Exhibit 1 presents the 2010 utilization of two existing radiation therapy providers in the service area. Both existing providers operated above 100% of capacity in 2010.



CRCC was recently approved to relocate one linear accelerator to Murrells Inlet and is requesting approval for an additional linear accelerator in Conway. GMH was approved to relocate its radiation therapy service to Murrells Inlet and to purchase a new unit. CRCC projected utilization to 2015 for its three proposed sites. GMH appears to have omitted projected utilization from its application; however, its 2010 utilization was used to estimate conservatively its 2015 utilization. These projections are summarized in Exhibit 2.

001014

EXHIBIT B



2010 – 2011 SOUTH CAROLINA HEALTH PLAN

**South Carolina State Health Planning Committee
South Carolina Department of Health and
Environmental Control**

Effective November 12, 2010

RADIOTHERAPY

<u>SERVICE AREAS</u>	<u>2009 POPULATION</u>	<u># OF LIN ACC</u>	<u>POP PER LIN ACC</u>	<u>TOTAL AREA TREATMENTS</u>	<u>TREATMENTS PER LIN ACC</u>	<u>PLANNING AREA CAPACITY</u>	<u>PERCENT CAPACITY</u>
ANDERSON,OCONEE	253,230	3	84,410	18,728	6,243	21,000	89.2%
GREENVILLE,PICKENS	541,950	6	90,325	29,754	4,959	42,000	70.8%
CHEROKEE,SPARTANBURG UNION	364,780	5	72,956	18,512	3,702	32,500	57.0%
CHESTER,LANCASTER,YORK	288,250	3	96,083	13,416	4,472	21,000	63.9%
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	232,640	2	116,320	6,747	3,374	14,000	48.2%
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	712,910	9	79,212	47,211	5,246	63,000	74.9%
CHESTERFIELD, DARLINGTON DILLON, FLORENCE, MARION MARLBORO	340,910	5	68,182	22,191	4,438	35,000	63.4%
CLARENDON,LEE,SUMTER	170,600	2	85,300	10,812	5,406	14,000	77.2%
GEORGETOWN,HORRY WILLIAMSBURG	332,400	4	83,100	20,918	5,230	26,000	80.5%
BAMBERG,CALHOUN ORANGEBURG	128,340	2	64,170	6,545	3,273	14,000	46.8%
ALLENDAL, BEAUFORT, HAMPTON,JASPER	200,890	2	100,445	17,108	8,554	14,000	122.2%
BERKELEY,CHARLESTON COLLETON,DORCHESTER	647,160	11	58,833	44,288	4,026	60,000	73.8%
AIKEN,BARNWELL	187,170	2	93,585	7,886	3,943	14,000	56.3%
STATE TOTAL	4,401,230	56	78,593	264,116	4,716	370,500	71.3%

MEGAVOLTAGE VISITS

<u>REGION & FACILITY</u>	<u>COUNTY</u>	<u># UNITS</u>	<u>FY 2007</u>	<u>FY 2008</u>	<u>FY 2009</u>
REGION I					
ANMED HEALTH MEDICAL CENTER	ANDERSON	2	10,811	12,781	12,449
GIBBS REGIONAL CANCER CTR SATELLITE 1	CHEROKEE	(1)	---	---	---
CANCER CENTERS OF THE CAROLINAS	GREENVILLE	1	6,175	5,821	4,834
CANCER CENTERS CAROLINAS - EASTSIDE		1	11,563	10,553	9,487
GREENVILLE MEMORIAL MEDICAL CENTER		3	17,669	18,309	15,433
GREER MEDICAL CAMPUS CANCER CTR 2		1	---	---	---
CANCER CENTERS CAROLINAS - OCONEE CO.	OCONEE	1	6,303	6,550	6,279
CANCER CENTER CAROLINAS - MARY BLACK 3	SPARTANBURG	1	---	---	---
SPARTANBURG REGIONAL MED CTR		3	18,853	17,480	18,512
VILLAGE AT PELHAM CANCER CENTER 1		1	---	---	---
REGION II					
SELF REGIONAL HEALTHCARE	GREENWOOD	2	6,060	6,589	6,747
LANCASTER RADIATION THERAPY CTR 4	LANCASTER	1	---	---	---
LEXINGTON MEDICAL CENTER	LEXINGTON	2	12,215	9,599	10,433
NEWBERRY ONCOLOGY ASSOCIATES 5	NEWBERRY	1	---	---	---
PALMETTO HEALTH RICHLAND	RICHLAND				
LINEAR ACCELERATORS		2	12,065	11,710	14,107
GAMMA KNIFE		1	232	206	210
SOUTH CAROLINA ONCOLOGY ASSOCIATES		4	20,242	26,881	22,671
ROCK HILL RADIATION THERAPY CENTER	YORK	2	14,721	14,210	13,416
REGION III					
CAROLINAS HOSPITAL SYSTEM	FLORENCE	1	5,358	4,557	5,015
MCLEOD REGIONAL MEDICAL CENTER		4	17,842	19,164	17,176
GEORGETOWN MEMORIAL HOSPITAL	GEORGETOWN	1	5,466	5,903	5,305

CAROLINA REGIONAL RADIATION CENTER		HORRY	3	13,107	14,335	15,613
TUOMEY		SUMTER	2	9,892	9,407	10,812
REGION IV						
RADIATION ONCOLOGY CTR OF AIKEN	6	AIKEN	2	6,916	7,371	7,886
BEAUFORT/HILTON HEAD RAD ONCOLOGY CTR		BEAUFORT	1	5,745	6,369	6,182
BEAUFORT MEMORIAL HOSPITAL	7		1	5,143	5,143	10,926
MUSC MEDICAL CENTER	8	CHARLESTON				
LINEAR ACCELERATORS			5	16,810	16,806	18,184
GAMMA KNIFE			1			
ROPER HOSPITAL	9		4	12,877	13,403	14,440
TRIDENT MEDICAL CENTER	10		2	11,971	11,461	11,664
REG MED CTR ORANGEBURG/CALHOUN	11	ORANGEBURG	2	5,545	7,060	6,545
TOTAL			56	253,349	261,462	264,116

- 1 GIBBES LINAC APPROVED 3/31/03; APPEALED. CON TO MOVE PROPOSED GIBBES LINAC TO VILLAGE AT PELHAM APPEALED 2/12/08. CONS ISSUED FOR GIBBES BY SUPREME CT RULING.
- 2 CON ISSUED 10/12/07, SC-07-53.
- 3 CON ISSUED BY SUPREME COURT RULING 3/31/10.
- 4 CON APPROVED 2/15/08; APPEALED. APPEAL DISMISSED 8/5/09; SC-09-39 ISSUED 8/12/09.
- 5 CON APPROVED 3/20/06.
- 6 CON ISSUED TO TRANSFER OWNERSHIP FROM AIKEN REGIONAL & ADD 2ND LINAC 6/11/09, SC-09-29.
- 7 DATA NOT AVAILABLE FOR 2008
- 8 CON FOR GAMMA KNIFE ISSUED 6/8/09. CON FOR 5TH LINAC ISSUED 7/8/09.
- 9 CON ISSUED FOR A CYBERKNIFE LINEAR ACCELERATOR 8/10/06. CON APPROVED FOR 3RD CONVENTIONAL LINAC 8/5/09.
- 10 CON ISSUED FOR REPLACEMENT LINAC 2/26/09 SC-09-07.
- 11 CON ISSUED FOR 2ND LINAC 10/14/10, SC-10-31.

Certificate of Need Standards for Stereotactic Radiosurgery

1. The capacity of a dedicated Stereotactic Radiosurgery unit is 300 procedures annually. This is based on an average of two procedures per day times three days per week times 50 weeks per year.
2. The service area for a dedicated Stereotactic Radiosurgery unit is defined as all facilities within 90 minutes one-way automobile travel time.
3. New Radiosurgery services shall only be approved if the following conditions are met:

EXHIBIT C



2012 – 2013

**SOUTH CAROLINA
HEALTH PLAN**

EFFECTIVE 11/9/12

5. There are 13 service areas established for Radiotherapy units as shown on the following chart.
6. New Radiotherapy services shall only be approved if the following conditions are met:
 - A. All existing units in the service area have performed at a combined use rate of 80 percent of capacity for the year immediately preceding the filing of the applicant's CON application; and
 - B. An applicant must project that the proposed service will perform a minimum number of treatments equal to 50 percent of capacity annually within three years of initiation of services, without reducing the utilization of the existing machines in the service area below the 80 percent threshold. If the new equipment is a specialized radiotherapy unit as described in Standards 2, 3 or 4 above, then the applicant may propose an annual capacity based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in CON application calculations, as well as future capacity calculations, for that applicant. The applicant must document where the potential patients for this new service will come from and where they are currently being served, to include the expected shift in patient volume from existing providers.
7. Expansion of an existing service, whether the expansion occurs at the existing site or at an alternate location in the service area, shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for each of the past two years and can project a minimum use rate of 50 percent of capacity per year on the additional equipment within three years of its implementation. If the additional equipment is a specialized radiotherapy unit as described in either Standards 2, 3 or 4 above, then the existing provider may propose an annual capacity for that additional equipment, based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in CON application calculations, as well as future capacity calculations, for that applicant.
8. The applicant shall project the utilization of the service and document referral sources for patients within its service area, including letters of support from physicians and health care facilities indicating a willingness to refer patients to the proposed service.
9. The applicant must affirm the following:
 - A. All treatments provided will be under the control of a board certified or board eligible radiation oncologist;

RADIOTHERAPY

<u>SERVICE AREAS</u>	<u>2011 POPULATION</u>	<u># OF LIN ACC</u>	<u>POP PER LIN ACC</u>	<u>TOTAL AREA TREATMENTS</u>	<u>TREATMENTS PER LIN ACC</u>	<u>PLANNING AREA CAPACITY</u>	<u>UNMET NEED?</u>	<u>PERCENT CAPACITY</u>
ANDERSON, OCONEE	263,900	3	87,967	17,816	5,939	18,500	NEED	96.3%
GREENVILLE, PICKENS	577,000	8	72,125	31,314	3,914	53,500	----	58.5%
CHEROKEE, SPARTANBURG UNION	371,800	5	74,360	17,954	3,591	32,500	----	55.2%
CHESTER, LANCASTER, YORK	339,900	3	113,300	15,054	5,018	21,000	----	71.7%
ABBEVILLE, EDGEFIELD GREENWOOD, LAURENS MCCORMICK, SALUDA	220,800	2	110,400	7,782	3,891	14,000	----	55.6%
FAIRFIELD, KERSHAW LEXINGTON, NEWBERRY RICHLAND	778,400	9	86,489	46,831	5,203	61,000	----	76.8%
CHESTERFIELD, DARLINGTON DILLON, FLORENCE, MARION MARLBORO	347,800	5	69,560	22,215	4,443	32,500	----	68.4%
CLARENDON, LEE, SUMTER	162,700	2	81,350	9,499	4,750	14,000	----	67.9%
GEORGETOWN, HORRY WILLIAMSBURG	369,600	5	73,920	31,902	6,380	33,000	NEED	96.7%
BAMBERG, CALHOUN ORANGEBURG	124,300	2	62,150	6,579	3,290	14,000	----	47.0%
ALLENDALE, BEAUFORT, HAMPTON, JASPER	222,000	2	111,000	10,242	5,121	14,000	----	73.2%
BERKELEY, CHARLESTON COLLETON, DORCHESTER	709,400	12	59,117	47,639	3,970	62,500	----	76.2%
AIKEN, BARNWELL	185,100	2	92,550	8,464	4,232	14,000	----	60.5%
STATE TOTAL	4,672,700	60	77,878	273,291	4,555	384,500	----	71.1%

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Grand Strand Regional Medical Center, LLC,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control,

Respondent.

Docket No.: 2012-ALJ-07-0090-CC

Grand Strand Regional Medical Center, LLC,

Petitioner;

vs.

South Carolina Department of Health and
Environmental Control and Carolinas Regional
Cancer Center,

Respondents.

Docket No.: 2012-ALJ-07-0091-CC

**MEMORANDUM IN OPPOSITION TO
MOTION FOR PARTIAL SUMMARY JUDGMENT**

Respondent Carolinas Regional Cancer Center ("CRCC"), by and through its undersigned counsel, hereby submits this Opposition to Petitioner Grand Strand Regional Medical Center's ("Grand Strand") Motion for Partial Summary Judgment in the above-referenced contested case proceedings.

BACKGROUND

This action arises from the December 28, 2011 decision of DHEC to approve a Certificate of Need ("CON") application filed by CRCC to add a linear accelerator in Horry County to a proposed location in Conway, South Carolina, while simultaneously denying two

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SC ADMIN. LAW COURT

R000156

competing CON applications to add services to Horry County – Petitioner Grand Strand Regional Medical Center, LLC (“Grand Strand”) and North Strand Radiation Oncology Center (“North Strand”). These actions were filed by Grand Strand. North Strand had filed separate contested case proceedings related to this same decision, Docket Nos. 2012-ALJ-07-0098-CC and 2012-ALJ-07-0099-CC, which had been consolidated by the Court. North Strand has since withdrawn its application and contested case proceedings.

Both CRCC and Grand Strand sought to provide radiation therapy services in Horry County, South Carolina, which is part of the three county service area of Georgetown, Horry and Williamsburg Counties. CRCC is an existing provider of linear accelerator services in the service area, with three machines located in Myrtle Beach, South Carolina. Georgetown Memorial Hospital has a unit on its campus in Georgetown County. The *2010-2011 State Health Plan* indicated that the four existing units in the service area were operating at greater than 80% capacity (80.5%) and therefore an additional machine could be considered under the *Plan*. CRCC and Grand Strand both filed their applications under the *2010-2011 State Health Plan*, which contains specific standards for the submission and review of applications to provide megavoltage radiotherapy and radiosurgery. *See 2010-2011 State Health Plan* at IX-1. Specifically, the State Health Plan contains a separate need analysis for the approval of new linear accelerators in a service area:

New Radiotherapy services shall only be approved if the following conditions are met:

- A. All existing units in the service area have performed at a combined use rate of 80 percent of capacity for the year immediately preceding the filing of the applicant’s CON application; and
- B. An applicant must project that the proposed service will perform a minimum number of treatments equal to 50 percent of capacity annually within three years of initiation of services, without reducing the utilization of the existing machines in the service area below the 80 percent threshold. . . .

2010-2011 State Health Plan at IX-5 to IX-6. As evidenced by the criteria, the State Health Plan criteria for a linear accelerator does not determine need solely by formula. The applicant must also demonstrate future capacity without reducing existing providers below 80 percent capacity. Therefore, Grand Strand cannot establish need solely based on the new State Health Plan.

In light of the data published in the *2010-2011 State Health Plan*, and based on all of the information submitted by the applicants, the Department correctly determined that the applications were competing under Regulation 61-15 and the CON Act because the approval of more than one linear accelerator would exceed the need for services in the service area. See S.C. Code Ann. Regs. 61-15 § 103(6); see also S.C. Code Ann. § 44-7-130(5). The Department correctly approved the CRCC application because it most fully complied with the CON Act, State Health Plan, project review criteria, and regulations. See S.C. Code Ann. Regs. 61-15 § 307(2). The Department's decision letter provides significant detail and support for both the finding of competing applications as well as the superiority of CRCC's project. See CRCC 000655-000675 (attached as **Exhibit A**).

Grand Strand has filed this Motion for Partial Summary Judgment seeking a ruling from this Court that in light of the data published in the recently enacted *2012-2013 State Health Plan* (effective November 11, 2012), the two applications before this Court are no longer 'competing' and therefore both machines may be approved. For the reasons set forth below, CRCC submits that Grand Strand's request is in direct violation of the law and that there remain genuine issues of material fact that prevent this Court from deciding the issue on summary judgment without further development of the factual record. Finally, the award of partial summary judgment to Grand Strand will have no impact on the trial of this case, thereby making this motion nothing

more than a request for an advisory opinion from the Court.

STANDARD OF REVIEW

“Summary judgment is appropriate when there is no genuine issue of material fact such that the moving party is entitled to prevail as a matter of law. In determining whether any triable issues of fact exist, the court must view the evidence and all reasonable inferences that may be drawn from the evidence in the light most favorable to the nonmoving party.” *Ray v. Austin*, 388 S.C. 605, 611, 698 S.E.2d 208, 211 (2010) (internal citations omitted). In this matter, all reasonable inferences must be viewed in the light most favorable to CRCC and the Department. Because summary judgment is a drastic remedy, it should be “cautiously invoked so that a litigant will not be improperly deprived of trial on disputed factual issues.” *Cunningham ex rel. Grice v. Helping Hands, Inc.*, 352 S.C. 485 491, 575 S.E.2d 549, 552 (2003). “[T]he non-moving party is only required to submit a mere scintilla of evidence in order to withstand a motion for summary judgment.” *Hancock v. Mid-South Mgmt. Co.*, 381 S.C. 326, 330 673 S.E.2d 801, 802 (2009).

ARGUMENT

A. GRAND STRAND’S REQUEST FAILS AS A MATTER OF LAW BECAUSE IT REQUIRES THE COURT TO IGNORE THE STATE HEALTH PLAN UNDER WHICH THE APPLICATIONS WERE FILED, IN DIRECT CONTRAVENTION OF THE LAW.

As Grand Strand points out, the CON Act provides that this Court *may* consider a State Health Plan enacted after the submission of an application, but glosses or avoids the mandate in the CON Act that this Court *must* consider the Plan in place at the time of the filing. Specifically, the CON Act states: “The department, the Administrative Law Court, and the Court of Appeals **shall** consider the South Carolina Health Plan in place at the time the application was filed and **may** consider the current South Carolina Health Plan when making its decision.” S.C. Code Ann. § 44-7-225 (emphasis added). The CON Regulations further

specifically require:

All decisions on Certificate of Need applications **shall** be made based on the currently approved South Carolina Health Plan in effect at the time such application is accepted. *Should a new plan be adopted during any phase of the review or appeals process, the applicant shall have the option of withdrawing the application and resubmitting under the newly adopted plan or continuing the review or appeal process under the plan in use when the application was submitted.*

S.C. Code Ann. Regs. 61-15 § 504 (emphasis added). Similar to the CON Act statute, the Department Regulation *requires* that decisions on application for CON *shall* be made based on the State Health Plan in effect at the time the application is accepted. The Regulation further anticipates the adoption of a new State Health Plan during the review or appeals process and provides the mechanism available in such circumstance – Grand Strand has the option of withdrawing its current CON and reapplying under the *2012-2013 State Health Plan* or “continuing the . . . appeal process under the plan in use when the application was submitted.” *Id.* Grand Strand’s assertion that “the *2012-2013 State Health Plan* establishes that this Court can approve both CRCC’s and Grand Strand’s CON applications without exceeding the need . . .” requires this Court to violate the CON Act and Regulations because it requires the Court to *ignore* the State Health Plan under which these applications were filed. Grand Strand’s request to this Court is simply contradictory to the law governing CON.

B. THERE ARE GENUINE ISSUES OF MATERIAL FACT IN DISPUTE PREVENTING THE COURT FROM RULING ON THIS ISSUE ON SUMMARY JUDGMENT.

The purposes of the CON Act and the Regulations promulgated thereunder are “to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State.” S.C. Code Ann. § 44-7-120; S.C. Code Ann. Regs. 61-15 § 101. In order to achieve these purposes, the Act

specifically defines those circumstances under which multiple applications for a CON must be considered competing. Specifically, “competing applicants” are defined by the Act as “two or more persons or health care facilities as defined in this article who apply for [CONs] to provide similar services or facilities in the same service area within a time frame as established by departmental regulations and whose applications, if approved, would exceed the need for services or facilities.” S.C. Code Ann. § 44-7-130(5). The established time frame is within fifteen days of publication of notice of the first application in the State Register. S.C. Code Ann. Regs. 61-15 § 103(6).

Therefore, for two CON applications to be considered competing applications, the Department must find:

1. The applications were filed within the time period prescribed in the statute and regulation; and
2. The applications were for similar services or facilities; and
3. The applications were servicing the same service area; and
4. The approval of both applications would exceed the need for the services or facilities.

See S.C. Code Ann. § 44-7-130(5); S.C. Code Ann. Regs. 61-15 § 103(6).

As a threshold matter, whether the approval of both applications would not exceed the need for the services as claimed by Grand Strand is a question of fact for this Court, rendering summary judgment improper. In *Spartanburg Reg'l Med. Ctr. v. Oncology and Hematology Assoc. of S.C., LLC*, 387 S.C. 79, 690 S.E.2d 783 (2010), the South Carolina Supreme Court discussed S.C. Code Ann. § 44-7-130(5), stating:

The ALC found that granting both CON applications would not exceed the need, and therefore, the applications were not competing. From a factual perspective,

there is abundant evidence in the record to support this based on CCC's data projections. Moreover, it is hard to interpret the plain language of section 44-7-130(5) any other way than the manner in which the ALC interpreted it: If granting both applications would not exceed the need, then the applications are not competing and both may be granted (provided all other relevant criteria are met). *See Brown v. S.C. Dep't of Health and Envtl. Control*, 348 S.C. 507, 515, 560 S.E.2d 410, 414 (2002) ("Where the terms of the statute are clear, the court must apply those terms according to their literal meaning.")

Id. at 90, 690 S.E.2d at 789 (emphasis in original). Based on the *Spartanburg* decision, two points are clearly established. First, if the approval of two CON applications will exceed the need for the services or facilities, the applications are competing. Second, the Administrative Law Court's determination of whether the approval of both CON applications would exceed the need for the services is a factual dispute for the Court to resolve.

Unlike the plethora of facts presented by the parties to the ALC in a five day trial, Grand Strand has not presented any evidence, other than the enactment of a new State Health Plan, to suggest or support that the approval of its application in addition to CRCC's application will not exceed the need for linear accelerator services in the service area. A party moving for summary judgment may not rest on mere conclusory statements but must present undisputed facts to establish the absence of a genuine issue of material fact. *See, e.g., Charleston County Assessor v. 4 Cousins, LLC*, 09-ALJ-17-0359-CC at *3 (May 27, 2010). In this case, far from presenting undisputed facts, Grand Strand presents no facts or empirical evidence to suggest that the approval of both applications would not exceed the need. Moreover, Grand Strand cannot meet its evidentiary burden to obtain summary judgment at this phase of the proceedings. Reliance on the updated data in the *2012-2013 State Health Plan* is not enough. The data contained in the *2012-2013 State Health Plan* does not establish that a new linear accelerator on Grand Strand's campus will operate at 50 percent or greater capacity within three years and that its operation will not adversely impact CRCC or Georgetown Memorial Hospital, the existing providers. *See*

2010-2011 State Health Plan at IX-5 to IX-6.

In contrast, many facts exist to support CRCC and DHEC's contention that the approval of both CON applications would exceed the need for linear accelerator services in the Georgetown/Horry/Williamsburg service area. As the Department correctly pointed out in its decision letter, Grand Strand's application would have an adverse impact on CRCC and Georgetown Memorial Hospital. *See* CRCC DHEC Record at 000670. Given the requirement in the State Health Plan that a new application cannot be approved if the operation of the new unit will drive the utilization of existing units below the 80 percent threshold, the issue of adverse impact is paramount to the need analysis for linear accelerators. Grand Strand offers no factual evidence to the contrary. While discovery has only just begun, with no deposition testimony as yet, what the Court does have is the prior input of Mr. Sam Tolbert, CRCC's expert, who advised the Department during the review process that for a variety of reasons, only one application should be approved and CRCC presented the superior application. *See* CRCC DHEC Record 000623-000628, attached as **Exhibit B**. As explained by Mr. Tolbert, the reasons for the approval of only one new machine at this time include the recent approvals for the relocation of two of the four existing machines, which will obviously impact patient treatments and referral patterns, as well as the need for actual utilization data for the new approved machines rather than reliance on conjecture and projections. *Id.* at 000626-000627.

In this circumstance, these genuine issues of material fact are intertwined with the prong of the competing application definition requiring analysis of whether the approval of both would exceed the need. This Court cannot analyze the need based on the limited record before it, with only basic written discovery having taken place and no deposition testimony available to the Court. Therefore, Grand Strand's Motion must be denied.

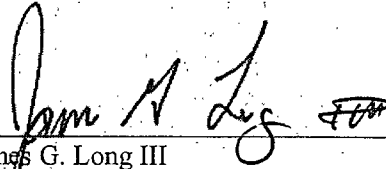
C. THE GRANTING OF PARTIAL SUMMARY JUDGMENT IS INAPPROPRIATE AT THIS STAGE OF THE LITIGATION.

Grand Strand's Motion for Partial Summary Judgment asks for a ruling of the Court that CRCC and Grand Strand cannot be deemed "competing applicants" in light of the *2012-2013 State Health Plan* and its inventory data. Grand Strand seeks no relief from the Court nor desires to obtain any redress that impacts the merits of the litigation. As such, the Motion for Partial Summary Judgment is no more than an impermissible request for an advisory opinion from this Court and should be denied. *See Foreign Academic & Cultural Exchange Svcs. v. Tripon*, 394 S.C. 197, 201, 715 S.E.2d 331, 332 (2011).

Grand Strand's request, if granted, does not limit or otherwise reduce the burden on the Court or the parties in evaluating each party's application and discovering the facts necessary to determine whether the applications may be approved. Moreover, Grand Strand's application was denied by Department staff. In fact, the Department's decision letter indicates a number of inadequacies within the materials presented by Grand Strand during the review process. *See* 12/28/11 Decision Letter and Analysis at pp. 10-13. Regardless of the Court's decision on the motion, CRCC will contest the Grand Strand CON Application and will contest the need for a linear accelerator at Grand Strand. Rendering an advisory opinion on the question of competing applications does not limit or reduce the discovery burden, number of witnesses, or length of trial. As noted, the parties in this matter have exchanged written discovery but to date have not taken a single deposition. "Since it is a drastic remedy, summary judgment should be cautiously invoked so that no person will be improperly deprived of a trial of the disputed factual issues." *Baughman v. American Tel. and Tel. Co.*, 306 S.C. 101, 112, 410 S.E.2d 537, 543 (1991) (internal citations omitted).

CONCLUSION

For the reasons set forth herein, CRCC respectfully requests that the Court deny the relief requested in the Motion for Partial Summary Judgment and for such other and further relief as the Court deems just and proper.



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Attorneys for Respondent
Carolinas Regional Cancer Center

June 10, 2012
Columbia, South Carolina

CERTIFICATE OF SERVICE

This is to certify that the forgoing Carolina Regional Cancer Center's Memorandum in Opposition to Motion for Partial Summary Judgment was served upon counsel of record by hand delivery and electronic mail this 10th day of June, 2013.

William R. Thomas, Esquire
Walter H. Cartin, Esquire
Parker Poe Adams & Bernstein, LLP
1201 Main Street, Suite 1450
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South Carolina Department of Health
and Environmental Control
2600 Bull Street
Columbia, SC 29201


Nexsen Pruet, LLC

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EXHIBIT A



G. Earl Hunter, Commissioner

Promoting and protecting the health of the public and the environment.

Certified Mail

91 7199 9991 7030 0506 9354

December 28, 2011

Patricia Price
Regional Administrator
Carolina Regional Cancer Center
4708 Oleander Drive
Myrtle Beach, SC 29577

RE: Carolina Regional Cancer Center-Conway
Conway, South Carolina

Dear Ms. Price:

It is the decision of this Department that a Certificate of Need be issued to Carolina Regional Cancer Center-Conway in Conway, South Carolina for the purchase and installation of a linear accelerator for a new cancer treatment center to be established in an existing medical office building located in Conway, SC.

The Department timely received three (3) Certificate of Need applications proposing to provide radiation therapy services in the radiotherapy service area comprised of Horry, Georgetown and Williamsburg Counties. Carolina Regional Cancer Center ("CRCC") proposed to expand their existing Myrtle Beach radiation therapy service location, whereas both North Strand Radiation Oncology Center ("NSROC") and Grand Strand Regional Medical Center ("GSRMC") proposed to establish a new service. Individually, the Department has determined all applications comply with the 2010-2011 South Carolina Health Plan. However, collectively, there are issues with exceeding the service area need. (See Analysis).

Section 103.6 of Regulation 61-15 "Certification of Need for Health Facilities and Services" defines "Competing applicants" as "two or more persons and/or health care facilities as defined in this regulation who apply for Certificates of Need to provide similar services and/or facilities in the same service area and whose applications if approved would exceed the need for this facility or service." Staff have determined that approval of more than one linear accelerator would exceed the need projected for this service area in the South Carolina Health Plan.

Therefore, Section 307.2 requires that "in the case of competing applications, the Department shall award a Certificate of Need, if appropriate, on the basis of which, if any, most fully complies with the requirements, goals, and purposes of the Certificate of Need program, State Health Plan, project review criteria, and any regulations developed by the Department." Staff concludes CRCC-Conway would better comply with the purpose of CON, with its funding from cash balances, lowest project cost, to include linear accelerator cost (cost containment), rapid ramp up time with advanced equipment in a more economically disadvantaged area (guide the establishment of health facilities and services which will best serve the public's needs), location in Conway (prevent unnecessary duplication) and extensive experience (ensure high quality

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SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

Health Regulation

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Ms. Price
December 28, 2011
Page 2

services). The SC Health Plan and project review criteria are addressed in the attached analysis. Adverse impact of GSRMC was considered. Staff determined approval of the GSRMC application could have substantial negative impact upon the approved, but appealed, relocated Francis B. Ford Cancer Center as well as the existing CRCC-Myrtle Beach. (See Analysis).

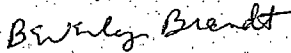
The decision is based upon the written findings contained in the attached Analysis and upon the following conclusions:

1. The applicant has documented the need for the proposed project within the application and the project will increase accessibility and availability of oncology services for residents of Horry County and surrounding areas;
2. The applicant's record is one of successful operation with adequate management experience;
3. Support, documented opposition and adverse effects on other facilities were considered; and,
4. The project appears to be financially feasible and cost effective based on the information available.

The findings pursuant to Section 501, Regulation No. 61-15, Certification of Need for Health Facilities and Services are not applicable to this project.

A copy of the Notice of Appeals Procedure is enclosed for your convenience. If you have any questions, please feel free to contact us at (803) 545-4200.

Sincerely,



Beverly Brandt, Chief
Bureau of Health Facilities and Services Development

Enclosures: Notice of Appeal Procedure
Analysis

cc: Wade Mullins, Esquire, Bruner Powell
Sam Tolbert, Strategic Directions
Dan Westbrook, Esquire, Nelson Mullins
Arnold Green, NSROC
Don Meyer, Moore & Van Allen
Doug White, CEO, Grand Strand Regional Medical Center
Will Thomas, Esquire, Parker Poe

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Notice of Appeal Procedure
Pursuant to S.C. Code Section 44-1-60

1. This decision of the S.C. Department of Health and Environmental Control (Department) becomes the final agency decision 15 calendar days after notice of the decision has been mailed or otherwise sent to the applicant, permittee, licensee and affected persons who have requested in writing to be notified, unless a written request for final review accompanied by a filing fee in the amount of \$100 is filed with the Department by the applicant, permittee, licensee, or affected person.
2. An applicant, permittee, licensee, or affected person who wishes to appeal this decision must file a timely written request for final review with the Clerk of the Board at the following address or by facsimile at 803-898-3393. A filing fee in the amount of \$100 made payable to SC DHEC must also be received by the Clerk within the time allowed for filing a request for final review. However, if a request for final review is filed by facsimile, the filing fee may be mailed to the Clerk of the Board if the envelope is postmarked within the time allowed for filing a request for final review.

Clerk of the Board
SC DHEC
2600 Bull Street
Columbia, SC 29201
3. In order to be timely, a request for final review must be received by the Clerk of the Board within 15 calendar days after notice of the decision has been mailed or otherwise sent to persons entitled to receive notice. If the 15th day occurs on a weekend or State holiday, the request is due to be received by the Clerk of the Board on the next working day. The request for final review must be received by the Clerk of the Board by 5:00 p.m. on the date it is due. A request for final review will be returned to the requestor if the filing fee is not received on time as described above.
4. The request for final review should include the following:
 - a. the grounds on which the Department's decision is challenged and the specific changes sought in the decision
 - b. a statement of any significant issues or factors the Board should consider in deciding whether to conduct a final review conference
 - c. a copy of the Department's decision for which review is requested
5. If a timely request for final review is filed with the Clerk of the Board, the Clerk will provide additional information regarding procedures. If the Board declines in writing to schedule a final review conference, the Department's decision becomes the final agency decision and an applicant, permittee, licensee, or affected person may request a contested case hearing before the Administrative Law Court within 30 calendar days after notice is mailed that the Board declined to hold a final review conference.

The above information is provided as a courtesy; parties are responsible for complying with all applicable legal requirements.

January 7, 2011

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Horry County Linear Accelerator Analysis

Summaries from the November 15, 2011 Project Review Meeting are incorporated by reference.

Background Information

Project Timeline. North Strand Radiation Oncology Center ("NSROC" or "North Strand") and Grand Strand Regional Medical Center ("GSRMC" or "Grand Strand") propose to establish a new service, whereas Carolina Regional Cancer Center ("CRCC") proposes to expand from their existing Myrtle Beach location. The Certificate of Need ("CON") application for NSROC was received on March 9, 2011. The facility is proposed to be located on the campus of Seacoast Medical Center in Little River as a non-profit joint venture between McLeod Regional Medical Center ("MRMC") and Loris Health Services, Inc. ("LHS"). The application for CRCC was received on March 10, 2011 and is proposed to be a facility near the campus of Conway Medical Center, to be named CRCC-Conway. The application for GSRMC, proposed to be a radiation therapy service attached to the main hospital in Myrtle Beach, was received on July 19, 2011. The GSRMC application was the last application to be "deemed complete" with Notification of Affected Persons published in the State Register on October 28, 2011. A Project Review Meeting was held on November 15, 2011.

Regulations. According to Section 101 of Regulation 61-15 "Certification of Need for Health Facilities and Services," the purpose of the Certificate of Need ("CON") program is to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State.

Section 103.6 of R. 61-15 defines "Competing applicants" as "two or more persons and/or health care facilities as defined in this regulation who apply for Certificates of Need to provide similar services and/or facilities in the same service area and whose applications if approved would exceed the need for this facility or service." All three providers filed CON application for a new linear accelerator ("linac"). Based on this definition, staff analyzed to determine if the need would be exceeded if more than one applicant was approved since all three applicants proposed to provide similar services and/or facilities in the same service area. Staff also evaluated compliance with the South Carolina Health Plan ("Plan"), the regulations, project review criteria and the purpose of CON.

Section 307.2 states that "in the case of competing applications, the Department shall award a Certificate of Need, if appropriate, on the basis of which, if any, most fully complies with the requirements, goals, and purposes of the Certificate of Need program, State Health Plan, project review criteria, and any regulations developed by the Department."

Service Area. Within Megavoltage Radiation Therapy Services, the Plan establishes different treatment capacities for different types of linacs. The Plan also has different standards that distinguish between a new service versus expansion of an existing service. As previously stated, NSROC and GSRMC propose to establish a new service, and CRCC-Conway proposes to be the expansion of an existing location.

2010-2011 South Carolina Health Plan. The following are excerpts from the Standards for Megavoltage Radiotherapy (with staff emphasis):

1. The capacity of a conventional linear accelerator, either with or without EPID, is 7,000 treatments per year.
2. Linear accelerators providing IMRT or IGRT have a capacity of 5,000 treatments per year. A facility must document that it is providing or will provide these specialized treatments in sufficient volume to justify why it should be held to this planning capacity.
6. **New Radiotherapy services** shall only be approved if the following conditions are met:
 - A. All existing units in the service area have performed at a combined use rate of 80 percent of capacity for the year immediately preceding the filing of the applicant's CON application; and
 - B. An applicant must project that the proposed service will perform a minimum number of treatments equal to 50 percent of capacity annually within three years of initiation of services, without reducing the utilization of the existing machines in the service area below the 80 percent threshold. If the new equipment is a specialized radiotherapy unit as described in Standards 2, 3 or 4 above, then the applicant may propose an annual capacity based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in CON application calculations, as well as future capacity calculations, for that applicant. The applicant must document where the potential patients for this new service will come from and where they are currently being served, to include the expected shift in patient volume from existing providers. (Note: Standards 3 and 4 are not applicable to these projects as Standard 3 applies to units with stereotactic capability and Standard 4 applies to stereotactic only units).
7. **Expansion of an existing service**, whether the expansion occurs at the existing site or at an alternate location in the service area, shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for each of the past two years and can project a minimum use rate of 50 percent of capacity per year on the additional equipment within three years of its implementation. If the additional equipment is a specialized radiotherapy unit as described in either Standards 2, 3 or 4 above, then the existing provider may propose an annual capacity for that additional equipment, based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in CON application calculations, as well as future capacity calculations, for that applicant.
8. The applicant shall project the utilization of the service and document referral sources for patients within its service area, including letters of support from physicians and health care facilities indicating a willingness to refer patients to the proposed service, with expected annual referral volumes.

Target Population / Service Area DHEC defines megavoltage radiotherapy service areas for the state. The service area for the applications under review consists of Georgetown, Horry, and Williamsburg Counties.

The following table presents the SC State Demographer's population projections for the service area and the state:

County	7/1/2009 Estimates	7/1/2010 Projection	7/1/2011 Projection	7/1/2012 Projection	7/1/2013 Projection	7/1/2014 Projection	7/1/2015 Projection
Georgetown	60,700	62,610	63,310	64,030	64,720	65,430	66,130
Horry	263,870	265,360	270,500	275,650	280,790	285,930	291,080
Williamsburg	34,450	35,370	35,350	35,320	35,300	35,270	35,240
Total for Service Area	359,020	363,340	369,160	375,000	380,810	386,630	392,450
South Carolina	4,561,240	4,549,150	4,596,170	4,643,230	4,690,500	4,737,670	4,784,700

Past Utilization of Existing Facilities. There are currently two providers of radiation therapy services in the service area: CRCC and Francis B. Ford Cancer Treatment Center located operated by Georgetown Memorial Hospital ("GMH") in Georgetown, SC.

The following table presents the service area linear accelerator utilization since 2005:

Radiation Treatments	2005	2006	2007	2008	2009	2010
CRCC	15,770	14,032	13,107	14,335	15,613	20,946
GMH	4,217	5,416	5,466	5,903	5,305	5,515
Region Total	19,987	19,448	18,573	20,238	20,918	26,461
Statewide	229,721	236,181	253,349	261,462	264,116	269,016

The treatment capacity for CRCC's three units is 19,000 treatments. CRCC operates one linear accelerator (Tomotherapy) which has a capacity of 5,000 treatments per year and two standard linear accelerators (Varian) having a capacity of 7,000 treatments per year each. The GMH Francis B. Ford linear accelerator has a capacity of 7,000 treatments. Therefore, the total capacity for the service area is 26,000 treatments. For 2009, the service area utilization was 80.5% of capacity and for 2010, the utilization was 101.8% of capacity. Francis B. Ford operated at 75.8% of capacity in 2009 and 78.9% of capacity in 2010. For 2009, the CRCC utilization was 82.2% of capacity and for 2010, the utilization was 110.2% of capacity.

Based on this data, the above Criteria 6A and 7 have been met. In fact, based upon the data, under Criterion 6A, both Grand Strand and North Strand could have applied as a new facility in 2010, but did not. Much analysis has been done regarding the adverse impact, to include as a component of Criterion 6B ("without reducing the utilization of the existing machines in the service area below the 80 percent threshold") and projecting the minimum use rate of 50% of capacity per year within three years.

Project Review Criteria

1. Compliance with the South Carolina Health Plan

Section 801.3 from R.61-15 states "A project does not have to satisfy every criterion in order to be approved, but no project may be approved unless it is consistent with the State Health Plan. A project may be denied if the Department determines that the project does not sufficiently meet one or more of the criteria."

Community Need Documentation – 2a, 2b, 2c, 2e

2a. The target population should be clearly identified as to the size, location, distribution, and socioeconomic status (if applicable).

2b. Projections of anticipated population changes should be reasonable and based upon accepted demographic or statistical methodologies, with assumptions and methodologies clearly presented in the application. The applicant must use population statistics consistent with those generated by the State Demographer, State Budget and Control Board.

2c. The proposed project should provide services that meet an identified (documented) need of the target population. The assumptions and methods used to determine the level of need should be specified in the application and based on a reasonable approach as judged by the reviewing

body. Any deviation from the population projection used in the State Health Plan should be explained.

2e. Current and/or projected utilization should be sufficient to justify the expansion or implementation of the proposed service.

Distribution (Accessibility) – 3a, 3b, 3c, 3e, 3f

3a. Duplication and modernization of services must be justified. Unnecessary duplication of services and unnecessary modernization of services will not be approved.

3b. The proposed service should be located so that it may serve medically underserved areas (or an underserved population segment) and should not unnecessarily duplicate existing services or facilities in the proposed service area.

3c. The location of the proposed service should allow for the delivery of necessary support services in an acceptable period of time and at a reasonable cost.

3e. The applicant must document the means by which a person will have access to its services (e.g. outpatient services, admission by house staff, admission by personal physician).

3f. The applicant should address the extent to which all residents of the area, and in particular low-income persons, racial and ethnic minorities, women, the elderly, handicapped persons, and other medically underserved groups, are likely to have access to those services being proposed.

Record of the Applicant – 13a, 13b

13a. The applicant's record should be one of successful operation with adequate management experience.

13b. The applicant should have a demonstrated ability to obtain necessary capital financing.

2. Acceptability – 4a

4a. The proposal and applicant should have the support of "affected persons" (including local providers and the target population). The lack of opposition should not be considered support for the purposes of these criteria. Staff will also consider, 4b, which states: Where documented opposition exists to a proposal, such opposition will be considered along with the application.

Distribution – 22

22. The existing distribution of the health service(s) should be identified and the effect of the proposed project upon that distribution should be carefully considered to functionally balance the distribution to the target population.

Adverse Effects on Other Facilities – 23a

23a. The impact on the current and projected occupancy rates or use rates of existing facilities and services should be weighed against the increased accessibility offered by the proposed services.

3. Financial Feasibility – 15

15. The applicant must have projected both the immediate and long-term financial feasibility of the proposal. Such projection should be reasonable and based upon accepted accounting procedures.

Cost Containment – 16a, 16c

16a. The applicant should have identified and sought alternative sources and/or methods of funding and demonstrated that the method chosen was the most feasible option.

16c. The impact of the project upon the applicant's cost to provide services and the applicant's patient charges should be reasonable. The impact of the project upon the cost and charges of other providers of similar services should be considered if the data are available.

Projected Revenue/Projected Expenses – 6a, 7

6a. The proposed charges should be comparable to those charges established by other facilities for similar services within the service area or state. The applicant should document how the proposed charges were calculated.

7. Projections of construction costs, start-up costs, operating costs, debt service, depreciation, manpower costs, etc. should be consistent with those experienced by similar facilities offering a similar level and scope of services (with proper consideration given to such factors as inflation, cost of capital, etc.).

North Strand Radiation Oncology Center

Total Project Cost = \$9,522,745

Linear Accelerator: Varian Clinac iX (\$2,811,534)

Facility = 5,500 square feet

It is noted that a letter of May 24, 2011 from Arnold Green, President, Loris Health Services, Inc., states that one of the members of NSROC has changed from Loris Community Hospital District to a non-profit affiliated corporation, Loris Health Services, Inc. However, during the November 15 Project Review Meeting, NSROC indicated Loris Community Hospital District as a partner in the joint venture without explanation.

1. Compliance with the South Carolina Health Plan- Standards for Radiotherapy

North Strand addressed all standards. Letters indicated support from physicians (including six from Coastal Cancer Center and five from Southern Medical Associates) and healthcare facilities (Loris Community Hospital) for the project, but North Strand did not provide documentation by any physician or group of a willingness to refer patients to the proposed service, with expected annual referral volumes as required by Standard 8. Dr. Lawrence Holt, Jr. with Coastal Cancer Center, the physician group that also provided letters of support for the other two applicants, stated in a letter of November 29, 2011, they want to reaffirm their support for the project and intend to establish physician offices and chemotherapy services on the campus of Seacoast Medical Center in order to demonstrate their willingness to work with NSROC. However, the letter did not specifically state a willingness to refer patients. North Strand indicated during project review that they expect to receive referrals from a broad range of physicians, including the medical staffs of Loris and McLeod and the physicians of Coastal Cancer Center. The referrals from McLeod were not explained or quantified. Staff questions the likely number of referrals from a facility 80 miles away in another service area. It is questionable that Criterion 8 was met. See also Community Need Documentation and Adverse Impact.

Community Need Documentation – 2a, 2b, 2c, 2e

The applicant clearly identified the target population. NSROC's proposed service area includes the following ZIP Codes: 29511, 29526, 29544, 29545, 29566, 29568, 29569, 29581, and

29582, which are located within northeastern Horry County. NSROC also stated Northern Horry County as the target population they will serve. Population projections were clearly presented.

Exhibit 3 presents LHS's ZIP Code specific patient origin for patients who received a cancer diagnosis in Fiscal Year 2009. This exhibit shows LHS rendered healthcare services to 1,154 patients from NSROC's expected service area during the period, which is less than other applicants. Another 508 cancer patients were served by LHS from the immediately adjacent areas of North Carolina, which is a notable portion of LHS's total cancer patients.

**Exhibit 3
Loris Healthcare Cancer Patient Origin
FY 2009**

<u>Zip Code</u>	<u>Total Patients</u>	<u>Percent of Total</u>	<u>Cumulative Percent</u>
29569	415	21.6%	21.6%
29566	227	11.8%	33.4%
29568	168	8.7%	42.1%
29582	130	6.8%	48.9%
29526	75	3.9%	52.8%
29581	51	2.7%	55.4%
29545	50	2.6%	58.0%
29511	29	1.5%	59.5%
29544	9	0.5%	60.0%
<i>SC Service Area</i>	<i>1,154</i>		
28463	203	10.6%	70.6%
28467	188	9.8%	80.3%
28468	40	2.1%	82.4%
28431	29	1.5%	83.9%
28472	28	1.5%	85.4%
28469	20	1.0%	86.4%
<i>Adjacent NC ZIPs</i>	<i>508</i>		
All Other SC	112	5.8%	92.3%
All Other NC	91	4.7%	97.0%
All Other	58	3.0%	100.0%
Total	1,923		

Source: Loris Internal Data

In addition, staff notes that of the 1,154 patients LHS rendered service to with a cancer diagnosis in FY2009, only 6.8% (130 patients) were from the North Myrtle Beach ZIP code and 3.9% (75 patients) from the Conway ZIP code. There were 508 cancer patients, or 26.5%, originating from NC, but out of state utilization cannot be used to demonstrate need. While Loris accounted for 21.6% of patients (415), Little River only accounted for 11.8%.

NSROC cited geographic distance and travel time as barriers. They state there is no direct provider in NSROC's proposed service area, mention residents from Little River, North Myrtle Beach and Loris, but do acknowledge radiation therapy services currently provided by CRCC and GMH. Data from CRCC indicates 22% of their patients originate from North Myrtle Beach, with 6% from the Loris area. Staff do not concur with NSROC's conclusion that residents do not

have reasonable access to radiation therapy services because of such remote locations and high traffic congestion roads. NSROC provided a chart with the closest providers of radiation therapy services to NSROC's proposed service area and indicated CRCC to be 16.4 miles away. Furthermore, North Strand classifies CRCC as being in Southern Horry County, but staff does not concur with this classification. The proposed North Strand location is shown to be 20.6 miles from Loris, with the CRCC-Conway location at 24.9 miles – a distance that is not appreciably greater. Conway, the area with the greatest population in the North Strand service area, is twice as distant at 22 miles, from NSROC than CRCC-Conway.

NSROC cited a drive time study that indicated a "portion of eastern Horry County" is currently outside of a 30-minute driving range to CRCC and considers the area to be underserved. These areas appear to include towns such as Longs, Worshams Ferry and Little River. Furthermore, North Strand cites travel impediments such as motor vehicle accidents, poor weather conditions, road construction, and special events, but staff maintain these could occur in any part of the service area.

North Strand provided travel time and traffic count data. But counters near all proposed locations, including the site for each applicant, indicated substantially higher counts during "tourist season." Staff concludes the study over emphasizes the alleged negative ramifications of the CRCC's proposed location.

North Strand stated that the northern Horry County area where they propose to locate is the fastest growing community in the Grand Strand and the population base in the service area is sufficiently large enough to justify this service (Exhibit 5, Project Review Summary). However, staff notes that Conway (ZIP code 29526) is the area of the highest population concentration followed by North Myrtle Beach (ZIP code 29582). It is noted that CRCC is currently serving this population with a patient origin of 22% for the Conway area and 22% for North Myrtle Beach. Staff feels it is not logical for North Strand's service area to encompass Conway and North Myrtle Beach, but not Myrtle Beach, as that area currently accounts for 20% of the CRCC patient origin.

Of the 1,154 patients LHS rendered service to with a cancer diagnosis in FY2009, only 6.8% (130 patients) were from North Myrtle Beach ZIP code and 3.9% (5 patients) from the Conway ZIP code. There were 508 LHS cancer patients, or 26.5%, originating from identified NC ZIP codes, but out of state utilization cannot be used to demonstrate need. Staff notes that Grand Strand had 4,860 patients with a primary or secondary cancer diagnosis in 2010 as opposed to North Strand's 1,154 patients in 2009. The Loris ZIP code accounted for 21.6% of LHS patients, 11.8% from Little River and 8.7% from Longs. Forty percent of patients originated from outside of the proposed service area, including over 30% from North Carolina when including "other NC."

For FY2010, LHS referred 637 cancer patients for radiation therapy, which is around 55% of patients diagnosed with cancer. Of these cases, 414 were from the service area (65%), 183 were from NC (29%) and 28 were "Other SC", 12 were "Other." Even though North Strand continues to project 29% of all cancer patients to originate from North Carolina, they projected 85% of radiation therapy patients to originate from the service area and around 10% from NC, which appears to be inconsistent.

North Strand assumes 25 visits (treatments) per patient and indicated in its project review presentation that "a course of treatment may mean up to 30 treatments per patient." North Strand projects being at 6,377 treatments or 127.5% of capacity by Year 3. This is substantially higher

than the 5,100 treatments projected by CRCC, a current provider, and 4,620 by Grand Strand, for Year 3. Staff is concerned the North Strand projections are neither reasonable nor achievable. North Strand indicated CRCC would maintain a utilization rate of over 80%, but did not specifically address the quantity.

North Strand expects to achieve its projected utilization (4,042 treatments in 2013, 5,797 in 2014 and 6,482 in 2015) largely due to the "benefit of the availability of McLeod Regional Medical Center's experience with operating a radiation therapy program." Staff does not argue this is of benefit, but feels the projections are unrealistically high and unachievable. Thus, compliance with the "50 percent of capacity" portion of Standard 6B is questionable. NSROC's project review presentation also stated the projections were based upon "McLeod's experience operating similar equipment" but did not provide details. Success of the project could be limited by the fact that MRMC is 80 miles away and the proposed location in Little River is adjacent to a recently opened small community hospital (Seacoast Medical Center) with only 50 beds and limited services.

Distribution (Accessibility) – 3a, 3b, 3c, 3e, 3f

North Strand claims to be the only applicant applying to serve the medically underserved area of northern Horry County and is not proposing to be located near existing providers. However, their proposed location is only 16 miles from the current Myrtle Beach location of CRCC. While North Strand considered actual cancer referral data from Coastal Cancer Center, it is noted that their physicians provided letters of support for the other two applicants.

North Strand is correct in stating there are no radiation therapy providers in northern Horry County, but clearly this area is currently being served by CRCC. Again, North Myrtle Beach is being served geographically by CRCC and their proposed Conway location will provide geographical access to these areas as well as the population center on Conway. While the CRCC-Conway and Grand Strand projects are not in northern Horry County, staff believes a location in Conway would better increase accessibility to these more rural areas. Furthermore, according to the travel time and distance data provided by North Strand, the rural areas of Nichols and Green Sea are approximately the same distance from CRCC-Conway as from NSROC, accounting for 5% of NSROC's proposed service area population as projected for 2015. The NSROC location in Little River is considerably closer to Little River and Longs (22.5% of 2015 population projection) than CRCC-Conway, but much further away from Aynor, Conway and Galivant's Ferry (41.5% of 2015 population projection). The remaining areas are North Myrtle Beach and Loris (20.6 miles from NSROC and 24.9 miles from CRCC-Conway). Note that this data is limited by the fact that it appears to pick a point in each ZIP code area and it would be useful to view the ZIP code map geographically. NSROC also cites tourist seasonal congestion reported on certain traffic counters, but the count for all project locations increased substantially during the July period when traffic was the heaviest as expected.

North Strand compares demographics between the Conway and Loris areas. While Loris has a higher rate of poverty, the rates are both substantially less than that of Myrtle Beach or North Myrtle Beach.

During project review, North Strand presented many testimonials from patients, one of whom mentioned traveling more than once daily to receive treatments. Project representatives admitted this occurs rarely and did not further quantify this occurrence. North Strand again mentioned in their November 28, 2011 correspondence that "NSROC will eliminate the need for northern

Horry County patients to travel long distances sometimes multiple times daily to receive treatments at different locations” but provided no data to support this statement.

North Strand will offer access to support services to accommodate the needs of their patients and has documented means by which a person will have access to its services.

Staff concludes all applicants demonstrate financial accessibility. The following table compares projected payor sources and financial accessibility among the applicants:

	CRCC	GSRMC	NSROC
Medicare	53.6%	51.8%	31.0%
Medicaid	3.3%	6.1%	11.0%
Self pay	1.6%	3.3%	6.4%
Charity Care	\$326,215	\$151,000	\$629,942
Charity Care % of Gross Revenue	2.5%	3.3%	5.4%

Record of the Applicant – 13a, 13b

North Strand expects to benefit from the availability of McLeod Regional Medical Center's experience with operating a radiation therapy program. Loris Healthcare System and MRMC have had a 15 year history of collaboration. As of January 12, 2012, McLeod will be the owner of the Loris Healthcare System. MRMC has extensive experience in providing radiation therapy.

2. Acceptability – 4a

North Strand received approximately 50 letters of support from patients, physicians and community leaders, which were substantially less letters of support than for Grand Strand or CRCC. Opposition to the project by Grand Strand and CRCC was considered. Dr. Lawrence Holt, Jr. with Coastal Cancer Center, the physician group that also provided letters of support for the other two applicants, stated in a letter of November 29, 2011 they want to reaffirm their support for the project and intend to establish physician offices and chemotherapy services on the campus of Seacoast Medical Center in order to demonstrate their willingness to work with NSROC.

Distribution – 22

The existing distribution and the effect of the proposed project upon that distribution was identified. See Community Need Documentation and Distribution (Accessibility).

Adverse Effects on Other Facilities – 23a

North Strand alleges no adverse impact upon “any other planning area providers.” However there will be an adverse impact upon CRCC as their 2010 patient origin data indicates 22% from the Conway area, 22% from the North Myrtle Beach area and 6% from the Loris area.

3. Financial Feasibility – 15

The proposed project appears to be financially feasible and will realize a negative balance during the first year of operation, a slight profit during the second year and a modest profit during the third year. As previously indicated, McLeod Health will be purchasing LHS, but the financial impact of this purchase was not disclosed. However, the utilization projections, thus the financial projections, are questionable (See Community Need Documentation).

The CFOs for both LHS and McLeod Health confirmed availability of funds for the proposed project. The project will be funded through equal capital contributions from NSROC's two members, McLeod Regional Medical Center ("MRMC") and Loris Health Services, Inc., each having 50% ownership. Loris Healthcare System ("LHS") and MRMC expect to contribute a total of up to \$4,761,373 towards the capital funds needed to implement the project and contribute additional money to provide start up working capital. LHS and MRMC will finance the capital cost from existing cash reserves.

Cost Containment – 16a, 16c

North Strand addressed cost containment and identified methods and availability of funding. The impact of the applicant's cost to provide services was documented.

Projected Revenue/Projected Expenses – 6a, 7

Proposed charges and cost projections appear to be reasonable. However, the utilization projections, thus the financial projections, are questionable (See Community Need Documentation).

Grand Strand Regional Medical Center

Total Project Cost = \$9,788,625

Linear Accelerator: Varian Clinac iX (\$2,812,533)

Facility = 9,519 square feet

1. Compliance with the South Carolina Health Plan

Grand Strand addressed all of the standards in the Plan. In a letter of November 16, 2011, Daniel Sullivan of the Sullivan Consulting Group responded to the staff request to provide information from Standard 8. Many letters expressed a willingness to refer, but did not quantify referral volumes. Mr. Sullivan stated most physician specialties do not refer patients directly to radiation therapy centers, but typically a primary care physician or a general surgeon, upon diagnosing cancer in a patient, would refer the patient to a medical oncologist to determine the most appropriate type of treatment. Six oncologists from Coastal Cancer Center provided letters of support.

Community Need Documentation – 2a, 2b, 2c, 2e

The applicant clearly identified the target population. Grand Strand is in the three-county service area that includes Georgetown, Horry, and Williamsburg Counties. Population projections were clearly presented. Grand Strand stated that for radiotherapy services, Horry County would be the primary service area and Georgetown and Williamsburg Counties would be the secondary service area.

When calculating existing utilization, it is noted that Grand Strand repeatedly assigns GMH a capacity of 5,000 treatments, but the facility has stated their capacity is 7,000 treatments and this capacity is reflected in the Plan.

According to 2008 DHEC data, there were 2,391 new cancer cases in the service area. Based on internal data, Grand Strand had 4,860 patients with a primary or secondary cancer diagnosis, currently referring them to CRCC or other providers. Grand Strand states they coordinate care for cancer patients with the medical oncologists of the Coastal Cancer Center. The oncologists also refer cancer patients requiring surgery to Grand Strand.

Grand Strand projects to capture 20% of Horry County patients (216 patients) plus 5% immigration (12 cases) for a total of 232 patients. They claim they will only be taking 26 patients (546 treatments) from CRCC in 2015. However, staff projects the impact will be greater. Based upon 55% of cancer patients requiring radiotherapy, Grand Strand projects the service area to have 1,249 radiotherapy cases in 2010 and 1,442 cases in 2015, resulting in an increase of 194 patients, which includes 173 Horry County patients. In order to achieve the projected 232 patients, Grand Strand would have to capture 100% of the additional 173 patients plus 43 CRCC patients to total 216 Horry County patients. Therefore, the impact upon CRCC of losing 26 patients does not appear to be accurate. Even at the higher number of patients taken from CRCC, it does not appear to decrease CRCC below 80% of capacity.

Grand Strand stated in a November 16, 2011 letter from Daniel Sullivan that a notable exception to the typical referral pattern is the case of the urologists in Horry County, most of which belong to the Atlantic Urology group that owns CCRC. Mr. Sullivan expects nearly 100% of these urological referrals to go to CRCC and this was considered in Grand Strand's utilization projections, though they were not quantified.

Distribution (Accessibility) – 3a, 3b, 3c, 3e, 3f

The staff concurs cancer treatment can be most effective when delivered in a comprehensive setting. However, GSRMC does not propose any inpatient treatments according to their pro forma. Staff concurs it is advantageous to have radiation oncologists and medical oncologists practicing in close proximity. Both Grand Strand and the main office for CRCC are both located within a few miles of Coastal Cancer Center, the primary referral source in that area for cancer treatment.

CRCC maintains that Conway Regional Medical Center and Loris Community Hospital will not refer patients for radiation therapy to Grand Strand. This is a reasonable concern and could limit accessibility. It is noted these facilities did not provide letters of support for Grand Strand.

The project will not increase geographic access since CRCC is currently located in Myrtle Beach in close proximity to Grand Strand. The Grand Strand project could provide greater access to inpatients at the hospital in need of cancer treatment services; however, their pro formas indicate no income from inpatients for this project.

Grand Strand will offer access to support services to accommodate the needs of their patients and has documented means by which a person will have access to its services.

Staff concludes all applicants demonstrate financial accessibility. The following table compares projected payor sources and financial accessibility among the applicants:

	CRCC	GSRMC	NSROC
Medicare	53.6%	51.8%	31.0%
Medicaid	3.3%	6.1%	11.0%
Self pay	1.6%	3.3%	6.4%
Charity Care	\$326,215	\$151,000	\$629,942
Charity Care % of Gross Revenue	2.5%	3.3%	5.4%

Record of the Applicant – 13a, 13b

Grand Strand has been providing health care services to the residents of Horry County since it opened in 1978. Services range from a Level III Trauma Center to the open-heart surgery program opened in June of 1995. Grand Strand is currently accredited by the American College of Surgeons as a Community Hospital Cancer Program. It is the service area's largest and most comprehensive tertiary care hospital. Grand Strand is a subsidiary of Hospital Corporation of America, Inc. (HCA), that provides a broad resource base of administrative and technical expertise in hospital operations.

2. Acceptability – 4a

Grand Strand has garnered significant support for this project, with over 240 letters of support. There were approximately 100 letters of support from physicians, 4 letters from elected officials and around 140 community letters. The majority of the community letters were from H2U members. H2U or Health to You, promotes living a healthy lifestyle and offers memberships through Grand Strand for health and wellness information, discounts, invitations to hospital sponsored activities, etc. Strand Orthopaedic Consultants supported this project as well as the CRCC project. Staff from Coastal Cancer Center supported this as well as the other two projects.

Staff considered opposition to the project. CRCC, North Strand and Georgetown Hospital System ("GHS") filed as affected persons opposing this project. See Adverse Effects.

Distribution – 22

The existing distribution and the effect of the proposed project upon that distribution was identified. See Community Need Documentation and Distribution (Accessibility)

Adverse Effects on Other Facilities – 23a

In the November 16, 2011 letter from Daniel Sullivan of Sullivan Consulting Group, Inc., a statement was made regarding Coastal Cancer Center that these physicians "serve a high percentage of the cancer patients in Horry County, and because Coastal's main office is next to the GSRMC campus and many of its patients receive chemotherapy treatment at the main office, it is reasonable to conclude that a significant percentage of Coastal's patients from the service area will choose GSRMC for radiation treatment." Mr. Sullivan did not quantify the percentage or number of patients, but "significant percentage" implies a sizeable impact upon the existing provider, CRCC, and Grand Strand projects serving 223 radiation therapy patients in the third year of operation.

Staff concludes there is adverse impact with this project and the approved relocation of the Francis B. Ford Cancer Treatment Center. A review of the proposed service area in the Francis B. Ford CON application indicates that there are six (6) overlapping ZIP codes with the Francis B. Ford project and the Grand Strand primary service area. The 6 ZIP codes account for 36.6% of the 2009 Francis B. Ford cancer patient origin and 48.2% of Grand Strand's 2010 inpatient discharges.

3. Financial Feasibility – 15

GSRMC proposes to fund the project from capital funds provided by HCA, which will be derived through internally generated and borrowed funds that are included in HCA's cash reserves. Grand Strand is owned by Healthtrust, Inc. – The Hospital Company, that is in turn, owned by HCA Inc.

Cost Containment – 16a, 16c

GSRMC addressed cost containment and identified methods of funding and demonstrated feasibility of this option. The impact of the applicant's cost to provide services was documented. GSRMC's project costs and patient charges appear to be reasonable.

Projected Revenue/Projected Expenses – 6a, 7

Proposed charges and cost projections appear to be reasonable.

Carolina Regional Cancer Center - Conway

Total Project Cost = \$9,522,745

Linear Accelerator: Varian TrueBeam (\$2,413,894)

Facility = 3,616 square feet

1. Compliance with the South Carolina Health Plan

CRCC demonstrated compliance with all standards in the Plan. A listing of patient referrals by referring physician for the previous 12 months was provided (November 2010 through October 2011). For a total unique patient count of 1,000 patients, 360 patients, or 36% of the total, were from Atlantic Urology. Coastal Cancer Center ("CCC") physicians accounted for 263 or 26.3% of referred patients. It is noted that three of the letters, from CCC physicians specifically mentioned a willingness to refer patients as required by Standard 8. Even though "expected annual referral volumes" were not provided, current volumes were provided from all referral sources. In their response to Item B-10, CRCC stated that 98% of its patients are from physician referrals, mostly from an attending physician.

2. Community Need Documentation – 2a, 2b, 2c, 2e

The applicant clearly identified the target population. CRCC treats patients from Georgetown, Horry, and Williamsburg Counties and considers the region to be its service area. Population projections were clearly presented.

Zip codes were grouped into six market areas based on geography and the following table summarizes the percent of CRCC patients from each area and the 2015 population projection

provided by Nielsen/Claritas.

Table 8 – Patient Origin in Service Area

Area	CRCC Patient Origin	2015 Population Projection*
Conway Area	22%	80,355
Georgetown Area & Williamsburg County	1%	72,415
Loris Area	6%	24,588
Murrells Inlet Area	29%	100,778
Myrtle Beach Area	20%	71,438
North Myrtle Beach Area	22%	53,310
Total	100%	402,884

The percentages are based on 495 patients from within the service area during the last six months of 2010. CRCC treated 571 total patients during this time period with 76 of those patients coming from locations outside of the three-county service area (22 from other locations in SC, 44 from NC, and 10 from other locations).

More than 22% of CRCC's patients live in the Conway area while 6% live in the Loris area. Combined, these two areas account for more than 28% of CRCC's patient volume. These patients would be served by a cancer treatment center in Conway, SC.

Projected Utilization: CRCC is proposing the expansion of an existing service based on its current patient volume and the unmet need in the Conway-Loris area. The following table projects the number of linear accelerator radiation treatments with two CRCC locations in the service area:

Table 10

Radiation Treatments	2009	2010	2011	2012	2013	2014
CRCC-Myrtle Beach	15,613	20,946	22,419	18,258	18,717	19,185
CRCC-Conway	NA	NA	NA	4,854	4,976	5,100
Total Treatments	15,613	20,946	22,419	23,112	23,693	24,285
Change over prev. year		34.2%	7.0%	3.1%	2.5%	2.5%

CRCC has experienced significant growth in utilization during 2010. The total treatments at CRCC grew 34.2% from 2009 to 2010 alone. To calculate projected utilization, a more conservative growth rate of 2.5% was applied. This is in contrast to the substantial growth experienced in 2010, which is attributed to the purchase of the facility by 21st Century Oncology. As previously shown, approximately 28% of CRCC's patients come from Conway and Loris area. CRCC conservatively expects that 75% of their patients from the Conway and Loris area will utilize the proposed linear accelerator located in Conway (i.e. 21% of their current patients will utilize CRCC-Conway).

Distribution (Accessibility) – 3a, 3b, 3c, 3e, 3f

This project projects the quickest implementation time with approximately six months, taking advantage of the existing vault, which will facilitate accessibility. This project will also improve the geographic accessibility for patients in the service area, especially those in the Conway and Loris areas. It is noted that the Conway area has a lower socio-economic status and the proposed site is more accessible to rural portions of the service area. North Strand promotes the accessibility of its site, but staff feels the sites are equally accessible and further notes that the

distance between Loris and Conway is approximately the same distance as Loris and Little River, the proposed site for NSROC. The Conway site is centrally located, serving more inland residents and accessible to rural residents.

Currently CRCC is operating 12 hour shifts to meet the current demand since they are operating well over capacity. Placing an additional accelerator in an area that currently accounts for 28% of patients will relieve capacity constraints.

Staff notes that the proposed Varian Trilogy True Beam system is more advanced than the iX systems proposed by the other applicants. Specifications for the unit include a higher dose rate, image guidance during treatment and is faster and more precise. Information from the manufacturer, Varian, supports the True Beam as being a more advanced system.

CRCC stated they will offer access to support services to accommodate the needs of their patients. CRCC adequately documented means by which a person will have access to its services (See Compliance with the SC Health Plan).

The following table presents the total amounts of indigent care provided by CRCC:

	2008	2009	2010
Gross Charges	\$35,959,784	\$36,978,776	\$46,520,118
Indigent Care	\$990,254	\$771,022	\$1,237,664
As % of Gross	2.8%	2.1%	2.7%

Projected:

	2011	2012	2013	2014
Gross Charges	\$59,574,787	\$61,417,306	\$62,952,739	\$64,526,557
Indigent Care	\$1,470,051	\$1,515,516	\$1,553,404	\$1,592,239
As % of Gross	2.5%	2.5%	2.5%	2.5%

The following table compares projected payor sources and financial accessibility among the applicants for each respective project, which indicates all applicants demonstrate financial accessibility:

	CRCC	GSRMC	NSROC
Medicare	53.6%	51.8%	31.0%
Medicaid	3.3%	6.1%	11.0%
Self pay	1.6%	3.3%	6.4%
Charity Care	\$326,215	\$151,000	\$629,942
Charity Care % of Gross Revenue	2.5%	3.3%	5.4%

Record of the Applicant – 13a, 13b

CRCC has provided radiation therapy services in the region for three decades. The center is accredited by the American College of Radiology (ACR), which has very high standards of compliance regarding radiological services. CRCC's current equipment appears focused on state of the art technology as evidenced by the tomotherapy unit and a recently replaced linear accelerator. CRCC has a 38 member team and has access to clinical trials.

3. Acceptability – 4a

CRCC has demonstrated strong support for this project, with over 100 letters of support. There were approximately 76 letters of support from medical providers, including 18 from Conway Medical Center. Strand Orthopaedic Consultants supported this project as well as the Grand Strand project. Staff from Coastal Cancer Center supported this as well as the other two projects. The community letters of support included over a dozen political letters (City of Conway, Town of Surfside Beach, etc.) and around 12 other community letters, such as from Agape Hospice and Mercy Care Hospice.

Staff considered opposition to the project. Grand Strand, North Strand and Georgetown Hospital System ("GHS") filed as affected persons opposing this project. See Adverse Impact.

Distribution – 22

The existing distribution and the effect of the proposed project upon that distribution was identified. See Community Need Documentation and Distribution (Accessibility).

Adverse Effects on Other Facilities – 23a

GHS contends that approval would significantly impact the recently approved Murrells Inlet projects with CRCC-Conway being 13 miles from the proposed relocation of Francis B. Ford. GHS mentions lack of need and significant adverse impact, but did not provide any data to support these claims. GHS feels approval of a linear accelerator in proximity to the recently approved projects without first allowing these providers to implement their projects would not constitute sound health planning. GHS claims the relocation was based on proving increased access to the majority of GHS patients who live in northern Georgetown and Horry Counties. Allowing another provider to enter the market would jeopardize the financial viability of their project. Staff notes that CRCC considered its Conway project within its Murrells Inlet application. Both projects are currently under appeal in the Administrative Law Court and staff is unsure at this time if or when the projects will be implemented. CRCC proposes to serve an existing market as the patient origin data indicated 22% of their patients are from the Conway area and only 1% are from the Georgetown area and Williamsburg County, areas proposed to be served by Francis B. Ford. CRCC also predicted a conservative growth rate of 2.5%.

4. Financial Feasibility – 15 (See also Cost Containment)

The pro formas show a profit during all years submitted – 2012 through 2015. Staff requested a breakdown showing the Murrells Inlet project, which is shown below:

2012				2013			
Myrtle Beach	Conway	Murrells Inlet	Combined	Myrtle Beach	Conway	Murrells Inlet	Combined
Gross Charges	\$48,519,672	\$12,897,634	\$-	\$61,417,306	\$37,142,116	\$13,220,075	\$12,590,548
Net Charges	\$17,655,993	\$4,693,365	\$-	\$22,349,358	\$13,514,933	\$4,810,699	\$4,581,618
Total Operating Expenses	\$7,791,255	\$2,738,530	\$-	\$10,527,785	\$7,188,178	\$2,807,597	\$3,310,133
Income Before Income Taxes	\$9,776,863	\$1,933,476	\$-	\$11,710,339	\$6,261,014	\$1,979,703	\$1,249,200
Net Income	\$6,012,771	\$1,189,088	\$-	\$7,201,859	\$3,850,524	\$1,217,517	\$768,258
Treatment Volume	18,258	4,854	-	23,112	13,978	4,976	4,739
2014				2015			
Myrtle Beach	Conway	Murrells Inlet	Combined	Myrtle Beach	Conway	Murrells Inlet	Combined
Gross Charges	\$38,070,669	\$13,550,577	\$12,095,311	\$64,526,557	\$39,022,436	\$13,889,341	\$13,227,944
							\$66,139,721

Net Charges	\$13,853,669	\$4,930,967	\$4,696,158	\$23,480,794	\$14,200,010	\$5,054,241	\$4,813,562	\$24,067,813
Total Operating Expenses	\$7,294,845	\$2,852,050	\$3,349,334	\$13,496,229	\$7,403,779	\$2,897,495	\$3,389,365	\$13,690,639
Income Before Income Taxes	\$6,491,439	\$2,054,932	\$1,323,982	\$9,870,353	\$6,727,161	\$2,132,162	\$1,400,784	\$10,260,107
Net Income	\$3,992,235	\$1,263,783	\$814,249	\$6,070,267	\$4,137,204	\$1,311,280	\$861,482	\$6,309,966
Treatment Volume	14,328	5,100	4,857	24,285	14,687	5,227	4,978	24,892

With an existing lease already in place for a specialty-built medical building with a radiation therapy vault and shielded area for a CT simulator, CRCC can have the new center and linear accelerator giving treatments within a matter of months from the receipt of the CON. Staff notes that North Strand claims the CRCC building is inadequately designed and does not promote operational efficiency. Staff concludes the building is much smaller without extra space for a conference room, etc., but 21st Century possesses much experience and should be able to make the very conservative design work. CRCC appears to have budgeted substantial funds to renovate the building.

Cost Containment – 16a, 16c

CRCC adequately addressed cost containment. They identified methods of funding and demonstrated the method chosen as the most feasible option. Radiation Therapy Services, Inc. (RTSI) indicates that they plan to finance the project with existing operating reserves but may lease the linear accelerator or choose to finance some of the costs through borrowing arrangements with lenders. They stated that CRCC and RTSI have the resources and credit rating to fully finance the project. RTSI has at its disposal cash from operations in excess of \$23 million as of March 31, 2011. Patient charges were also indicated to be reasonable.

The applicant also provided the following to demonstrate cost containment: use of existing building; least total project cost, substantially lower than the other projects; shorter time-frame to bring their new linear accelerator online; large discounts on equipment and medical supplies available due to being a subsidiary of one of the nation's largest providers of radiation therapy services; economies of scale by the sharing of administrative support, computer systems, etc.; state of the art Varian TrueBeam System; clinical, operational, management and financial resources from 21st Century Oncology/Radiation Therapy Services, Inc.

Projected Revenue/Projected Expenses – 6a, 7

Pro formas were also submitted without the Murrells Inlet location (prior to its approval). Proposed charges and cost projections appear to be reasonable.

Conclusion

Staff has determined the applications are competing. CRCC, GSRMC, and NSROC each applied for a CON to provide radiation therapy services in Horry, Georgetown, and Williamsburg Counties and the need for radiation therapy services in the defined services area will be exceeded if more than one application is approved. Additionally, Staff believes that approval of more than one of these CON applications will have an adverse impact on other providers in the service area, and that this negative impact exceeds the benefits of improved accessibility.

The project proposed by CRCC best meets project review criteria, standards in the Plan and the purpose of CON. Therefore, staff has concluded that a CON should be awarded to CRCC-Conway.

Even though the Grand Strand project contributes to the continuum of care for current oncology services, it does not substantially improve accessibility since the location is in the vicinity of the CRCC Myrtle Beach location. The overlapping service area ZIP codes for patient origin are significant with the approved Francis B. Ford Cancer Center relocation. This can also be seen as unnecessary duplication. The location also does not improve access to Conway, an area of rapid growth. North Strand's project is not located in an area of rapid growth, if North Myrtle Beach is not considered. This area is also well served by CRCC's existing office. The utilization projections for North Strand appeared to be unrealistic. This project with the least support and did not provide adequate referral documentation.

Staff recognizes the strong support received by Grand Strand and the fact that it is one of two hospitals of its size (besides Providence with its cardiology focus) without a radiation therapy program. Staff believes the projected utilization could have substantial adverse impact upon the existing CRCC location as evidenced in the statement by Grand Strand's consultant indicating "it is reasonable to conclude that a significant percentage of Coastal Cancer Center's patients from the service area will choose GSRMC for radiation treatment." Staff concurs with some concerns expressed by GHS over the fact that the Murrells Inlet linear accelerator projects have not been completed due to ongoing litigation. However, CRCC is currently operating significantly over capacity. Staff concludes it is prudent to consider that there are two other service area radiation therapy projects tied up in appeal and approving one project, particularly an expansion project, would better comply with the purpose of CON, with its funding from cash balances, lowest project cost, to include linear accelerator cost (cost containment), rapid ramp up time with advanced equipment in a more disadvantaged area (guide establishment best serving the public's needs), location in Conway (no unnecessary duplication) and extensive experience (high quality services).

EXHIBIT B

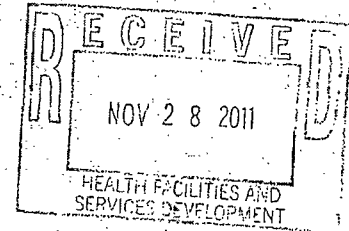


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November 28, 2011

Beverly Brandt, Chief
Bureau of Health Facilities and Services Development
South Carolina Department of Health and Environmental Control
Heritage Building, Suite 201
1777 St. Julian Place
Columbia, SC 29204



Subject: Purchase and installation of a linear accelerator for a new cancer treatment center to be established in an existing medical office building located in Conway, SC (Horry County); Carolina Regional Cancer Center, LLC – Follow-up on Project Review Meeting

Dear Ms. Brandt:

This letter is in follow-up to the project review meeting held on November 15, 2011, which addressed our CON application and the applications by Grand Strand Medical Center and North Strand Radiation Oncology Center.

In our presentation, we addressed Carolina Regional Cancer Center's compliance with the standards in the SC Health Plan and our fulfillment of the criteria established for review of these applications. After reflecting on the project review meeting, we are providing the following comments:

A. Regarding Grand Strand Regional Medical Center.

1. Grand Strand overestimated its projected utilization.
 - a. NC zip codes are used in its primary and secondary market. Nearly 5% of patients are expected from beyond its service area, presumably from NC since NC patients represent approximately 5% of the hospital's inpatient origin.
 - b. The new cancer cases are overestimated by approximately 5% in comparison with trendline analysis of cancer incidence growth from 1998-2009.
2. Grand Strand undervalued its capacity at 5,000 treatments per year.
 - a. The *SC Health Plan* Standard #2 for Radiotherapy Services states: "Linear accelerators providing IMRT or IGRT have a capacity of 5,000 treatments per year. A facility must document that it is providing or will provide these specialized treatments in sufficient volume to justify why it should be held to this planning capacity."
 - b. This standard does not reflect the new technology in modern linear accelerator treatment. CRCC and the Ford Cancer Center have linear accelerators that provide IMRT and IGRT procedures, but have not determined that these procedures significantly slow treatment times and have not requested a reduction in capacity to 5,000. Clearly IMRT and IGRT can be performed while still maintaining a linear accelerator capacity of 7,000.

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- c. CRCC recently analyzed treatment volumes on its Varian iX for a two month period. The treatments included 70% IMRT and/or IGRT and CRCC averaged 3.5 patients per hour. At 252 operating days per year and a limited schedule of 8 hours per day, the unit can comfortably handle 7,056 treatments.
 - d. Grand Strand has not demonstrated its proposed unit should be at the lower volume. In fact, in its application it arbitrarily recalculated the capacity of the existing providers using this lower level for one unit in each provider.
3. Grand Strand's proposed project is nearly twice the cost of CRCC's (\$9.8 million versus \$5.1 million for CRCC's, which includes land cost excluded from Grand Strand's).
4. Grand Strand's proposed project will take three times longer to complete. (18 months versus six for CRCC's).
5. Grand Strand's proposed facility in Myrtle Beach does not provide increased access to underserved areas of Horry County or the region.
6. Grand Strand's proposed facility provides an unnecessary duplication of services since its proposed location is within three miles of CRCC's existing facility.
7. Grand Strand's proposed project will adversely impact CRCC by significantly reducing CRCC's utilization below its current level.
8. Grand Strand does not provide strong evidence of why a tertiary healthcare facility should initiate a radiation therapy service line.
 - a. There are several other larger hospitals without radiation therapy services and the commonality being a private provider like CRCC in the service area.
 - b. Radiation therapy is almost exclusively an outpatient treatment; therefore, a hospital based program has no direct benefit to increasing the continuity of care for the patient.
9. Grand Strand relies on its affiliation with HCA to provide the necessary resources to ensure operating a quality radiotherapy program and did not explain the mechanism for support. Such limited applicant experience and lack of backup staffing does not enhance services in the area. Grand Strand's lack of specificity is demonstrated in the fact that a radiation oncologist for the center has not been identified.

B. Regarding North Strand Radiation Oncology Center.

1. North Strand overestimated its projected utilization.
 - a. Their projections assumed an average of 25 treatments per patient while 21 is the average for existing providers in the region. This results in a 19% overestimation of its expected volume.
 - b. North Strand projects 259 patients in Year 3 with 10% of these patients residing outside of SC. Patients outside of SC cannot be used to justify utilization for CON purposes.
 - c. These over-projections amount to about 1/3 of North Strand's utilization.
2. North Strand undervalued its capacity at 5,000 treatments per year.

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- a. The SC Health Plan Standard #2 for Radiotherapy Services states: "Linear accelerators providing IMRT or IGRT have a capacity of 5,000 treatments per year. A facility must document that it is providing or will provide these specialized treatments in sufficient volume to justify why it should be held to this planning capacity."
 - b. This standard does not reflect the new technology in modern linear accelerator treatment. CRCC and the Ford Cancer Center have linear accelerators that provide IMRT and IGRT procedures, but have not determined that these procedures significantly slow treatment times and have not requested a reduction in capacity to 5,000. It can be assumed that IMRT and IGRT can be performed while still maintaining a linear accelerator capacity of 7,000.
 - c. North Strand provided no documentation to support its claim of a capacity of 5,000. Furthermore, it projects operating at 130% capacity in Year 3 which is evidence that the proposed unit's functional capacity is 7,000 instead of 5,000.
3. North Strand's proposed project is nearly twice the cost of CRCC's (\$9.5 million versus \$5.1 million for CRCC's, which include land cost excluded from North Strand's).
 4. North Strand's proposed project will take nearly three times longer to complete. (17 months versus 6 for CRCC's)
 5. North Strand's proposed project will adversely impact CRCC by significantly reducing CRCC's utilization below its current level.
 6. North Strand's proposed service area does not provide improved access of radiation therapy services in the service area.
 - a. The proposed facility is not centrally located to serve the growing population of Conway and all surrounding underserved areas and is dependent on in-migration to support utilization growth.
 - b. During the project review, representatives from North Strand attempted to demonstrate that patients receiving chemotherapy at Loris hospital and in need of radiation would be better served by having a treatment center located in Little River rather than Conway. The fact is that patients from Loris would be just as easily, if not better served, by a facility located in Conway. The travel distance and time are basically the same from the Loris Hospital to each location.
 7. Several zip codes provided in the North Strand service area analysis, to include 29511 and 29526, are closer to CRCC. Therefore, the patients can best be served at the CRCC facility.
 8. North Strand heavily relies on its relationship with McLeod Health and Loris Healthcare to offer optimal radiation therapy services; which attests to their lack of experience and financial security in establishing a quality program.
 9. The financial viability of North Strand's project is questionable due to the well-publicized financial difficulties experienced by its 50% owner Loris Healthcare.

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10. North Strand touts Loris' not for profit status as an indication of providing service to the indigent. However, recently published documentation states a decrease in state disproportionate share payment to Loris Healthcare because the amount of care provided to underserved patients seen at their facility is not considered to be a disproportionate level.
11. North Strand states their proposed project will improve access to North Myrtle Beach and surrounding areas; yet, they fail to consider the second highest populated area in the county as a factor of need and support their proposed location with flawed data from an outdated traffic study.

C. Regarding the Question of Approving two Linear Accelerators:

During the project review meeting the applicants were asked about the potential to approve two new linear accelerators in the region.

1. CRCC's position is that only one linear accelerator should be approved and we have presented the application that best addresses the unmet need in the region, best complies with the standards outlined in the SC Health Plan, and best adheres to the criteria set forth in the regulation.
2. After the meeting, we completed an extensive analysis of the impact on the existing units in the region. The SC Health Plan is very specific in this regard and states *"An applicant must project that the proposed service will perform a minimum number of treatments equal to 50 percent of capacity annually within three years of initiation of services, without reducing the utilization of the existing machines in the service area below the 80 percent threshold."*
3. Exhibit A presents the analysis if any two of the applications are approved and shows that in every case the utilization of the existing units is below the 80% threshold. See the highlighted utilization levels on pages 2, 3, and 4. Page 1 presents the underlying assumptions of the analysis: The number of radiation therapy treatments in the region will grow at 2.4-2.7% per year and the number of patients to be seen at the Grand Strand, North Strand, and the Ford Cancer Center in Murrells Inlet would have otherwise been referred to CRCC. All three are entering markets almost exclusively served by CRCC.
4. In addition, recent approvals to relocate existing linear accelerators to the Murrells Inlet area will naturally cause a shift in patient volumes among existing providers. To approve two new radiation therapy providers in the area without historical data to address any new shifts would not be a true indication of linear accelerator need in the area. For instance, the approval to relocate the Ford Cancer Center from Georgetown to Murrells Inlet will likely cause a change in referral patterns to the Ford Center. This potential impact would be for patients in the Georgetown area and Williamsburg County to be referred out of the region. This would cause a lower than predicted market for services and further undermine the need to two new linear accelerators.
5. The first enumerated purpose in the CON Act is to promote cost containment. These projects are all capital intensive with CRCC's significantly less costly.

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It seems most logical, with regards to furthering the purpose of the CON Act and from a health planning standpoint, to approve CRCC's project which can be brought online in six months as opposed to seventeen to eighteen months and then evaluate the need for a second new linear accelerator to be added to the service areas once the impact on the market is shown.

6. It would be prudent to approve only one additional linear accelerator until it can be determined there is sufficient need for additional machines. The Department's recent experience with Ambulatory Surgical Centers, which required a change to the State Health Plan to better control the growth of ASCs, is an example of why it is necessary to proceed cautiously before approving two linear accelerators. During the project review, Mr. Bailey, CEO of Georgetown Hospital noted if the previously approved linear accelerator projects in Murrells Inlet are initiated and two additional linear accelerators are approved for Horry County, the total cost for additional accelerators will exceed 40 million dollars. This will represent an unreasonable cost and unnecessary duplication of services.

D. Regarding Carolina Regional Cancer Center.

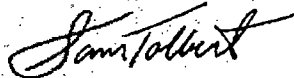
1. There were some comments made at the project review meeting regarding CRCC's proposed Varian TrueBeam System and insinuations that it could not be much different from the Varian iX proposed by North Strand and Grand Strand since the prices were similar.
 - a. 21st Century Oncology is the largest provider of radiation therapy services in the nation and as such has a very favorable purchasing agreement with Varian. The price in CRCC's CON application is for a fully equipped TrueBeam System.
 - b. The TrueBeam System is significantly superior to the Varian iX proposed by North Strand and Grand Strand. Exhibit B presents a letter from Constantine A. Mantz, M.D., Chief Medical Officer for 21st Century, that describes the major advantages of the TrueBeam System in terms of technical performance, patient comfort and patient safety.
2. By email on November 16, you requested a current index of letters of support and expected referral volumes. The *SC Health Plan* Standard #8 for Radiotherapy Services states "The applicant shall project the utilization of the service and document referral sources for patients within its service area, including letters of support from physicians and health care facilities indicating a willingness to refer patients to the proposed service, with expected annual referral volumes."
 - a. Exhibit C presents the requested index of our letters of support.
 - b. As an existing provider and in contrast to the two other applicants, we have a well-documented history of referrals from other providers in the region. Standard #8 does not require the letters to include expected annual referral volumes and CRCC's projection of utilization is based on its well documented volume as reported in its Joint Annual Reports. As additional documentation, we are including as Exhibit D a report of patient referrals by referring physician for the previous 12 months.

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3. We are confident you will find that CRCC's proposal most fully meets the purposes of the CON Act:
- a. **Promote cost containment.** CRCC's project proposes superior equipment at a total project cost that is approximately 1/2 of the cost of each other applicant. CRCC size and relationship with 21st Century Oncology brings increased continuity of care, economies of scale, immediate back-up, access to manpower through its own training program for radiation therapists and dosimetrists which it has operated since 1992 and 2004 respectively.
 - b. **Prevent unnecessary duplication of health care facilities and services.** The SC Health Plan provides separate standards that allow the expansion of existing providers over new ones. CRCC is a highly qualified existing provider that is applying to expand its existing service. Grand Strand will unnecessarily duplicate services just 3 miles away from an existing facility. CRCC Conway is geographically superior to North Strand's location in that it is centrally located to serve a region of greater need. CRCC's proposal is the best solution and will not be a duplication of services.
 - c. **Guide the establishment of health facilities and services that will best serve the public needs.** The Conway location provides local services to the highest populated area in the region without radiation therapy service. The patients in the Conway area are more disadvantaged socio-economically. CRCC provides services to all referrals regardless of a patient's ability to pay for the services. The other proposed projects will take 3 times longer to initiate. CRCC's proposed Varian TrueBeam system is superior to the Varian iX proposed by the other applicants.
 - d. **Ensure that high quality services are provided in health facilities in this State.** North Strand has no experience in radiation oncology and has partnered with a provider 81 miles away. Grand Strand has no experience in radiation oncology. CRCC's depth of experience in Horry County (31 years) proves its long-term commitment to the region. CRCC's extensive referral base and growing utilization attest to a high level of quality and patient service. Its ACR accreditation validates its level of quality. CRCC's CON application demonstrates the proposed project is viable and allows CRCC to better serve the region and better meets the need of its residents. It should be noted that less than 10% of radiation treatment centers nationally are ACR accredited. Over 90% of our affiliated locations have received either ACR or ACRO accreditation. As noted in our presentation, there is no evidence that a hospital provides superior service than a freestanding center specializing exclusively in radiation treatment; in fact, there are well documented problems with hospital operated centers.

If you have any questions or require further information, please let me know.

Respectfully submitted,



Sam Tolbert

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Catherine B. Templeton, Director

Promoting and protecting the health of the public and the environment

June 10, 2013

RECEIVED

JUN 12 2013

NEXSEN PRUET, LLC

VIA HAND DELIVERY

The Honorable Ralph King Anderson, III
Administrative Law Court
Edgar A. Brown Building, Suite 224
1205 Pendleton Street
Columbia, SC 29201

RE: *Grand Strand Regional Medical Center, LLC vs. SCDHEC*
Docket #12-ALJ-07-0090-CC
Grand Strand Regional Medical Center, LLC vs. SCDHEC and Carolina Regional Cancer Center, LLC
Docket #12-ALJ-07-0091-CC

Dear Judge Anderson:

Enclosed for filing with your office is the original and one copy of the following:

1. **DHEC'S MEMORANDUM OF LAW IN OPPOSITION TO GRAND STRAND REGIONAL MEDICAL CENTER, LLC'S MOTION FOR PARTIAL SUMMARY JUDGMENT**
2. **CERTIFICATE OF SERVICE**

Please return a clocked copy to the courier.

By copy of this letter to all parties of record, I am enclosing the above for service.

Thank you for your assistance.

Very truly yours,


Ashley C. Biggers

cc: James G. Long, III, Esquire
Jennifer J. Hollingsworth, Esquire
E. Wade Mullins, Esquire

William R. Thomas, Esquire
Walter H. Cartin, Esquire
David B. Summer, Esquire

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Grand Strand Regional Medical
Center, LLC,

Petitioner,

vs.

South Carolina Department of Health
and Environmental Control,

Respondent.

Docket No. 12-ALJ-07-0090-CC

Grand Strand Regional Medical
Center, LLC,

Petitioner,

vs.

South Carolina Department of Health
and Environmental Control and
Carolina Regional Cancer Center,

Respondents.

Docket No. 12-ALJ-07-0091-CC

**DHEC'S MEMORANDUM OF LAW IN OPPOSITION TO GRAND STRAND REGIONAL
MEDICAL CENTER, LLC'S MOTION FOR PARTIAL SUMMARY JUDGMENT**

The South Carolina Department of Health and Environmental Control ("DHEC" or "Department") submits this memorandum in opposition to Grand Strand Regional Medical Center, LLC's ("Grand Strand") motion for partial summary judgment. Grand Strand filed its motion on the grounds that the Department erred in concluding that Grand Strand and Carolina Regional Cancer Center ("CRCC") were "competing" Certificate of Need ("CON") applicants. The Department requests that the Court deny Grand Strand's motion because Grand Strand and CRCC are "competing applicants" pursuant to the S.C. Code Ann. § 44-7-130(5) and S.C. Code Ann. Regs. 61-15 §

103(6). In the alternative, the Court should deny Grand Strand's motion because there are genuine issues of material fact as to whether Grand Strand and CRCC are "competing applicants."

BACKGROUND

1. The CON Program

DHEC is the sole state agency charged with the administration of the *State Certificate of Need and Health Facility Licensure Act*, S.C. Code Ann. § 44-7-110, *et seq.* (2002 & Supp. 2012) ("CON Act"). S.C. Code Ann. § 44-7-140 (2002). The purpose of the CON Act is to promote cost containment, to prevent the unnecessary duplication of health care facilities and services in the state, to guide the establishment of health facilities and services in such a way as will best serve public needs, and to ensure that high quality services are provided in health facilities in the state. S.C. Code Ann. § 44-7-120 (2002). "To achieve these purposes, [the CON Act] requires: (1) the issuance of a Certificate of Need before undertaking a project prescribed by this article; (2) adoption of procedures and criteria for submittal of an application and appropriate review before issuance of a Certificate of Need; (3) preparation and publication of a State Health Plan; and (4) the licensure of facilities rendering medical, nursing, and other health care." *Id.*

The CON application process contains numerous notice requirements. First, an applicant must publish notification that it plans to submit an application to the Department in a newspaper serving the area of the proposed project for three consecutive days *prior to submitting the application to the Department*. S.C. Code Ann. § 44-7-200(B) (2002). The notification must contain a description of the scope and

nature of the proposed project. *Id.*; see also S.C. Code Ann. Regs. 61-15 § 201 (Supp. 2012). Second, after the Department receives a CON application, it must publish a notice in the State Register that the application has been accepted for filing. S.C. Code Ann. § 44-7-200(D) (2002); see also S.C. Code Ann. Regs. 61-15 § 302(1) (Supp. 2012). Third, after the Department has had an opportunity to request and receive additional information, and has determined that the application is complete, the Department must publish a notice in the State Register that the review cycle for the project has begun. S.C. Code Ann. § 44-7-210(A) (Supp. 2012); S.C. Code Ann. Regs. 61-15 § 305(1) (Supp. 2012).

The South Carolina Health Plan ("Health Plan") is the starting point for the consideration of a CON application. Adopted at least once every two years with the advice of the health planning committee, its purpose is to outline the need for health facilities and services in the State. See S.C. Code Ann. § 44-7-180(B). The determination of whether a particular facility or service is needed depends upon the projection of need set forth in the Health Plan. S.C. Code Ann. § 44-7-210(B); S.C. Code Ann. Regs. 61-15 § 802(1) (Supp. 2012). No CON application can be approved unless it complies with the Health Plan. S.C. Code Ann. § 44-7-210(B); see also S.C. Code Ann. Regs. 61-15 § 802(1) ("The proposal shall not be approved unless it is in compliance with the South Carolina Health Plan.").

Regulation 61-15, *Certification of Need for Health Facilities and Services*, also governs review of CON applications. It contains the project review criteria that may be relevant in review of a CON application. "The department may not issue a Certificate of Need unless an application complies with the State Health Plan, Project Review

Criteria, and other regulations.” S.C. Code Ann. § 44-7-120(C) (2002). “A project does not have to satisfy every criterion in order to be approved, but no project may be approved unless it is consistent with the South Carolina Health Plan.” S.C. Code Ann. Regs. 61-15 § 801(3) (Supp. 2012).

“In the case of competing applications, the department shall award a Certificate of Need, if appropriate, on the basis of which, if any, most fully complies with the requirements, goals, and purposes of [Title 44, Chapter 7, Article 3] and the State Health Plan, Project Review Criteria, and the regulations adopted by the department.” S.C. Code Ann. § 44-7-210(B) (Supp. 2012). “Competing applicants” is defined as “two or more persons or health care facilities ... who apply for certificates of need to provide similar services or facilities in the same service area within a time frame as established by departmental regulations and whose applications, if approved, would exceed the need for services or facilities.” S.C. Code Ann. § 44-7-130(5) (2002). The time frame established in Regulation 61-15 for filing competing applications is fifteen days from publication of notice to affected persons for the first application. S.C. Code Ann. Regs. 61-15 § 103(6) (Supp. 2012).

2. Review of the Linear Accelerator Applications for the Tri-County Service Area of Georgetown, Horry, and Williamsburg Counties

DHEC received three (3) Certificate of Need (CON) applications for megavoltage radiotherapy services in the tri-county Service Area of Georgetown, Horry, and Williamsburg Counties (“Service Area”). North Strand Radiation Oncology Center’s (“North Strand”) application was received first, on March 9, 2011; CRCC’s application was received on March 10, 2011; and Grand Strand’s application was received on July 19, 2011, all within the regulatory time period to be considered as potentially “competing

applicants." All three applicants sought to purchase a linear accelerator to be operated in a radiation therapy center. Of the three applicants, only CRCC was an existing provider of radiotherapy services in the Service Area. CRCC sought to expand its existing service by establishing a new location in an existing medical office building in Conway. North Strand sought to construct a new radiotherapy center on the campus of Seacoast Medical Center in Little River. Grand Strand sought to provide its new radiotherapy services in new construction that would be attached to its main hospital in Myrtle Beach. All three applications were submitted under the *2010-2011 South Carolina Health Plan* ("*2010-2011 Plan*").

"The South Carolina Health Plan outlines the need for medical facilities and services in the State." Exhibit A, *2010-2011 Plan*, at I-1. The *2010-2011 Plan* set the capacity of each conventional linear accelerator at 7,000 treatments per year. *Id.* at IX-5. Under the *2010-2011 Plan*, a new linear accelerator would only be approved if the following conditions were met:

- A. ***All existing units in the service area have performed at a combined use rate of 80 percent of capacity for the year immediately preceding the filing of the applicant's CON application***, and
- B. An applicant ***must project that the proposed service will perform a minimum number of treatments equal to 50 percent of capacity annually within three years of initiation of services, without reducing the utilization of the existing machines in the service area below the 80 percent threshold***. If the new equipment is a specialized radiotherapy unit as described in Standards 2, 3 or 4 above, then the applicant may propose an annual capacity based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in the CON application calculations, as well as future capacity calculations, for that applicant. The applicant must document where the potential patients for this new service will come from and where

they are currently being served, to include the expected shift in patient volume from existing providers.

Id. at IX-5 – IX-6 (emphasis added). The standards for the expansion of an existing under the 2010-2011 Plan included:

7. **Expansion of an existing service**, whether the expansion occurs at the existing site or at an alternate location in the service area, **shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for each of the past two years and can project a minimum use rate of 50 percent of capacity per year on the additional equipment within three years of its implementation.** If the additional equipment is a specialized radiotherapy unit as described in either Standards 2, 3 or 4 above, then the existing provider may propose an annual capacity for that additional equipment, based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in CON application calculations, as well as future capacity calculations, for the applicant.

Id. at IX-6 (emphasis added).

CRCC and the Francis B. Ford Cancer Treatment Center, which is operated by Georgetown Memorial Hospital, are the two providers of radiation therapy services in the Service Area. At the time of review, CRCC had three linear accelerators and Francis B. Ford had one linear accelerator. See Exhibit B, Grand Strand DHEC Record, at p. 930. The 2010-2011 Plan assigned an 80.5% capacity for the Service Area in 2009. Exhibit A at IX-8; see also Exhibit B at p. 930. For 2010, the Department determined the utilization for the Service Area was 101.8% of capacity. See Exhibit B at p. 930. In 2010, Francis B. Ford operated at 78.9% of capacity and CRCC operated at 110.2% of capacity. See *id.*

Department staff requested additional information from the applicants, and held a joint project review meeting on November 15, 2011. As a result of staff's review of the information submitted with respect to all three applications, staff concluded that the

applications were "competing" as that term is defined in statute and regulation. See Exhibit B at p. 944. The Department concluded that the approval of more than one linear accelerator would exceed the need for radiation therapy services projected for the Service Area. See *id.* Further, the Department determined that the approval of more than one CON application would have an adverse impact on other providers in the service area, and that this negative impact would exceed the benefits of improved accessibility. See *id.*

After deeming the applications competing, staff compared the applications and concluded that CRCC's application most fully complied with relevant project review criteria, Plan standards for radiotherapy, and the purposes of the CON Act. See *id.* at pp. 925 & 945. Therefore, by letter dated December 28, 2011, the Department notified the applicants of its decision to grant CRCC's application and to deny North Strand's and Grand Strand's applications.

Following the issuance of the Department's decision on December 28, 2011, North Strand and Grand Strand submitted requests for final review by the DHEC Board. The Board declined to hold a final review conference, thus rendering staff's decision as the final agency decision. Grand Strand and North Strand then filed requests for contested case hearings with this Court to review the Department's decisions. Pursuant to the Order Dismissing North Strand Radiation Oncology With Prejudice, this Court dismissed North Strand from this action.

STANDARD OF REVIEW

Rule 56(c), SCRCP provides that a trial court may grant a motion for summary judgment "if the pleadings, depositions, answers to interrogatories, and admissions on

file, together with the affidavits, if any, show there is no genuine issue as to any material fact and the moving party is entitled to a judgment as a matter of law." "In deciding a Rule 56 motion, the Court must view the facts and inferences therefrom in the light most favorable to the nonmoving party." *Thomas v. Waters*, 315 S.C. 524, 526, 445 S.E.2d 659, 661 (Ct. App. 1994). The Department correctly determined that under the 2010-2011 Plan, Grand Strand and CRCC were competing applicants for a linear accelerator in the tri-county Service Area of Georgetown, Horry, and Williamsburg Counties. At the very least, there are genuine issues of material fact to be decided by the Court on the "competing applicants" issue.

ARGUMENT

The Board of Health and Environmental Control ("Board") approved the 2012-2013 Plan at its November 8, 2012 meeting, approximately a year and a half after the applications at issue in this case were filed and roughly eleven months after the Department's December 28, 2011 decision. Grand Strand, in its Motion, asserts that "[b]ecause the 2012-2013 Plan establishes that there is an unmet need for an additional linear accelerator in the Service Area, . . . Grand Strand and CRCC are not 'competing applicants'" Grand Strand Motion at p. 10.

Section 44-7-225 was added to the CON Act by 2010 Act 278, § 20, effective July 1, 2010. It provides: "The department, the Administrative Law Court, and the Court of Appeals shall consider the South Carolina Health Plan in place at the time the application was filed and may consider the current South Carolina Health Plan when making its decision." S.C. Code Ann. § 44-7-225 (Supp. 2012).

Regulation 61-15 also addresses the applicable Health Plan for CON applications. Section 504 of Regulation 61-15, which was in existence prior to the passing of Act 278 and which has not been substantively amended since, provides:

All decisions on Certificate of Need applications shall be made based on the currently approved South Carolina Health Plan in effect at the time such application is accepted. Should a new plan be adopted during any phase of the review or appeals process, the applicant shall have the option of withdrawing the application and resubmitting under the newly adopted plan or continuing the review or appeal process under the plan in use when the application was submitted. In cases where applications are withdrawn and resubmitted under the newly adopted South Carolina Health Plan within forty-five (45) calendar days of the date of withdrawal, no additional filing fee shall be required.

S.C. Code Ann. Regs. 61-15 § 504 (Supp. 2012).

The Department properly considered the *2010-2011 Plan* and determined that Grand Strand's and CRCC's CON applications were "competing" as defined by the CON Act and Regulation. CRCC submitted its application to expand its radiotherapy services on March 10, 2011. Grand Strand submitted its application to develop new radiotherapy services on July 11, 2011. Both applications were submitted under the *2010-2011 Plan*. Both the CON Act and the CON Regulation require that the Department **shall** consider the Health Plan in effect at the time the application is submitted. S.C. Code Ann. § 44-7-225 (Supp. 2012); S.C. Code Ann. Regs. 61-15 § 504 (Supp. 2012). Therefore the *2010-2011 Plan* **must** be considered in making the decision on the two applications.

Grand Strand argues that because the CON Act also makes it **permissible** for the department, ALC, and Court of Appeals to consider the current Health Plan when making its decision, the Court should find the CON applications are not competing. Grand Strand bases this argument on S.C. Code Ann. § 44-7-225 (Supp. 2012) and the

identification in the *2012-2013 South Carolina Health Plan* ("*2012-2013 Plan*") of an unmet need for a linear accelerator in the tri-county service area of Georgetown, Horry, and Williamsburg Counties.

The CON Act and Regulation contain specific procedures for the filing and review of CON applications. Compliance with the procedures is necessary to provide all applicants and affected persons a fair and equitable opportunity to participate in the CON process. Following Grand Strand's argument and declaring the applicants as non-competing applicants pursuant to the *2012-2013 Plan* would deprive affected parties from the Service Area from being able to apply for radiotherapy services under the *2012-2013 Plan* and/or oppose Grand Strand's effort to be awarded a CON for radiotherapy services under the *2012-2013 Plan*. This would circumvent the CON process. Such a result would be absurd, and Grand Strand's argument should be rejected. *New York Times Co. v. Spartanburg Cnty. Sch. Dist. No. 7*, 374 S.C. 307, 312, 649 S.E.2d 28, 30 (2007) (holding that courts will reject a statutory interpretation which would lead to a result so plainly absurd that it could not have been intended by the legislature or would defeat the plain legislative intention).

CONCLUSION

For the aforementioned reasons, the Department respectfully requests that the Court deny Grand Strand's Motion for Partial Summary Judgment.

[Signature Page Follows]

Respectfully submitted,



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June 10, 2013
Columbia, South Carolina

Exhibit A



2010 – 2011 SOUTH CAROLINA HEALTH PLAN

**South Carolina State Health Planning Committee
South Carolina Department of Health and
Environmental Control**

Effective November 12, 2010

CHAPTER I

INTRODUCTION

A. Legal Basis:

Section 44-7-180 of the South Carolina Code of Laws requires the Department of Health and Environmental Control, with the advice of the S.C. State Health Planning Committee, to prepare a State Health Plan for use in the administration of the Certificate of Need Program.

B. Purpose:

The South Carolina Health Plan outlines the need for medical facilities and services in the State. This document is used as one of the criteria for reviewing projects under the Certificate of Need Program.

C. Health Planning Committee:

This committee is composed of fourteen members. Twelve are appointed by the Governor with at least one member from each congressional district. Health care consumers, health care financiers, including business and insurance, and health care providers are equally represented. One member is appointed by the Chairman of the Board of Health and Environmental Control and the State Consumer Advocate is an ex-officio member. The State Health Planning Committee will review the South Carolina Health Plan and submit it to the Board of Health and Environmental Control for final revision and adoption.

D. Relationship With Other Agencies:

The Department has received consultation and advice from a number of State Agencies, including the Department of Mental Health, Department of Disabilities and Special Needs, Vocational Rehabilitation Department, Department of Social Services, Department of Alcohol and Other Drug Abuse Services, Continuum of Care for Emotionally Disturbed Children, and the Department of Health and Human Services, during the development of this plan including the collection and analysis of data. Other organizations affected under the program, such as the S.C. Hospital Association, the S.C. Home Care Association and the S.C. Health Care Association, have been consulted as the need arises. The Department wishes to express its appreciation for their assistance.

The Department is aware that the ultimate responsibility for administering this program cannot be shared with any individual or organization; however, it does recognize the valuable contributions that can be made by other interested organizations and individuals. For that reason it will be the policy to actively seek cooperation and guidance from anyone who wishes to comment on this plan.

CHAPTER IX

MEGAVOLTAGE RADIOTHERAPY & RADIOSURGERY

Cancer is a group of many related diseases, all involving out-of-control growth and spread of abnormal cells. These cells accumulate and form tumors that invade and destroy normal tissue. Cancer is the second leading cause of death, both nationally and in South Carolina, accounting for approximately 22% of all deaths. According to the South Carolina Central Cancer Registry (SCCCR), there were 21,532 new cases of cancer diagnosed in South Carolina in 2006 and 9,063 cancer deaths. Different types of cancer vary in their rates of growth, patterns of spread and responses to different types of treatment. The overall five-year survival rate is approximately 62%.

Megavoltage radiation has been utilized for decades as a standard modality for cancer treatment. It is best known as Radiation Therapy, but is also called Radiotherapy, X-Ray Therapy, or Irradiation. It kills cancer cells and shrink tumors by damaging their genetic material, making it impossible for these cells to continue to grow and divide. Approximately 50% of all cancer patients receive radiation therapy at some time during their illness, either alone or in combination with surgery or chemotherapy. It can be used as a therapeutic treatment (to attempt to cure the disease), a prophylactic treatment (to prevent cancer cells from growing in the area receiving the radiation) or as a palliative treatment (to reduce suffering and improve quality of life when a cure is not possible).

Beams of ionizing radiation are aimed to meet at a specific point and deliver radiation to that precise location. The amount of radiation used is measured in "gray" (Gy) and varies depending on the type and stage of cancer being treated. Radiation damages both cancer cells and normal cells, so the goal is to damage as many cancer cells as possible, while limiting harm to nearby healthy tissue. A typical course of treatment lasts for two to 10 weeks, depending on the type of cancer and the treatment goal. The relevant CPT Procedure codes are: 77371-77373, 77401-77404, 77406-77409, 77411-77414, 77416, 77418, 77432 and 77470.

1. Definitions:

There are varying types of radiation treatment and definitions are often used interchangeably. The following definitions apply:

Adaptive Radiation Therapy (ART): Patient setup and/or radiation delivery is evaluated and modified periodically during the treatment course based on imaging and dose measurements made prior to or during treatment.

Conformal Radiation Therapy (CRT): Since the target often has a complex shape, CT, MRI, or PET is used to create a 3-D image of the tumor. Using the image, the computer designs the radiation beams to be shaped exactly (conform) to the contour of the treatment area. Synonyms include Conformal External Beam Radiation Therapy (CEBRT), 3-D radiation therapy (3-DRT), 3-D Conformal Beam Radiation Therapy (3-

DCBRT), 3-D Conformal Radiation Therapy (3-DCRT), and 3-D External Beam Radiation Therapy (3-DEBRT, 3-DXBRT).

Conventional External Beam Radiotherapy (2DXRT) is delivered via 2-D beams using a linear accelerator. Conventional refers to the way the treatment is planned on a simulator to target the tumor. It consists of a single beam of radiation delivered to the patient from several directions. It is reliable, but is being surpassed by Conformal and other more advanced modalities due to the reduced irradiation of healthy tissue.

Because of the increased complexity of treatment planning and delivery techniques, Electronic Portal Imaging Devices (EPIDs) have been developed. The most common EPIDs are video-based systems; on-line digital port images are captured and analyzed before or during treatment. These systems are used for pre-treatment verification of IMRT fields and to reduce errors in patient positioning.

Fractionation: A small fraction of the entire prescribed dose of radiation is given in each treatment or session. Individual treatment plans are created to minimize the side effects for normal tissue. The typical fractionation schedule for adults is once per day, five days a week. Hyperfractionation (Superfractionation) refers to radiation given in smaller doses twice a day. In Hypofractionation, individual doses are given less often than daily, such as in two-five sessions.

Image-Guided Radiation Therapy (IGRT) combines with IMRT or 3DCRT to visualize (by means of EPIDs, kV scans or mV scans) the patient's anatomy during treatments. This allows for confirmation of beam location and adjustment of the beams if needed during treatments due to breathing. IGRT facilitates more accurate patient positioning and reduces healthy tissue damage.

IMRT (Intensity Modulated Radiation Therapy) creates a 3-D radiation dose map to treat the tumor. It uses a multi-leaf collimator to modulate or control the outlines and intensity of the radiation field during cancer treatment. Due to its precision it can spare more healthy tissue, but it also requires detailed data collection and takes longer than conventional therapy.

Stereotactic body radiation therapy (SBRT) is a precision radiation therapy delivery concept derived from cranial stereotactic radiosurgery. It is characterized by one to five fraction delivery of focal high-dose radiation while limiting dose to surrounding normal tissues. SBRT has become an established treatment technique for lung, liver, and spinal lesions.

Stereotactic Radiosurgery (SRS) is a single-session procedure used to treat brain tumors and other brain disorders that cannot be treated by regular surgery. The patient's head is placed in a special frame, which is attached to the patient's skull. The frame is used to aim high-dose radiation beams directly at the tumor inside the patient's head. The radiation dose given in one session is usually less than the total dose that would be given with radiation therapy. However, the tumor receives a very high one-time dose of radiation

with radiosurgery versus smaller fractions over time with radiation therapy. It is also known as Stereotaxic Radiosurgery or Radiation Surgery.

Stereotactic Radiation Therapy (SRT) is an approach similar to Stereotactic Radiosurgery which delivers radiation to the target tissue. However, the total dose of radiation is divided into several smaller doses given over several days, rather than a single large dose. The treatment time per session typically ranges from 30 to 90 minutes for two-five sessions. It can be used to treat both brain and extracranial tumors.

2. Types of Radiation Equipment:

A. Particle Beam (Proton):

Particle beams use heavy charged subatomic particles to deliver radiation to the tumor. Unlike the other equipment forms, some particle beams can only penetrate a short distance into tissue. Therefore, they are often used to treat cancers located on the surface of or just below the skin. There are only a few facilities that operate particle beam (or cyclotron) units, which can be used to treat brain cancers and fractionated to treat other cancers. There are currently only 5 facilities in the United States and the cost of more than \$100 million will limit their expansion.

B. Linear Accelerator (X-Ray):

The linear accelerator produces high energy x-rays that are collected to form a beam that matches the size and shape of the patient's tumor. The patient lies on a movable couch and radiation is transmitted through the gantry, which rotates around the patient. Radiation can be delivered to the tumor from any angle by rotating the gantry, moving the couch, or moving the accelerator with a robotic arm. The accelerator must be located in a room with lead and concrete walls to keep the rays from escaping. A conventional linac requires modifications, such as additional equipment, in order to be used for IMRT or other advanced techniques.

Minimal equipment requirements for a linear accelerator include:

1. at least 1 teletherapy unit, with an energy exceeding 1 megavolt (MV); the distance from the source to the isocenter must be at least 80 cm;
2. access to an electron beam source or a low energy X-ray unit;
3. adequate equipment to calibrate and measure dosimetric characteristics of all treatment units in the department;
4. capability to provide appropriate dose distribution information for external beam treatment and brachytherapy;

5. equipment for accurate simulation of the treatment units in the department (in general, one simulator can service 2-3 megavoltage treatment units);
6. field-shaping capability; and
7. access to CT scanning capability.

The capacity standards for a linear accelerator vary by the capability of the equipment. A conventional linear accelerator, either with or without EPID, has a capacity of 7,000 treatments per year, based upon an average of 28 patients treated per day, 5 days per week, 50 weeks per year. Linacs with IMRT and IGRT systems (such as Tomotherapy and Novalis TX) take longer to set up and perform treatments than those relying on previously generated images. Therefore, a lower capacity of 5,000 treatments per year is established for such equipment (20 patients treated per day, 5 days per week, 50 weeks per year). IMRT/IGRT machines that perform stereotactic procedures have a lower capacity of 4,500 treatments per year (18 patients treated per day, 5 days per week, 50 weeks per year). MUSC has three linacs designated with a capacity of 5,000 treatments and two with a capacity of 4,500. The Tomotherapy unit at Spartanburg Regional has been designated with a capacity of 4,500 treatments and the Tomotherapy unit at Carolina Regional Radiation Center has been designated as having a capacity of 5,000 treatments per year. The capacities for these machines and the need calculations for their service areas have been adjusted accordingly.

There is also linac equipment designed strictly to provide Stereotactic Radiotherapy in 1-5 treatment sessions. These specialized linacs have an even lower capacity because of the treatment time associated with this type of care. The capacity for such equipment is established as 2,000 treatments per year per unit, based on 8 treatments per day, 5 days per week, for 50 days per year. The Cyberknife at Roper Hospital is the only equipment so designated. It is an older generation unit with a previously designated capacity of 1,000 treatments per year. The capacity and need calculations for this facility and service area have also been adjusted.

C. Cobalt-60 (Photon):

This modality, best known by the trade name of Gamma Knife, is used to perform Stereotactic Radiosurgery. It is primarily used to treat brain tumors, although it can also be used for other neurological conditions like Parkinson's Disease and Epilepsy. Its use is generally reserved for cancers that are difficult or dangerous to treat with surgery. The radiation damages the genetic code of the tumor in a single treatment, preventing it from replicating and causing it to slowly shrink. Installation of a Gamma Knife system costs between \$3.4 and \$5 million, plus an additional \$0.25 to \$0.5 million every 5-10 years to replenish the cobalt-60 power source.

The Gamma Knife consists of a large shield surrounding a large helmet-shaped device with 201 separate, fixed ports that allow the radiation to enter the patient's head in small beams that converge on the designated target. A rigid frame is attached to the patient's

skull to provide a solid reference for both targeting and treatment. The patient is then sent for imaging, to accurately determine the position of the target. The computer system develops a treatment plan to position the patient and the paths and doses of radiation. The patient is positioned with the head affixed to the couch, and the treatment is delivered. The patient goes home the same day.

3. Status of South Carolina Providers:

A. Linear Accelerators:

There are currently 28 facilities either operating or approved for a total of 56 linear accelerators in South Carolina. In 2009, the 47 operational linear accelerators performed 264,116 treatments, or an average of 5,620 treatments per unit.

B. Gamma Knife:

Palmetto Health Richland performed 210 Gamma Knife treatments in 2009. MUSC's Gamma Knife became operational in February 2010.

4. Certificate of Need Standards for Radiotherapy

1. The capacity of a conventional linear accelerator, either with or without EPID, is 7,000 treatments per year.
2. Linear accelerators providing IMRT or IGRT have a capacity of 5,000 treatments per year. A facility must document that it is providing or will provide these specialized treatments in sufficient volume to justify why it should be held to this planning capacity.
3. IMRT/IGRT linear accelerators performing stereotactic procedures have a capacity of 4,500 treatments per year. A facility must document that it is providing or will provide these specialized treatments in sufficient volume to justify why it should be held to this planning capacity.
4. Linear Accelerators designed strictly to provide Stereotactic Radiotherapy have a capacity of 2,000 treatments per year. A facility must document that it is providing or will provide these specialized treatments in sufficient volume to justify why it should be held to this planning capacity.
5. There are 13 service areas established for Radiotherapy units as shown on the following chart.
6. New Radiotherapy services shall only be approved if the following conditions are met:

- A. All existing units in the service area have performed at a combined use rate of 80 percent of capacity for the year immediately preceding the filing of the applicant's CON application; and
 - B. An applicant must project that the proposed service will perform a minimum number of treatments equal to 50 percent of capacity annually within three years of initiation of services, without reducing the utilization of the existing machines in the service area below the 80 percent threshold. If the new equipment is a specialized radiotherapy unit as described in Standards 2, 3 or 4 above, then the applicant may propose an annual capacity based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in CON application calculations, as well as future capacity calculations, for that applicant. The applicant must document where the potential patients for this new service will come from and where they are currently being served, to include the expected shift in patient volume from existing providers.
7. Expansion of an existing service, whether the expansion occurs at the existing site or at an alternate location in the service area, shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for each of the past two years and can project a minimum use rate of 50 percent of capacity per year on the additional equipment within three years of its implementation. If the additional equipment is a specialized radiotherapy unit as described in either Standards 2, 3 or 4 above, then the existing provider may propose an annual capacity for that additional equipment, based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in CON application calculations, as well as future capacity calculations, for that applicant.
8. The applicant shall project the utilization of the service and document referral sources for patients within its service area, including letters of support from physicians and health care facilities indicating a willingness to refer patients to the proposed service, with expected annual referral volumes.
9. The applicant must affirm the following:
- A. All treatments provided will be under the control of a board certified or board eligible radiation oncologist;
 - B. The applicant will have access to a radiation physicist certified or eligible for certification by the American Board of Radiology or its equivalent;
 - C. The applicant will have access to simulation equipment capable of precisely producing the geometric relationships of the equipment to be used for treatment of the patient;

- D. The applicant will have access to a custom block design and cutting system; and

The institution shall operate its own tumor registry or actively participate in a central tumor registry.

Quality

Incorrect doses of radiation can be dangerous. Two patients in New York died from lethal overdoses. In response, the Medical Imaging & Technology Alliance and the Advanced Medical Technology Alliance recently announced the Radiation Therapy Readiness Check Initiative, which is intended to incorporate safety-check mechanisms into radiation therapy equipment. The manufacturers have agreed to make equipment modifications to improve patient safety, by preventing equipment from operating unless the users verify that safeguards are in place.

The initiative requires medical physicists to record the performance of quality-assurance reviews of treatment plans. Technicians are required to perform beam modification checks, verify correct placement of machine accessories, and confirm correct patient placement. Individual manufacturers will be responsible for incorporating the safety-check software into new equipment and creating software add-ons that can be incorporated into existing equipment. However, some older machines may not be capable of adding the safeguards.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for these services:

- a. Compliance with the Need Outlined in this Section of the Plan;
- b. Community Need Documentation;
- c. Distribution (Accessibility);
- d. Projected Revenues;
- e. Projected Expenses;
- f. Financial Feasibility; and
- g. Cost Containment.

The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

RADIOTHERAPY

<u>SERVICE AREAS</u>	<u>2009 POPULATION</u>	<u># OF LIN ACC</u>	<u>POP PER LIN ACC</u>	<u>TOTAL AREA TREATMENTS</u>	<u>TREATMENTS PER LIN ACC</u>	<u>PLANNING AREA CAPACITY</u>	<u>PERCENT CAPACITY</u>
ANDERSON, OCONEE	253,230	3	84,410	18,728	6,243	21,000	89.2%
GREENVILLE, PICKENS	541,950	6	90,325	29,754	4,959	42,000	70.8%
CHEROKEE, SPARTANBURG UNION	364,780	5	72,956	18,512	3,702	32,500	57.0%
CHESTER, LANCASTER, YORK	288,250	3	96,083	13,416	4,472	21,000	63.9%
ABBEVILLE, EDGEFIELD GREENWOOD, LAURENS MCCORMICK, SALUDA	232,640	2	116,320	6,747	3,374	14,000	48.2%
FAIRFIELD, Kershaw, LEXINGTON, NEWBERRY RICHLAND	712,910	9	79,212	47,211	5,246	63,000	74.9%
CHESTERFIELD, DARLINGTON DILLON, FLORENCE, MARION MARLBORO	340,910	5	68,182	22,191	4,438	35,000	63.4%
CLARENDON, LEE, SUMTER	170,600	2	85,300	10,812	5,406	14,000	77.2%
GEORGETOWN, HORRY WILLIAMSBURG	332,400	4	83,100	20,918	5,230	26,000	80.5%
BAMBERG, CALHOUN ORANGEBURG	128,340	2	64,170	6,545	3,273	14,000	46.8%
ALLENDALE, BEAUFORT, HAMPTON, JASPER	200,890	2	100,445	17,108	8,554	14,000	122.2%
BERKELEY, CHARLESTON COLLETON, DORCHESTER	647,160	11	58,833	44,288	4,026	60,000	73.8%
AIKEN, BARNWELL	187,170	2	93,585	7,886	3,943	14,000	56.3%
STATE TOTAL	4,401,230	56	78,593	264,116	4,716	370,500	71.3%

MEGAVOLTAGE VISITS

<u>REGION & FACILITY</u>	<u>COUNTY</u>	<u># UNITS</u>	<u>FY 2007</u>	<u>FY 2008</u>	<u>FY 2009</u>
REGION I					
ANMED HEALTH MEDICAL CENTER	ANDERSON	2	10,811	12,781	12,449
GIBBS REGIONAL CANCER CTR SATELLITE 1	CHEROKEE	(1)	---	---	---
CANCER CENTERS OF THE CAROLINAS	GREENVILLE	1	6,175	5,821	4,834
CANCER CENTERS CAROLINAS - EASTSIDE		1	11,563	10,553	9,487
GREENVILLE MEMORIAL MEDICAL CENTER		3	17,669	18,309	15,433
GREER MEDICAL CAMPUS CANCER CTR 2		1	---	---	---
CANCER CENTERS CAROLINAS - OCONEE CO.	OCONEE	1	6,303	6,550	6,279
CANCER CENTER CAROLINAS - MARY BLACK 3	SPARTANBURG	1	---	---	---
SPARTANBURG REGIONAL MED CTR		3	18,853	17,480	18,512
VILLAGE AT PELHAM CANCER CENTER 1		1	---	---	---
REGION II					
SELF REGIONAL HEALTHCARE	GREENWOOD	2	6,060	6,589	6,747
LANCASTER RADIATION THERAPY CTR 4	LANCASTER	1	---	---	---
LEXINGTON MEDICAL CENTER	LEXINGTON	2	12,215	9,599	10,433
NEWBERRY ONCOLOGY ASSOCIATES 5	NEWBERRY	1	---	---	---
PALMETTO HEALTH RICHLAND	RICHLAND				
LINEAR ACCELERATORS		2	12,065	11,710	14,107
GAMMA KNIFE		1	232	206	210
SOUTH CAROLINA ONCOLOGY ASSOCIATES		4	20,242	26,881	22,671
ROCK HILL RADIATION THERAPY CENTER	YORK	2	14,721	14,210	13,416
REGION III					
CAROLINAS HOSPITAL SYSTEM	FLORENCE	1	5,358	4,557	5,015
MCLEOD REGIONAL MEDICAL CENTER		4	17,842	19,164	17,176
GEORGETOWN MEMORIAL HOSPITAL	GEORGETOWN	1	5,466	5,903	5,305

CAROLINA REGIONAL RADIATION CENTER		HORRY	3	13,107	14,335	15,613
TUOMEY		SUMTER	2	9,892	9,407	10,812
REGION IV						
RADIATION ONCOLOGY CTR OF AIKEN	6	AIKEN	2	6,916	7,371	7,886
BEAUFORT/HILTON HEAD RAD ONCOLOGY CTR		BEAUFORT	1	5,745	6,369	6,182
BEAUFORT MEMORIAL HOSPITAL	7		1	5,143	5,143	10,926
MUSC MEDICAL CENTER	8	CHARLESTON				
LINEAR ACCELERATORS			5	16,810	16,806	18,184
GAMMA KNIFE			1			
ROPER HOSPITAL	9		4	12,877	13,403	14,440
TRIDENT MEDICAL CENTER	10		2	11,971	11,461	11,664
REG MED CTR ORANGEBURG/CALHOUN	11	ORANGEBURG	2	5,545	7,060	6,545
TOTAL			56	253,349	261,462	264,116

- 1 GIBBES LINAC APPROVED 3/31/03; APPEALED. CON TO MOVE PROPOSED GIBBES LINAC TO VILLAGE AT PELHAM APPEALED 2/12/08. CONS ISSUED FOR GIBBES BY SUPREME CT RULING.
- 2 CON ISSUED 10/12/07, SC-07-53.
- 3 CON ISSUED BY SUPREME COURT RULING 3/31/10.
- 4 CON APPROVED 2/15/08; APPEALED. APPEAL DISMISSED 8/5/09; SC-09-39 ISSUED 8/12/09.
- 5 CON APPROVED 3/20/06.
- 6 CON ISSUED TO TRANSFER OWNERSHIP FROM AIKEN REGIONAL & ADD 2ND LINAC 6/11/09, SC-09-29.
- 7 DATA NOT AVAILABLE FOR 2008
- 8 CON FOR GAMMA KNIFE ISSUED 6/8/09. CON FOR 5TH LINAC ISSUED 7/8/09.
- 9 CON ISSUED FOR A CYBERKNIFE LINEAR ACCELERATOR 8/10/06. CON APPROVED FOR 3RD CONVENTIONAL LINAC 8/5/09.
- 10 CON ISSUED FOR REPLACEMENT LINAC 2/26/09 SC-09-07.
- 11 CON ISSUED FOR 2ND LINAC 10/14/10, SC-10-31.

Certificate of Need Standards for Stereotactic Radiosurgery

1. The capacity of a dedicated Stereotactic Radiosurgery unit is 300 procedures annually. This is based on an average of two procedures per day times three days per week times 50 weeks per year.
2. The service area for a dedicated Stereotactic Radiosurgery unit is defined as all facilities within 90 minutes one-way automobile travel time.
3. New Radiosurgery services shall only be approved if the following conditions are met:

- A. All existing units in the service area have performed at a combined use rate of 80 percent of capacity for the most recent year; and
 - B. An applicant must project that the proposed service will perform a minimum of 200 procedures annually within three years of initiation of service, without reducing the utilization of existing units below the 80 percent threshold.
4. Expansion of an existing radiosurgery service shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for each of the past two years and can project a minimum of 200 procedures per year on the additional equipment within three years of its implementation.
5. The applicant shall project the utilization of the service, to include:
- A. Epidemiological evidence of the incidence and prevalence of conditions for which radiosurgery treatment is appropriate, to include the number of potential patients for these procedures;
 - B. The number of patients of the applicant who were referred to other radiosurgery providers in the preceding three years and the number of those patients who could have been served by the proposed service; and
 - C. Current and projected patient origin information and referral patterns for the facility's existing radiation therapy services. The applicant shall document the number of additional patients, if any, that will be generated through changes in referral patterns, recruitment of specific physicians or other changes in circumstances.
6. The applicant must include letters of support from physicians and health care facilities indicating a willingness to refer patients to the proposed service.
7. The applicant must document that protocols will be established to assure that all clinical radiosurgery procedures performed are medically necessary and that alternative treatment modalities have been considered.
8. The applicant must affirm the following:
- A. The radiosurgery unit will have a board certified neurosurgeon and a board certified radiation oncologist, both of whom are trained in stereotactic radiosurgery;
 - B. The applicant will have access to a radiation physicist certified or eligible for certification by the American Board of Radiology or its equivalent;

- C. Dosimetry and calibration equipment and a computer with the appropriate software for performing radiosurgical procedures will be available;
 - D. The applicant has access to a full range of diagnostic technology, including CT, MRI and angiography; and
 - E. The institution shall operate its own tumor registry or actively participate in a central tumor registry.
9. Due to the unique nature and limited need for this type of equipment, the applicant should document how it intends to provide accessibility for graduate medical education students in such fields as neurosurgery and oncology.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for these services:

- a. Compliance with the Need Outlined in this Section of the Plan;
- b. Community Need Documentation;
- c. Distribution (Accessibility);
- d. Projected Revenues;
- e. Projected Expenses;
- f. Financial Feasibility; and
- g. Cost Containment.

The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

Exhibit B



G. Earl Hunter, Commissioner

Promoting and protecting the health of the public and the environment

CERTIFIED MAIL

91 7199 9991 7030 0506 9361

December 28, 2011

Doug White, CEO
Grand Strand Regional Medical Center
809 82nd Parkway
Myrtle Beach, SC 29572

RE: Grand Strand Regional Medical Center
Myrtle Beach, South Carolina

Dear Mr. White:

It is the decision of this Department that a Certificate of Need application submitted by Grand Strand Regional Medical Center for the construction for the establishment of a new radiation therapy service in a center attached to the main hospital be denied.

The Department timely received three (3) Certificate of Need applications proposing to provide radiation therapy services in the radiotherapy service area comprised of Horry, Georgetown and Williamsburg Counties. Carolina Regional Cancer Center ("CRCC") proposed to expand their existing Myrtle Beach radiation therapy service location, whereas both North Strand Radiation Oncology Center ("NSROC") and Grand Strand Regional Medical Center ("GSRMC") proposed to establish a new service. Individually, the Department has determined all applications comply with the 2010-2011 South Carolina Health Plan. However, collectively, there are issues with exceeding the service area need. (See Analysis).

Section 103-6 of Regulation 61-15 "Certification of Need for Health Facilities and Services" defines "Competing applicants" as "two or more persons and/or health care facilities as defined in this regulation who apply for Certificates of Need to provide similar services and/or facilities in the same service area and whose applications if approved would exceed the need for this facility or service." Staff have determined that approval of more than one linear accelerator would exceed the need projected for this service area in the South Carolina Health Plan.

Therefore, Section 307.2 requires that "in the case of competing applications, the Department shall award a Certificate of Need, if appropriate, on the basis of which, if any, most fully complies with the requirements, goals, and purposes of the Certificate of Need program, State Health Plan, project review criteria, and any regulations developed by the Department." Staff concludes CRCC-Conway would better comply with the purpose of CON, with its funding from cash balances, lowest project cost, to include linear accelerator cost (cost containment), rapid ramp up time with advanced equipment in a more economically disadvantaged area (guide the establishment of health facilities and services which will best serve the public's needs), location in Conway (prevent unnecessary duplication) and extensive experience (ensure high quality

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

Health Regulation

2600 Bull Street • Columbia, SC 29201 • www.scthec.gov

000925

R000224

Mr. White
December 28, 2011
Page 2

services). The SC Health Plan and project review criteria are addressed in the attached analysis. Adverse impact of GSRMC was considered. Staff determined approval of the GSRMC application could have substantial negative impact upon the approved, but appealed, relocated Francis B. Ford Cancer Center as well as the existing CRCC-Myrtle Beach. (See Analysis).

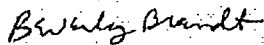
The decision is based upon the written findings contained in the attached Analysis and upon the following conclusions:

1. The applicant has documented the need for the proposed project within the application and the project will increase accessibility and availability of oncology services for residents of Horry County and surrounding areas;
2. The applicant's record is one of successful operation with adequate management experience;
3. Support, documented opposition and adverse effects on other facilities were considered; and,
4. The project appears to be financially feasible and cost effective based on the information available.

The findings pursuant to Section 501, Regulation No. 61-15, Certification of Need for Health Facilities and Services are not applicable to this project.

A copy of the Notice of Appeals Procedure is enclosed for your convenience. If you have any questions, please feel free to contact us at (803) 545-4200.

Sincerely,



Beverly Brandt, Chief
Bureau of Health Facilities and Services Development

Enclosures: Notice of Appeal Procedure
Analysis

cc: Patricia Price, CRCC
Wade Mullins, Esquire, Bruner Powell
Sam Tolbert, Strategic Directions
Dan Westbrook, Esquire, Nelson Mullins
Arnold Green, NSROC
Don Meyer, Moore & Van Allen
Will Thomas, Esquire, Parker Poe

000926

R000225

Notice of Appeal Procedure
Pursuant to S.C. Code Section 44-1-60

1. This decision of the S.C. Department of Health and Environmental Control (Department) becomes the final agency decision 15 calendar days after notice of the decision has been mailed or otherwise sent to the applicant, permittee, licensee and affected persons who have requested in writing to be notified, unless a written request for final review accompanied by a filing fee in the amount of \$100 is filed with the Department by the applicant, permittee, licensee, or affected person.
2. An applicant, permittee, licensee, or affected person who wishes to appeal this decision must file a timely written request for final review with the Clerk of the Board at the following address or by facsimile at 803-898-3393. A filing fee in the amount of \$100 made payable to SC DHEC must also be received by the Clerk within the time allowed for filing a request for final review. However, if a request for final review is filed by facsimile, the filing fee may be mailed to the Clerk of the Board if the envelope is postmarked within the time allowed for filing a request for final review.

Clerk of the Board
SC DHEC
2600 Bull Street
Columbia, SC 29201
3. In order to be timely, a request for final review must be received by the Clerk of the Board within 15 calendar days after notice of the decision has been mailed or otherwise sent to persons entitled to receive notice. If the 15th day occurs on a weekend or State holiday, the request is due to be received by the Clerk of the Board on the next working day. The request for final review must be received by the Clerk of the Board by 5:00 p.m. on the date it is due. A request for final review will be returned to the requestor if the filing fee is not received on time as described above.
4. The request for final review should include the following:
 - a. the grounds on which the Department's decision is challenged and the specific changes sought in the decision
 - b. a statement of any significant issues or factors the Board should consider in deciding whether to conduct a final review conference
 - c. a copy of the Department's decision for which review is requested
5. If a timely request for final review is filed with the Clerk of the Board, the Clerk will provide additional information regarding procedures. If the Board declines in writing to schedule a final review conference, the Department's decision becomes the final agency decision and an applicant, permittee, licensee, or affected person may request a contested case hearing before the Administrative Law Court within 30 calendar days after notice is mailed that the Board declined to hold a final review conference.

The above information is provided as a courtesy; parties are responsible for complying with all applicable legal requirements.

January 7, 2011

000927

R000226

Horry County Linear Accelerator Analysis

Summaries from the November 15, 2011 Project Review Meeting are incorporated by reference.

Background Information

Project Timeline. North Strand Radiation Oncology Center ("NSROC" or "North Strand") and Grand Strand Regional Medical Center ("GSRMC" or "Grand Strand") propose to establish a new service, whereas Carolina Regional Cancer Center ("CRCC") proposes to expand from their existing Myrtle Beach location. The Certificate of Need ("CON") application for NSROC was received on March 9, 2011. The facility is proposed to be located on the campus of Seacoast Medical Center in Little River as a non-profit joint venture between McLeod Regional Medical Center ("MRMC") and Loris Health Services, Inc. ("LHS"). The application for CRCC was received on March 10, 2011 and is proposed to be a facility near the campus of Conway Medical Center, to be named CRCC-Conway. The application for GSRMC, proposed to be a radiation therapy service attached to the main hospital in Myrtle Beach, was received on July 19, 2011. The GSRMC application was the last application to be "deemed complete" with Notification of Affected Persons published in the State Register on October 28, 2011. A Project Review Meeting was held on November 15, 2011.

Regulations. According to Section 101 of Regulation 61-15 "Certification of Need for Health Facilities and Services," the purpose of the Certificate of Need ("CON") program is to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State.

Section 103.6 of R. 61-15 defines "Competing applicants" as "two or more persons and/or health care facilities as defined in this regulation who apply for Certificates of Need to provide similar services and/or facilities in the same service area and whose applications if approved would exceed the need for this facility or service." All three providers filed CON application for a new linear accelerator ("linac"). Based on this definition, staff analyzed to determine if the need would be exceeded if more than one applicant was approved since all three applicants proposed to provide similar services and/or facilities in the same service area. Staff also evaluated compliance with the South Carolina Health Plan ("Plan"), the regulations, project review criteria and the purpose of CON.

Section 307.2 states that "in the case of competing applications, the Department shall award a Certificate of Need, if appropriate, on the basis of which, if any, most fully complies with the requirements, goals, and purposes of the Certificate of Need program, State Health Plan, project review criteria, and any regulations developed by the Department."

Service Area. Within Megavoltage Radiation Therapy Services, the Plan establishes different treatment capacities for different types of linacs. The Plan also has different standards that distinguish between a new service versus expansion of an existing service. As previously stated, NSROC and GSRMC propose to establish a new service, and CRCC-Conway proposes to be the expansion of an existing location.

2010-2011 South Carolina Health Plan. The following are excerpts from the Standards for Megavoltage Radiotherapy (with staff emphasis):

1. The capacity of a conventional linear accelerator, either with or without EPID, is 7,000 treatments per year.
2. Linear accelerators providing IMRT or IGRT have a capacity of 5,000 treatments per year. A facility must document that it is providing or will provide these specialized treatments in sufficient volume to justify why it should be held to this planning capacity.
6. New Radiotherapy services shall only be approved if the following conditions are met:
 - A. All existing units in the service area have performed at a combined use rate of 80 percent of capacity for the year immediately preceding the filing of the applicant's CON application; and
 - B. An applicant must project that the proposed service will perform a minimum number of treatments equal to 50 percent of capacity annually within three years of initiation of services, without reducing the utilization of the existing machines in the service area below the 80 percent threshold. If the new equipment is a specialized radiotherapy unit as described in Standards 2, 3 or 4 above, then the applicant may propose an annual capacity based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in CON application calculations, as well as future capacity calculations, for that applicant. The applicant must document where the potential patients for this new service will come from and where they are currently being served, to include the expected shift in patient volume from existing providers. (Note: Standards 3 and 4 are not applicable to these projects as Standard 3 applies to units with stereotactic capability and Standard 4 applies to stereotactic only units).
7. Expansion of an existing service, whether the expansion occurs at the existing site or at an alternate location in the service area, shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for each of the past two years and can project a minimum use rate of 50 percent of capacity per year on the additional equipment within three years of its implementation. If the additional equipment is a specialized radiotherapy unit as described in either Standards 2, 3 or 4 above, then the existing provider may propose an annual capacity for that additional equipment, based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in CON application calculations, as well as future capacity calculations, for that applicant.
8. The applicant shall project the utilization of the service and document referral sources for patients within its service area, including letters of support from physicians and health care facilities indicating a willingness to refer patients to the proposed service, with expected annual referral volumes.

Target Population / Service Area. DHEC defines megavoltage radiotherapy service areas for the state. The service area for the applications under review consists of Georgetown, Horry, and Williamsburg Counties.

The following table presents the SC State Demographer's population projections for the service area and the state:

County	7/1/2009 Estimates	7/1/2010 Projection	7/1/2011 Projection	7/1/2012 Projection	7/1/2013 Projection	7/1/2014 Projection	7/1/2015 Projection
Georgetown	60,700	62,610	63,310	64,030	64,720	65,430	66,130
Horry	263,870	265,360	270,500	275,650	280,790	285,930	291,080
Williamsburg	34,450	35,370	35,350	35,320	35,300	35,270	35,240
Total for Service Area	359,020	363,340	369,160	375,000	380,810	386,630	392,450
South Carolina	4,561,240	4,549,150	4,596,170	4,643,230	4,690,500	4,737,870	4,784,700

Past Utilization of Existing Facilities. There are currently two providers of radiation therapy services in the service area: CRCC and Francis B. Ford Cancer Treatment Center located operated by Georgetown Memorial Hospital ("GMH") in Georgetown, SC.

The following table presents the service area linear accelerator utilization since 2005:

Radiation Treatments	2005	2006	2007	2008	2009	2010
CRCC	15,770	14,032	13,107	14,335	15,613	20,946
GMH	4,217	5,416	5,466	5,903	5,305	5,515
Region Total	19,987	19,448	18,573	20,238	20,918	26,461
Statewide	229,721	236,181	253,349	251,462	264,116	269,016

The treatment capacity for CRCC's three units is 19,000 treatments. CRCC operates one linear accelerator (Tomotherapy) which has a capacity of 5,000 treatments per year and two standard linear accelerators (Varian) having a capacity of 7,000 treatments per year each. The GMH Francis B. Ford linear accelerator has a capacity of 7,000 treatments. Therefore, the total capacity for the service area is 26,000 treatments. For 2009, the service area utilization was 80.5% of capacity and for 2010, the utilization was 101.8% of capacity. Francis B. Ford operated at 75.6% of capacity in 2009 and 78.9% of capacity in 2010. For 2009, the CRCC utilization was 82.2% of capacity and for 2010, the utilization was 110.2% of capacity.

Based on this data, the above Criteria 6A and 7 have been met. In fact, based upon the data, under Criterion 6A, both Grand Strand and North Strand could have applied as a new facility in 2010, but did not. Much analysis has been done regarding the adverse impact, to include as a component of Criterion 6B ("without reducing the utilization of the existing machines in the service area below the 80 percent threshold") and projecting the minimum use rate of 50% of capacity per year within three years.

Project Review Criteria

1. Compliance with the South Carolina Health Plan

Section 801.3 from R.61-15 states "A project does not have to satisfy every criterion in order to be approved, but no project may be approved unless it is consistent with the State Health Plan. A project may be denied if the Department determines that the project does not sufficiently meet one or more of the criteria."

Community Need Documentation – 2a, 2b, 2c, 2e

2a. The target population should be clearly identified as to the size, location, distribution, and socioeconomic status (if applicable).

2b. Projections of anticipated population changes should be reasonable and based upon accepted demographic or statistical methodologies, with assumptions and methodologies clearly presented in the application. The applicant must use population statistics consistent with those generated by the State Demographer, State Budget and Control Board.

2c. The proposed project should provide services that meet an identified (documented) need of the target population. The assumptions and methods used to determine the level of need should be specified in the application and based on a reasonable approach as judged by the reviewing

body. Any deviation from the population projection used in the State Health Plan should be explained.

2e. Current and/or projected utilization should be sufficient to justify the expansion or implementation of the proposed service.

Distribution (Accessibility) - 3a, 3b, 3c, 3e, 3f

3a. Duplication and modernization of services must be justified. Unnecessary duplication of services and unnecessary modernization of services will not be approved.

3b. The proposed service should be located so that it may serve medically underserved areas (or an underserved population segment) and should not unnecessarily duplicate existing services or facilities in the proposed service area.

3c. The location of the proposed service should allow for the delivery of necessary support services in an acceptable period of time and at a reasonable cost.

3e. The applicant must document the means by which a person will have access to its services (e.g. outpatient services, admission by house staff, admission by personal physician).

3f. The applicant should address the extent to which all residents of the area, and in particular low income persons, racial and ethnic minorities, women, the elderly, handicapped persons, and other medically underserved groups, are likely to have access to those services being proposed.

Record of the Applicant - 13a, 13b

13a. The applicant's record should be one of successful operation with adequate management experience.

13b. The applicant should have a demonstrated ability to obtain necessary capital financing.

2. Acceptability - 4a

4a. The proposal and applicant should have the support of "affected persons" (including local providers and the target population). The lack of opposition should not be considered support for the purposes of these criteria. Staff will also consider, 4b, which states: Where documented opposition exists to a proposal, such opposition will be considered along with the application.

Distribution - 22

22. The existing distribution of the health service(s) should be identified and the effect of the proposed project upon that distribution should be carefully considered to functionally balance the distribution to the target population.

Adverse Effects on Other Facilities - 23a

23a. The impact on the current and projected occupancy rates or use rates of existing facilities and services should be weighed against the increased accessibility offered by the proposed services.

3. Financial Feasibility - 15

15. The applicant must have projected both the immediate and long-term financial feasibility of the proposal. Such projection should be reasonable and based upon accepted accounting procedures.

Cost Containment - 16a, 16c

16a. The applicant should have identified and sought alternative sources and/or methods of funding and demonstrated that the method chosen was the most feasible option.

16c. The impact of the project upon the applicant's cost to provide services and the applicant's patient charges should be reasonable. The impact of the project upon the cost and charges of other providers of similar services should be considered if the data are available.

Projected Revenue/Projected Expenses – 6a, 7

6a. The proposed charges should be comparable to those charges established by other facilities for similar services within the service area or state. The applicant should document how the proposed charges were calculated.

7. Projections of construction costs, start-up costs, operating costs, debt service, depreciation, manpower costs, etc. should be consistent with those experienced by similar facilities offering a similar level and scope of services (with proper consideration given to such factors as inflation, cost of capital, etc.).

North Strand Radiation Oncology Center

Total Project Cost = \$9,522,745

Linear Accelerator: Varian Clinac IX (\$2,811,534)

Facility = 5,500 square feet

It is noted that a letter of May 24, 2011 from Arnold Green, President, Loris Health Services, Inc., states that one of the members of NSROC has changed from Loris Community Hospital District to a non-profit affiliated corporation, Loris Health Services, Inc. However, during the November 15 Project Review Meeting, NSROC indicated Loris Community Hospital District as a partner in the joint venture without explanation.

1. Compliance with the South Carolina Health Plan- Standards for Radiotherapy

North Strand addressed all standards. Letters indicated support from physicians (including six from Coastal Cancer Center and five from Southern Medical Associates) and healthcare facilities (Loris Community Hospital) for the project, but North Strand did not provide documentation by any physician or group of a willingness to refer patients to the proposed service, with expected annual referral volumes as required by Standard 8. Dr. Lawrence Holt, Jr. with Coastal Cancer Center, the physician group that also provided letters of support for the other two applicants, stated in a letter of November 29, 2011 they want to reaffirm their support for the project and intend to establish physician offices and chemotherapy services on the campus of Seacoast Medical Center in order to demonstrate their willingness to work with NSROC. However, the letter did not specifically state a willingness to refer patients. North Strand indicated during project review that they expect to receive referrals from a broad range of physicians, including the medical staffs of Loris and McLeod and the physicians of Coastal Cancer Center. The referrals from McLeod were not explained or quantified. Staff questions the likely number of referrals from a facility 80 miles away in another service area. It is questionable that Criterion 8 was met. See also Community Need Documentation and Adverse Impact.

Community Need Documentation – 2a, 2b, 2c, 2e

The applicant clearly identified the target population. NSROC's proposed service area includes the following ZIP Codes: 29511, 29526, 29544, 29545, 29566, 29568, 29569, 29581, and

29582, which are located within northeastern Horry County. NSROC also stated Northern Horry County as the target population they will serve. Population projections were clearly presented.

Exhibit 3 presents LHS's ZIP Code specific patient origin for patients who received a cancer diagnosis in Fiscal Year 2009. This exhibit shows LHS rendered healthcare services to 1,154 patients from NSROC's expected service area during the period, which is less than other applicants. Another 508 cancer patients were served by LHS from the immediately adjacent areas of North Carolina, which is a notable portion of LHS's total cancer patients.

Exhibit 3
Loris Healthcare Cancer Patient Origin
FY 2009

<u>Zip Code</u>	<u>Total Patients</u>	<u>Percent of Total</u>	<u>Cumulative Percent</u>
29569	415	21.6%	21.6%
29566	227	11.8%	33.4%
29568	168	8.7%	42.1%
29582	130	6.8%	48.9%
29526	75	3.9%	52.8%
29581	51	2.7%	55.4%
29545	50	2.6%	58.0%
29511	29	1.5%	59.5%
29544	9	0.5%	60.0%
<i>SC Service Area</i>	<i>1,154</i>		
28463	203	10.6%	70.6%
28467	188	9.8%	80.3%
28468	40	2.1%	82.4%
28431	29	1.5%	83.9%
28472	28	1.5%	85.4%
28469	20	1.0%	86.4%
<i>Adjacent NC ZIPs</i>	<i>508</i>		
All Other SC	112	5.8%	92.3%
All Other NC	91	4.7%	97.0%
All Other	58	3.0%	100.0%
Total	1,923		

Source: Loris Internal Data

In addition, staff notes that of the 1,154 patients LHS rendered service to with a cancer diagnosis in FY2009, only 6.8% (130 patients) were from the North Myrtle Beach ZIP code and 3.9% (75 patients) from the Conway ZIP code. There were 508 cancer patients, or 26.5%, originating from NC, but out of state utilization cannot be used to demonstrate need. While Loris accounted for 21.6% of patients (415), Little River only accounted for 11.8%.

NSROC cited geographic distance and travel time as barriers. They state there is no direct provider in NSROC's proposed service area, mention residents from Little River, North Myrtle Beach and Loris, but do acknowledge radiation therapy services currently provided by CRCC and GMH. Data from CRCC indicates 22% of their patients originate from North Myrtle Beach, with 6% from the Loris area. Staff do not concur with NSROC's conclusion that residents do not

have reasonable access to radiation therapy services because of such remote locations and high traffic congestion roads. NSROC provided a chart with the closest providers of radiation therapy services to NSROC's proposed service area and indicated CRCC to be 16.4 miles away. Furthermore, North Strand classifies CRCC as being in Southern Horry County, but staff does not concur with this classification. The proposed North Strand location is shown to be 20.6 miles from Loris, with the CRCC-Conway location at 24.9 miles — a distance that is not appreciably greater. Conway, the area with the greatest population in the North Strand service area, is twice as distant at 22 miles, from NSROC than CRCC-Conway.

NSROC cited a drive time study that indicated a "portion of eastern Horry County" is currently outside of a 30-minute driving range to CRCC and considers the area to be underserved. These areas appear to include towns such as Longs, Worshams Ferry and Little River. Furthermore, North Strand cites travel impediments such as motor vehicle accidents, poor weather conditions, road construction, and special events, but staff maintain these could occur in any part of the service area.

North Strand provided travel time and traffic count data. But counters near all proposed locations, including the site for each applicant, indicated substantially higher counts during "tourist season." Staff concludes the study over emphasizes the alleged negative ramifications of the CRCC's proposed location.

North Strand stated that the northern Horry County area where they propose to locate is the fastest growing community in the Grand Strand and the population base in the service area is sufficiently large enough to justify this service (Exhibit 5, Project Review Summary). However, staff notes that Conway (ZIP code 29526) is the area of the highest population concentration followed by North Myrtle Beach (ZIP code 29582). It is noted that CRCC is currently serving this population with a patient origin of 22% for the Conway area and 22% for North Myrtle Beach. Staff feels it is not logical for North Strand's service area to encompass Conway and North Myrtle Beach, but not Myrtle Beach, as that area currently accounts for 20% of the CRCC patient origin.

Of the 1,154 patients LHS rendered service to with a cancer diagnosis in FY2009, only 6.8% (130 patients) were from North Myrtle Beach ZIP code and 3.9% (5 patients) from the Conway ZIP code. There were 508 LHS cancer patients, or 26.5%, originating from identified NC ZIP codes, but out of state utilization cannot be used to demonstrate need. Staff notes that Grand Strand had 4,860 patients with a primary or secondary cancer diagnosis in 2010 as opposed to North Strand's 1,154 patients in 2009. The Loris ZIP code accounted for 21.6% of LHS patients, 11.8% from Little River and 8.7% from Longs. Forty percent of patients originated from outside of the proposed service area, including over 30% from North Carolina when including "other NC."

For FY2010, LHS referred 637 cancer patients for radiation therapy, which is around 55% of patients diagnosed with cancer. Of these cases, 414 were from the service area (65%), 183 were from NC (29%) and 28 were "Other SC", 12 were "Other." Even though North Strand continues to project 29% of all cancer patients to originate from North Carolina, they projected 85% of radiation therapy patients to originate from the service area and around 10% from NC, which appears to be inconsistent.

North Strand assumes 25 visits (treatments) per patient and indicated in its project review presentation that "a course of treatment may mean up to 30 treatments per patient." North Strand projects being at 6,377 treatments or 127.5% of capacity by Year 3. This is substantially higher

than the 5,100 treatments projected by CRCC, a current provider, and 4,620 by Grand Strand, for Year 3. Staff is concerned the North Strand projections are neither reasonable nor achievable. North Strand indicated CRCC would maintain a utilization rate of over 80%, but did not specifically address the quantity.

North Strand expects to achieve its projected utilization (4,042 treatments in 2013, 5,797 in 2014 and 6,482 in 2015) largely due to the "benefit of the availability of McLeod Regional Medical Center's experience with operating a radiation therapy program." Staff does not argue this is of benefit, but feels the projections are unrealistically high and unachievable. Thus, compliance with the "50 percent of capacity" portion of Standard 6B is questionable. NSROC's project review presentation also stated the projections were based upon "McLeod's experience operating similar equipment" but did not provide details. Success of the project could be limited by the fact that MRMCC is 80 miles away and the proposed location in Little River is adjacent to a recently opened small community hospital (Seacoast Medical Center) with only 50 beds and limited services.

Distribution (Accessibility) – 3a, 3b, 3c, 3e, 3f

North Strand claims to be the only applicant applying to serve the medically underserved area of northern Horry County and is not proposing to be located near existing providers. However, their proposed location is only 16 miles from the current Myrtle Beach location of CRCC. While North Strand considered actual cancer referral data from Coastal Cancer Center, it is noted that their physicians provided letters of support for the other two applicants.

North Strand is correct in stating there are no radiation therapy providers in northern Horry County, but clearly this area is currently being served by CRCC. Again, North Myrtle Beach is being served geographically by CRCC and their proposed Conway location will provide geographical access to these areas as well as the population center on Conway. While the CRCC-Conway and Grand Strand projects are not in northern Horry County, staff believes a location in Conway would better increase accessibility to these more rural areas. Furthermore, according to the travel time and distance data provided by North Strand, the rural areas of Nichols and Green Sea are approximately the same distance from CRCC-Conway as from NSROC, accounting for 5% of NSROC's proposed service area population as projected for 2015. The NSROC location in Little River is considerably closer to Little River and Longs (22.5% of 2015 population projection) than CRCC-Conway, but much further away from Aynor, Conway and Galivant's Ferry (41.5% of 2015 population projection). The remaining areas are North Myrtle Beach and Loris (20.6 miles from NSROC and 24.9 miles from CRCC-Conway). Note that this data is limited by the fact that it appears to pick a point in each ZIP code area and it would be useful to view the ZIP code map geographically. NSROC also cites tourist seasonal congestion reported on certain traffic counters, but the count for all project locations increased substantially during the July period when traffic was the heaviest as expected.

North Strand compares demographics between the Conway and Loris areas. While Loris has a higher rate of poverty, the rates are both substantially less than that of Myrtle Beach or North Myrtle Beach.

During project review, North Strand presented many testimonials from patients, one of whom mentioned traveling more than once daily to receive treatments. Project representatives admitted this occurs rarely and did not further quantify this occurrence. North Strand again mentioned in their November 28, 2011 correspondence that "NSROC will eliminate the need for northern

Horry County patients to travel long distances sometimes multiple times daily to receive treatments at different locations" but provided no data to support this statement.

North Strand will offer access to support services to accommodate the needs of their patients and has documented means by which a person will have access to its services.

Staff concludes all applicants demonstrate financial accessibility. The following table compares projected payor sources and financial accessibility among the applicants:

	CRCC	GSRMC	NSROC
Medicare	53.6%	51.8%	31.0%
Medicaid	3.3%	6.1%	11.0%
Self pay	1.6%	3.3%	6.4%
Charity Care	\$326,215	\$151,000	\$629,942
Charity Care % of Gross Revenue	2.5%	3.3%	5.4%

Record of the Applicant – 13a, 13b

North Strand expects to benefit from the availability of McLeod Regional Medical Center's experience with operating a radiation therapy program. Loris Healthcare System and MRMC have had a 15 year history of collaboration. As of January 12, 2012, McLeod will be the owner of the Loris Healthcare System. MRMC has extensive experience in providing radiation therapy.

2. Acceptability – 4a

North Strand received approximately 50 letters of support from patients, physicians and community leaders, which were substantially less letters of support than for Grand Strand or CRCC. Opposition to the project by Grand Strand and CRCC was considered. Dr. Lawrence Holt, Jr. with Coastal Cancer Center, the physician group that also provided letters of support for the other two applicants, stated in a letter of November 29, 2011 they want to reaffirm their support for the project and intend to establish physician offices and chemotherapy services on the campus of Seacoast Medical Center in order to demonstrate their willingness to work with NSROC.

Distribution – 22

The existing distribution and the effect of the proposed project upon that distribution was identified. See Community Need Documentation and Distribution (Accessibility)

Adverse Effects on Other Facilities – 23a

North Strand alleges no adverse impact upon "any other planning area providers." However there will be an adverse impact upon CRCC as their 2010 patient origin data indicates 22% from the Conway area, 22% from the North Myrtle Beach area and 6% from the Loris area.

3. Financial Feasibility – 15

The proposed project appears to be financially feasible and will realize a negative balance during the first year of operation, a slight profit during the second year and a modest profit during the third year. As previously indicated, McLeod Health will be purchasing LHS, but the financial impact of this purchase was not disclosed. However, the utilization projections, thus the financial projections, are questionable (See Community Need Documentation).

The CFOs for both LHS and McLeod Health confirmed availability of funds for the proposed project. The project will be funded through equal capital contributions from NSROC's two members, McLeod Regional Medical Center ("MRMC") and Loris Health Services, Inc., each having 50% ownership. Loris Healthcare System ("LHS") and MRMC expect to contribute a total of up to \$4,761,373 towards the capital funds needed to implement the project, and contribute additional money to provide start up working capital. LHS and MRMC will finance the capital cost from existing cash reserves.

Cost Containment - 16a, 16c

North Strand addressed cost containment and identified methods and availability of funding. The impact of the applicant's cost to provide services was documented.

Projected Revenue/Projected Expenses - 6a, 7

Proposed charges and cost projections appear to be reasonable. However, the utilization projections, thus the financial projections, are questionable (See Community Need Documentation).

Grand Strand Regional Medical Center

Total Project Cost = \$9,788,625
Linear Accelerator: Varian Clinac iX (\$2,812,533)
Facility = 9,519 square feet

1. Compliance with the South Carolina Health Plan

Grand Strand addressed all of the standards in the Plan. In a letter of November 16, 2011, Daniel Sullivan of the Sullivan Consulting Group responded to the staff request to provide information from Standard 8. Many letters expressed a willingness to refer, but did not quantify referral volumes. Mr. Sullivan stated most physician specialties do not refer patients directly to radiation therapy centers, but typically a primary care physician or a general surgeon, upon diagnosing cancer in a patient, would refer the patient to a medical oncologist to determine the most appropriate type of treatment. Six oncologists from Coastal Cancer Center provided letters of support.

Community Need Documentation - 2a, 2b, 2c, 2e

The applicant clearly identified the target population. Grand Strand is in the three-county service area that includes Georgetown, Horry, and Williamsburg Counties. Population projections were clearly presented. Grand Strand stated that for radiotherapy services, Horry County would be the primary service area and Georgetown and Williamsburg Counties would be the secondary service area.

When calculating existing utilization, it is noted that Grand Strand repeatedly assigns GMH a capacity of 5,000 treatments, but the facility has stated their capacity is 7,000 treatments and this capacity is reflected in the Plan.

According to 2008 DHEC data, there were 2,391 new cancer cases in the service area. Based on internal data, Grand Strand had 4,860 patients with a primary or secondary cancer diagnosis, currently referring them to CRCC or other providers. Grand Strand states they coordinate care for cancer patients with the medical oncologists of the Coastal Cancer Center. The oncologists also refer cancer patients requiring surgery to Grand Strand.

Grand Strand projects to capture 20% of Horry County patients (216 patients) plus 5% immigration (12 cases) for a total of 232 patients. They claim they will only be taking 26 patients (546 treatments) from CRCC in 2015. However, staff projects the impact will be greater. Based upon 55% of cancer patients requiring radiotherapy, Grand Strand projects the service area to have 1,249 radiotherapy cases in 2010 and 1,442 cases in 2015, resulting in an increase of 194 patients, which includes 173 Horry County patients. In order to achieve the projected 232 patients, Grand Strand would have to capture 100% of the additional 173 patients plus 43 CRCC patients to total 216 Horry County patients. Therefore, the impact upon CRCC of losing 26 patients does not appear to be accurate. Even at the higher number of patients taken from CRCC, it does not appear to decrease CRCC below 80% of capacity.

Grand Strand stated in a November 16, 2011 letter from Daniel Sullivan that a notable exception to the typical referral pattern is the case of the urologists in Horry County, most of which belong to the Atlantic Urology group that owns CCRC. Mr. Sullivan expects nearly 100% of these urological referrals to go to CRCC and this was considered in Grand Strand's utilization projections, though they were not quantified.

Distribution (Accessibility) — 3a, 3b, 3c, 3e, 3f

The staff concurs cancer treatment can be most effective when delivered in a comprehensive setting. However, GSRMC does not propose any inpatient treatments according to their pro forma. Staff concurs it is advantageous to have radiation oncologists and medical oncologists practicing in close proximity. Both Grand Strand and the main office for CRCC are both located within a few miles of Coastal Cancer Center, the primary referral source in that area for cancer treatment.

CRCC maintains that Conway Regional Medical Center and Loris Community Hospital will not refer patients for radiation therapy to Grand Strand. This is a reasonable concern and could limit accessibility. It is noted these facilities did not provide letters of support for Grand Strand.

The project will not increase geographic access since CRCC is currently located in Myrtle Beach in close proximity to Grand Strand. The Grand Strand project could provide greater access to inpatients at the hospital in need of cancer treatment services; however, their pro formas indicate no income from inpatients for this project.

Grand Strand will offer access to support services to accommodate the needs of their patients and has documented means by which a person will have access to its services.

Staff concludes all applicants demonstrate financial accessibility. The following table compares projected payor sources and financial accessibility among the applicants:

	CRCC	GSRMC	NSROC
Medicare	53.6%	51.8%	31.0%
Medicaid	3.3%	6.1%	11.0%
Self pay	1.6%	3.3%	6.4%
Charity Care	\$326,215	\$151,000	\$629,942
Charity Care % of Gross Revenue	2.5%	3.3%	5.4%

Record of the Applicant - 13a, 13b

Grand Strand has been providing health care services to the residents of Horry County since it opened in 1978. Services range from a Level III Trauma Center to the open-heart surgery program opened in June of 1995. Grand Strand is currently accredited by the American College of Surgeons as a Community Hospital Cancer Program. It is the service area's largest and most comprehensive tertiary care hospital. Grand Strand is a subsidiary of Hospital Corporation of America, Inc. (HCA), that provides a broad resource base of administrative and technical expertise in hospital operations.

2. Acceptability - 4a

Grand Strand has garnered significant support for this project, with over 240 letters of support. There were approximately 100 letters of support from physicians, 4 letters from elected officials and around 140 community letters. The majority of the community letters were from H2U members. H2U or Health to You, promotes living a healthy lifestyle and offers memberships through Grand Strand for health and wellness information, discounts, invitations to hospital sponsored activities, etc. Strand Orthopaedic Consultants supported this project as well as the CRCC project. Staff from Coastal Cancer Center supported this as well as the other two projects.

Staff considered opposition to the project. CRCC, North Strand and Georgetown Hospital System ("GHS") filed as affected persons opposing this project. See Adverse Effects.

Distribution - 22

The existing distribution and the effect of the proposed project upon that distribution was identified. See Community Need Documentation and Distribution (Accessibility)

Adverse Effects on Other Facilities - 23a

In the November 16, 2011 letter from Daniel Sullivan of Sullivan Consulting Group, Inc., a statement was made regarding Coastal Cancer Center that these physicians "serve a high percentage of the cancer patients in Horry County, and because Coastal's main office is next to the GSRMC campus and many of its patients receive chemotherapy treatment at the main office, it is reasonable to conclude that a significant percentage of Coastal's patients from the service area will choose GSRMC for radiation treatment." Mr. Sullivan did not quantify the percentage or number of patients, but "significant percentage" implies a sizeable impact upon the existing provider, CRCC, and Grand Strand projects serving 223 radiation therapy patients in the third year of operation.

Staff concludes there is adverse impact with this project and the approved relocation of the Francis B. Ford Cancer Treatment Center. A review of the proposed service area in the Francis B. Ford CON application indicates that there are six (6) overlapping ZIP codes with the Francis B. Ford project and the Grand Strand primary service area. The 6 ZIP codes account for 36.6% of the 2009 Francis B. Ford cancer patient origin and 48.2% of Grand Strand's 2010 inpatient discharges.

3. Financial Feasibility – 15

GSRMC proposes to fund the project from capital funds provided by HCA, which will be derived through internally generated and borrowed funds that are included in HCA's cash reserves. Grand Strand is owned by Healthtrust, Inc. – The Hospital Company, that is in turn, owned by HCA Inc.

Cost Containment – 16a, 16c

GSRMC addressed cost containment and identified methods of funding and demonstrated feasibility of this option. The impact of the applicant's cost to provide services was documented. GSRMC's project costs and patient charges appear to be reasonable.

Projected Revenue/Projected Expenses – 6a, 7

Proposed charges and cost projections appear to be reasonable.

Carolina Regional Cancer Center - Conway

Total Project Cost = \$9,522,745
Linear Accelerator: Varian TrueBeam (\$2,413,894)
Facility = 3,616 square feet

1. Compliance with the South Carolina Health Plan

CRCC demonstrated compliance with all standards in the Plan. A listing of patient referrals by referring physician for the previous 12 months was provided (November 2010 through October 2011). For a total unique patient count of 1,000 patients, 360 patients, or 36% of the total, were from Atlantic Urology. Coastal Cancer Center ("CCC") physicians accounted for 263 or 26.3% of referred patients. It is noted that three of the letters, from CCC physicians specifically mentioned a willingness to refer patients as required by Standard 8. Even though "expected annual referral volumes" were not provided, current volumes were provided from all referral sources. In their response to Item B-10, CRCC stated that 98% of its patients are from physician referrals, mostly from an attending physician.

2. Community Need Documentation – 2a, 2b, 2c, 2e

The applicant clearly identified the target population. CRCC treats patients from Georgetown, Horry, and Williamsburg Counties and considers the region to be its service area. Population projections were clearly presented.

Zip codes were grouped into six market areas based on geography and the following table summarizes the percent of CRCC patients from each area and the 2015 population projection

provided by Nielsen/Claritas.

Table 8 – Patient Origin in Service Area

Area	CRCC Patient Origin	2015 Population Projection*
Conway Area	22%	80,355
Georgetown Area & Williamsburg County	1%	72,415
Loris Area	6%	24,588
Murrells Inlet Area	29%	100,778
Myrtle Beach Area	20%	71,438
North Myrtle Beach Area	22%	53,310
Total	100%	402,884

The percentages are based on 495 patients from within the service area during the last six months of 2010. CRCC treated 571 total patients during this time period with 76 of those patients coming from locations outside of the three-county service area (22 from other locations in SC, 44 from NC, and 10 from other locations).

More than 22% of CRCC's patients live in the Conway area while 6% live in the Loris area. Combined, these two areas account for more than 28% of CRCC's patient volume. These patients would be served by a cancer treatment center in Conway, SC.

Projected Utilization. CRCC is proposing the expansion of an existing service based on its current patient volume and the unmet need in the Conway-Loris area. The following table projects the number of linear accelerator radiation treatments with two CRCC locations in the service area:

Table 10

Radiation Treatments	2009	2010	2011	2012	2013	2014
CRCC-Myrtle Beach	15,613	20,946	22,419	18,258	18,717	19,185
CRCC-Conway	NA	NA	NA	4,854	4,976	5,100
Total Treatments	15,613	20,946	22,419	23,112	23,693	24,285
Change over prev. year		34.2%	7.0%	3.1%	2.5%	2.5%

CRCC has experienced significant growth in utilization during 2010. The total treatments at CRCC grew 34.2% from 2009 to 2010 alone. To calculate projected utilization, a more conservative growth rate of 2.5% was applied. This is in contrast to the substantial growth experienced in 2010, which is attributed to the purchase of the facility by 21st Century Oncology. As previously shown, approximately 28% of CRCC's patients come from Conway and Loris area. CRCC conservatively expects that 75% of their patients from the Conway and Loris area will utilize the proposed linear accelerator located in Conway (i.e. 21% of their current patients will utilize CRCC-Conway).

Distribution (Accessibility) – 3a, 3b, 3c, 3e, 3f

This project projects the quickest implementation time with approximately six months, taking advantage of the existing vault, which will facilitate accessibility. This project will also improve the geographic accessibility for patients in the service area, especially those in the Conway and Loris areas. It is noted that the Conway area has a lower socio-economic status and the proposed site is more accessible to rural portions of the service area. North Strand promotes the accessibility of its site, but staff feels the sites are equally accessible and further notes that the

distance between Loris and Conway is approximately the same distance as Loris and Little River, the proposed site for NSROC. The Conway site is centrally located, serving more inland residents and accessible to rural residents.

Currently CRCC is operating 12 hour shifts to meet the current demand since they are operating well over capacity. Placing an additional accelerator in an area that currently accounts for 28% of patients will relieve capacity constraints.

Staff notes that the proposed Varian Trilogy True Beam system is more advanced than the iX systems proposed by the other applicants. Specifications for the unit include a higher dose rate, image guidance during treatment and is faster and more precise. Information from the manufacturer, Varian, supports the True Beam as being a more advanced system.

CRCC stated they will offer access to support services to accommodate the needs of their patients. CRCC adequately documented means by which a person will have access to its services (See Compliance with the SC Health Plan).

The following table presents the total amounts of indigent care provided by CRCC:

	2008	2009	2010
Gross Charges	\$35,959,784	\$36,978,776	\$46,520,118
Indigent Care	\$990,254	\$771,022	\$1,237,664
As % of Gross	2.8%	2.1%	2.7%

Projected:

	2011	2012	2013	2014
Gross Charges	\$59,574,787	\$61,417,306	\$62,952,739	\$64,526,557
Indigent Care	\$1,470,051	\$1,515,516	\$1,553,404	\$1,592,239
As % of Gross	2.5%	2.5%	2.5%	2.5%

The following table compares projected payor sources and financial accessibility among the applicants for each respective project, which indicates all applicants demonstrate financial accessibility:

	CRCC	GSRMC	NSROC
Medicare	53.6%	51.8%	31.0%
Medicaid	3.3%	6.1%	11.0%
Self pay	1.6%	3.3%	6.4%
Charity Care	\$326,215	\$151,000	\$629,942
Charity Care % of Gross Revenue	2.5%	3.3%	5.4%

Record of the Applicant— 13a, 13b

CRCC has provided radiation therapy services in the region for three decades. The center is accredited by the American College of Radiology (ACR), which has very high standards of compliance regarding radiological services. CRCC's current equipment appears focused on state of the art technology as evidenced by the tomotherapy unit and a recently replaced linear accelerator. CRCC has a 38 member team and has access to clinical trials.

3. Acceptability—4a

CRCC has demonstrated strong support for this project, with over 100 letters of support. There were approximately 76 letters of support from medical providers, including 18 from Conway Medical Center. Strand Orthopaedic Consultants supported this project as well as the Grand Strand project. Staff from Coastal Cancer Center supported this as well as the other two projects. The community letters of support included over a dozen political letters (City of Conway, Town of Surfside Beach, etc.) and around 12 other community letters, such as from Agape Hospice and Mercy Care Hospice.

Staff considered opposition to the project. Grand Strand, North Strand and Georgetown Hospital System ("GHS") filed as affected persons opposing this project. See Adverse Impact.

Distribution - 22

The existing distribution and the effect of the proposed project upon that distribution was identified. See Community Need Documentation and Distribution (Accessibility).

Adverse Effects on Other Facilities - 23a

GHS contends that approval would significantly impact the recently approved Murrells Inlet projects with CRCC-Conway being 13 miles from the proposed relocation of Francis B. Ford. GHS mentions lack of need and significant adverse impact, but did not provide any data to support these claims. GHS feels approval of a linear accelerator in proximity to the recently approved projects without first allowing these providers to implement their projects would not constitute sound health planning. GHS claims the relocation was based on proving increased access to the majority of GHS patients who live in northern Georgetown and Horry Counties. Allowing another provider to enter the market would jeopardize the financial viability of their project. Staff notes that CRCC considered its Conway project within its Murrells Inlet application. Both projects are currently under appeal in the Administrative Law Court and staff is unsure at this time if or when the projects will be implemented. CRCC proposes to serve an existing market as the patient origin data indicated 22% of their patients are from the Conway area and only 1% are from the Georgetown area and Williamsburg County, areas proposed to be served by Francis B. Ford. CRCC also predicted a conservative growth rate of 2.5%.

4. Financial Feasibility - 15 (See also Cost Containment)

The pro formas show a profit during all years submitted - 2012 through 2015. Staff requested a breakdown showing the Murrells Inlet project, which is shown below:

2012				2013			
Myrtle Beach	Conway	Murrells Inlet	Combined	Myrtle Beach	Conway	Murrells Inlet	Combined
Gross Charges	\$48,519,672	\$12,897,834	\$-	\$61,417,306	\$37,142,116	\$13,220,076	\$12,590,548
Net Charges	\$17,655,993	\$4,893,365	\$-	\$22,349,356	\$13,514,933	\$4,810,899	\$4,581,618
Total Operating Expenses	\$7,791,255	\$2,736,530	\$-	\$10,527,785	\$7,188,179	\$2,807,597	\$3,310,133
Income Before Income Taxes	\$9,778,863	\$1,933,478	\$-	\$11,710,339	\$6,261,014	\$1,979,703	\$1,249,200
Net Income	\$6,012,771	\$1,189,088	\$-	\$7,201,869	\$3,850,524	\$1,217,517	\$788,258
Treatment Volume	18,258	4,854	23,112	13,978	4,978	4,739	23,693
2014				2015			
Myrtle Beach	Conway	Murrells Inlet	Combined	Myrtle Beach	Conway	Murrells Inlet	Combined
Gross Charges	\$38,070,669	\$13,560,577	\$12,095,311	\$64,526,557	\$39,022,436	\$13,889,341	\$13,227,944
Net Charges	\$13,560,577	\$12,095,311	\$84,526,557	\$39,022,436	\$13,889,341	\$13,227,944	\$68,139,721

Net Charges	\$13,853,889	\$4,830,987	\$4,698,158	\$23,480,794	\$14,200,010	\$5,054,241	\$4,813,582	\$24,067,813
Total Operating Expenses	\$7,284,845	\$2,852,060	\$3,349,334	\$13,495,229	\$7,403,779	\$2,897,496	\$3,389,365	\$13,690,639
Income Before Income Taxes	\$6,491,439	\$2,054,932	\$1,323,982	\$9,870,353	\$6,727,161	\$2,132,182	\$1,400,784	\$10,280,107
Net Income	\$3,092,235	\$1,263,783	\$814,249	\$6,070,267	\$4,137,204	\$1,311,280	\$861,482	\$8,309,866
Treatment Volume	14,328	6,100	4,857	24,285	14,887	5,227	4,978	24,892

With an existing lease already in place for a specialty-built medical building with a radiation therapy vault and shielded area for a CT simulator, CRCC can have the new center and linear accelerator giving treatments within a matter of months from the receipt of the CON. Staff notes that North Strand claims the CRCC building is inadequately designed and does not promote operational efficiency. Staff concludes the building is much smaller without extra space for a conference room, etc., but 21st Century possesses much experience and should be able to make the very conservative design work. CRCC appears to have budgeted substantial funds to renovate the building.

Cost Containment – 16a, 16c

CRCC adequately addressed cost containment. They identified methods of funding and demonstrated the method chosen as the most feasible option. Radiation Therapy Services, Inc. (RTSI) indicates that they plan to finance the project with existing operating reserves but may lease the linear accelerator or choose to finance some of the costs through borrowing arrangements with lenders. They stated that CRCC and RTSI have the resources and credit rating to fully finance the project. RTSI has at its disposal cash from operations in excess of \$23 million as of March 31, 2011. Patient charges were also indicated to be reasonable.

The applicant also provided the following to demonstrate cost containment: use of existing building; least total project cost, substantially lower than the other projects; shorter time-frame to bring their new linear accelerator online; large discounts on equipment and medical supplies available due to being a subsidiary of one of the nation's largest providers of radiation therapy services; economies of scale by the sharing of administrative support, computer systems, etc.; state of the art Varian TrueBeam System; clinical, operational, management and financial resources from 21st Century Oncology/Radiation Therapy Services, Inc.

Projected Revenue/Projected Expenses – 6a, 7

Pro formas were also submitted without the Murrells Inlet location (prior to its approval). Proposed charges and cost projections appear to be reasonable.

Conclusion

Staff has determined the applications are competing. CRCC, GSRMC, and NSROC each applied for a CON to provide radiation therapy services in Horry, Georgetown, and Williamsburg Counties and the need for radiation therapy services in the defined services area will be exceeded if more than one application is approved. Additionally, Staff believes that approval of more than one of these CON applications will have an adverse impact on other providers in the service area, and that this negative impact exceeds the benefits of improved accessibility.

The project proposed by CRCC best meets project review criteria, standards in the Plan and the purpose of CON. Therefore, staff has concluded that a CON should be awarded to CRCC-Conway.

Even though the Grand Strand project contributes to the continuum of care for current oncology services, it does not substantially improve accessibility since the location is in the vicinity of the CRCC Myrtle Beach location. The overlapping service area ZIP codes for patient origin are significant with the approved Francis B. Ford Cancer Center relocation. This can also be seen as unnecessary duplication. The location also does not improve access to Conway, an area of rapid growth. North Strand's project is not located in an area of rapid growth, if North Myrtle Beach is not considered. This area is also well served by CRCC's existing office. The utilization projections for North Strand appeared to be unrealistic. This project with the least support and did not provide adequate referral documentation.

Staff recognizes the strong support received by Grand Strand and the fact that it is one of two hospitals of its size (besides Providence with its cardiology focus) without a radiation therapy program. Staff believes the projected utilization could have substantial adverse impact upon the existing CRCC location as evidenced in the statement by Grand Strand's consultant indicating "it is reasonable to conclude that a significant percentage of Coastal Cancer Center's patients from the service area will choose GSRMC for radiation treatment." Staff concurs with some concerns expressed by GHS over the fact that the Murrells Inlet linear accelerator projects have not been completed due to ongoing litigation. However, CRCC is currently operating significantly over capacity. Staff concludes it is prudent to consider that there are two other service area radiation therapy projects tied up in appeal and approving one project, particularly an expansion project, would better comply with the purpose of CON, with its funding from cash balances, lowest project cost, to include linear accelerator cost (cost containment), rapid ramp up time with advanced equipment in a more disadvantaged area (guide establishment best serving the public's needs), location in Conway (no unnecessary duplication) and extensive experience (high quality services).

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Grand Strand Regional Medical Center,
LLC,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control,

Respondent.

Docket No. 12-ALJ-07-0090-CC

Grand Strand Regional Medical Center,
LLC,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control and Carolina
Regional Cancer Center,

Respondents.

Docket No. 12-ALJ-07-0091-CC

CERTIFICATE OF SERVICE

I, Ashley C. Biggers, attorney with the South Carolina Department of Health and Environmental Control, do hereby certify that I have on this 10th day of June, 2013, served a copy of the following:

1. **DHEC'S MEMORANDUM OF LAW IN OPPOSITION
TO GRAND STRAND REGIONAL MEDICAL
CENTER, LLC'S MOTION FOR PARTIAL SUMMARY
JUDGMENT**

upon all parties and counsel of record in the above-captioned case, via United States Mail, First Class, postage prepaid, addressed as follows:

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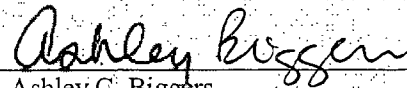
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SOUTH CAROLINA DEPARTMENT OF HEALTH AND
ENVIRONMENTAL CONTROL

By:


Ashley C. Biggers

Date: June 10, 2013

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Grand Strand Regional Medical Center, LLC,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control,

Respondent.

Docket No.: 2012-ALJ-07-0090-CC

MOTION TO ALTER OR AMEND

Grand Strand Regional Medical Center, LLC,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control and Carolinas Regional
Cancer Center,

Respondents.

Docket No.: 2012-ALJ-07-0091-CC

(Consolidated)

Respondent Carolinas Regional Cancer Center ("CRCC"), by and through its undersigned counsel, respectfully moves the Court, pursuant to Rule 59(e), SCRCP and ALC Rule 68, to alter or amend the Final Order and Decision dated March 10, 2014, which found the parties' Certificate of Need applications were not competing and approved both parties' proposed projects for radiation therapy centers in Horry County. *See Home Medical Sys., Inc. v. S.C. Dep't of Revenue*, 382 S.C. 556, 563, 677 S.E.2d 582, 586 (2009) (holding that Rule 59(e) motions are permitted in ALC proceedings).

As described in more detail in the accompanying memorandum of law, this Court: (1) exceeded its authority by approving the application of Grand Strand Regional Medical Center, LLC ("Grand Strand") rather than remanding the matter so that the South Carolina Department

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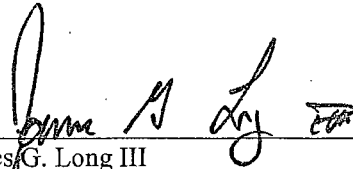
MAR 20 2014

SC ADMIN. LAW COURT

R000247

of Health and Environmental Control could make that determination, (2) improperly provided an advisory opinion as to which application more fully complied after specifically stating that it was not engaging in the exercise of comparing the two applications, (3) improperly considered the 2012-2013 State Health Plan, (4) erroneously shifted the burden of proof onto CRCC when it made its decision by discounting the opinions of CRCC's expert rather than by relying on the opinions of Grand Strand's expert, and (5) overlooked the substantial evidence in the record which required a finding that the applications were competing and that CRCC's project better complied.

RESPECTFULLY SUBMITTED,



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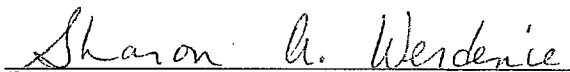
CERTIFICATE OF SERVICE

This is to certify that the forgoing Carolina Regional Cancer Center's Motion to Alter or Amend and Memorandum of Law in Support were served upon the Administrative Law Court and counsel of record by hand delivery this 20th day of March, 2014.

The Honorable Ralph K. Anderson, III
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FILED

MAR 20 2014

SC ADMIN. LAW COURT

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Grand Strand Regional Medical Center, LLC,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control,

Respondent.

Docket No.: 2012-ALJ-07-0090-CC

Grand Strand Regional Medical Center, LLC,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control and Carolinas Regional
Cancer Center,

Respondents.

Docket No.: 2012-ALJ-07-0091-CC

(Consolidated)

MEMORANDUM OF LAW IN SUPPORT OF MOTION TO ALTER OR AMEND

Respondent Carolinas Regional Cancer Center ("CRCC") submits this memorandum of law in support of its motion to alter or amend the Final Order and Decision dated March 10, 2014. This Court's Final Order found the parties' Certificate of Need ("CON") applications were not competing and approved both parties' proposed projects for radiation therapy centers in Horry County. The decision to reverse the Department and find that the CON applications are not competing was critical because in the case of competing applications, the CON Act is clear that only one CON Application can be approved. The Court further determined in a footnote that Grand Strand's application more fully complies with the applicable requirements, even though such a determination was unnecessary in light of its finding that the applications were not

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SC ADMIN LAW COURT

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competing. CRCC asks this Court to reconsider those rulings and to alter or amend its Final Order based on the arguments below.

I. Grand Strand's CON Application Should Have Been Remanded to the Department

In its Final Order, this Court reversed the decision of the South Carolina Department of Health and Environmental Control ("DHEC" or "the Department"), which found the parties' applications were competing. Once that decision was made, this Court should have remanded the Grand Strand CON application to the Department to review the application separately from the CON application of CRCC. Instead, this Court exceeded its authority by weighing the project review criteria itself and approving Grand Strand's CON application, even though DHEC only compared the applications and never made an initial decision on whether Grand Strand's application could independently be approved.

The Record is clear that once DHEC determined that the CON applications of CRCC, Grand Strand, and North Strand were competing, the Department proceeded to compare the applications to determine which application most fully complied with the requirements, goals, and purposes of the CON program, State Health Plan, project review criteria and any regulations developed by the Department. *See* S.C. Code Ann. § 44-7-210(B); S.C. Code Ann. Regs. 61-15 § 103(6). Neither in its Decision Letter nor in the testimony of Ms. Brandt (who is the decision-maker for the Department) did DHEC state that the Grand Strand application had been reviewed independently or that it could be approved. As outlined in the Decision Letter and Ms. Brandt's testimony, the Department had serious reservations about the Grand Strand CON application. For example, the analysis that accompanies the Decision Letter states that the Grand Strand project will have an adverse impact on CRCC and Georgetown Hospital System and that the Grand Strand project does not increase geographic access. Joint Ex. #2 at 911-913. In the

conclusion of the analysis, the Department specifically identifies the deficiencies in the Grand Strand CON application. *Id.* at 917-18. Furthermore, in the Decision Letter itself, the Department stated “approval of the [Grand Strand] application could have substantial negative impact upon the approved, but appealed, relocated Francis B. Ford Cancer Center as well as the existing CRCC-Myrtle Beach.” *Id.* at 899. During Ms. Brandt’s testimony, Grand Strand never asked Ms. Brandt if she would have approved Grand Strand’s CON if the applications were not competing. Ms. Brandt never testified and the Decision Letter never states that DHEC made a decision about the Grand Strand CON application independent from comparing it to the CRCC and North Strand applications. As a result, the Court must remand the Grand Strand CON application to the Department to make an initial decision on the propriety of granting Grand Strand’s application.¹

This case is similar to *South Carolina Department of Health and Environmental Control v. Armstrong*, 293 S.C. 209, 359 S.E.2d 302 (Ct. App. 1987). In that case, Mr. Armstrong applied for a permit to operate a restaurant. *Id.* at 211, 359 S.E.2d at 303. When DHEC expressed concerns regarding Armstrong’s sewage disposal system, Armstrong revised his permit but began operating the restaurant before DHEC granted or denied his permit application. *Id.* DHEC issued an administrative order directing Armstrong to close his restaurant, and when Armstrong ignored that order, DHEC petitioned the circuit court for relief. *Id.* After conducting a hearing, the circuit court ordered DHEC to issue an operating permit to Armstrong. *Id.* at 212, 359 S.E.2d at 304. The Court of Appeals reversed and remanded, explaining, “The evaluation of the adequacy of a sewage disposal system is uniquely within the competency of DHEC, not the

¹ A remand regarding CRCC’s CON is unnecessary because DHEC engaged in the necessary analysis with regard to CRCC’s application, and this Court affirmed DHEC’s decision to grant a CON to CRCC.

court. . . . [T]he trial judge deprived the department of its opportunity to exercise the discretion granted it by the General Assembly.” *Id.* at 215-16, 359 S.E.2d at 305.

Just as DHEC has the authority to review applications for restaurant permits, the General Assembly has charged DHEC with the authority and corresponding responsibility to review proposed projects under the criteria found in the CON regulations and under the policies and standards set forth in the applicable State Health Plan to determine whether to grant or deny an application for CON. *See* S.C. Code Ann. §§ 44-7-140, -160, -210(C). *See also Amisub of South Carolina, Inc. v. S.C. Dept. of Health & Envtl. Control*, 403 S.C. 576, 587, 743 S.E.2d 786, 792 (2013) (“The General Assembly has designated DHEC as the sole state agency for control and administration of the program for granting CONs and the licensure of health facilities and other related activities.”). Pursuant to that authority, DHEC has the discretion to deny a CON application if it determines that the project does not sufficiently meet one or more project review criteria. Once a decision by DHEC has been made, an aggrieved party can request a contested case hearing before the Administrative Law Court. In this case, DHEC never engaged in the exercise of reviewing the project criteria of Grand Strand’s proposed radiation therapy center but instead determined only that CRCC’s project most fully complied with the requirements, goals, and purposes of the CON program. In fact, DHEC raised several issues with Grand Strand’s project in regards to the project review criteria, and the record contains no evidence that DHEC would have approved the project on its own merit. Thus, it was error for this Court to approve Grand Strand’s CON without allowing the Department to “exercise its discretion granted it by the General Assembly” and make a determination on a subject matter that is “uniquely within the competency of DHEC.” *Armstrong*, 293 S.C. at 215-16, 359 S.E.2d at 305.

A careful review of this Court's findings with regard to the project review criteria further demonstrates why a remand is required under the circumstances of this case. In reviewing the criteria, this Court addressed only those criteria deemed important and made no specific finding that the other project review criteria were considered. As explained above, DHEC has the discretion to deny a CON if it determines that the project does not sufficiently meet one or more project review criteria, so even if the findings in this Court's order were not contradicted (which they are), DHEC may still have denied Grand Strand's project based on the other criteria that were never evaluated by this Court.

Additionally, the Administrative Law Court has a history of remanding matters to the Department in situations similar to this one. For instance, in *The Charlotte-Mecklenburg Hospital Authority v. S.C. Department of Health & Environment Control*, 06-ALJ-07-0713-CC (Dec. 9, 2009), the ALC disagreed with the Department's determination that three different CON applications for hospital beds were not competing. When reviewing the applications, DHEC had determined that all three applications complied with the project review criteria, and the record in the subsequent contested case before the ALC was replete with evidence in that regard. Nevertheless, once the ALC found the applications were competing, it remanded the matter so that DHEC could make the initial determination of which application better complied with the project review criteria and the purposes of the CON Act. Just as a remand was appropriate under those circumstances, so too is a remand appropriate here where DHEC never made a determination of whether Grand Strand's CON application, standing alone, should be granted.

Finally, based on the testimony of Grand Strand, the Court found in footnote 11 that Grand Strand intends to purchase a True Beam linear accelerator instead of the linear accelerator identified in its application. Such a purchase is likely a substantial change to the application and,

therefore, provides an additional reason for this Court to remand the Grand Strand application to the Department.

II. Footnote 37 Should be Deleted

In the Final Order, this Court noted that it did not take into consideration certain matters because those matters were irrelevant in light of its decision that the parties' applications were not competing. (*See, e.g.*, footnote 34 "I do not consider this potential move and the potential of higher project costs for CRCC, given that I have decided that the applications are not competing.") After specifically announcing that it would not engage in the exercise of comparing the two applications, this Court summarily states in footnote 37 that it would choose Grand Strand's project over CRCC's if the applications were competing. Such a finding was impossible to make considering this Court purposefully did not consider certain facts, and the finding ignores DHEC's detailed analysis, which determined that CRCC's application better complied with the State Health Plan because of CRCC's "funding from cash balances, lowest project cost, to include linear accelerator cost . . . ; rapid ramp up time with advanced equipment in a more economically disadvantaged area . . . , location in Conway . . . and extensive experience" (Joint Ex. #1 at 655-656). During the trial, CRCC's expert presented CRCC Exhibit #6, a twenty-four page exhibit analyzing each criteria, comparing the applications for each criteria and providing multiple and different reasons for why CRCC's application was superior to Grand Strand. In contrast, Grand Strand's expert provided the same reason for each criteria as to why Grand Strand was superior, namely that Grand Strand's project was in a hospital.

In the Court's discussion of the Project Review Criteria, the Court never compared the two applications. (Order pg. 17-20). A comparison requires the decision maker to determine which one was better. For each criteria, the Court found that both applications met or satisfied

the criteria which is not a comparison of the applications. After determining that the applications were not competing, it was correct not to compare them. Therefore, footnote 37 should not have been included in the Order.

Furthermore, because footnote 37 has no practical effect on the outcome of the case, its inclusion is purely advisory and should be removed from the Order. See *Booth v. Grissom*, 265 S.C. 190, 192, 217 S.E.2d 223, 224 (1975) (“It is elementary that the courts of this State have no jurisdiction to issue advisory opinions.”). See also *Hitter v. McLeod*, 274 S.C. 616, 618, 266 S.E.2d 418, 420 (1980) (“[I]t does not ipso facto confer jurisdiction on this Court, or the court below, to render an advisory opinion, which we have repeatedly refused to do even on constitutional issues” (emphasis added)); *Horry County v. Parbel*, 378 S.C. 253, 264, 662 S.E.2d 466, 472 (Ct. App. 2008) (“A court renders an advisory opinion when commenting on an issue will have no practical effect on the outcome of the case.”) *overruled on other grounds by State v. Oxner*, 391 S.C. 132, 134 n.1, 705 S.E.2d 51, 52 n.1 (2011).

III. The 2012-2013 State Health Plan was Improperly Considered

In addition to exceeding its authority by issuing a CON to Grand Strand, this Court overlooked S.C. Code Ann. Regs. 61-15 § 504 when it took into consideration the 2012-2013 State Health Plan on pages 2, 7, 11, and 24 of the Final Order. Section 44-7-225 of the South Carolina Code provides that the ALC “may consider the current South Carolina Health Plan when making its decision;” however, the extent of that consideration is clarified by S.C. Code Ann. Regs. 61-15 § 501. See *Society of Professional Journalists v. Sexton*, 283 S.C. 563, 567, 324 S.E.2d 313, 315 (1984) (explaining that regulations have the force of law so long as they do not alter or add to a statute); *Young v. South Carolina Dept. of Hwys. & Pub. Transp.*, 287 S.C. 108, 113, 336 S.E.2d 879, 882 (Ct. App. 1985) (allowing administrative agencies to “fill up the

details by prescribing rules and regulations for the complete operation and enforcement of the law within its expressed general purpose.” (internal quotations omitted)).

Pursuant to Regulation 61-15 § 501:

All decisions on Certificate of Need applications shall be made based on the currently approved South Carolina Health Plan in effect at the time such application is accepted. Should a new plan be adopted during any phase of the review or appeals process, the applicant shall have the option of withdrawing the application and resubmitting under the newly adopted plan or continuing the review or appeal process under the plan in use when the application was submitted.

S.C. Code Ann. Regs. 61-15 § 504 (emphasis added). Grand Strand elected not to withdraw its application and chose to appeal the process under the 2010-2011 State Health Plan.

The apparent purposes of Regulation 61-15 § 504 are two-fold: (1) to ensure that healthcare providers have a fair opportunity to apply for a CON and (2) to prevent providers from prematurely filing an application in hopes that, by the time the application is reviewed, a new and more favorable Health Plan is in place. These purposes were thwarted in this case when the Court based its decision on the 2012-2013 State Health Plan, thereby effectively awarding the linear accelerator identified in that Plan to Grand Strand without giving any other potential applicant an opportunity to apply for it.

IV. This Court’s Analysis Improperly Shifted the Burden of Proof to CRCC

In addition to the errors above, this Court appears to have confused which party bore the burden of proof. Once DHEC found the parties’ applications were competing, Grand Strand had the burden of proving by a preponderance of the evidence that DHEC’s determination was incorrect. *See Anon. v. State Bd. of Med. Exam’rs*, 329 S.C. 371, 378, 496 S.E.2d 17, 20 (1998) (adopting the preponderance of evidence standard of proof for administrative proceedings); 2 Am. Jur.2d *Administrative Law* § 354 (2014) (explaining that in administrative proceedings, the

party bringing forward a matter for litigation has the burden of proof, unless otherwise provided by statute). *Cf. Lewis v. Lewis*, 392 S.C. 381, 388-89, 709 S.E.2d 650, 653-54 (2011) (explaining that *de novo* review does not relieve the complaining party of demonstrating that the preponderance of the evidence is against the findings of the lower tribunal). Initially, this Court recognized that the burden of proof rested squarely on the shoulders of Grand Strand; however, it failed to apply that standard and overlooked the dearth of evidence provided by Grand Strand when it reversed DHEC's determination and focused instead on the perceived weaknesses in CRCC's evidence and expert testimony. This was error. *Cf. CarMax Auto Superstores West Coast, Inc. v. S.C. Dep't of Revenue*, 397 S.C. 604, 612, 725 S.E.2d 711, 715 (Ct. App.2012) (reversing the ALC for shifting the burden of proof to the taxpayer when the Department of Revenue bore the burden of proving that its alternate accounting method was reasonable).

A review of the record reveals that Grand Strand did not offer into evidence any revised or updated utilization projections nor did it independently analyze impact on referral patterns. (Sullivan Trial Tr. 2139:12-2141:1) Additionally, Grand Strand relied solely on the projections in its application, completely ignoring Grand Strand's market share data which was easily and readily available to Grand Strand executives. (Sullivan Trial Tr. 2141:2145:4) In footnote 14, the Court found discrepancies in Mr. Sullivan's math but based its decision on the old and limited data and assumptions presented by Grand Strand. Furthermore, although this Court rejected CRCC's inpatient market share as a proxy for market share,² it overlooked the fact that outpatient market share was rejected by both experts. Grand Strand's expert provided no reasonable alternative for predicting market share, and its expert testified based on assumptions

² Inpatient market share was previously accepted by this Court as a proxy for market share in *Beaufort-Hilton Head Radiation Oncology Center v. S.C. Department of Health & Environmental Control*, 01-ALJ-07-0507-CC (Marc. 19, 2003 S.C.A.L.C), and it was error for this Court to reject inpatient market share in this case.

that were not logically connected to any cancer-related market share. (Sullivan Trial Tr. 813:22-815:11)

This Court should have recognized Grand Strand's failure to overcome its burden of proof rather than merely discounting the evidence presented by CRCC.

V. This Court Overlooked or Misapprehended Key Facts

Finally, CRCC asks this Court to alter or amend its order because it overlooked or misapprehended the following:

- On page 6 of the Order, this Court overstates Mr. Sullivan's experience with radiation therapy applications in recent years, his knowledge of this market and importantly, ignores the lack of information and research contained in his file or done by him in preparing the Grand Strand CON application and more particularly in making the assumptions and projections in his draw rate analysis. (Sullivan Trial Tr. 838:18-839:9).
- On page 8 of the Order, this Court ignores the overwhelming testimony that Grand Strand's stated intention to provide comprehensive cancer care will not occur for several critical reasons. First, chemotherapy will be provided at the office of Dr. Holt so one of the main elements of cancer treatment will be conducted at a different location. Second, Grand Strand has a mobile PET/CT housed at the South Strand campus. The mobile PET/CT will not be housed at the hospital. Third, Grand Strand is not constructing a cancer center on its campus. In addition, the Court failed to recognize that interdisciplinary cancer care is occurring in Horry County at this very moment and has for some time through the tumor boards. These tumor boards are when specialists meet to develop a treatment plan for the care of the patient. The implication that Grand Strand's project will implement interdisciplinary care is not accurate or supported in the Record.
- On page 9 of the Order, this Court finds that Grand Strand "can reasonably assume a 20% market share for radiation therapy in Horry County by 2017." In so finding, this Court overlooked Grand Strand's documented overall market share in its primary and secondary service areas of 35.09% in 2009 and its oncology market share of 29.13% in 2009. (CRCC Ex. #97 at GSRMC-003081) This Court also ignored the internal calculations circulated between Grand Strand and its parent entity, which evidence that Grand Strand contemplated much higher market share. (CRCC Ex. #15; CRCC Ex. #12)
- In finding that Dr. Holt never committed that Coastal Cancer Center, the largest referral source of radiation therapy patients to CRCC, would send a substantial

portion of its patients to Grand Strand (see footnote 13), this Court failed to acknowledge that Dr. Holt wrote a letter in support of Grand Strand's project, not CRCC's. (Joint Ex. #2 37, 866; Tolbert Trial Tr. 2048:25-2049:19) This Court also ignored that Grand Strand's application referred to its relationship with Coastal Cancer Center at least seven times. (Tolbert Trial Tr. 1832:21-23; Joint Ex. #2 352-357, 596, 866, 891) and Mr. Sullivan wrote to the Department during the review process and stated that a significant percentage of Coastal's patients would choose Grand Strand.

- In footnotes 14 and 15, this Court noted that CRCC's draw-rate analysis was not reliable because it was unreasonable to assume that the penetration rate would be the same for radiation therapy as it was for inpatient services; however, this Court overlooked CRCC's expert testimony explaining that the draw-rate analysis took into account this difference in penetration rates and backed out data for things like urology referrals. This is critical since the Court apparently believed that Mr. Tolbert did not consider the lack of urology referrals to be received by Grand Strand. In fact, CRCC Exhibit 12 clearly removes the urology patients when calculating Grand Strand's market share.
- On page 11, this Court focused on the quality of the facilities housing the linear accelerators rather than on the superiority of CRCC's linear accelerator, which was undisputed. Furthermore, the purpose of the CON Act is to contain costs. Therefore, focusing on the size and appearance of buildings is inconsistent with the CON Act.
- Although this Court recognized on page 12 that patients from Conway and Loris drive an average of 45 minutes to the current cancer centers with linear accelerators, it inexplicably downplayed the 20-minute reduction in drive time that CRCC's Conway facility would afford to the average patient.
- In footnote 18, this Court stated that CRCC never argued to DHEC that Grand Strand's project would adversely impact its operation, yet CRCC was the only applicant who complained to DHEC that Grand Strand's project would have an adverse impact. Ms. Brandt testified that she considered the impact on referral patterns to CRCC and Georgetown Hospital System thereby proving that the issue was properly considered below. (Brandt Trial Tr. 1003-1005).
- The Court's finding on page 14 that 13,205 treatments are not available to Grand Strand in 2017 is not correct or supported in the Record. Mr. Sullivan's number is lower than that and is based on the unreliable and unrealistic assumption that all prostate cancer patients will receive the highest number of treatments (40) while all other forms of cancer will receive less than 20 treatments which is substantially below the typical number of treatments as testified to by the physician witnesses.

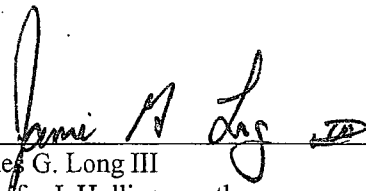
- On page 15, this Court discounted the most current utilization data (within one month of trial) that clearly showed declining utilization at CRCC year after year from 2011 to 2012 to 2013. (CRCC Ex. #12, Joint Ex. #11, CRCC Ex. #22, CRCC Ex. #139)
- On page 16, this Court misapprehended Mr. Tolbert's referral analysis contained at CRCC Ex. 10. This analysis, first suggested by Mr. Sullivan who chose not to do the analysis, is a conservative estimate of the shift in referral patterns. Mr. Tolbert did not allocate all of Coastal's cancer patients to Grand Strand while he did allocate all of the urology patients to CRCC. The small volume referrals were allocated in a balanced approach with a significant number of referrals allocated to Georgetown Hospital. The significant point of the analysis was that the volume projected from the change in referral patterns was substantial, greater than the tipping point, and consistent with Grand Strand achieving a market share in line with its historical inpatient market share.
- On page 17, this Court incorrectly determined that Grand Strand's project was not an unnecessary duplication when it is located a mere three miles from CRCC and the number of inpatient radiation therapy patients is minimal.
- On page 19, this Court noted that competition enhances the negotiating power of payors and therefore found that Grand Strand's project would promote cost containment. This finding completely ignored the evidence showing that Grand Strand's service would cost more than CRCC's. In fact, Grand Strand conceded that its charges will be higher for patients insured by governmental programs and that a substantial majority of patients are reimbursed from government payors. Further commercial or private payors set reimbursement in relation to governmental payors. Having a higher priced provider enter the market will not cause reimbursement by private payors to decline and Grand Strand will have no impact on government reimbursement.
- On page 20, this Court ignored the testimony of all witnesses about the "nasty" relationship between the urologists and the prior owner of CRCC and that 21st Century had made many efforts to educate and collaborate between the AUC urologists and the CRCC radiation therapists. Further, there was no evidence that any patient treated by CRCC's radiation therapy center was not a cancer patient in need of radiation treatment.
- In footnote 32, this Court misapprehends the factors DHEC was supposed to consider when comparing the projects. The Court complains that DHEC Staff failed to consider CRCC's monopoly of radiation therapy services in Horry County; however, the Court overlooks the fact that such a finding is not a factor for DHEC to consider.

- This Court ignored that the adverse impact model used by CRCC's expert was initially raised by Grand Strand's expert in his deposition. (Tolbert Trial Tr. 1942:8-21; Sullivan Trial Trs. 2139:17-2140:11).
- This Court overlooked the substantial evidence in the record when it found that the applications were not competing even though every scenario presented to the court, except for the pre-discovery projections contained in Grand Strand's CON application, indicated that approval of both applications would reduce the existing units below the 80% threshold. (CRCC Ex. 12 at TOLBERT012904; Tolbert Trial Tr. 1690:24-1691:17)

VI. Conclusion

For the foregoing reasons, CRCC respectfully requests this Court alter or amend its Final Order and Decision.

RESPECTFULLY SUBMITTED,



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March 20, 2014
 Columbia, South Carolina

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT DIVISION

Grand Strand Regional Medical) Docket No:
Center, LLC,) 12-ALJ-07-0090-CC
)
Petitioner,)
)
v.)
)
South Carolina Department of)
Health and Environmental Control,)
)
Respondent.)
_____)

Grand Strand Regional Medical) Docket No:
Center, LLC,) 12-ALJ-07-0091-CC
)
Petitioner,)
)
v.)
)
South Carolina Department of)
Health and Environmental Control)
and Carolina Regional Cancer)
Center,)
)
Respondents.)
_____)

ADMINISTRATIVE HEARING

DAY ONE - Thursday, September 12, 2013
9:56 a.m. - 5:09 p.m.

DAY TWO - Friday, September 13, 2013
9:27 a.m. - 3:54 p.m.

DAY THREE - Monday, September 16, 2013
9:27 a.m. - 5:00 p.m.

DAY FOUR - Tuesday, September 17, 2013
9:28 a.m. - 5:38 p.m.

DAY FIVE - Wednesday, September 18, 2013
9:32 a.m. - 5:21 p.m.

DAY SIX - Thursday, September 19, 2013
9:27 a.m. - 3:17 p.m.

DAY SEVEN - Friday, September 20, 2013
8:58 a.m. - 7:45 p.m.

DAY EIGHT - Monday, September 23, 2013
9:26 a.m. - 12:48 p.m.

DAY NINE - Tuesday, September 24, 2013
12:57 p.m. - 4:13 p.m.

The hearing before the Honorable Ralph King
Anderson, III was taken at the Edgar A. Brown
Building, 1205 Pendleton Street, Suite 224, Columbia,
South Carolina, on the 12th day of September, 2013,
through the 24th day of September, 2013, before
Andrea R. Taylor, Court Reporter and Notary Public in
and for the State of South Carolina.

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EXHIBITS:

The exhibits admitted into evidence in this hearing
are listed in a separate document.

STIPULATIONS

It is stipulated and agreed that this hearing
is being taken pursuant to the rules of the
Administrative Law Judge Division and the South
Carolina Rules of Civil Procedure.

DAY 1 - THURSDAY, SEPTEMBER 12, 2013:

THE COURT: This is a hearing in the matter of Grand Strand Regional Medical Center, LLC, Petitioner, vs. South Carolina Department of Health and Environmental Control and Carolinas Regional Cancer Center, Respondents. The Docket Numbers are 12-ALJ-07-0090-CC, and correspondingly, 0091. All right. Now I'll wait for Ms. Biggers to get here. I can just start my computer up anyway.

(Off the Record)

THE COURT: Opening statements.

OPENING STATEMENT - BY MR. THOMAS:

MR. THOMAS: Your Honor, may it please the Court.

Will Thomas for Petitioner Grand Strand Regional Medical Center. And before I jump into that, I just want to let you know we have Doug White, our CEO for exactly two more days. He's about to retire, so this is kind of his last hurrah; and Adam Rudd, the chief operating officer of Grand Strand Regional Medical Center; and then Dan Sullivan is healthcare consultant that has been working on this case. Okay. Your Honor, December 2011, DHEC denied Grand Strand's CON application for a hospital

1 based linear accelerator. And they approved --
2 they approved CRCC's application for a
3 freestanding radiation therapy center in the
4 service area, which is Georgetown, Horry,
5 Williamsburg County. This will be CRCC's
6 fourth linear accelerator in Horry County.
7 CRCC is, incidentally, the only provider of
8 radiation therapy in Horry County, and they
9 have maintained their market dominance in Horry
10 County for approximately 30 years, maybe a
11 little bit longer. There are currently no
12 hospital-based radiation therapy centers in
13 Horry County, and there are no in-hospital
14 radiation therapy centers within the service
15 area. Today, Grand Strand is going to ask this
16 Court, and for the next, you know, seven to ten
17 days to do one of two things. First, Grand
18 Strand is actually asking this Court to go
19 ahead and approve both the applications of the
20 applicants before you today, Your Honor,
21 because the evidence is actually going to show
22 that the CON applications are not competing and
23 that both can be approved standing alone on
24 their own merits, Your Honor. Second, if the
25 Court finds that the applications are

1 competing, we believe that DHEC erred, we being
2 Grand Strand, that DHEC erred and that Grand
3 Strand's application should have been proved
4 instead. Competing applicants, of course,
5 means two or more persons or healthcare
6 facilities as defined in the CON Act who
7 applied for certificates of need to provide
8 similar services or facilities in the same
9 service area within a time frame as established
10 by the Department regulations whose
11 applications, if approved, Your Honor, would
12 exceed the need for those services. Grand
13 Strand asserts that the evidence, very strong,
14 compelling evidence, will show that the
15 applicants are not competing. Now, Your Honor,
16 I believe that probably the starting point for
17 any analysis of a CON application is to look at
18 the purpose of the Act. And the very first
19 purpose of the Act and the article is to
20 promote cost containment, and then you've got
21 to prevent the unnecessary duplication of
22 healthcare facilities and services and guide
23 the establishment of health services and
24 facilities which will best serve public needs
25 and ensure that high quality services are

1 provided in the state. Grand Strand asserts
2 that the Department, if the applicants are
3 competing, really didn't make those
4 considerations, didn't consider the actual
5 purposes of the Act and probably just looked at
6 the project review criteria on some kind of
7 head-to-head basis, which we don't believe is
8 necessarily proper. Again, Your Honor, the
9 applicants are not competing. Why? The 2012-
10 2013 State Health Plan actually shows a need
11 for a new linear accelerator in addition to the
12 one that DHEC has already approved for CRCC to
13 be located in Conway. So we now have a State
14 Health Plan that's come out and actually
15 vindicated what Grand Strand was saying all
16 along during the review process is that, DHEC,
17 you can approve two. And, luckily, there's a
18 statute that you're probably well aware of,
19 South Carolina Code Annotated 44-7-225, which
20 says that the Department, the Administrative
21 Law Court, and the Court of Appeals even shall
22 consider the South Carolina Health Plan in
23 place at the time the application was filed and
24 may consider the current South Carolina Health
25 Plan when making its decision. So Grand Strand

1 is asking you to consider that 2012-2013 Health
2 Plan, which is actually based on 2011 numbers.
3 This is a screen shot of the 2012-2013 State
4 Health Plan page -- Section 9 or IX, page 8,
5 and what it shows you, Your Honor, is in the
6 service area there with a population of 370,000
7 people, it states five linacs. Well, there are
8 actually only four in actual operation, Your
9 Honor. One of those is -- the Department
10 actually included the one that it approved for
11 CRCC, but it's not operational. But even with
12 that fifth one there, the percent capacity of
13 all the linear accelerators, including the one
14 that's not even operational based on the 2011
15 volumes is 96.7 percent, so almost 100 percent
16 capacity. And what they said is there was a
17 need. There's only one other service area that
18 had a need, and that was Anderson/Oconee, so --
19 and what's more, CRCC in Georgetown's 2012
20 volumes also show that if there were a 2013-
21 2014 State Health Plan published, Your Honor,
22 that there would be a need for a linear
23 accelerator in addition to the one approved by
24 DHEC. Some of the volumes have come down a
25 little bit, and we'll get into a little bit

1 more of that with the actual case in chief.
2 But this is what it would look like today with
3 the five approved. The total area treatments
4 are 28,000. When you compare that against the
5 planning area capacity, 85.4 percent capacity.
6 So is there an unmet need under DHEC's
7 threshold of 80 percent? The answer is yes.
8 Your Honor, what the evidence is going to show
9 is that CRCC actually concealed its 2011
10 volumes throughout the entire review process of
11 these two CON applications, and there were
12 actually three, Your Honor, but North Strand's
13 not in this action anymore. The application
14 process and the review process lasted all the
15 way until December 28, 2011. And I've haven't
16 checked, but I think that's a Friday. So
17 really the last business day of the year, or
18 close to it, excuse me. And we believe Grand
19 Strand believes the evidence is going to show
20 you, Your Honor, that there was a reason why
21 CRCC's 2011 numbers, which were astounding,
22 they had 25,000 treatments in one year, were
23 not revealed to DHEC. There were several
24 occasions during the review process that CRCC
25 could have demonstrated to DHEC that its

1 volumes in 2011 were going to exceed 25,000
2 treatments on three linear accelerators, which
3 would have showed the Department that they
4 could have approved two, Your Honor, not just
5 one. But even as late as November 28th, and of
6 submission, they still went with the earlier
7 projections that they had made back in February
8 of that year, and they just said they were
9 going to do 22,000 linear accelerator
10 treatments. Now, to comply with the State
11 Health Plan's standards, Your Honor, for linear
12 accelerators, an applicant must show that
13 they're going to do by the third year of
14 operation, achieve 50 percent capacity on the
15 linear accelerator that they're applying for
16 without reducing the existing linear
17 accelerators in the service area below the 80
18 percent threshold.

19 THE COURT: Is that out of a statute or reg? I
20 can't remember.

21 MR. THOMAS: That was actually out of the State
22 Health Plan, Your Honor.

23 THE COURT: All right.

24 MR. THOMAS: I'm sorry. That's one of the
25 standards. I believe, it's Standard 6-A and 6-

1 B, You Honor.

2 THE COURT: Okay.

3 MR. THOMAS: So the evidence is going to show that

4 Grand Strand is going to achieve its 50 percent

5 capacity threshold. I don't think that's

6 really an issue in this case, Your Honor, to be

7 honest with you. But we think we're going to

8 be able to do it without reducing the 80

9 percent threshold, the capacity threshold of

10 the existing linear accelerators. We believe

11 that's just not going to be the case given

12 several factors that you will hear more about.

13 Really, I think you've -- almost that the case

14 really boils down to that 80 percent threshold

15 issue. Now, Your Honor, if you do happen to

16 find that the applications are competing, we

17 believe the evidence is going to show that

18 Grand Strand and not CRCC should have been

19 approved. So, as you're aware, in the case of

20 competing applications, the Department is

21 charged with awarding the CON, if appropriate,

22 on this basis of which, if any, most complies

23 with the requirements, goals, and purposes of

24 this article, and this article in this case is

25 the CON Act. So that's the very first thing

1 they're saying you need to do. And the State
2 Health Plan, and then the project review
3 criteria, and then the regulations adopted by
4 the Department. A little bit about Grand
5 Strand, Your Honor. What you're going to see
6 is it's one of the only highly utilized
7 tertiary facilities in the state of South
8 Carolina that does not have an affiliated
9 radiation therapy program. All right? As
10 mentioned previously, in this service area
11 there are only freestanding radiation therapy
12 facilities, and there are no hospital
13 affiliated radiation centers in Horry County
14 whatsoever. Georgetown, to the south, does
15 have a hospital affiliated radiation therapy
16 program, but it's not -- and it's 40 miles to
17 the south, by the way, but it's a freestanding
18 center. There are no in-hospital radiation
19 therapy centers in the service area. Now,
20 2015, which is basically a year and three
21 months away, the census of Horry County is
22 going to be 300,000 people. It's going to be
23 one of the largest counties by population in
24 the state. And as Mr. White informed me last
25 night at dinner, he said that Horry County was

1 the largest county by area, is that correct, in
2 the state of South Carolina.

3 THE COURT: Matter of fact, you're about to get a
4 new area code, apparently.

5 MR. THOMAS: And this is a chart, I don't know if
6 it's easier to read on your screen, Your Honor,
7 but it basically summarizes the linear
8 accelerators and hospitals with inpatient
9 utilization over 50,000 patient days. This was
10 done based on 2009 patient days because two
11 years have passed by. But I'll draw your
12 attention to the two facilities that in '09 had
13 over 50,000 patient days that didn't have some
14 type of radiation therapy program affiliated
15 with it. St. Francis Downtown was one of
16 those. It has since applied, and has been
17 approved for, and I believe has maybe even
18 installed a linear accelerator. So now that
19 leaves Grand Strand. And I would like to just
20 tell you that the evidence is going to show
21 that Grand Strand is not doing 57,593 patient
22 days anymore, they're about at 71,000 patient
23 days. And here's another chart that was
24 presented during the review process, Your
25 Honor, that basically shows there five of the

1 highest populated counties in the state of
2 South Carolina. And it shows how many of them
3 have hospital-based linear accelerator and how
4 many have freestanding. You see Charleston --
5 I think that's actually a typo. There's -- I
6 think there's ten hospital-based and there's
7 one freestanding linear accelerator in East
8 Cooper. But Horry County has no in-hospital
9 linear accelerators and no hospital-based
10 linear accelerators, but there are three linear
11 accelerators in a freestanding facility. And
12 if obviously CRCC is approved, there will be
13 four. So why Grand Strand, Your Honor? As
14 you'll see the evidence will show that they're
15 already accredited as a community cancer
16 program by the American College of Surgeons.
17 They already have board certified oncologists
18 and oncology nurses on their medical staff.
19 They're going to offer for the first time in
20 Horry County access to comprehensive cancer
21 treatment. And this is a setting that is not
22 available in Horry County today. So you're
23 going to surgery, inpatient medical oncology
24 services and radiation therapy services that
25 are all going to be offered in one location, as

1 well as most of the ancillary services that
2 cancer patients may require. And one of the
3 things that's -- another thing is that there's
4 a medical oncology office that's very close by,
5 Coastal Cancer Center in Myrtle Beach. They
6 have five different locations, but they also do
7 infusion therapy there, which is chemo, and I
8 believe they also have a PET/CT scanner there
9 as well. So everything is really going to be
10 in this one local area. For the patients that
11 want this hospital-based treatment, they'll be
12 able to get it. And the eventual idea here,
13 Your Honor, is that this comprehensive cancer
14 treatment center is going to foster something
15 called interdisciplinary cancer care, or ICC as
16 it's sometimes called. And basically, this is
17 something that Mr. Sullivan will get a little
18 bit more into and our medical expert, but it's
19 where there's an interdisciplinary team
20 approach to cancer care where lots of different
21 physicians get together on a particular
22 patient's case and come up with the best
23 therapies. And this is happening all over the
24 United States. It's happening at MUSC where a
25 lot of Grand Strand's patients go -- I mean,

1 Horry County residents go today to get that,
2 but it's also 100 miles to the south. So
3 essentially, this program is going to offer
4 something new in the service area, Your Honor,
5 that is not currently there. One of the things
6 that this concept fosters also is it's going to
7 bring in medical specialists that currently
8 aren't in the service area. Mr. White and Mr.
9 Sullivan will talk more about that. And then
10 while not a huge part of the project from a
11 volume standpoint, inpatients that are in the
12 hospital in the medical/surgical wards of Grand
13 Strand who may require radiation therapy will
14 no longer have to be transported to another
15 facility to get that type of service. And I
16 guess the evidence is going to show something
17 about 30, 35 patients a year may require that
18 type treatment. Doesn't sound like a lot to
19 us, but for that patient who has to undergo a
20 transport and get on an ambulance and get off
21 and do it three or four times over their
22 inpatient stay, it's significant, Your Honor.
23 The other issue that I've touched on but didn't
24 get into is the evidence is going to show that
25 the patients who require something called dual

1 therapy, that's chemo therapy and radiation
2 therapy, not at the very same time, but you
3 know, maybe on the same day of the week, Grand
4 Strand's radiation therapy center is going to
5 be less than a two or three minute drive from
6 the medical oncology offices nearby where they
7 do chemo infusion services. These chemo
8 infusion services are done at all the medical
9 oncology offices in the service area, Your
10 Honor, but they do -- they also do them in
11 Myrtle Beach. So for those Myrtle Beach
12 patients, it could be convenient. And lastly,
13 Your Honor, certainly not least, the referral
14 services -- the referral sources to Grand
15 Strand are not financially incentivized to
16 refer to Grand Strand, so cost to the
17 healthcare system will be contained. We
18 believe the evidence is going to show that
19 there are several reasons why CRCC should not
20 have been approved by DHEC, Your Honor. The
21 number one thing is that they're not really
22 offering access to anything new. Their primary
23 justification in their CON application, Your
24 Honor, is that patients who live in the
25 Conway/Loris area are going to save ten minutes

1 one way travel time, on average, if CRCC-Conway
2 gets a facility. And again, Grand Strand
3 believes that both of these projects should be
4 approved, but we don't think that a ten minute
5 savings in drive time should be the basis for
6 overturning a hospital-based radiation therapy
7 program that's going to eventually offer
8 comprehensive cancer treatment in a setting
9 that is a little bit different than what CRCC's
10 offering. And, Your Honor, this is CRCC's
11 facility in Conway where they are proposing to
12 locate their linear accelerator, and it's
13 essentially a modular -- like a modular office,
14 about 2,000/1,500 square feet. And then you'll
15 see this building to the back, Your Honor.
16 This is what they call the vault. That's where
17 the linear accelerator will be placed. So
18 you're going to hear a little bit about project
19 costs in this case, and that's maybe --
20 probably the primary reason that CRCC's project
21 costs are going to be lower than Grand Strand
22 because Grand Strand is used to building
23 centers more look like this, and they would
24 never attach something like that to their
25 hospital. They're in a hurricane zone; they're

1 going to sprinkle their building. The evidence
2 will show that there is no sprinkle system,
3 that we're aware of, based on a site visit of
4 this building. And so fire and life safety
5 issues are very important to Grand Strand. So
6 at the end of the day, Grand Strand is going to
7 put in a very nice world class facility,
8 radiation therapy center on its campus in
9 Myrtle Beach. What the Court will learn is
10 that CRCC's interested in one thing, and we
11 believe one thing only, that's maintaining an
12 81 percent market share in the area. That's
13 pretty astounding. Right now, you'll find that
14 CRC is fighting not just Grand Strand's
15 competitor coming into the market, but
16 Georgetown Memorial Hospital that's trying to
17 move a radiation therapy facility from their
18 campus in Georgetown up to their Waccamaw
19 campus, just moving, just relocating. CRCC met
20 that relocation with a relocation of their own
21 after an application was filed. Now, we
22 believe that you're going to see emails and a
23 variety of other documents that the longer CRCC
24 can delay its competitors, the longer it can
25 sustain fairly astounding profits from one

1 service line, which is radiation therapy. And
2 this chart here, which was taken from CRCC's
3 production documents shows their net revenues
4 and their EBITDA. So 2010, which is the year
5 21st Century Oncology purchased CRCC, their
6 revenue is 12.4 million, their EBITDA was 6.7
7 million. In a short year, they figured out a
8 way to take the EBITDA and the revenue per
9 treatment up \$260 per treatment and double
10 their EBITDA, that's earning before interest
11 taxes depreciation amortization, and you'll see
12 the treatments there 2,946 to 25,709. They
13 dialed back a little bit in 2012, Your Honor,
14 but still a very profitable enterprise. And
15 this is simply a bar graph representation of
16 what I just went over. So what you're really
17 going to see, Your Honor, is that CRCC's on the
18 defensive with this project. They're kind of
19 trying to put out fires in the service area by
20 responding -- to reacting to things, and this
21 isn't just some kind of magnanimous thing.
22 Well, let's go down to our patients in Murrells
23 Inlet, or let's go down to our patients or over
24 to our patients in Conway. This is we need to
25 get over there to stop any competition from

1 coming in this market, and the evidence is
2 pretty clear about that. And so far the plan's
3 worked well. So since both Georgetown and
4 Grand Strand have applied to either relocate or
5 establish a new service, CRCC has kept both
6 those parties mired in litigation, and they
7 continue to earn millions of dollars. Now,
8 Your Honor, make this graph -- it's the best
9 rendition I could find for red herrings, and
10 then some kind of explosive increase here.
11 What you're really going to see, Your Honor,
12 are a lot of red herrings and what I call
13 absurd projections, projections that just don't
14 make any sense on any level. We believe that
15 Grand Strand expects that CRCC is going to
16 dwell on Grand Strand's internal deliberations
17 regarding where to place its facility to show
18 two things, that it has a good relationship
19 with the local medical oncology group, and that
20 its goal was never about exclusively
21 eliminating inpatient transports. At the end
22 of the day, Your Honor, these are classic red
23 herring issues. It ignores the fact, first of
24 all, there's a need for two of these linear
25 accelerator facilities in the service areas per

1 the last two State Health Plans, and it ignores
2 the fact that a hospital-based facility would
3 be very good for the residents of Horry County,
4 Your Honor. So we're going to make it easy on
5 CRCC right now. Grand Strand has a good
6 relationship with the local medical
7 oncologists, at least three of whom wrote
8 letters of support for CRCC's project in Conway
9 in addition to Grand Strand's project, and
10 we're going to tell you right now that Grand
11 Strand's project was never about simply
12 eliminating the transport of inpatients to
13 radiation therapy, but its ultimate decision to
14 locate the linear accelerator in the hospital,
15 Your Honor, no matter how they want to cut it
16 will do just that; it will eliminate the
17 transport of inpatients outside of the
18 hospital. But the bottom line is, Your Honor,
19 very few hospitals in the United States of
20 America could basically make a go of a
21 radiation therapy program on inpatients alone.
22 Maybe something like the Mayo Clinic or Johns
23 Hopkins, I'm not sure, but Grand Strand has
24 never said that that's what their project is
25 going to be about. So Your Honor, the evidence

1 is going to show that Grand Strand considered
2 Coastal Cancer Center's property for the
3 location of its linear accelerator, looked hard
4 at it. It was going to buy property from a
5 local medical oncology group for \$1.4 million
6 located right next to its campus. And what
7 you're going to hear from hospital management,
8 they weren't very keen on the idea of locating
9 that linear accelerator on that project, but
10 they have, and maybe some background, Grand
11 Strand is an affiliate of HCA, which is -- I
12 think stands for Hospital Corporation of
13 America. They're based in Nashville, and they
14 have corporate leadership to answer to. And
15 corporate leadership, which you will find in
16 these organizations, wants the administration
17 to explore every single option and leave no
18 stone unturned, and so that's what they did.
19 But it ended up going back to the hospital,
20 Your Honor. And the primary reason was it was
21 going to be cost prohibitive. Now, I'll tell
22 you, even if this option had been chosen, Your
23 Honor, it would have been bad for the
24 community. It would have actually put the
25 cancer patients who require infusion services,

chemo therapy, right across the hall,
essentially, from the radiation therapy
provider and still in very close proximity to
the hospital campus. But at the end of the
day, the decision was not to put it there. And
this is a map, Your Honor, I hope I can show --
and it's not the best one in the world, but Mr.
Long made it. But here's the hospital right
here, this is Grand Strand, okay? Here's one
of their large parking areas, and here is the
medical oncology office right there. And to
get from the medical oncology office, you drive
on this road, go over here and it's about -- I
did it in two and a half minutes; some people
might do faster or slower. But the idea was
either to put it here where they were
considering Coastal Cancer Center's property
here on this side or maybe even one right here
on the parking lot and have some kind of road
that, you know, closed-loop road. But that --
that was the general idea. Now, what you're
going to see is the evidence is going to show
that the Grand Strand had to reject that
because the cost of the land, in addition to
some other factors, but the cost was very

1 prohibitive. We will show you and we believe
2 that DHEC will not -- DHEC's witness will not
3 deny this, that had Grand Strand come in with
4 a project cost due to the land that was over
5 \$11 million, they wouldn't have had a shot in
6 this -- in the review process because their --
7 at that time was North Strand Radiation
8 Oncology whose project cost was also in the
9 nine million dollar range. And remember, Your
10 Honor, as we looked at earlier, what's the very
11 first element listed as a purpose of the CON
12 Act, it's cost containment. So Grand Strand
13 needed to make sure that it was containing the
14 cost so that it would have some reasonable
15 chance in this CON review process. Let's talk
16 about kind of these absurd or what I call wild
17 projections. Now, just a couple -- a little
18 bit of background, Your Honor. CRCC is the --
19 at least on 2011 volumes, we've -- that's in
20 terms of all the state volumes we have, that's
21 were we have all, you know, that's the last
22 year we had all the volumes for the state from
23 the State Health Plan. In 2011, CRCC was the
24 single largest volume provider of radiation
25 therapy in South Carolina, it's affiliated with

1 corporations sold -- I believe it's the largest
2 radiation therapy provider in the United
3 States. Even so, they're going to show this
4 Court, or they're going to attempt to show this
5 Court that Grand Strand's utilization is going
6 to be just off the charts when compared with
7 other similarly sized programs in the state.
8 And they've got to do this to show you two
9 things, that under the competing application
10 theory that -- well, they are competing because
11 there's too much need in the service area or
12 there's an excess need, and then from an
13 adverse impact perspective, that Grand Strand's
14 program is going to bring the existing
15 services, the existing linear accelerators in
16 the service area below their 80 percent
17 treatment threshold or their capacity
18 threshold, Your Honor. And they really need to
19 show that if the Court approves both projects,
20 the 80 percent capacity, because pretty much no
21 matter how they cut these numbers, if Grand
22 Strand is the only project approved, Your
23 Honor, there's no way that the existing linear
24 accelerator providers come below the 80 percent
25 threshold. And they haven't presented any

1 evidence throughout the process to even think
2 about that. So the Court is going to see that
3 CRCC's health planning consultant created
4 three, he had to do three separate adverse
5 impact models to finally get Grand Strand where
6 he wanted them, which was the -- which under
7 his projections that Grand Strand would become
8 the single -- I mean, the largest single unit
9 provider of radiation therapy in South Carolina
10 after just three years of operation. So what
11 I mean to say is, as a single unit operator,
12 they don't have more than one, they just have
13 one, if you look at all the other single unit
14 operators in the state of South Carolina, there
15 are many, Grand Strand would be the single
16 largest by volume after just three years in a
17 market with entrenched competitors. You would
18 literally have to -- I think it was Coleridge
19 who said the willing suspension of disbelief,
20 Your Honor. That's what you would have to do
21 to find that CRCC's projections are reasonable.
22 Well, what did he say? He said its most likely
23 projections shows Grand Strand performing 8,210
24 treatments in the third year of operation, Your
25 Honor. So the average single unit provider in

1 South Carolina, Your Honor, and we got this
2 from the State Health Plan, did 4,891
3 treatments in 2011. The highest single unit
4 provider in South Carolina only did 6,800
5 treatments in 2011, and that was an
6 established, a long-established provider.
7 Think about this, Your Honor, CRCC is the
8 largest provider in the state of South Carolina
9 by volume as of 2011 volumes, according to the
10 State Health Plan, they only averaged 7,599
11 treatments per linear accelerator in 2012, so
12 -- and it's been operating for 30 years. So
13 all the sudden, Grand Strand is going to be
14 able to come in and operate at like 150 to 160
15 percent of capacity, Your Honor, that's what
16 they're saying, and that doesn't make any
17 sense, and it's incredulous. What you're going
18 to see is that CRCC's consultant had to take
19 some pretty big liberties to get Grand Strand
20 up there as a world beater. If you contrast --
21 what's interesting, Your Honor, is that during
22 the project review process, CRCC basically
23 denigrated Grand Strand's ability to become an
24 operator of linear accelerator services. They
25 said Grand Strand had no experience, that their

1 technology was going to be inferior, just went
2 on and on about how we just -- Grand Strand
3 didn't know what they were doing though the
4 bottom line is they can't have it both ways.
5 And I guess now what their position is is that
6 Grand Strand is going to be an excellent
7 provider of high quality services such that so
8 many of the patients in the service area and so
9 many of the referral sources are going to want
10 to abandon CRCC. And so I ask the Court this
11 critical question: If so many people will
12 quickly abandon CRCC upon the opening of Grand
13 Strand's linear accelerator project, what does
14 that say about the quality of CRCC's services?
15 I mean, Your Honor, it doesn't make a lot of
16 sense that if they vastly improve provider
17 relations as they've maintain to DHEC, as they
18 represented to DHEC in the project review
19 process, and they've been entrenched in this
20 community for 30 years, and as they say,
21 they've put in the best technology, they've
22 upgraded all their facilities, why then, you
23 know, a third or 40 percent of the patients
24 just going to abandon them, or their referral
25 sources just going to say, we've got to go

1 somewhere else. I mean, Your Honor, two
2 purposes of the CON Act we went over earlier is
3 the establishment of health facilities and
4 services which will best serve the public needs
5 and ensure that high quality services are
6 provided in health facilities. So our -- what
7 Grand Strand's position is is that if these
8 referral -- physician referral sources are so
9 quick to abandon Grand Strand -- CRCC for Grand
10 Strand's brand new startup radiation therapy
11 program, a program that CRCC has said is going
12 to be inferior to its own, then maybe you
13 should consider denying CRCC's application and
14 granting Grand Strand's because if something
15 goes to best serving the public needs and that
16 perhaps the quality of services are higher. I
17 mean, we can't roll in every referral source,
18 you know, that's over 200 as, you know, the
19 referral source is to Grand Strand -- I mean,
20 to CRCC and ask them each this question. But
21 the bottom line is CRCC doesn't offer
22 reasonable explanations, Your Honor, for why
23 these referral sources. And as I just
24 mentioned to you earlier, at the project review
25 meeting, CRCC represented to DHEC that its

1 volume spiked from 15,000 in 2009 to 25,000 in
2 2011 because they had greatly improved provider
3 relations with their referral sources. Well,
4 is that statement true? Was it simply said to
5 justify an improbable 64 percent increase in
6 radiation therapy treatments? All that
7 statewide increased was about two percent, Your
8 Honor. And this is a graphic representation.
9 And they said this occurred, this jump from
10 2009 to 2010, a 34 percent increase, and then
11 again from 2010 to '11, 64.7 over 2009 was
12 because they greatly improved provider
13 relations. Well, if that's true, then how is
14 Grand Strand going to come in and simply take
15 all their patients from them as they assert?
16 The bottom line is, Your Honor, is that we
17 don't think anything has happened, all right,
18 to the provider relations. They say they're
19 good, they say they offer high quality
20 services, they've been there 30 years, they
21 offer high technology, well, good for them.
22 And that's probably going to allow them to hang
23 on to a lot of their market share. But, you
24 know, in order to maintain 81 percent of the
25 market share, what CRCC has had to assert is

1 that Grand Strand is going to become this
2 overnight dominant player in the market, which
3 doesn't make sense when you look at what's
4 happening out there in the rest of the state,
5 and really kind of what's happening local.
6 Now, again, I want to touch one last time on
7 why these referral sources, why would they be
8 so eager to switch. Again, CRCC really offers
9 no answers other than Grand Strand has a good
10 relationship with Coastal Cancer Center. CRCC
11 didn't oppose anyone from Coastal Cancer
12 Center, nor did they subpoena any documents for
13 them to determine if their patterns, referral
14 patterns, would materially change. In fact, as
15 you're going to see is that CRCC's entire
16 adverse impact case hinges on a gut feeling
17 that Grand Strand's CON -- excuse me, Grand
18 Strand's CEO had two years ago about Coastal
19 Cancer Center's relationship with CRCC. And
20 what we've learned as of yesterday is that
21 CRCC's health planner, desperate to gin up
22 Grand Strand's projected treatment volumes,
23 volumes he never questioned, all right, Your
24 Honor, until the day of his first deposition,
25 that he simply guessed about where physicians

1 would likely refer patients for radiation
2 therapy if Grand Strand enters the marketplace.
3 And apparently, these guesstimates, as the
4 evidence will show, testimony, were based on
5 nothing more than two 30-minute conversations
6 with CRCC's medical director, Dr. Francke, and
7 the officer manager, Ms. Sissy Price. They are
8 two interested parties who may actually be a
9 little bit predisposed to saying that more
10 market share is going to go away. Again, Your
11 Honor, the evidence is going to show that at
12 the end of the day, CRCC won't be able to show
13 that Grand Strand is going to take CRCC or the
14 other existing units in the service area below
15 the 80 percent threshold, okay? And that's one
16 of the -- in order to comply with the State
17 Health Plan, you've got to meet that capacity
18 threshold from an adverse impact perspective,
19 that's not going to happen in that service
20 area. So really, Your Honor, that's what's
21 going to allow you to approve both of these CON
22 applications, which we think is probably in the
23 best interest of Horry County. So here are a
24 few things. We ask you to ignore the red
25 herrings and the projections and stick with the

1 evidence, which basically shows that CRCC's
2 actual volumes and status as the highest volume
3 radiation therapy center in South Carolina as
4 of 2011, is probably unchanged; the fact that
5 CRCC is an entrenched provider with three
6 decades as being the sole provider in Horry
7 County; the fact that -- and you'll see in the
8 evidence, 46 percent of CRCC's treatments come
9 from one physician group who are loyal to CRCC,
10 Your Honor; and the fact that local and
11 corporate leadership, that CRCC's local
12 leadership and the corporate leadership, they
13 know how to compete in the marketplace against
14 a single-unit hospital provider. They're not
15 going to just lay down and roll over and go
16 away if a new competitor comes in, and their
17 witnesses have admitted basically that. But we
18 ask you to consider that CRCC doesn't operate
19 in a vacuum, they know how to compete. And you
20 know, here's another thing to consider, Your
21 Honor, the fact that with another provider in
22 the marketplace, CRCC's going to probably have
23 to step up the quality of services they offer.
24 And guess what? For the first time in 30 years
25 in Horry County, there's going to be a

1 competitor if you approve Grand Strand and
2 approve CRCC-Conway. But if you approve Grand
3 Strand, there's going to be a competitor in the
4 marketplace, all right? And so CRCC may have
5 to offer their services at a lower cost
6 because, for the first time, insurance
7 companies are going to have some financial
8 leverage against CRCC in Horry County when
9 they're negotiating their pay rates. They
10 don't have that right now. There's only one
11 provider of radiation therapy services, and
12 this could mean lower copays for patients, Your
13 Honor. Now Grand Strand's adverse impact
14 analysis, as you'll see, accounts for CRCC's
15 consultant's very basic mistakes and accounts
16 for basic factors such as the urologist
17 referral dominance to CRCC and CRCC's
18 entrenchment in the market. We believe that
19 Grand Strand's consultant's adverse impact
20 analysis is very reasonable and consistent, and
21 that their volumes are consistent with what a
22 startup provider is going to do, Your Honor.
23 In conclusion, Your Honor, as you know, the CON
24 program was not created to protect healthcare
25 facilities from competition, all right?

1 Nowhere in the CON Act is such a statement
2 found. The Court should not allow CRCC to
3 continue to use the CON program in Horry County
4 in that service area as a shield to protect its
5 dominant market share. And Horry County
6 residents, Your Honor, deserve a choice in a
7 county that size of a hospital-based provider,
8 which is in most counties of that size, there
9 is exactly that. And the great thing is is the
10 Court can give this public both -- give the
11 public in Horry County both options because you
12 can approve two. So you can put one over in
13 Conway, save the patients ten minutes one-way
14 drive time; you can put one in Myrtle Beach in
15 a hospital for those patients who want to use
16 a hospital-based center. So if the Court finds
17 that the CON applications are competing, Your
18 Honor, Grand Strand is going to show that
19 standing alone is the -- it should have been
20 chosen over DHEC. But we do assert that the
21 applications are not competing given the most
22 recent State Health Plan and the full year 2012
23 treatment volumes I showed you earlier;
24 therefore, the Court can and should approve
25 both of them. Thank you, Your Honor.

1 THE COURT: All right.

2 MR. LONG: Your Honor, we just need one second to
3 put up our ...

4 OPENING STATEMENT - BY MR. LONG:

5 MR. LONG: May it please the Court, Your Honor, I'm
6 here today, I'm Jimmy Long representing
7 Carolina Regional Cancer Center in this
8 certificate of need case. And we will use some
9 acronyms for you during the trial, so hopefully
10 you'll learn them quickly. We usually refer to
11 ourselves as CRCC.

12 THE COURT: Already got that one down.

13 MR. LONG: You got that one down. There is a
14 medical oncology group in town that's Coastal,
15 Dr. Holt's group; they go by Coastal. We're
16 going to refer to them as Coastal even though
17 sometimes people call them CCC, but we're going
18 to try to not do that. Today here with us for
19 the trial are three people from our
20 organization, Rich Lewis is here from Florida;
21 Sissy Price, who is in Myrtle Beach at our
22 facility there; and Rosa Maynor, who works
23 really all over North Carolina and South
24 Carolina for 21st Century. Lisa Sanders is
25 also here today. Sam Tolbert is our expert As

1 we discussed on Monday, Mr. Tolbert teaches on
2 Thursdays, and so he and Ms. Sanders will be
3 kind of trading out on some of the days. Mr.
4 Tolbert will be testifying at the trial. Of
5 course, my co-counsel here is Wade Mullins, and
6 he and I will be doing -- handling most of the
7 witnesses. Ms. Hollingsworth is here with us.
8 Also, Ms. Ellington will be helping us with all
9 of the technology here. Your Honor, and I know
10 Your Honor has done some of these cases before,
11 but as I -- in doing all this work for this
12 case and people asking me what I'm going to be
13 doing over the next week or two, and I tell
14 them that I'm doing a certificate of need trial
15 about a linear accelerator, I often get a blank
16 look and people say what is a linear
17 accelerator. So I thought if I could I'd just
18 take a minute or two and let's remind the Court
19 of some of the basics about what this case is
20 about in regards to the medical technology.
21 It's about radiation therapy.

22 THE COURT: Well, since my wife went through breast
23 cancer, I'm very familiar with a linear
24 accelerator.

25 MR. LONG: You're very familiar with it, Your Honor.

1 Well, I'll just roll through these. As you
2 know, radiation therapy is the actual radiation
3 treatment. It shoots a beam at the tumors. It
4 treats cancers often in conjunction with
5 surgery or chemotherapy, and it can be two
6 types. You know, sometimes people have
7 radiation therapy as curative; sometimes it's
8 palliative. In other words, it's for people at
9 the end of their life when they're just
10 relieving symptoms of suffering, and it's done
11 by radiation oncology. The important thing
12 about it is it's a very specialized service,
13 that's why it's covered under the State Health
14 Plan. It is a -- has to be done in a -- it's
15 a very expensive machine with very highly
16 skilled technicians who are physicists, and it
17 also has to be done in a specially-constructed
18 vault. So it is expensive to construct it, to
19 buy it, to operate it, and it's one of the
20 important reasons as to why it would be
21 regulated by the CON program. Most people who
22 have radiation therapy, it's out -- almost
23 everybody that has radiation therapy is
24 outpatient. The number of inpatients, the
25 people who are actually in the hospital having

1 it is very small. It's outpatient. People
2 typically go and have, you know, a treatment a
3 day for maybe up to five weeks or so every day
4 for 15 or 20 minutes. Young people when they
5 have this service often work, do go and work
6 and do, and other people, you know, don't work.
7 People like to have it near their home.
8 Typically -- we will estimate in our estimates
9 here for the Court. We have a little bit of a
10 disagreement on how many typical treatments a
11 patient will have. They have estimated 21
12 treatments. The more recent data at our
13 facility is that it's 25 treatments or 26
14 treatments per patient. It's not a dramatic
15 difference, but it is important to remember
16 that treatments are different from patients
17 when we're doing the mathematical calculations
18 for Your Honor and the experts who are
19 testifying about this. And -- but the health
20 plan things focuses on treatments. They don't
21 focus on patients. So the State Health Plan
22 criteria focuses on that. Our practice at
23 CRCC, we've been in Myrtle Beach for 33 years
24 providing radiation therapy treatment there as
25 one of the first places in the state to offer

1 3-D conformal radiation treatment in the mid
2 '90s. We were one of the first ones to do IMRT
3 treatments in 2002. We were the first
4 radiation oncology center in South Carolina to
5 be accredited by the ACR, the American College
6 of Radiology in 2008. We also were one of the
7 first in the state to do IGRT imaging. And
8 what these things are, Your Honor, is now the
9 machines have become so sophisticated, it used
10 to be when the patients would lay there, they
11 would have these blocks and all to try to block
12 the beams to make sure they hit the tumors
13 exactly right. Now these machines are so
14 sophisticated that they can basically move
15 around and they use little collimators and all
16 to block the beams, and it's very sophisticated
17 and that kind of technology that's constantly
18 advancing. Several years ago, CRCC was
19 involved in a linear accelerator case here in
20 South Carolina. It did not go to trial, but it
21 was a competing application situation. We
22 added a tomotherapy unit, which is a a highly
23 specialized machine. The Department granted
24 that CON for CRCC. Now, in 2010, 21st Century
25 Oncology, which is one of the largest physician

1 owned or physician radiation therapy companies,
2 they go by that name as a d/b/a, came to Myrtle
3 Beach and purchased the practice of CRCC from
4 Dr. Bass, who had been the radiation oncologist
5 there for a number of years. All right. And
6 we entered the market, 21st Century did, in May
7 of 2010, okay, and almost immediately after
8 arriving in the market, we began to invest in
9 South Carolina. We upgraded one of the
10 equipments in Myrtle Beach, and then almost
11 promptly thereafter, we've been in the process
12 of disbursing our machines throughout the
13 county to better distribute those services to
14 patients, and so that's why we have -- I'll
15 mention in a minute about their Georgetown,
16 about the relocation of Murrells Inlet, and
17 then also this application to Conway. All
18 right. And we also, as you can see here, we're
19 the first in South Carolina to offer Calypso,
20 the GPS time-tracking device. All right. So
21 our current facility here today, we have state-
22 of-the-art equipment that's been invested in,
23 and that investment should be protected by the
24 program, Your Honor. That's part of what the
25 CON program is about. We've got three board

1 certified radiation oncologists. We've got a
2 -- we've got access to the 21st Century
3 physicians all over the United States with
4 clinical trials and protocols and consistent in
5 management support resources. We're the most
6 experienced team with the most options, and we
7 offer very high quality service there. Now,
8 we're also involved in the community with a
9 number of different support groups, awareness
10 programs and other education activities. We
11 participate in the tumor boards here. Now,
12 radiation therapy in South Carolina is set by
13 looking at the State Health Plan first. First
14 thing to remember about -- the first thing
15 that's important about the State Health Plan in
16 regards to radiation therapy is that the State
17 Health Plan identifies the service areas for
18 the service. All right. All of the service
19 areas in South Carolina are multi-county
20 service areas. All right. And in this area of
21 the state, Horry and Georgetown are a service
22 area together. The 13 service areas -- I'm
23 sorry, Horry, Georgetown and Williamsburg.
24 There are 13 service areas for 46 counties. I
25 don't think there's a single county in the

1 state that's its own service area. They're all
2 multi-county. And in this service area, there
3 are two providers, Georgetown Memorial Hospital
4 has been a provider for a number of years and
5 CRCC, so there is no monopoly. The Court
6 should look at the service area because that's
7 what the State Health Plan says is what's
8 appropriate to do in regards to looking at the
9 service. Now, Your Honor, this map is a little
10 small now. We have a lot bigger one over here
11 on this board, but this kind of shows, if you
12 can see it, where the services are located
13 currently and what the proposals are. And as
14 you can see, Mr. Thomas didn't show you any
15 maps because when you look at the maps of Grand
16 Strand, what Grand Strand proposes and where
17 CRCC is located, you see the dots are almost on
18 top of each other, because where Grand Strand
19 proposes to relocate is three miles from our
20 current facility. We're right down the road.
21 We propose to locate a new facility in Conway.
22 We have a relocation to Murrells Inlet.
23 Georgetown is currently located in Georgetown
24 near the Georgetown Memorial Hospital. All
25 right. We think that's the important fact, the

1 fact that Grand Strand wants to be so close
2 distributing these services throughout the
3 service area is what's best for patients. All
4 right. In addition to the current
5 applications, which we'll get to in a second,
6 it is important to know about the relocation
7 application. Prior to these applications,
8 Georgetown proposed to move its machine from
9 basically downtown Georgetown north to Murrells
10 Inlet to its Waccamaw Hospital, right south of
11 the county line. We also proposed to relocate
12 a machine from our Myrtle Beach facility to
13 Murrells Inlet. Both of those relocations were
14 approved, okay. Neither one of us thinks that
15 two linear accelerators should be located a
16 mile from each other in Murrells Inlet. Both
17 of us disagree with the Department's decision.
18 We think the Department should have only
19 allowed one of those relocations to occur. We
20 think that they should have allowed ours.
21 Georgetown thinks they should have allowed
22 theirs. The Department approved both
23 relocations. Now these are not new machines,
24 they're relocations. We disagree with that;
25 those cases are on appeal. And here's what's

1 important for our purposes. Those approvals --

2 -

3 THE COURT: They're on appeal. What's the status?

4 MR. LONG: That case is basically just kind of
5 starting, Your Honor.

6 THE COURT: Okay.

7 MR. LONG: And it's probably scheduled for a trial
8 in 2014.

9 THE COURT: Okay. Who did I assign that to?

10 MR. LONG: Lenski. McLeod, I'm sorry, McLeod. I
11 have another one with Lenski. It's McLeod,
12 Judge McLeod. So those approvals were on
13 September 26, 2011, three months before the
14 decisions were made in this case. So at the
15 time the Department made the decision in this
16 case, it had to assume that those relocations
17 were going to occur, and I think the Court has
18 to assume that also because those were the
19 circumstances that the Department made the
20 decision in December of 2011. Now, under the
21 State Health Plan, our -- it's a little -- the
22 criteria are slightly different but really not
23 significantly for our purposes. We're seeking
24 to expand our service, all right. So we had to
25 show that the service has been operating at 80

1 percent capacity for the previous two years,
2 and that we can project a minimum of 50 percent
3 capacity by year three. We did both of those
4 thresholds in our application, and we met the
5 50 -- we met the 80 percent for two years, and
6 we projected 50 percent capacity, which was not
7 difficult to do, Your Honor. So our Conway
8 application satisfies the State Health Plan.
9 Grand Strand proposes to add a new machine to
10 the service area -- to add a new service, a
11 brand new service. Both of us are adding
12 machines, all right. To do that to satisfy the
13 State Health Plan, they must show that the
14 units have been operating at 80 percent
15 capacity for one year before the filing of the
16 application, that they'll be at 50 percent
17 capacity in year three. They didn't have any
18 trouble meeting those. It is above 80 percent
19 capacity for a year; they'll have no trouble
20 hitting the 50 percent threshold in year three.
21 But they have to also show that they won't
22 drive the existing units below 80 percent
23 capacity. If they do not satisfy the 80
24 percent threshold, there's no need for the
25 service. All right. And if they can't satisfy

1 need in the State Health Plan, you can't comply
2 with the State Health Plan. If you're not in
3 compliance with the State Health Plan, you
4 can't be approved. All right? Now, the 2010-
5 2011 Health Plan showed -- this is the one that
6 we applied under, that we were barely above the
7 80 percent threshold, so three applicants
8 applied. CRCC, we applied to expand adding a
9 machine in Conway; Grand Strand proposed to put
10 a machine right next to their hospital in
11 Myrtle Beach; North Strand applied to go to the
12 northern part of Horry County, but they've
13 withdrawn, and they've been dismissed from this
14 case. So there are two applicants left. DHEC
15 determined that they were competing
16 applications and approved the CRCC application.
17 And we think that as the trial progresses,
18 we'll show that it wasn't even a close
19 decision, Your Honor, our application and our
20 project is far superior to the other two
21 applicants. All right. Today Grand Strand
22 comes before you, they're the petitioner, as
23 Your Honor knows. They have the burden of
24 proof. The Department awarded the certificate
25 of need to us. They have the burden of proof

1 to reverse the Department's decision. Let's
2 talk about first about the competing, and Mr.
3 Thomas did raise that issue a little bit in his
4 opening and I want to -- I'd like to review it
5 for a minute with the Court here. Here's the
6 statute and the regulation. There are
7 basically four requirements to determine
8 whether two applications would be competing.
9 There's no dispute that the first three are
10 satisfied. We're applying for the same
11 service, radiation therapy service linear
12 accelerators; it's in the same service area;
13 and it was done within the time frame and
14 established by the regulation. So there's no
15 doubt that three of the four elements of the
16 definition are satisfied. Now, Mr. Thomas
17 seemed to argue -- he seemed to ---

18 THE COURT: 44-7-125?

19 MR. LONG: 120 which is the definition section of
20 the CON Act, subsection 5.

21 THE COURT: All right.

22 MR. LONG: I think it's the competing application
23 definition. And then the regs are at 103-6.

24 THE COURT: Well, when I looked up that statute a
25 while ago, I didn't ---

1 MR. LONG: That could be. I don't know if we've got
2 the number -- I thought that was the correct
3 number, Your Honor, when we were looking at it,
4 but I'm sure that's the statute. So the key
5 part for Your Honor is Number 4, which is, will
6 the approval of both exceed the need for the
7 services in the service area. Now, Mr. Thomas
8 seemed to argue that you could just approve the
9 two applications based on the purposes of the
10 Act. I disagree strongly about that. That is
11 not what the law says. The law says that if
12 the two applications are competing, only one
13 can be approved, period. All right. It
14 doesn't matter whether they thought -- whether
15 they satisfied anything. If there are two
16 competing applications, only one can be
17 approved. And so therefore, if they're
18 competing, Your Honor would then move and do
19 what the Department did in its analysis, which
20 is to compare the applications and choose the
21 one that is most superior looking at the
22 regulations, the purposes of the Act, the
23 Health Plan, the project review criteria, and
24 the other DHEC regulations. So there's a
25 comparison to be done. And that's where the

1 purposes of the Act would come in. The
2 purposes of the Act would not come in based on
3 the determination of whether the applications
4 are competing. That is solely looking at --
5 based on this criteria set out in the -- set up
6 in the Act.

7 THE COURT: Which by the way, that should have been
8 130.

9 MR. LONG: 130, oh.

10 THE COURT: The definition.

11 MR. LONG: Sorry about that, Your Honor.

12 THE COURT: That's fine.

13 MR. LONG: It's 130 subsection 5.

14 THE COURT: I'm on Westlaw, I've already got it.

15 MR. LONG: Okay. Thank you, Your Honor. All right.

16 THE COURT: All right. Hold on just a second before
17 you move on.

18 MR. LONG: Sure.

19 THE COURT: All right. Proceed ahead.

20 MR. LONG: Okay. Thank you, Your Honor. All right.

21 Now, Grand Strand has asked this Court in this
22 case to approve both applications. And Your
23 Honor, the fact is, these applications are
24 competing because this service area cannot
25 support two new machine increasing the number

1 of linear accelerators in the service area from
2 four to six ---

3 THE COURT: So where I can be clear. If I was to
4 decide that Grand Strand meets the criteria the
5 best, then CRCC would not be seeking a linear
6 accelerator?

7 MR. LONG: Your Honor, if you were to do -- if you
8 were to decide -- I think the analysis would be
9 this way, Your Honor. You decide if the
10 applications are competing, you determine that
11 the applications are competing, which we state
12 that they are, then Your Honor should compare
13 the applications. If Your Honor determines
14 that the Department's comparison was faulty or
15 you disagree with it based on the evidence that
16 you hear, you can flip the decision and award
17 the linear accelerator to Grand Strand and deny
18 the one to Conway.

19 THE COURT: All right.

20 MR. LONG: And that's the -- and that is the correct
21 legal outcome. We would -- we do not believe
22 that there should be two linear accelerators
23 approved in this process, and therefore, Your
24 Honor should only approve one of the two. We
25 don't think it's a close question of whether

1 it's ours or theirs, but if Your Honor
2 disagreed, then yes, that would be the result.

3 THE COURT: All right.

4 MR. LONG: All right. Some of the reasons that we
5 think that you cannot approve the two machines
6 in the service area, one is that from going
7 from four to six is too great. What's
8 happening in the service area in regards to
9 treatments, Your Honor, is that from 2010 to
10 2011, there was an increase in treatments, all
11 right, and then, Your Honor, the treatments
12 have declined. They've declined from 2011 to
13 2012 at CRCC and they're declining still to
14 2013, all right? And we will have some
15 testimony to try to give some conjecture on
16 that, but that's what's happening. Same thing
17 in Georgetown. So the treatments are not
18 continuing to decline. They've actually --
19 it's looking and coming apparent that 2011 was
20 a blip and not any sort of trend or new thing
21 that was occurring. The approval of two
22 machines in the service area will dramatically
23 push the existing providers below 80 percent.
24 The only way in which you could find that they
25 -- existing providers are above 80 percent

1 based on the 2012 numbers, Your Honor, is to
2 adopt Grand Strand's projection of their
3 utilization, which we're going to show this
4 Court is significantly under projected, all
5 right. They've just simply ignored certain
6 areas of the county in which they're going to
7 draw patients, and they have greatly
8 underestimated the impact of their attempt to
9 divide the medical community in their project.
10 And we're going to -- you're going to see it in
11 the emails and you're going to see it on the
12 maps that we've prepared for Your Honor, and I
13 think Your Honor come away clearly convinced
14 that the approval of a machine at Grand Strand
15 will be successful in regards to its capturing
16 of treatments, and it will be significantly
17 higher than what they have projected. And once
18 you just move a little bit over what they
19 projected, you've pushed the existing providers
20 below the 80 percent; and once that occurs, the
21 approval of both pushes it below 80 percent,
22 you should not approve both. All right. You
23 also need to remember that Georgetown projects
24 in their relocation application to Murrells
25 Inlet that they're going to increase their

1 treatments, okay, too. And that really goes to
2 the adverse impacts, Your Honor, to the
3 existing -- it's just based on existing
4 providers because you've got to assume that
5 Conway is going to have a certain number of
6 treatments, and you're going to have a certain
7 number of treatments at Grand Strand, and both
8 of those together will push the existing
9 providers below 80 percent. Now, there are
10 also other reasons as to why Your Honor should
11 conclude that the approval of both will exceed
12 the need. Two relocations and two new machines
13 in the same service area and the same health
14 plan cycle is too much change for an expensive
15 and important service, and that's what Grand
16 Strand is seeking to ask the Court. Those
17 relocations have been approved and they need to
18 be considered by the Court. And then also two
19 new machines in Horry County. All right.
20 Putting a new machine three miles from an
21 existing provider is an unnecessary duplication
22 of services that is not needed, okay. And
23 just, you know, -- Grand Strand's contention
24 that the 2012-2013 Health Plan means that they
25 can get appointed for a linear accelerator is

1 a complicated issue which Your Honor dealt with
2 on motion for summary judgment. I just want to
3 go over again our position on that in regards
4 to that issue. They're, in effect, asking you
5 to give them a linear accelerator that is
6 listed in the new Health Plan, and therefore,
7 foreclose any other applicant in South Carolina
8 from applying for it because once you, if you
9 were to award both machines, everybody has
10 testified that there's not a need for three.
11 So that would mean that the new one under the
12 2012-2013 Plan would be gone. And that's what
13 they're asking you to do, and that is not the
14 proper way of analysis. That's not what the
15 Department would expect in regards to the
16 program. If they think that they're entitled
17 to the 2012-2013 State Health Plan, it should
18 dismiss this case and file for that CON under
19 that plan and state their case under the new
20 data that they can satisfy the criteria, and if
21 other applicants come in, which they probably
22 will, then they can show that they're superior.
23 They should not try to circumvent that by using
24 this argument to ask you to approve both. All
25 right. Your Honor, if you determine that the

1 two applications are competing, then the
2 question is going to be which one is going to
3 -- well, Your Honor, let me back up a second if
4 I could because I -- just because, obviously,
5 we prepared these PowerPoints in advance so Mr.
6 -- I didn't have an opportunity to see all of
7 Mr. Thomas' comments, so I don't -- I hope Your
8 Honor doesn't believe that anything that I
9 don't respond to here is something I accept,
10 because I don't. But I wanted to comment on a
11 couple of things about the approval of the need
12 that he set. First, Mr. Tolbert's analysis as
13 to what Grand Strand's projections will be is
14 very conservative. He did it based on market
15 share analysis, based on information we learned
16 in discovery about Grand Strand's market shares
17 for their services and for their inpatients in
18 the service area, and then he went and he
19 looked at the individual physicians, and he
20 made very conservative projections. He
21 projected that the urology group in town would
22 continue to refer all their patients to CRCC.
23 He projected that we would continue to get
24 patients from Dr. Holt's group, even though I
25 think internally Grand Strand may think they're

1 going to get almost all of those treatments.
2 He also -- but he did say that Grand Strand
3 would get referrals from the employed
4 physicians at Grand Strand and would get a
5 significant number of referrals from Dr. Holt's
6 medical oncology group at Coastal, which is
7 certainly what they project, and they've stated
8 in their application in numerous different
9 places that that's going to be their primary
10 referral source. And so, he looked at that
11 analysis and he easily showed that they would
12 have a significant number of treatments. And
13 Mr. Thomas wants you to focus on the fact that
14 it's so many treatments per machine. It's per
15 location is what Your Honor ought to be
16 thinking about because what they're intended --
17 we have multiple ---

18 THE COURT: When say that I ought to be thinking, is
19 that ---

20 MR. LONG: In other words ---

21 THE COURT: Is that pursuant to regulation or
22 statute, or is that logical?

23 MR. LONG: In regards to your analysis of his
24 comments that our projections are absurd
25 because they're so high.

1 THE COURT: All right.

2 MR. LONG: All right. And Your Honor, I would think
3 about it in terms of location. They're going
4 to have one machine there, but they've already
5 -- in their plan, they're already shelling in
6 a second machine. They've got the space
7 shelled in to add another vault and another
8 machine. They fully intend to be pretty full
9 almost immediately so they can try to basically
10 apply for a second machine.

11 THE COURT: Well, I thought you just said that
12 they're -- in your previous argument that
13 that's foreclosed at this point in time.

14 MR. LONG: It would be foreclosed, but they're
15 planning for it because they know they're going
16 to be successful there. They're not building
17 a machine there thinking we're just going to
18 have one machine at Grand Strand going forward.
19 They have shelled in a space for a second
20 linear accelerator sometime in the future
21 because they fully intend to basically have a
22 successful service that they can expand upon.
23 And the second thing I would point out is we
24 have multiple machines at our location, so that
25 causes our averages to be off somewhat from

1 what he would project; okay. And we should not
2 -- the two major referral sources, or you can
3 divide the -- Your Honor, you can divide the
4 referral sources up into three groups: the
5 urology group, the medical oncology group, and
6 then everybody else, which would be surgeons,
7 maybe ENT doctors, other kinds of physicians,
8 all right. The two major referral sources,
9 urologists and the medical oncologists, they
10 want to split that. They want to take the
11 medical oncologists for their one machine, and
12 then they want the -- and a major portion of
13 the other group, and then they want to leave
14 the urologists for our center, which has
15 multiple machines. That's not good for the
16 community. That's not good for the community,
17 Your Honor. Now, in regards to the comparison
18 of the two -- of the applications here moving
19 to looking at both of them, DHEC properly
20 compared the applications and determined that
21 ours was superior, and it's superior in a
22 number of different criteria. All right.
23 First, our project cost or, first, the number
24 one thing is, Your Honor -- well, let me back
25 up. Project cost, cost containment. Our

1 project is significantly less expensive than
2 theirs. All right. We're going to spend less
3 money to basically put a linear accelerator in
4 Conway because we're using a facility there
5 that already had a vault constructed, and so we
6 are able to basically save considerable cost by
7 using a location where a vault has already been
8 constructed. And it's significant -- it's
9 plenty large enough. It's actually a large
10 vault. And so by doing that, we save a lot of
11 money. And that's what cost containment is
12 about, Your Honor, using your resources in an
13 efficient way to try to save cost. They
14 criticize it and laugh at our facility. But
15 the fact is we're making the right choice there
16 because we're using resources that are already
17 in existence, and that's one of the main
18 reasons that our project will cost less than
19 the other applicants. The other reason is is
20 because we get a better deal on the machine.
21 We have a superior machine to them, There's no
22 question about it. The machine that we're
23 planning to put in Conway is a TrueBeam. It's
24 a state-of-the-art equipment. They're not.
25 They've decided to try to save money, and

1 they've taken a machine that's a generation
2 below. All right. We have the iPhone 5 and
3 they have the iPhone 3 or whatever, I don't
4 know. At one time their machine was state-of-
5 the-art. We have one at our facility. We
6 purchased it when it was the state-of-the-art
7 machine. It is no longer the state-of-the-art
8 machine, TrueBeam is, and we're purchasing a
9 TrueBeam.

10 THE COURT: Well, if you're the iPhone 5, they're
11 coming out with an iPhone 5s, so.

12 MR. LONG: That's exactly right, Your Honor. And so
13 what happens is he's even further down, you
14 know. And that's what happens in regards to
15 this technology because it is a rapidly change
16 in technology. That's why you need to stay on
17 top of it. Because if you go back in time, the
18 old technology, it's really going to be old
19 once you get the project built and get moving.
20 All right. Your Honor, we're increasing
21 accessibility and distribution of services by
22 going to Conway. All right. We're not
23 unnecessarily duplicating location, and we
24 don't adversely impact the existing providers.
25 All right. The other thing about our project,

1 Your Honor, is we will get up and running
2 quicker. Because we're using a machine and a
3 vault that's already been constructed, we can
4 basically bring our machine online at least 6,
5 8, 12 months faster than Grand Strand. Okay.
6 And Your Honor, I want to talk about a couple
7 of the things about Grand Strand's application
8 and why the -- well, let me look at a couple of
9 the population areas too, Your Honor. When you
10 look at our maps in regards to population,
11 you'll see that Conway is in an area that has
12 a significant population. The ones in purple
13 have the largest -- are the zip codes with the
14 largest population in Horry and Georgetown
15 County. All right. And so you'll see that
16 Conway in that zip code, that large zip code
17 that encompasses Conway has a large population,
18 okay. And then we have -- and it's also
19 inland. Where the other providers are kind of
20 very much right on the coast, we're now going
21 to be taking this service inland, which is a
22 more rural area, less affluent population. So
23 that's another thing that's important in
24 regards to the regulations. All right. Now,
25 Grand Strand's application suffers from a

1 number of different deficiencies.. All right.

2 In addition to the fact that it's three miles

3 from our current location and it has an adverse

4 impact on existing providers, they're going to

5 split the medical community, as I've already

6 discussed. They understate their market share

7 to diminish the adverse impact. It's more

8 expensive. The machine is less sophisticated.

9 And here's another thing that's important, Your

10 Honor. They get -- almost all of the majority

11 of the patients for radiation therapy are over

12 the age of 65 and have Medicare coverage. The

13 government is the major payer. Between

14 Medicare and Medicaid it's probably well over

15 60 percent of the patients are being paid by

16 the government, if not higher. Government

17 reimbursement is set in Washington; it's not

18 negotiated. You don't negotiate with Medicare

19 or Medicaid in regards to reimbursement. The

20 government consistently reimburses a hospital

21 more than a freestanding facility. So

22 actually, to improve a hospital-based service,

23 which is what they have now because they're

24 going to move their machine at the hospital,

25 they'll be reimbursed higher than what we would

1 be at a freestanding facility. And so
2 therefore, when you look at the cost, that's
3 another issue to focus on in regards to the
4 cost. This discussion ---

5 THE COURT: Well, when you say they would be
6 reimbursed higher, they would be reimbursed
7 higher for the inpatient individuals ---

8 MR. LONG: No, everybody.

9 THE COURT: --- or for all?

10 MR. LONG: For all. So every patient that comes to
11 see them, will be -- they'll be -- for the same
12 treatment, same illness, they get paid more
13 than we do. That's just the way the system is
14 set up, and there's no question about it. It's
15 about -- we get -- it's about ten percent less
16 is what we get reimbursed than they do in
17 regards to that. Now, and also I would say,
18 Your Honor, we're going to -- and because of
19 that, you need -- and I'm going to point out to
20 the Court some issues in regards to their pro
21 forma, you can't take -- they are -- they're
22 going to try to argue that they basically --
23 that theirs is cheaper. It's not. In regards
24 to this argument that he makes about our
25 ability to negotiate with payers differently,

1 Your Honor, I think that's a total red herring.
2 There's no evidence to support that that would
3 occur. Those are the commercial payers. The
4 focus really should be on the government
5 reimbursement because that's the main payer in
6 the market. A couple of other issues. The
7 inpatients is one of the reasons that they say
8 that they should get the linear accelerator.
9 It is something they said to the Department.
10 They think it's one of the things that makes
11 their project superior to ours. It's not. All
12 right. And here are the two reasons for that
13 primarily. The first is the number of
14 inpatients is de minimis. It's like 30 a year
15 maybe. It is important to those patients. And
16 the number of inpatients who received radiation
17 therapy, it's almost all in it's palliative
18 care. We've been treating -- we were treating
19 inpatients at Grand Strand Hospital for 30
20 years. All right. The patients were put in an
21 ambulance; they're driven three miles over.
22 They come in; they have their treatment; they
23 go back to the hospital. Most of the medical
24 testimony will be that most of the patients who
25 receive inpatient treatment, it's just a few

1 treatments. It's usually designed to reduce
2 pain. It's not a course of treatment for 25 or
3 four or five weeks for inpatients. All right.
4 In fact, those kind of treatments are almost
5 always outpatient. And that was done for
6 decades without problem and without a
7 complaint. All right. So inpatient alone is
8 not a reason to -- for theirs to be superior to
9 ours. You're also going to see a number of
10 emails and documents and a timeline that shows
11 for most of the time that they were working on
12 this project, they wanted -- and it wasn't the
13 people in Nashville who wanted this, it was the
14 people in Myrtle Beach wanted to put the free
15 -- put a freestanding facility at Dr. Holt's
16 property. That was what their plan was because
17 they knew internally this was not a big deal.
18 Freestanding is perfectly appropriate for
19 radiation therapy, and that's what they wanted
20 to do. It's what was -- they wanted to be
21 linked up with Dr. Holt so they could get his
22 patients. They're not going to have a
23 comprehensive cancer center there. They're not
24 going to do the chemotherapy. It's going to be
25 done at Dr. Holt's office. They know that.

1 They're not trying to take the chemotherapy
2 from Dr. Holt, so it's not going to be any
3 dramatically different for the patients at
4 Grand Strand. It's not going to offer a lot of
5 new services. The patients are simply going to
6 drive to the hospital parking lot, which is a
7 lot bigger than ours, have to fight through the
8 traffic, walk in through a door, get treated,
9 and walk out to their car. That is basically
10 what they're proposing. It is not -- there's
11 no cancer center being constructed, and there's
12 no interdisciplinary cancer thing being housed
13 under one roof. All right. That's not what
14 the application is. The other thing, this
15 thing about -- well, you've heard something,
16 Your Honor, too about the urologists
17 employment. He didn't talk too much about that
18 in his opening, but we have talked a number of
19 times about that. And I'll just say, Your
20 Honor, they're just chasing rabbits with that.
21 The evidence will be clear that the radiation
22 oncologist is the one who's making the
23 decisions about whether the patients need to
24 have radiation therapy services. And physician
25 compensation is not part of the CON review

1 process; never has been. It's not in the regs;
2 it's not in the statute; it's not an issue for
3 the Court. That's all I have, Your Honor.

4 THE COURT: Can I ask you one quick question?

5 MR. LONG: Sure.

6 THE COURT: In your presentation, you had -- I
7 thought it was 61-15, Subsection 308.2. I
8 don't see a 308.2.

9 MR. LONG: Oh, is that supposed to be 304?

10 THE COURT: Is that it? If you could just go back
11 and just -- there it is, that one.

12 MR. LONG: I think it ---

13 THE COURT: I just need to know the right ---

14 MR. LONG: Yes, Your Honor, I'm going to give it to
15 you. I think it ---

16 THE COURT: And I've got 308, but ---

17 MR. LONG: I think it's 502, Your Honor.

18 THE COURT: Oh, 502.

19 MR. LONG: No. I think it's ---

20 THE COURT: It's not that big a deal.

21 MR. LONG: Yeah.

22 THE COURT: I can figure it out later.

23 MR. LONG: Is it 307?

24 MR. MULLINS: Yeah 307.

25 MR. LONG: Sorry, Your Honor, it's 307.2.

1 THE COURT: All right. 307.2?

2 MR. LONG: That's the regulation that says that Your
3 Honor can only approve one.

4 THE COURT: Okay.

5 MR. LONG: Correct? In case of competing
6 applications.

7 THE COURT: All right.

8 MR. LONG: 307.2, and I apologize about that, Your
9 Honor.

10 THE COURT: That's fine. I just wanted to have it
11 in my notes. All right. Thank y'all. Oh, Ms.
12 Biggers?

13 MS. BIGGERS: Your Honor, the Department concurs
14 with CRCC's position in this case, and so we're
15 not going to add to that opening statement.

16 THE COURT: All right. You can call your first
17 witness, or do y'all -- do we need a break?
18 Okay. All right.

19 MR. THOMAS: Your Honor, at this time, Grand Strand
20 would call it's CEO, Doug White, to the stand.

21 THE COURT: All right.

22 ROBERT DOUGLAS WHITE, being duly sworn, testifies as
23 follows:

24 MR. WHITE - DIRECT EXAMINATION BY MR. THOMAS:

25 Q: Good morning, Mr. White. How are you?

1 A: Good, thank you.

2 Q: Before we jump right into this, tell the Court
3 a little bit about your family.

4 A: Well, I've been married 33 years. I've only
5 been married once. I have five daughters, one
6 a USC graduate, two went to Furman, one to
7 Columbia International University, one the
8 University of Florida, and one adopted son
9 who's 21 and goes to Coastal Carolina
10 University. We have nine grandkids.

11 Q: So you're a busy man with your family. Where
12 do you work, Mr. White?

13 A: Grand Strand Regional Medical Center in Myrtle
14 Beach.

15 Q: What is your position there?

16 A: I'm the chief executive officer.

17 Q: And how long have you been at Grand Strand?

18 A: Since first quarter, I believe it was, February
19 1995. About 18 and a half years.

20 Q: Okay. And is Grand Strand affiliated with a
21 parent corporation?

22 A: We're an affiliate of Hospital Corporation of
23 America. It's the nation's largest provider of
24 hospital services, and we have about 174
25 hospitals.

1 Q: Does HCA operate radiation therapy centers?

2 A: I believe we have about 40 linear accelerators
3 or hospitals that provide their services all
4 over the country.

5 Q: Okay. Where is HCA based out of?

6 A: In Nashville.

7 Q: And in terms of that corporation, is there
8 leadership there that you answer to?

9 A: I suppose I do answer to them, but I have very
10 little interaction with the corporate
11 leadership in Nashville.

12 Q: Who is your direct report?

13 A: Jamie Thomas. He's the South Atlantic division
14 president for HCA in Charleston. And we have
15 three hospitals in Jacksonville, Florida, one
16 in Walterboro, one in Charleston, and a
17 satellite facility, and then Grand Strand in
18 that division.

19 Q: Okay. And does Mr. Thomas, maybe that's the
20 way to say it, does Mr. Jamie Thomas, does he
21 report to someone in Nashville?

22 A: Yes.

23 Q: Who is that?

24 A: Chuck Hall, and he's the president of the
25 national group, which has several divisions

1 similar to the South Atlantic division.

2 Q: Okay. Who is your executive management team at
3 Grand Strand?

4 A: Well, I have Adam Rudd, who's with us today.
5 Adam has been with me three years. He's chief
6 operating officer. Robert Grace is our chief
7 financial officer. He's been with HCA a number
8 of years as well, and has been in Myrtle Beach
9 about five years.

10 Q: Okay. Do you ever have the occasion or
11 opportunity to have, I think they're called
12 administrative residents or administrative
13 associates come through and train?

14 A: Yeah. We've had a chief nursing officer
15 development candidate who spent about a year
16 with us before being put in a line spot in
17 another hospital. And we've had David Was, who
18 is a chief operating officer development
19 program candidate that HCA selected and put
20 with us for about a year as well. And we've
21 had numerous internships and residencies done
22 by guys and girls studying health
23 administration.

24 Q: Just real briefly for me kind of give the Court
25 a little bit of your educational background, if

1 you would, Mr. White.

2 A: Well, I went through grades one through 12 in
3 the same building as my dad did in rural
4 Columbus County, North Carolina, same English
5 teacher, same principal, but that's probably
6 not what you're interested in the most. Four
7 years in the Navy as a hospital corpsman. And
8 after I flunked out of NC State, came back and
9 went to UNC Wilmington for a semester and made
10 the Dean's List, transferred to Appalachian
11 State where I got a bachelor's degree in
12 business with a major in healthcare management,
13 and then went to night school while I was
14 personnel director in Fayetteville, North
15 Carolina, for an HCA hospital and got my MBA
16 from Campbell University in Buies Creek.

17 Q: And is anything significant happening tomorrow
18 in your life?

19 A: Tomorrow is supposed to be my last day. I just
20 turned 60 in August and announced my retirement
21 back in May, so technically the 15th is my last
22 day, but I'm not accustomed to working on
23 Saturday and Sunday, so I'm assuming tomorrow
24 will be it.

25 Q: Very good.

1 MR. THOMAS: Your Honor, I'm going to put in what I
2 think has been marked as Joint Exhibit 2. This
3 is the Grand Strand CON application, and I'm
4 going to ask the Court to go to -- it's in the
5 DHEC record for Grand Strand, Bates labeled
6 page 972, and we're also going to try to get it
7 up on the screen as well, Your Honor.

8 Q: All right. There we go, good. All right.
9 There we are. All right. Mr. White, I've
10 handed you -- it's the project review slides
11 that Grand Strand presented at the DHEC project
12 review meeting for this case. And if you'd
13 turn to 974, you might be able to use this to
14 tell the judge and the Court a little bit about
15 the hospital.

16 A: Well, we are a 269-bed tertiary facility. We
17 currently have a certificate of need to add
18 additional beds to the facility, and we're in
19 the process of developing that project as well.
20 We opened in 1978 at the request of local
21 citizens to replace a non-profit community
22 hospital that was built by raising funds, not
23 using Hillburton money in the community and
24 started with about 150 beds and have grown
25 today to become really the tertiary hospital

1 for the region. We have a very successful open
2 heart surgery program. We'll do about 450 open
3 heart surgeries this year. Interventional
4 cardiology is very, very busy service as well.
5 We have been selected by Health Grades for four
6 consecutive years as the number one heart
7 surgery program in the state of South Carolina.
8 That's based on the outcomes. And we have a
9 level II trauma center that we started a couple
10 years ago, a huge commitment of resources by
11 HCA and the hospital. We're the only level II
12 trauma center in the region. The closest
13 trauma centers that level or above are in
14 Charleston 100 miles to the south and
15 Wilmington about 60 miles to the north. And
16 we're accredited by the American College of
17 Surgeons for that trauma center, which is a
18 real big deal. We're seeing about ten trauma
19 patients a day. We also are accredited by a
20 joint commission, of course, as an acute care
21 hospital. We were the second hospital in the
22 country a few months ago to receive
23 accreditation for sepsis care, which is
24 actually a huge issue in hospitals because so
25 many people die as a result of getting sepsis

1 and not having it properly treated. We're also
2 an accredited chest pain center by the national
3 society that accredits chest pain centers. And
4 we're an accredited stroke program by the Joint
5 Commission as well. We're the only sepsis,
6 stroke, chest pain accredited center in our
7 region.

8 Q: Now, one of the things I heard -- Mr. Long
9 showed me was that there's no plans to offer
10 any interdisciplinary cancer care at Grand
11 Strand. Does Grand Strand offer any
12 interdisciplinary cancer care today?

13 A: Yeah. We are also an accredited community
14 cancer center by the American College of
15 Surgeons. And the basic requirement is that we
16 provide an interdisciplinary approach to cancer
17 care. And in fact, we're the only hospital in
18 the region that is an accredited center by the
19 American College of Surgeons. We provide, for
20 example, interdisciplinary care for lung cancer
21 where we have a cancer committee that meets
22 regularly, and we have surgeons, medical
23 oncologists, radiation oncologists are invited,
24 radiologists, pathologists, to discuss care of
25 lung cancer patients. We also have a breast

1 care conference on a very regular basis where
2 we have interdisciplinary participation from a
3 host of different physicians as well where care
4 is coordinated and planned. Oddly enough, the
5 missing piece on a regular basis at those
6 meetings relates to our inability to plan or
7 provide radiation therapy services as part of
8 the continuum of care in the hospital.

9 Q: So Mr. Long was incorrect when he was stating

10 ---

11 A: He was dead wrong on that.

12 Q: Okay. You've mentioned the term "tertiary
13 care." Can you just basically provide a
14 definition of that to the Court and Your Honor.

15 A: Well, tertiary care generally relates to
16 provision of higher level services than are
17 found in community hospitals. Those typically
18 relate to having specialized medicine doctors
19 as well as surgical physicians. Open heart
20 surgery is a basic block of the tertiary
21 provider. We provide and are the only hospital
22 in the region, including Georgetown, Conway,
23 Waccamaw, Loris, and Seacoast, that provide
24 round-the-clock neurosurgery coverage. We
25 have intensivists services in the hospital,

1 provide care of intensive care patients. We're
2 the only ones that provide level II trauma
3 services, the open heart surgery. We're the
4 only ones that have the accreditations that I
5 mentioned earlier. And in general, the only
6 thing we're really lacking at this point is
7 level II neonatal services, transplant patient
8 services, and radiation therapy in the hospital
9 to kind of complete the circle.

10 Q: Go to 976 in your book there, Mr. White, if you
11 would.

12 A: Okay.

13 Q: I'm going to show you some utilization numbers
14 that hopefully will pop on the screen here.
15 There we go. Now, these are 2010 utilization
16 numbers. Has anything changed on this slide --

17 -

18 A: Let's see.

19 Q: --- that you can recall?

20 A: Well, I can't really tell you about any of the
21 numbers. I know for the ED visits in 2012, we
22 had about 79,100 ED visits, and we had about
23 71,000 patient days last year. I'm sure our
24 cardiac caths were higher last year, and I
25 really can't honestly speak to the other.

1 Q: Okay. You mentioned something about open heart
2 surgery services earlier. When you arrived at
3 the hospital in February of '95, was there an
4 open heart surgery program?

5 A: No, there wasn't. We had a diagnostic cardiac
6 cath lab at that point and a very highly
7 trained competent staff of cardiologists. A
8 certificate of need had been attained and we
9 had -- the hospital had built the
10 infrastructure to provide open heart surgery
11 services after the CON was received, and we
12 didn't start providing those services until a
13 couple months after I got here.

14 Q: What had that program developing into?

15 A: Well, again, it is a world-class program where
16 our outcomes, again according to Health Grades,
17 a consumer health grading service, if you will,
18 has ranked us four consecutive years, including
19 2012, as the number one heart surgery program
20 in South Carolina for outcomes. It's provided
21 us with an opportunity to attract world class
22 talent in a number of areas that are necessary
23 to support open heart surgery from nephrology
24 and pulmonology through interventional
25 cardiologists. We've added -- it's also given

1 us the ability to draw patients from a larger
2 area in the region and keep them from having to
3 drive to Charleston or Florence or Wilmington.

4 Q: Is Grand Strand's cardiac or CV service line
5 something -- how would you describe it; is it
6 comprehensive?

7 A: It's absolutely comprehensive. We've also
8 added cardiology electrophysiology services,
9 and we have one physician providing those
10 services. And last -- in 2011, at least, I
11 don't know about last year, we provided more EP
12 procedures, which is doing studies and
13 interventions for the electrical problems of
14 the heart rather than the plumbing problems of
15 the heart, we did more procedures than were
16 done at MUSC by their EP program. So we do
17 have a very comprehensive program. We just
18 completed a \$50 million addition to the
19 hospital that includes three cardiac cath labs
20 and a bi-plane electrophysiology lab as well
21 with a very nice pre and post-op area for
22 cardiac cath patients and all the ancillaries
23 that go with that.

24 Q: Is Grand Strand, from your perspective, an
25 operational, financially successful enterprise?

1 A: Grand Strand is one of the more successful
2 facilities in the company, which is great
3 because it affords us the opportunity to get
4 more capital from HCA to expand services and do
5 more things for the community, attract world
6 class physicians, and pretty much ensure that
7 patients don't have to leave the region for
8 care. Our next major goal is this first block.
9 The attorney was correct that we don't have a
10 comprehensive cancer center built around linear
11 -- the linear accelerator in our CON
12 application because this is a building block
13 for the beginning of that comprehensive cancer
14 center that will enable us to offer that
15 service.

16 Q: You mentioned the 50 bed tower.

17 A: Uh-huh (affirmative response).

18 Q: How much did that project cost?

19 A: That was about \$50 million, including an
20 expansion of our emergency department to 50
21 beds. And it's a world class facility with
22 shell space on the third floor built with
23 DHEC's permission, of course, during
24 construction of that project to enable us to
25 add beds at a future point, which we're getting

1 ready to do, at a lower cost.

2 Q: You bring up shell space, and before I forget
3 it, I want to touch on that. Is the linear
4 accelerator facility that you're -- that Grand
5 Strand is proposing to build, does it have
6 shelled space for a second vault already, Mr.
7 White?

8 A: No, it doesn't. I know I've been left out a
9 lot of discussions since I announced my
10 retirement, and I was thinking maybe a new map
11 could have been constructed, but the map --
12 none of the drawings we've got have any shelled
13 space at all for a second vault. There is an
14 area at a right angle, you will see a square,
15 but it's raw land outside of the walls of the
16 building that if a new vault were to be added,
17 that would where -- that would be where a
18 second vault would be added. And we plan for
19 these things just like I just noted about the
20 shell space on the third floor of this \$50
21 million heart tower we just built. But no,
22 there is no shell space built.

23 Q: Okay. Just generally, Mr. White, tell the
24 Court why Grand Strand wants to build a
25 radiation therapy center attached to its

1 hospital.

2 A: Well, basically, the development of a
3 comprehensive cancer center, in addition to the
4 cancer services we're already providing, allows
5 us to put facilities under one roof that will
6 allow cancer patients and their families an
7 opportunity to go to one facility to receive
8 interdisciplinary care, radiation services.
9 The attorney was incorrect again that we had no
10 plans to provide chemotherapy services ---

11 MR. LONG: Your Honor, I've just got to object here,
12 okay. The opening statement is not evidence
13 and they're just pitting me -- they've done it
14 like three or four times in the ten minutes or
15 15 minutes he's been testifying. I think it's
16 improper.

17 MR. THOMAS: And he can cross-examine him, Your
18 Honor, last time I checked.

19 MR. LONG: Sure I can cross-examine him, but I mean,
20 I'm not -- I mean, I gave an opening statement,
21 but they're just pitting the whole direct about
22 what I said, okay.

23 THE COURT: There is the rule of pitting witnesses.
24 I don't know if there's a rule of pitting
25 lawyers, but ---

1 MR. LONG: That's the point, Your Honor. I mean,

2 that's why it's so -- I mean, I ---

3 THE COURT: It's unusual.

4 MR. LONG: --- the first question I kind of looked

5 at it like it was strange, and now they've done

6 it like three times. I mean, I just think --

7 I mean ---

8 MR. THOMAS: He says they. We haven't been -- Mr.

9 White is responding to what he just heard, Your

10 Honor. I mean ---

11 THE COURT: I understand that, but let's just avoid

12 that and keep moving. You can answer the

13 question without referring to ---

14 MR. THOMAS: Referring to counsel.

15 THE COURT: Yes.

16 MR. WHITE: I'm sorry.

17 THE COURT: No, you're ---

18 MR. WHITE: It's kind of hard to hear things that I

19 know is blatantly incorrect and not address

20 them, but I can understand the rules of the

21 court.

22 THE COURT: Okay.

23 THE WITNESS: And I will certainly respect that.

24 Q: Okay. So again, Mr. White, before you were

25 interrupted, what -- tell -- explain why Grand

1 Strand wants to add a radiation therapy center
2 to its campus.

3 A: Okay. Well, in addition to what I said earlier
4 about providing the care under one roof, it
5 will prevent inpatients, albeit a relatively
6 small number from having to get an ambulance,
7 be transported to another facility for
8 radiation therapy and transferred back to our
9 hospital. Since we stopped doing that earlier
10 this year and have pretty much told physicians
11 that the patient needs to have inpatient care
12 while they're -- I mean, radiation therapy
13 while they're an inpatient, then they need to
14 go to a facility that offers that inpatient
15 service. It will also allow us to attract the
16 surgical and medical sub-specialists, such as
17 GYN oncologists, oncological surgeons,
18 radiation therapists, radiation physicists, the
19 necessary medical and surgical sub-specialists
20 that will be providing that care.

21 Q: Are you aware of any hospital-based radiation
22 therapy centers in Horry County today?

23 A: There are none. In Georgetown County, which is
24 in our planning area for the purposes of
25 radiation therapy, down in Georgetown, which is

1 40/50 miles south of us, they do have a
2 radiation therapy unit on the campus of their
3 hospital, but ---

4 Q: Is it attached to their hospital?

5 A: I don't believe it is, and ours would be
6 attached. So this is a -- as far as we're
7 concerned, this is a new service. It is a
8 linear accelerator, granted using the
9 definitions in the health plan, but it's the
10 only comprehensive cancer center that's going
11 to be in a hospital and attached to the
12 hospital that we know of in the region.

13 Q: I'm going to bring your attention to Joint
14 Exhibit 2, Grand Strand 125, and you can look
15 at it on the screen there, but what is this
16 rendering here, Mr. White?

17 A: Well, that's a drawing. If you look at the one
18 o'clock position, that is the outside corner of
19 the proposed building that would house the
20 linear accelerator. The the dark shaded area
21 is where the vault would be located. Of
22 course, immediately north of the vault there,
23 you see that blank area with the right angle I
24 was talking about.

25 Q: Right.

1 A: That would be shrubs and grass and pine straw
2 until such time that an additional vault was
3 needed to be constructed, but it is connected
4 to the hospital, connected by hallways, and
5 there are also rooms in there for chemotherapy
6 administration.

7 Q: Do you expect much chemotherapy administration
8 is going to be done in that facility?

9 A: I think we will see some chemotherapy
10 administration, but the medical oncology group
11 has been providing that for a long time in
12 Myrtle Beach; it's quite profitable for them to
13 provide, and all other hospital linear
14 accelerators that I have been told also have,
15 and it's a part of their comprehensive cancer
16 centers, the ability to provide chemo. So it's
17 not -- we don't expect it to become a major
18 service line, but it's certainly something we
19 continue -- we plan to do going forward.

20 Q: Okay. What, if anything, will a hospital-based
21 radiation therapy center mean in terms of
22 medical staff recruitment?

23 A: Well, as I said earlier, the recruitment of
24 medical and surgical sub-specialists that care
25 for largely cancer patients is pretty

1 restricted if you don't have the comprehensive
2 cancer center services in the hospital. For
3 example, gynecologic oncologists is a surgeon,
4 an OB/GYN with sub-specialty training in that
5 specialty. There's not one -- there's one in
6 -- there's some at MUSC; I think there's one or
7 two even in Columbia. I don't think there's
8 one in Florence. I don't know about
9 Wilmington, but it's just a service not even
10 remotely available, immediately available to
11 the people in our area. Having a comprehensive
12 cancer center that includes the full range of
13 services, including radiation therapy, will
14 allow us a better opportunity to recruit that
15 type of surgeon, specially trained breast
16 surgeons, fellowship trained breast surgeons,
17 surgical oncologists who primarily operate on
18 cancers, colorectal surgeons, a lot of those
19 cases are cancer cases. We don't have one of
20 those and haven't been able to recruit one
21 because it's an essential part of their
22 practice.

23 Q: Where do the patients in the service area then
24 go for this, that type of treatment?

25 A: Well, pretty much now they go to MUSC down in

1 Charleston if they need those comprehensive
2 services. My father died of esophageal cancer
3 in 1998. He was from North Carolina, but he
4 lived with us for 11 months during his rather
5 rapid decline, received radiation therapy
6 services at CRCC, received his chemotherapy
7 over at Dr. Holt's office, and had his surgery
8 and other specialized tests with the
9 interdisciplinary conference of -- for example,
10 esophageal surgeon, Carolyn Reed, who
11 specialized in that surgery down at MUSC. So
12 I was burning up the road the whole time going
13 to all of these different locations trying to
14 obtain this care for my dad. And even though
15 I successfully obtained the care, of course, it
16 was -- you know, he ended up dying from it, but
17 it was a eye-opening experience about the
18 frustration level that patients needing that
19 care, really what they have to go through to
20 get it if they don't have a go-to comprehensive
21 cancer center like we want to build.

22 Q: Mr. White, could you tell the Court and Judge
23 Anderson what you're asking the Court on behalf
24 of Grand Strand to do today.

25 A: Well, I'm not an attorney, so I don't know all

1 the nuances and the specifics of the health
2 plan, Your Honor, but basically we're asking
3 the Court to please consider one of two things.
4 Number one, the new health plan does provide
5 that there is a need for two linear
6 accelerators in our area. Let CRCC continue
7 with their plans to build one over in Conway
8 and give people from that side of the county
9 quicker access for outpatient radiation
10 therapy, but please allow us an opportunity to
11 use that second CON, if that is available in
12 any health plan, to provide services in a
13 hospital setting for the reasons I mentioned
14 earlier. If two are not going to be approved
15 like the new health plan says are able to be
16 approved, we're asking the Court to please
17 overturn DHEC's original decision because this
18 is a new service. CRCC clearly has a monopoly
19 in Horry County, and I think it's pretty
20 obvious that there are various moves to
21 different parts of the county to -- and to
22 Georgetown County to put additional outpatient
23 units are always have been in response to other
24 entities wanting to put outpatient units in.
25 This is not an outpatient unit, even though we

1 will do outpatients, but we would love to be
2 able to offer this service to patients in our
3 hospital.

4 Q: Thank you. I'm going to show you what's been
5 marked as Petitioner's 43, Mr. White.

6 A: Okay.

7 MR. THOMAS: Kind of put that off to the side there
8 and see if we've got it up -- oh, boy. It's
9 small, Your Honor.

10 Q: Mr. White, what is this chart?

11 A: This is a market share report of our primary
12 service area and our secondary service area for
13 inpatients first quarter 2012 through us for
14 the whole year of 2012, and you can see the zip
15 codes there with the names of the towns under
16 the zip codes, and it's produced by an HCA
17 department. I don't even know where they're
18 located. We access them by computer, decision
19 support services, and they obtain the data from
20 Office of Research and Statistics at the state
21 level.

22 Q: Is this a type of chart that you would normally
23 review as a CEO?

24 A: Sure is. We look at market share reports on a
25 very regular basis.

1 Q: And can you tell the Court what this particular
2 market share, you know, what type of market
3 share it's speaking to and what it shows?

4 A: Well, this oncology product line includes all
5 patients, inpatients who had a primary or
6 secondary diagnosis of cancer of any type. And
7 it shows that we had -- it shows where the
8 patients from these zip codes received care,
9 where there discharges were from. And this
10 shows that 185 patients from our area were
11 discharged from our hospital, and the second
12 largest number was 156 down at MUSC, and that's
13 just reflective of the fact that we provided
14 more services to patients with a primary or
15 secondary diagnosis of cancer than any other
16 hospital in the planning area for linear
17 accelerator services, Horry, Georgetown,
18 Williamsburg County, in that there's a huge
19 amount of patients that, like my dad did, go to
20 MUSC for their inpatient care for cancer
21 because we can't provide all the services they
22 need.

23 Q: And why do you think folks from Horry County,
24 your primary service area and secondary service
25 area are having to travel to MUSC?

1 A: Well, again, MUSC at the Hollings Cancer
2 Center, they do a fabulous job of
3 interdisciplinary care where they have
4 different specialties meeting on specific
5 patients to devise plans and recommendations
6 for cancer care for those patients. They have
7 all the services, linear accelerators,
8 specialty surgery, chemotherapy, diagnostic
9 services under one roof to provide care for
10 those patients, and there's not an option in
11 Horry, Georgetown, Williamsburg County.

12 THE COURT: So when you said the 185 patients who
13 were discharged.

14 MR. WHITE: Yes, sir.

15 THE COURT: Were they all discharged for inpatient
16 care or ---

17 MR. WHITE: They were inpatients at our facility.

18 THE COURT: Inpatient at your facility?

19 MR. WHITE: Yes, sir, who were discharged.

20 THE COURT: Okay. But for what? It doesn't reflect
21 for what. It just says they were discharged.

22 MR. WHITE: Okay. I may understand ---

23 THE COURT: If they were inpatient ---

24 MR. WHITE: They were inpatients and they got well
25 enough to go home.

1 THE COURT: Okay.

2 MR. WHITE: I'm sorry. This vernacular, we live and
3 breathe it, so.

4 THE COURT: No, I just want to be clear ---

5 MR. WHITE: Yes, sir.

6 THE COURT: --- because you went to the next subject
7 of them going to other hospitals for
8 interdisciplinary care, but that wasn't
9 referring to necessarily them going to those
10 hospitals for inpatient interdisciplinary care?

11 MR. WHITE: Well, Your Honor, 185 patients left our
12 hospital, were discharged home from our
13 hospital, who had primary and secondary
14 diagnosis of cancer.

15 THE COURT: Yeah.

16 MR. WHITE: I'm simply saying that the 156 that went
17 to MUSC, I would contend -- I don't know for
18 positive, but I would contend like my Dad and
19 a lot of other people I know or have known,
20 ended up going to Charleston to MUSC and
21 receiving their interdisciplinary care on an
22 inpatient basis there and being subsequently
23 discharged home or died from MUSC.

24 THE COURT: Okay.

25 Q: Just so the record is clear, Mr. White, so how

1 many patients from your primary, Grand Strand's
2 primary and secondary service area from the zip
3 codes listed above there traveled to MUSC for
4 the type of inpatient cancer care?

5 A: There were 156 that left our primary and
6 secondary service area zip codes to go to MUSC
7 and were subsequently discharged from there for
8 care.

9 Q: Okay.

10 A: For cancer.

11 Q: Sure. Thank you. If you'd go to Tab 26,
12 Petitioner's 26 in this same book. I think
13 it's going to be pretty close to the front
14 there, and we'll get it pulled up on the
15 screen. Let me know when you get there..

16 A: Okay. I'm there.

17 Q: Okay. Again, this oncology product line market
18 share report, is something that you would
19 typically look at?

20 A: Sure, it is.

21 Q: And is this from HCA's decision support
22 services?

23 A: Yes, sir, it is.

24 Q: Okay.

25 A: Again, the data came from Office of Research

1 and Statistics at the state leve.

2 Q: Okay. And what -- for what counties is this
3 reflecting Grand Strand's market share?

4 A: This is Georgetown, Horry, and Williamsburg
5 Counties.

6 Q: So the service area at issue in this case?

7 A: Again, it's the primary and secondary service
8 area, but it's a three county area that's the
9 planning area for linac in the State Health
10 Plan.

11 Q: What does it show from 2011 to 2012, which
12 facility has the largest market share oncology
13 inpatients in those counties?

14 A: Well, again, it's showing, unlike the other
15 report, but for the three county area, instead
16 of just our primary and secondary service --
17 zip codes, for the whole three county area,
18 it's showing MUSC down in Charleston had the
19 largest part of the market share in 2011 with
20 27 percent decreased very slightly down to 26
21 percent in 2012.

22 Q: Okay. And what was Grand Strand's market share
23 for each of those two years for the three
24 county area?

25 A: Our market share in 2011 was 23.96 percent, and

1 in 2012 we had a dip to 20.33 percent.

2 Q: What, if any, expectations do you have about
3 having a similar market share for radiation
4 therapy as these market shares if the Court
5 were to approve Grand Strand for a linear
6 accelerator?

7 A: I'm not sure I understand the question.

8 Q: Do you expect to have the same market share for
9 the three county area that you have for your
10 inpatient market share?

11 A: Absolutely not. I don't think that it would
12 significantly change because I can't in my
13 wildest dreams imagine anybody from Georgetown
14 driving to Myrtle Beach instead of MUSC for
15 radiation therapy services. Horry County being
16 -- or Williamsburg County for that matter, and
17 Horry County being the largest county
18 geographically in South Carolina, there are
19 even parts of Horry County that I don't think
20 patients would drive to Myrtle Beach instead of
21 Charleston to receive care.

22 Q: Do you think your radiation therapy program
23 would have a similar market share as the market
24 share that's listed in this document?

25 A: If approved, I would think it would be similar,

1 but it wouldn't match it. I think it would be
2 slightly less.

3 Q: Does Grand Strand employee a significant number
4 of physicians who would refer to radiation
5 therapy services?

6 A: Well, I wouldn't say a significant number. We
7 employee two neurosurgeons. They are in a
8 position to refer patients. We employee
9 several trauma surgeons. I think six or maybe
10 seven or eight trauma/general surgeons. They
11 are frequently in a position to refer for
12 consideration for radiation therapy. We don't
13 employee any medical oncologists, and unlike
14 21st Century, we don't employee all of the
15 urologists in the county. And so we would
16 control zero or even be able to influence zero
17 of the urology referrals, but very limited with
18 just general surgery and two neurosurgeons.

19 Q: What's your understanding of how long CRCC has
20 been in this market in Horry County, basically?

21 A: Well, I met Dr. Bass when I came 18 and a half
22 years ago, and they had been in business for
23 about -- total now for about 32/33 years.

24 Q: And again, any other providers in the county of
25 radiation therapy services?

1 A: There are none in our county at all. There are
2 -- again, Georgetown provides a linear
3 accelerator down in Georgetown, which is,
4 again, 40 or 50 miles south of us.

5 Q: Okay. I'll take that out of your way. I'm
6 going to show you what's been marked as
7 Respondent's Exhibit 82.

8 A: Okay.

9 Q: Ask you if you recognize that document.

10 THE COURT: That was -- did you say Petitioner's or
11 Respondent's?

12 MR. THOMAS: Respondent's.

13 A: Yes, sir.

14 Q: Okay. What is this document, Mr. White? Did
15 you receive it?

16 A: This is an email from my boss, Jamie Thomas, in
17 Charleston to me, copied to Adam Rudd and
18 Robert Grace, my COO and CFO.

19 Q: What's the date on this document, sir?

20 A: November 10th, 2010.

21 Q: Coming up on about three years ago then, huh?

22 A: Yes, sir.

23 Q: All right. Can you tell me a little bit about
24 this email. First of all, ask you a couple of
25 questions, don't know if it's gotten into the

1 record yet. What's the name of the local
2 medical oncology group in Horry County?

3 A: Coastal Cancer Center.

4 Q: Okay. You can refer to them as Mr. Long says
5 Coastal, and that's fine.

6 A: Okay.

7 Q: Tell me a little bit about what's going on in
8 this email here. And if you need to take a
9 second to read it, that's fine.

10 A: Okay. This is an email from Mr. Thomas where
11 he's relating to us there's likely an opening
12 in the State Health Plan, is what he's talking
13 about, for a new linac in Horry -- linac is our
14 abbreviation, kind of acronym for linear
15 accelerator -- in the three-county area noting
16 that 21st Century, who had bought the center
17 from Dr. Bass for I don't know how many tens of
18 millions of dollars. And they've employed the
19 urologists, which is true. Every urologist in
20 the county, I'm pretty sure, works for 21st
21 Century. The medical oncology group that
22 services this area, which is Coastal Cancer
23 Center, is estranged from 21st Century, and has
24 been contacted by McLeod to support --
25 actually, it was radiation therapy CON

1 application that they were putting out there to
2 start linac services up in Little River at
3 Seacoast. Imperative that we submit a CON
4 application; I'm sure he meant for linear
5 accelerator immediately. We can then oppose
6 Georgetown's intent to move their accelerator
7 to Waccamaw. Our CON should then create a
8 dialogue with both 21st and Loris/SeaCoast.
9 Employed medical oncologists might be a part of
10 this progression.

11 Q: Okay. Let's go back to the medical oncology
12 group for a second. Do you know the names of
13 the physicians in the Coastal group?

14 A: Well, Dr. Holt is the one I'm most familiar
15 with because he treated my dad years ago. We
16 developed a good, you know, relationship
17 through that all as you can imagine. There's
18 Dr. Paudel, there's Dr. Goldberg, there's a
19 female medical oncologist, I can't recall her
20 name, and I think I may be leaving one out.

21 Q: Karpenko?

22 A: Karpenko is one of them.

23 Q: And Cody; does that sound familiar?

24 A: Rebecca Cody, yes.

25 Q: Okay. And do they only have offices, does

1 Coastal only have an office next to your campus
2 in Myrtle Beach?

3 A: No, I think they have -- I'm not positive, but
4 I think they have offices in -- where I know
5 they have offices, this may not be all
6 inclusive, is Supply, North Carolina right
7 across the line in Brunswick County; Loris;
8 Conway; Myrtle Beach and Georgetown County down
9 by Waccamaw.

10 Q: Okay. And do the physicians at Coastal Cancer
11 Center have some called medical staff
12 privileges at Grand Strand?

13 A: Yes. All of the physicians that are a part of
14 that group have medical staff privileges at our
15 hospital. They also have them at, I believe,
16 all the other hospitals in the area as well
17 because they do kind of cross cover for each
18 other in all the hospitals.

19 Q: Who, if you know, who informed Mr. Thomas that
20 21st -- that the medical oncology group was
21 estranged from 21st Century?

22 A: It was probably me. I either informed him or
23 Jim Rardin, who was the development person down
24 in their office about that.

25 Q: Okay. So you would have done this. Would you

1 have done this prior to November 10th, 2010?

2 A: I'm sure I did.

3 Q: Do you recall what information you would have
4 imparted to Mr. Thomas?

5 A: Yeah. I remember having a conversation with
6 him and Jim Rardin at some point prior to this
7 email, essentially relating the fact that Dr.
8 Holt, who is really the only person I've ever
9 talked to over there about any business aspect
10 of oncology services in Myrtle Beach, I talked
11 to him about his relationship as a -- with the
12 urologists and with Carolina Regional Cancer
13 Center as a result of them having gone through
14 a proposed deal of some sort where the medical
15 oncologists were going to be a part of some
16 sort of linear accelerator cancer treatment
17 facility that essentially fell apart. Dr. Holt
18 felt slanted by that process and kind of had --
19 I just had a real strong gut feeling that he
20 had a very sour taste in his mouth for both of
21 those groups after that was -- that had been
22 concluded.

23 Q: Okay.

24 A: And then I think the fact that 21st Century
25 then immediately gobbled up all the urologists

1 in the county and employed them, you know, that
2 was an irritant as well because, you know, it
3 was perceived as a -- kind of a, I guess -- it
4 was an offense to Dr. Holt. We didn't have
5 any lengthy detailed discussion about it.

6 Q: That was three years ago?

7 A: Yeah.

8 Q: Has he made any mention of bad blood or
9 estrangement from 21st Century since then to
10 you?

11 A: No.

12 Q: Okay. Have you had any other discussions with
13 anyone other than Dr. Holt in that Coastal
14 Cancer practice about how they feel about CRCC?

15 A: I sure haven't.

16 Q: Let me ask you this, since you -- since Grand
17 Strand actually applied for the CON application
18 in July of 2011, have you had any discussions
19 with Dr. Holt about CRCC?

20 A: Okay. Repeat that, I'm not sure.

21 Q: Since Grand Strand applied for the CON
22 application at issue in this case in July of
23 2011, have you had any discussions with Dr.
24 Holt about Carolina Regional Cancer Center in
25 any way, shape, or form?

1 A: Not that I recall. I mean, Dr. Holt and I
2 might have three conversations a year, four at
3 most, and I don't recall last time I talked to
4 him about linear accelerator.

5 Q: Do you have any idea about how Dr. Holt feels
6 today about CRCC and their services that they
7 offer?

8 A: No, I don't.

9 Q: Do you know if Dr. Holt is in any way, shape,
10 or form estranged from 21st Century today?

11 A: I don't know, and I didn't know back then.
12 Again, I just had this gut feeling from kind of
13 brief couple conversations that I had with him.
14 I don't he's totally estranged because he still
15 sends some patients to them over there.

16 Q: That's what I was going to ask you. Are you
17 aware that they're the -- and I think Mr. Long
18 said this in his opening, they're the largest
19 single referral source by practice of any other
20 practice in Horry County to CRCC?

21 A: I wasn't aware of that.

22 Q: Okay.

23 A: I don't recall. I thought urologists would
24 have been since they're financially
25 incentivized to send them patients.

1 Q: Well, let me ask you this. There's a reference
2 in here that you read about employing the
3 medical oncologists might be a part of this
4 progression. Mr. White, are you aware -- well,
5 let me ask you this. Are you involved in the
6 strategic and business planning at Grand Strand
7 Regional Medical Center?

8 A: Absolutely, yes.

9 Q: Okay. And is that a in-depth, Is strategic and
10 business planning an in-depth exercise at Grand
11 Strand?

12 A: Every year we do a strategic plan for the
13 following year, and it's a very detailed
14 process.

15 Q: Are you aware in those business plans,
16 strategic plans, or otherwise of any plans to
17 employ the medical oncologists if Grand Strand
18 is awarded a linear accelerator?

19 A: Absolutely not. And I doubt seriously that it
20 could ever be approached with any level of
21 seriousness because Dr. Holt's developed a
22 very, very successful practice all over the
23 county and Georgetown County and Brunswick
24 County over the years, multiple locations, lots
25 of real estate, which is the result of his

1 success and the chemotherapy services that he
2 provides, the PET/CT scan services he provides
3 in his practice are very profitable, and that
4 would typically -- that typically would
5 preclude any discussion, serious discussion of
6 employment by a physician group in that
7 setting.

8 Q: Well what, if any, understanding do you have
9 with respect to CRCC's provider relations in
10 Horry County since 21st Century purchased CRCC?

11 A: Say that again. I'm sorry.

12 Q: What's your understanding of the provider
13 relations that CRCC has with its referral base
14 in Horry County?

15 A: Well, I -- my sense of their provider
16 relations, they are not highly regarded by a
17 lot of physicians in the community because of
18 their relationship with the urologists of
19 employing them, and suddenly we do no radical
20 prostatectomies to speak of, and it all shifted
21 as soon as they bought them to radiation
22 therapy. But that's kind of anecdotal doctor's
23 lounge discussion, little comments after 18 and
24 a half years, you know, you kind of become
25 accustomed to hearing people talk. They don't

1 have near the reputation they had when Dr. Bass
2 ran the center, that's for sure. Dr. Francke
3 at the project review hearing informed the
4 group in response to a question from one of the
5 DHEC staff as to what he attributed the
6 unbelievable increase in procedures being done
7 at the center from before 21st Century bought
8 the center and hired all the urologists in the
9 county to after, and Dr. Francke said he
10 attributed it to we have greatly -- and this
11 might not be an exact quote, but we have
12 greatly improved our provider relations. So
13 I'm assuming he's not only talking about the
14 urologists that they hired but other physicians
15 as well. And it's possible he's talking about
16 the medical oncologists because -- I mean, if
17 medical oncologists are the ones that refer the
18 majority of patients to the CRCC, then
19 obviously they've had some remarkable
20 improvement in provider relations there.

21 Q: Okay. I'm going to show you what's been marked
22 as Exhibit, Joint Exhibit 1. It's the CRCC
23 application, CON application.

24 A: In this book?

25 Q: I'm going to bring it up there to you, sir.

1 I'll ask you if this is what you're referring
2 to. I've handed you up, it's a project review
3 presentation from CRCC ---

4 A: Okay.

5 Q: --- that was also given to Grand Strand. And
6 is that what you're referring to, Mr. White, in
7 terms of the representation made by CRCC
8 project review meeting?

9 A: I didn't recall -- this was the project review
10 meeting.

11 Q: Yeah.

12 A: And I don't specifically recall reading this.
13 I remember the audible gasp in the audience
14 when he said that in response to a question
15 from a DHEC staffer as to why the monumental
16 increase in procedures year over year. I don't
17 remember reading it, but ---

18 Q: Okay. But what else did 21st Century and Dr.
19 Francke say in this slide?

20 A: You're talking about page ---

21 MR. LONG: Your Honor, I think he just said he
22 didn't remember. Your Honor, I have to object
23 to the question. He just said he didn't
24 remember.

25 MR. THOMAS: Let me do it this way, Your Honor.

1 THE COURT: Yeah, I was ---

2 Q: Mr. White, were you present at the project
3 review meeting?

4 A: Yes.

5 Q: Okay. Did you actually give a presentation at
6 the project review meeting?

7 A: Yes.

8 Q: Okay. And does this slide on page 586, now
9 that you've read it, does it reflect your
10 recollection or refresh your recollection of
11 what Dr. Francke stated at the project review
12 meeting?

13 A: Although I haven't read this prior to now, it
14 absolutely accurately reflects what he
15 verbalized in his presentation.

16 Q: Well, you got a copy of this as the CEO of
17 Grand Strand, correct?

18 A: Yes.

19 Q: Okay. And did you review it?

20 A: I probably scanned it, but having been there
21 and having listened to it be presented, I
22 probably didn't read it word for word.

23 Q: Okay. Well, did you take it at its face value?

24 A: The parts I read, yes.

25 Q: Okay. What are the other two things that this

1 slide states from CRCC in addition to providing
2 or improving provider relations and reversing
3 historic patient outmigration, what are the
4 other two bullet points there?

5 A: It says that they have -- it says that they
6 have greatly enhanced technology, and that they
7 have enhanced operational effectiveness.

8 Q: Okay. Thank you. Let me grab this out of your
9 way. I just want to go to another exhibit.

10 A: Okay.

11 Q: And I think in the same notebook, let's see
12 here, we were looking at earlier. Let's go to
13 Respondent's 84 if we could.

14 A: Okay.

15 Q: Give the respondents a second to get there.

16 Okay. And look at the top of the page here,
17 Mr. White. What is this document?

18 A: Well, it is a series of emails, this being the
19 last email from me to Sissy Price at CRCC.

20 Q: Okay. And take a second to just look at them.
21 I'm going to ask you just a couple of questions
22 about it. It's got a -- yeah, it's got kind of
23 a long string there.

24 A: Okay. It's kind of a series of emails.

25 Q: Right. The first one I'm interested in is the

1 one on the very first page at the very top that
2 you wrote to Ms. Price. Let me ask you just
3 for background for the Court, so who is Ms. --
4 or Sissy Price?

5 A: Sissy's here with us. I saw her earlier today
6 in the back row back there. Sissy and I have
7 been -- had a great relationship for years and
8 years. They took fantastic care of my dad
9 insofar as the radiation therapy part of his
10 treatment, so I became enamored with a lot of
11 people over there in that process, but she is
12 also the, I guess, practice administrator over
13 there for the non-clinical administration at
14 the center, CRCC.

15 Q: I'd like you to read the very first line into
16 the record that you wrote to her.

17 A: It says, please -- from me to Sissy, "Please
18 send me a draft with all the blanks filled in
19 so we can put on letterhead and send. Will you
20 folks also support our CON application if we
21 apply to put a linac in the hospital?"

22 Q: Do you remember what her response was to that?

23 A: Zero response.

24 Q: Okay. And again, in this line right here that
25 you wrote, where does it say in December that

1 you were going to put the linac?

2 A: Well, we were going to put it in the hospital,
3 which is pretty much what we had expected and
4 intended all along even though we looked at a
5 lot of different options.

6 Q: Okay. And I guess -- let me ask you this, Mr.
7 White. We're off of this exhibit now, but can
8 you explain to me in a little bit how the
9 process would work for Grand Strand and HCA and
10 the corporate interaction that you had with
11 respect to developing and getting funding for
12 a nine million dollar radiation therapy center?

13 A: Well, of course, the certificate of need
14 process is one that we look at first to
15 determine the likelihood of us being able to
16 get a CON and what the need is for the service.
17 Internally, in the company, we have a process
18 of developing proformas. We'll do a proforma
19 that uses data that we have available.
20 Largely, we depend on external consultants and
21 health planners who do this stuff for a living
22 to make sure that we are accurately forecasting
23 need. We develop building, rough building
24 estimates and equipment estimates using
25 corporate resources and design and construction

1 and equipment specialists. And then we do
2 what's called a CAMS model, which is Current
3 Asset Management System model that prices it
4 out, looks at revenues, expenses, and determine
5 what an internal rate of return might be on a
6 proposed project. And if the models appear
7 that it justifies a capital expenditure by the
8 company, then it goes to the corporate officers
9 for their -- first to my boss, then if he --
10 after he tears it apart and goes through it
11 with us, then he submits it to the guys at the
12 group, national group office, and they may come
13 back and ask us directly questions or have
14 conversation, ask us to develop, you know,
15 hypothetical models, what if it's not as
16 pictured in the model or what if it's, you
17 know, twice as good as you think it's going to
18 be in the model, what would the proforma look
19 like.

20 Q: Okay. Let me ask you ---

21 A: They control the purse strings for the capital,
22 so we have to pretty much justify the project.

23 Q: Well, you kind of anticipated my next question
24 there. Can Grand Strand spend anything it
25 wants on a radiation therapy project?

1 A: Absolutely not. We're limited by HCA's capital
2 resource allocation to us.

3 Q: Okay. So we've seen a couple of emails where
4 as we get started on the project, what if --
5 what did you do in preparation to add this
6 service personally prior to submitting the CON?

7 A: Well, first of all, we started looking at
8 outmigration of patients to other hospitals,
9 specifically MUSC since that was the -- where
10 the bulk of the inpatient market share was
11 going to try to start gauging what the demand
12 for the service might be. We noted that the
13 urologist referrals were simply not going to
14 happen, and we discounted those immediately as
15 a referral source. The only other medical
16 specialists that we went to to ascertain
17 whether, in general, they would support the
18 project, I went to Dr. Holt and talked to him.
19 I didn't talk to his group, didn't talk to any
20 other doctors. And then we started sending out
21 proposed letters of support that were to go
22 with the CON application to DHEC to physicians
23 up and down the Grand Strand, political
24 officials, community leaders, and that sort of
25 thing. And that was a good indication of what

1 support level we could expect.

2 Q: And why did you levels of -- I mean, why do you
3 need letters of support?

4 A: Well, DHEC requires that we demonstrate
5 community support for a proposed project. And
6 quite honestly, if Dr. Holt had come back and
7 said no way, no how, we're not going to support
8 your application, I'm confident we wouldn't
9 have bothered applying because it would not
10 have a chance if some of his patients were not
11 going to come to our facility.

12 Q: Do you know if the Coastal group supported any
13 other of -- there were two other applicants.
14 Do you know if they supported any of the other
15 applicants?

16 A: I know they signed the original application for
17 -- to put one up in Little River. They signed
18 one up there, and I think they signed the CRCC
19 letter as well, support letter.

20 Q: Did you ---

21 A: And ours.

22 Q: In terms of an operational standpoint, did you
23 go look at any other radiation therapy
24 facilities?

25 A: We went down to Trident Regional Medical

1 Center, which is an HCA hospital down in
2 Charleston, and spent the day looking at their
3 inpatient linear accelerator facilities, their
4 chemotherapy administration facilities, and
5 looked at kind of the layout and patient flow,
6 the equipment, and that sort of thing, staffing
7 requirements, and we did that in preparation of
8 proposing our project.

9 Q: Okay. Let me ask you this, did you draft any
10 portion of the CON application? Is that
11 something that the CEO would do?

12 A: No, I did not. I pretty much delegate it to
13 Adam Rudd, the COO, and he heads up that
14 process using health planners, using you as our
15 legal counsel and CON expert, and Robert Grace
16 did all the financial projections.

17 MR. THOMAS: Your Honor, it's 12:20. I'm good to
18 keep going. We've been going a while, but I
19 figured we'd break for lunch and then probably
20 what I'll do is get into the CON application.

21 THE COURT: All right.

22 MR. THOMAS: If everybody is ---

23 THE COURT: Are you good with that?

24 MR. LONG: Whatever your preference is, Your Honor.

25 Do you usually stop around 12:30 or 1:00 or

1 12:00, or do you just play it by ear?

2 THE COURT: I normally stop when I feel like there's
3 a breaking point.

4 MR. LONG: Okay.

5 THE COURT: So it's anywhere from 12:00 to 1:00.

6 MR. LONG: Okay.

7 THE COURT: So if there's a breaking point in the
8 transition of what we're going to be asking,
9 I'll call that said type of breaking point, and
10 let us break for lunch. Be back at, let's see,
11 do we want to make it 1:30, or do you want a
12 little longer? I don't know how this day is
13 going according to y'all's schedule.

14 MR. THOMAS: I can do 1:45.

15 MR. LONG: 1:45 maybe, Your Honor.

16 THE COURT: All right.

17 MR. LONG: We're going to walk back to our office.

18 MR. THOMAS: That's great.

19 THE COURT: 1:45 it shall be.

20 (Lunch break from 12:22 p.m. until 1:45 p.m.)

21 MR. THOMAS: Mr. White, take the stand.

22 THE COURT: You're still under oath.

23 MR. WHITE: Yes, sir.

24 BY MR. THOMAS:

25 Q: Mr. White, you should have before you Joint

1 Exhibit 2 in front of you.

2 A: Okay.

3 Q: Which is the Grand Strand CON application. And

4 if you'd turn literally to the third Bates page

5 there, Bates labeled page, which should have a

6 little three at the bottom.

7 A: Okay.

8 Q: Okay. Now, did you sign this CON application

9 on behalf of Grand Strand?

10 A: Yes.

11 Q: And what was the date there that you signed it?

12 A: July 11th, 2011.

13 Q: And let me ask you to turn -- well, let me ask

14 you this. When did you speak to Dr. Holt, if

15 you remember the date, before sending out the

16 community letters of support; do you recall?

17 A: I do not recall.

18 Q: It would have been before you signed the

19 application, correct?

20 A: Yes.

21 Q: Okay. And I think you referenced, maybe I'm

22 wrong, but was he in support of the project?

23 A: Yes.

24 Q: And why is it important to have the medical

25 oncologists support the radiation therapy

1 project at Grand Strand?

2 A: Well, they certainly serve more cancer patients
3 than any other specialty, and since we know --
4 knew then and know now, we couldn't count on
5 any of the urologists who are the second
6 biggest category of potential referral sources
7 for any referrals, if we didn't have some
8 indication that Dr. Holt believed that his
9 practice would be supportive, it would be
10 futile to attempt to start the service.

11 Q: And when you spoke with him, did you ever ask
12 him to commit a certain number of referrals to
13 Grand Strand?

14 A: Never.

15 Q: Did he commit a certain number of referrals to
16 Grand Strand?

17 A: No. We never had any discussion about any
18 quantity of referrals or anything along that
19 line.

20 Q: Okay. Turn in Joint Exhibit 2 of Grand
21 Strand's CON application for me to page, Bates
22 page 7, if you would, sir.

23 A: Okay.

24 Q: I ask you to read the very first line under B-
25 2, which is generally as we all know in the

1 courtroom that it's the description of the
2 project.

3 A: "Grand Strand Regional Medical Center desires
4 to establish a radiation therapy center
5 attached to the main hospital on its campus in
6 Myrtle Beach, South Carolina."

7 Q: Okay. And would that have been the facility
8 that we showed the Court earlier that -- with
9 the schematic design?

10 A: Yes.

11 Q: Okay. I want to ask you, prior to submitting
12 this in July of 2011, did your team or anyone
13 at the corporate division consider any other
14 locations or options for this project?

15 A: Yeah. There were several other locations
16 considered, albeit very briefly considered.
17 One was, of course, originally it was the main
18 hospital where we always felt it was going to
19 end up anyway. We looked at the South Strand
20 Ambulatory Care Center campus, which is an
21 outpatient satellite facility we own about, I
22 guess, ten miles south of the hospital. I had
23 a conversation with Dr. Holt about potentially
24 buying a piece of property adjacent to his
25 property that was owned by his group as a

1 possible location. And, of course, we came
2 back to where I thought it was going to be all
3 along, that was the main campus.

4 Q: Okay. Let's talk about Dr. Holt's or the
5 Coastal Cancer Center's property first.

6 A: Okay.

7 Q: Why was there consideration to locate the
8 linear accelerator on that property?

9 A: Well, realizing that a lot of cancer patients
10 like my dad who needed both chemo and radiation
11 could possibly benefit from having those
12 facilities very close to one another and still
13 be a what, 30 second ride from the back of our
14 parking lot where that center -- where that
15 facility might be to the hospital, if it had to
16 be an inpatient that was going over for care,
17 I felt there may be some synergy there,
18 convenience to patients, and that it would
19 certainly enhance our ability to get referrals,
20 make it easier for patients to go from that --
21 from Dr. Holt's practice over to radiation if
22 they needed it.

23 Q: Okay. Try to put Respondent 24 up on the
24 screen for you again. This is the Google map
25 that was shown in the opening statement for

1 Grand Strand. What is this facility I'm
2 pointing to, Mr. White?

3 A: That's the new -- that's the loading dock and
4 the back side of the hospital, the heart center
5 to the left.

6 Q: And so is this Grand Strand's parking area
7 here?

8 A: That's one of our parking areas, yes.

9 Q: Okay. And then where -- and if this -- what is
10 this building here?

11 A: That's Coastal Cancer Center.

12 Q: Okay. And I think it actually says it on
13 there, but it's kind of hard to read.

14 A: And they own that parking lot to the left of
15 that red building where that center is located
16 as well.

17 Q: Okay.

18 A: And the spot we were looking at is in that
19 parking lot area to potentially buy, but we
20 discounted that fairly quickly.

21 Q: Was there going to be any kind of access from
22 the hospital to that location?

23 A: Yeah. We were going to -- if we were to do it,
24 we were going to take those woods, clear them
25 out, put a drive connection, a closed loop, if

1 you will, from the parking lot of the hospital
2 over to the back side of that addition to his
3 property and not allow drive through from the
4 road in front of the Coastal Cancer Center so
5 people wouldn't use it as a drive through
6 between -- a shortcut to the hospital. But to
7 provide easy access to the hospital from that
8 location.

9 Q: Now, I think we all know today that that option
10 was rejected. Can you explain why the option
11 was rejected?

12 A: Well, it was probably a poor idea on my part to
13 start with, but of course, there were two main
14 drivers. First and foremost to be in
15 compliance with the State Health Plan and the
16 criteria for CONS, cost was a major
17 consideration. Dr. Holt's value that he had
18 placed on that property -- we never had an
19 appraisal done or anything, it never got that
20 far -- was about \$1.4 million. We already knew
21 that with the, only way I know how to say it is
22 cheap, modular building that CRCC was going to
23 put over in Conway, their cost was extremely
24 low, and at the time, the facility that Little
25 River -- that Loris Seacoast was going to put

1 up in Little River was, I believe, less than
2 nine million dollars. So the additional cost
3 of the \$1.4 million land cost there where we
4 already had existing land on the hospital
5 campus that wouldn't cost us anything
6 incrementally was pretty much the major reason
7 that we discounted it. And in keeping with the
8 grand plan to do a comprehensive cancer center,
9 you know, we decided that it would probably be
10 a much easier project to have this first
11 building block on if it was contiguous with the
12 hospital because, as I said earlier, we already
13 have comprehensive cancer services going on
14 with lung cancer and breast care, and breast
15 cancer now.

16 Q: What was Dr. Holt's response, if any, regarding
17 the change in location from his property to the
18 hospital?

19 A: I don't recall any ---

20 MR. LONG: Objection, Your Honor. I think that's
21 clearly hearsay.

22 Q: Well, let me ask you this. Are you aware of
23 any issues from the Coastal Cancer Center
24 regarding ...

25 MR. THOMAS: Strike that, Your Honor. That's fine.

1 We don't need to go there. As long as I get
2 the same leeway on their direct -- or their
3 cross, excuse me, Your Honor.

4 Q: You mentioned something about South Strand, a
5 South Strand location consideration.

6 A: Uh-huh (affirmative response).

7 Q: What is South Strand?

8 A: Well, it's a ambulatory care center that we
9 have a location, like I said, about ten miles
10 south of the hospital that's got a 24-hour
11 emergency department, imaging services, cardiac
12 rehabilitation facility, a laboratory, and
13 there's a medical office building on the same
14 campus not owned by the hospital.

15 Q: Okay.

16 A: And a defunct surgery center, ambulatory
17 surgery center, which was on the back side of
18 that building. That's where the initial idea
19 to perhaps use that unused space for the linear
20 accelerator came from.

21 Q: Okay. And why was this location rejected?

22 A: Again, cost was a major factor, the distance
23 from the hospital, which would make it in our
24 book pretty much just another freestanding
25 linear accelerator like CRCC has in, you know,

1 planning or has for multiple locations. It
2 would be nothing special about it, no ability
3 to develop it into a comprehensive cancer
4 center and have multidisciplinary care
5 available there. It also flew in the face of
6 logic to think that DHEC would consider
7 approving a rather expensive center that would
8 be south of CRCC's location and close to
9 Murrells Inlet where DHEC, and I'll never
10 understand this, had approved two facilities to
11 be within a half mile of each other down there.
12 So that would really put a concentration of
13 outpatient, purely outpatient facilities in a
14 pretty tight little cluster. So we discounted
15 that actually not as quick as we discounted
16 Holt's land as an option, but pretty darn
17 quick.

18 Q: Okay. I want you to go back to the DHEC record
19 and, if you would, and read on -- there on page
20 7 of the DHEC record the second sentence into
21 the record for us.

22 A: "Grand Strand proposes to install a state-of-
23 the-art Varian Clinac iX linear accelerator
24 along with CT simulator and will provide
25 conventional radiotherapy services as well as

1 IMRT and IGRT services to residents of and
2 visitors to the state-defined service area of
3 Horry, Georgetown, and Williamsburg Counties.

4 Q: You heard Mr. Long a little bit earlier talking
5 today about iPhones, iPhone 7, iPhone 5. I
6 think I've maybe still got the 4, 5, I'm not
7 sure. Let me ask you this. What is your
8 understanding about Grand Strand's plans for a
9 linear accelerator?

10 A: Well, at the time we did this application, we
11 had planned to put a Varian Clinac IV or iX
12 linear accelerator as this says. In the last
13 couple of weeks, we've had discussions with
14 corporate, and we're going to put a TrueBeam in
15 because the cost of the TrueBeam has come down,
16 and we expect it to be very close to what the
17 cost of this was previously, if not slightly
18 less.

19 Q: Okay.

20 MR. LONG: Your Honor, I move to dismiss the case
21 because Mr. White has just said that they are
22 -- they've substantially changed their
23 application.

24 MR. THOMAS: They haven't, Your Honor, basically ---

25 MR. LONG: I mean, they just said right there we're

1 going to do a different machine than what we've
2 put in. We've decided we're going to put a
3 different machine in at the location. I mean,
4 he has just substantially changed the
5 application, which means that their application
6 has to be denied.

7 THE COURT: No, it doesn't, I don't think. I think
8 it ---

9 MR. THOMAS: Absolutely not, Your Honor.

10 THE COURT: It means that you can alter your --
11 well, you're right. If it substantially
12 changes the application, it has to be ---

13 MR. LONG: You've got to start over ---

14 THE COURT: --- you have to start over.

15 MR. LONG: --- it's got to either be remand or they
16 need to reapply.

17 MR. THOMAS: Your Honor ---

18 MR. LONG: They have to reapply. It's a substantial
19 change, Your Honor.

20 MR. THOMAS: Your Honor, that's a ---

21 THE COURT: Well, I have to determine if it's a
22 substantial change.

23 MR. LONG: Yes, Your Honor. And he just did it.

24 MR. THOMAS: Your Honor, substantial change goes to
25 cost. He just said he could get the cost of

1 the TrueBeam for the same thing as the Clinic
2 iX. It's ten percent of your cost of whether
3 it goes up.

4 THE COURT: Yeah, I remember that.

5 MR. THOMAS: Yeah.

6 MR. LONG: Well, Your Honor, that was your opinion

7 in that case. But I don't think there's
8 anything in the regulations or the statute.

9 It's actually a determination for the

10 Department to see whether it's a substantial

11 change or not. It should be remand. There

12 application should be remanded. This case

13 should be dismissed, their application should

14 be remanded back to the Department to be

15 considered as to whether this is a substantial

16 change or not.

17 THE COURT: Well, I deny that motion.

18 MR. THOMAS: Thank you, Your Honor.

19 THE COURT: Although, I will let you argue that

20 later on if you wish, obviously in the -- if we

21 do get to proposed orders if for some reason it

22 doesn't get dismissed for another reason. But

23 I'll let you present that argument obviously,

24 but at this point in time it's denied.

25 MR. THOMAS: Thank you.

1 MR. LONG: Thank you. We will.

2 THE COURT: So that was Anderson on the law, the ten
3 percent?

4 MR. THOMAS: That's correct, sir. And I didn't
5 think I had to cite your case, and I'm glad Mr.
6 Long remembered it.

7 Q: Mr. White, if you'd look down to page DHEC ---

8 MR. LONG: One thing, Your Honor, I'd like to raise
9 a second ground to my motion.

10 THE COURT: Okay.

11 MR. LONG: By changing the application like he just
12 did, he has now interjected a new issue in the
13 case on which there's no discovery, there's no
14 disclosure, and there's no ability for us to
15 really even respond to it here in the lawsuit,
16 so I think that's the second reason as to why
17 the matter ought to be dismissed or remanded
18 back to the Department.

19 THE COURT: I overrule that objection.

20 MR. THOMAS: Thank you, Your Honor.

21 Q: Mr. White, if you'd look down at kind of the
22 last sentence of that first full paragraph on
23 DHEC record page 7 where it starts with "the
24 location."

25 A: Uh-huh (affirmative response).

1 Q: Okay. I'd like you to just read that into the
2 record and then tell the Court a little bit
3 about that.

4 A: We're talking the beginning of the second
5 paragraph beginning "Grand Strand proposes"?

6 Q: Right where it says, The location of Grand
7 Strand's radiation therapy ---

8 A: Oh, okay. "The location of Grand Strand's
9 radiation therapy facility on its hospital
10 campus and approximate to Coastal Cancer Center
11 will enhance the continuity of cancer care in
12 the service area, and will increase convenience
13 of care for those patients receiving combined
14 chemo and radiation therapy services and
15 inpatients in need of radiation therapy
16 services."

17 Q: And do you agree with that statement, sir?

18 A: Yes.

19 Q: Okay. Was that what you've been discussing and
20 testifying about from the beginning?

21 A: That's the strategic goal, yes, sir.

22 Q: Okay. I'd like you to turn to page DHEC Record
23 8, if you would, in Joint 2 and look at the
24 second full paragraph.

25 A: Okay.

1 Q: And ---

2 MR. THOMAS: Roshel, I wonder if you can pull out
3 kind of in the middle right after where it
4 says, As the service area's largest and most
5 comprehensive, starting about right here.

6 Q: And Mr. White, can see that?

7 A: In the middle of the paragraph?

8 Q: Yeah, as the service area's largest and most
9 comprehensive.

10 A: Yeah.

11 Q: Can you read that into the record.

12 A: "As the service area's largest and most
13 comprehensive tertiary care hospital, radiation
14 therapy is the only high level service Grand
15 Strand does not currently offer residents and
16 temporary residents who live and visit the
17 service area."

18 Q: Do you agree with that statement?

19 A: Yes.

20 Q: How many temporary residents does Grand Strand
21 normally treat, if you know?

22 A: I really don't know. Our permanent population
23 is about 290,000 and counting.

24 Q: And can you go to DHEC record 57 real quickly,
25 if you'd turn to that page. This is a chart

1 that was referenced earlier in the opening, but
2 what does this chart mean to you, Mr. White?

3 A: Well, this is a chart that came out of the
4 State Health Plan, 2011 State Health Plan, that
5 was describing or listing hospitals with over
6 50,000 patient days and the number of linear
7 accelerators as of 2009 that they had in their
8 facility.

9 Q: And how many does Grand Strand obviously have?

10 A: Well, we have zero linear accelerators, and
11 again, our patient days are now 71,000, and
12 it's still zero linear accelerators.

13 Q: So is it your understanding that St. Francis
14 Downtown has been approved for a linear
15 accelerator?

16 A: My understanding, that's correct. And we're
17 the only, what I'd consider to be a large
18 hospital that's on this list that doesn't have
19 one.

20 Q: Okay. I'm sorry, I have to make you flip back.
21 If you go back to DHEC record page 9 for me.

22 A: Okay.

23 Q: Now, in terms of the project costs here on the
24 page, what can you tell the Court about the
25 project cost in general?

1 A: Well, of course the cost is done by our design
2 and construction equipment people at the
3 corporate office. You'll notice that there's
4 a \$466,000 contingency in here. We build
5 plenty of surplus into the actual cost of
6 building the project realizing that there's a
7 substantial penalty if there's a ten percent
8 change, which would be a substantial change in
9 the actual project versus the CON ---

10 MR. LONG: Objection, Your Honor. I mean, he's just
11 giving you the law. He's not qualified to do
12 that. He's giving an opinion on what the law
13 is. He just said ---

14 THE COURT: Apparently ---

15 MR. LONG: --- substantial change and put it in
16 there because of law and all ---

17 MR. THOMAS: It's what he understands as being a
18 hospital administrator the last 18 years and
19 dealing with the Department.

20 THE COURT: Well, if that's true, you need to lay
21 the foundation for why he's testifying to how
22 he's testifying.

23 MR. THOMAS: Okay. Well ---

24 THE COURT: So at this point in time, I'll sustain
25 it.

1 MR. THOMAS: Okay.

2 Q: Well, is it typical that Grand Strand builds in
3 a contingency into their project cost?

4 A: Yes.

5 Q: And why ---

6 A: Above and beyond the owner's project
7 contingency.

8 Q: Okay.

9 A: And law or not, it's common knowledge in
10 hospital administration circles, Your Honor,
11 that, you know, you better build some fat into
12 the cost because if you go more than ten
13 percent over you're going to be in trouble with
14 DHEC. I don't know how that interprets to the
15 law, but that's the practicality of how we do
16 it in a hospital setting.

17 Q: Okay. What is your understanding, if any, of
18 why Grand Strand's project costs are higher
19 than Carolina Regional Cancer Center's project
20 costs for the facility in Conway?

21 MR. LONG: Objection, Your Honor. He hasn't laid
22 any foundation about our CON application. I'd
23 also remind the Court that Mr. White's last
24 answer to Mr. Thomas' question right before
25 lunch was that he delegated all the

1 responsibility of the CON to Mr. Rudd, the
2 lawyers, and the consultants.

3 THE COURT: Any response?

4 MR. THOMAS: Yeah, my response is is that he has
5 read CRCC's CON. He's familiar with it. He
6 went to project review. I'm asking him what
7 his understanding is generally about why his
8 project as the CEO of Grand Strand and his
9 knowledge of the costs are higher than what I
10 think CRCC in Conway, Your Honor. It just
11 doesn't seem like a difficult question.

12 THE COURT: Mr. Long, I'm sorry to ---

13 MR. LONG: He's asking him for an opinion to -- he's
14 just asking him something that you would ask an
15 expert. He's just asking him to compare the
16 applications without any foundation or any sort
17 of basis as to how he would know that or what
18 he's even going to say. I think the question
19 so far ---

20 THE COURT: I overruled the previous objection.

21 I'll hear your response on that objection that
22 he's -- you're now asking for an expert opinion
23 because you're ---

24 MR. THOMAS: I'm not asking for an expert opinion,
25 Your Honor. I'm asking him why -- his

1 understanding as someone who builds projects
2 for a, literally a living as a hospital
3 administrator and the CEO and his knowledge of
4 medical project costs, of why he thinks his
5 project costs at Grand Strand are higher than
6 CRCC's. And he's certainly familiar with their
7 application and our application. And that's
8 what he's going to -- Mr. Long is going to ask
9 his clients to make other comparisons and to
10 have -- render opinions that are fact
11 witnesses, Your Honor. And if he doesn't want
12 to let any of his fact witnesses give their
13 opinion on the stand, I'm absolutely fine with
14 that.

15 MR. LONG: Your Honor, why -- I mean, it's a
16 question. It's objectionable. I made an
17 objection.

18 MR. THOMAS: And I heard you overrule it.

19 MR. LONG: The question is ---

20 THE COURT: I overruled the first, but I'm on the
21 opinion ---

22 MR. THOMAS: I'm not even sure what the second one
23 is.

24 THE COURT: He's objecting because it calls for an
25 opinion ---

1 MR. THOMAS: It doesn't call for an expert opinion,
2 though. He's the CEO of a hospital, Your
3 Honor. He does -- he told you -- talked you
4 about \$50 million they just finished up.

5 THE COURT: Well, if it's -- it doesn't call for an
6 expert opinion if it's based on his own
7 knowledge.

8 MR. THOMAS: Right.

9 MR. LONG: It kind of circles back. I don't know
10 how he has any knowledge. I mean, he hadn't --
11 all the stuff he just said hadn't -- I mean ---

12 THE COURT: Well, back to where I was again, let's
13 just -- you lay the foundation for the
14 knowledge. At this point in time, I'm going to
15 let him proceed if he lays the foundation for
16 the knowledge.

17 MR. LONG: Thank you.

18 MR. THOMAS: Okay.

19 THE COURT: If your seat gets uncomfortable again,
20 you can object again.

21 MR. LONG: Thank you, Your Honor.

22 Q: Well, let me ask you this, Mr. White. Maybe
23 it's the best way to do it. Obviously it says
24 here that the project costs are \$9.7 million.
25 Is that -- in your experience as a hospital

1 administrator, is that a reasonable price for
2 a project such as this one to be on your
3 campus?

4 A: Yes, I would say so. I mean, it's going to be
5 a first class brick facility sprinkled that
6 meets building code requirements for hospital,
7 for inpatient care. It's going to have to
8 match the other buildings on our campus, and
9 it's definitely more expensive than a modular
10 building that I saw a picture of here and
11 before that CRCC wants to put in Conway.

12 Q: Well, let me ask you this. Could Grand Strand
13 have placed a modular building on its hospital
14 campus to keep the cost down?

15 A: I suppose we could have. I think it's
16 unthinkable to believe that we would do such a
17 thing.

18 Q: Okay. Fair enough. Well, let me ask you this.
19 Do you have any reason to believe that as a
20 result of your project costs, \$9.7 million, and
21 I think you said there was a lot of contingency
22 baked into there, but do you have any reason to
23 believe that those project costs will result in
24 Grand Strand having to increase its patient
25 charges to make up for those sub-costs?

1 A: Absolutely not.

2 Q: And why not?

3 A: Well, we would believe that the revenue from
4 the services being provided in that -- in this
5 new comprehensive cancer center would be self-
6 sustaining or we wouldn't do the project more
7 than likely. And raising prices in hospitals
8 nowadays is generally not an optimal way to
9 boost revenue significantly since most payers
10 are fixed payment based on diagnosis or
11 something other than percent of charges. The
12 vast majority of charges are immaterial to what
13 you're actually getting paid.

14 Q: Okay. Would you turn over to page 18, Bates
15 page 18 in Joint Exhibit 2 of the Grand Strand
16 DHEC record.

17 A: Okay.

18 Q: Let me ask you this, did you draft -- this is
19 B-11. This is what, I think, is commonly
20 referred to as the need analysis. And let me
21 ask you, did you draft the need analysis in the
22 CON application?

23 A: No, I did not.

24 Q: Did you know who did?

25 A: Our health planner, Dan Sullivan.

1 Q: And who is Dan Sullivan?

2 A: He's a consultant. We used him when we did our
3 Certificate of Need application for the 50-bed
4 addition and the heart center that we built.
5 And, in my opinion, he's an expert. He does a
6 lot of health planning work for a lot of
7 different organizations, and he's done great
8 work for us.

9 Q: Okay. Is he familiar with Grand Strand's
10 utilization and their -- how they operate in
11 the market?

12 A: He is by virtue of conversations we've had and,
13 of course, by the assistance he gave us on the
14 50-bed project.

15 Q: And did you review the -- his work product
16 specifically that was in the CON application
17 before you signed it?

18 A: I reviewed everything in the application before
19 I signed it, not just his work. I mean, I
20 didn't do the application, but I certainly read
21 the application before I signed it and said
22 everything in it was true.

23 Q: Okay. I'd like you to turn over to page 23 for
24 me in Joint Exhibit 2, the DHEC record.

25 A: Okay.

1 Q: And if you go down to the third paragraph for
2 me, sir, it starts, Grand Strand coordinates
3 care, would you read that into the record,
4 please.

5 A: Okay. "Grand Strand coordinates care for
6 cancer patients with the medical oncologists of
7 Coastal Cancer Center, which has offices in
8 Myrtle Beach, Loris, Conway, and Murrells Inlet
9 in South Carolina as well as Supply, North
10 Carolina. Among the services Coastal Cancer
11 Center provides are chemotherapy, hormonal
12 therapy, targeted therapy, stem cell
13 transplantation, biological therapy, and
14 complementary and alternative medicine."

15 Q: Okay. Well, let me ask you this. To your
16 knowledge, and your knowledge of the market and
17 Coastal Cancer Center, is Grand Strand the only
18 hospital that coordinates cancer care with
19 Coastal Cancer Center?

20 A: No.

21 Q: Do you know what other hospitals in the area
22 they coordinate care with?

23 A: I don't know specifically of the details of how
24 they coordinate it, but it's my understanding
25 all the hospitals in the area work with Coastal

1 Cancer Center to coordinate care for their
2 patients in the facilities as best as they can
3 without radiation therapy.

4 Q: Why would Grand Strand coordinate care for
5 cancer patients with the medical oncologists;
6 why would they do that?

7 A: Well, they're the ones with the patients.
8 They're the ones with the most extensive
9 knowledge and training, and they're the ones
10 that generally direct the care of the patients
11 with cancer.

12 Q: If you turn the page to the DHEC record 24 of
13 Joint Exhibit 2 for me.

14 A: Okay.

15 Q: And read into the record, if you would, just
16 the first sentence of the second paragraph,
17 full paragraph there, or the first full
18 paragraph. I'm sorry.

19 A: "Cancer treatment can be most effective when
20 delivered in a comprehensive setting that
21 permits cancer patients to minimize travel and
22 provides for efficient and effective
23 consultation and coordination among care
24 providers."

25 Q: Okay. Go ahead and read the second sentence

1 for me, if you would.

2 A: "With the addition of radiotherapy services to
3 a new facility located on Grand Strand's campus
4 in close proximity to Coastal Cancer Center,
5 there will be a comprehensive cancer setting in
6 Horry County for the first time."

7 Q: And do you agree with that statement?

8 A: Yes.

9 Q: Is there anything you can expand upon in that
10 paragraph?

11 A: No. Again, I think that's the main piece we're
12 missing to begin the founding or foundation or
13 a comprehensive cancer center is a linear
14 accelerator, and that will give us the ability
15 to recruit cancer specialists, resident
16 surgical and medical specialists.

17 Q: Are you familiar with how many new cancer
18 patients typically undergo radiation therapy?

19 A: I can't recall.

20 Q: Do you know if it's a large number, small
21 number, if you ---

22 A: I think ---

23 MR. LONG: He said he could not recall it, Your
24 Honor. I object.

25 THE COURT: I sustain that one.

1 MR. THOMAS: Okay. That's fine, Your Honor. That's
2 why we have expert witnesses.

3 Q: And do you expect Grand Strand to become a
4 comprehensive cancer center overnight?

5 A: Absolutely not. Like I've said, it's going to
6 be -- this is the first foundation of that
7 comprehensive cancer center, and I'm sure it
8 will take a number of years before we will be
9 able to look back and say we have built a
10 comprehensive cancer center, and it's operating
11 and serving patients as such.

12 Q: How long did it take you to get the heart
13 center to where you wanted it?

14 A: It took us at least eight years to really take
15 off and do the best job that could be done, I
16 think, quality-wise and all the ancillary
17 support and to hard wire the processes to
18 optimize care for cardiac patients.

19 Q: If you'd turn over to the DHEC record page 34
20 for me.

21 A: Okay.

22 Q: These are the projections, I guess, in Exhibit
23 14 is what I want you to look at.

24 A: Okay.

25 Q: When you reviewed this, did these projections

1 seem reasonable to you?

2 A: Yes.

3 Q: Okay. Did you have any input into these
4 particular numbers in this table?

5 A: I did not. And we absolutely relied upon our
6 health planning consultant to provide this
7 data.

8 Q: And why do you rely on the health planning
9 consultant to do that?

10 A: Because he is our expert in health planning,
11 and he does it for a living, and he is well
12 accustomed to these computations and getting
13 the right data.

14 Q: Okay. How often -- I think you mentioned
15 earlier about CON applications and Mr. Sullivan
16 has worked on it. Do you typically instruct
17 your third-party health planner on how to do a
18 need analysis?

19 A: No.

20 Q: Do you have confidence here, I think if you
21 look at the -- it says, Projected Grand Strand
22 Radiotherapy Market Share. Do you have
23 confidence in Mr. Sullivan's market share
24 projections there?

25 A: Absolutely.

1 Q: And why is that?

2 A: He's an expert in what he does, and he has done
3 nothing to cause us to have anything but 100
4 percent confidence in his calculations.

5 Q: Is he familiar with the Horry County market?

6 A: Yes, sir, he is, having done our 50-bed project
7 for us before.

8 Q: Okay. Mr. White, does Grand Strand have any
9 control over where physicians in Horry County
10 can refer its patients?

11 A: No.

12 Q: Okay. Now, have you heard CRCC's assertions,
13 and I think you heard them today, that Grand
14 Strand will materially impact or adversely
15 impact its utilization at its center?

16 A: Yes.

17 Q: Well, what are your thoughts about that?

18 A: Well, I think it's incredulous to think that we
19 would go from no radiation treatments,
20 radiation therapy treatments in our hospital to
21 what they believe would put us as the largest
22 single unit provider of treatments in the state
23 of South Carolina in just a couple of years if
24 we were to have a comprehensive cancer center
25 in our hospital that includes linear

1 accelerators. It's unthinkable to me how we
2 could go from zero to a phenomenal volume that
3 I'm not sure from a capacity perspective we
4 could even handle.

5 Q: Let me ask you this. Do you expect physicians
6 who are not on Grand Strand's medical staff to
7 refer patients to Grand Strand's radiation
8 therapy center?

9 A: I wouldn't count on them. I mean, I would have
10 no reason to think that they would refer to
11 Grand Strand, particularly if they were not on
12 our medical staff, you know, unless patient
13 preferred our hospital because of other
14 services they received or some other
15 extenuating, unusual circumstances that might
16 cause that to occur. Normally, it doesn't
17 happen. If they're not on our staff, we don't
18 get hardly any referrals for other services.

19 Q: And again, I apologize if I asked you this, but
20 what about physicians on your medical staff
21 that are not employed, are they in any way
22 required or incentivized to refer patients to
23 Grand Strand's ---

24 A: Absolutely not.

25 Q: --- outpatient program?

1 A: No, they're not. They're not. They're not
2 required. And by law, as you know, we can't
3 induce them or entice them to refer patients
4 with any sort of remuneration or incentive to
5 refer.

6 Q: Okay. Let me ask you this. There's some pro
7 formas that come in that are in the
8 application. Did you have anything to do with
9 financial pro formas in the CON application?

10 A: Other than review them, no.

11 Q: Do they appear reasonable to you when you
12 reviewed them?

13 A: Yes.

14 Q: Okay. And I think what I'm going to ask you to
15 do is just turn over to -- unless it's in the
16 back here. It's the DHEC decision letter.
17 I'll give you a page number if you give me one
18 second. Here we go. Go to 9 -- the Grand
19 Stand portion is on page Bates labeled 937, Mr.
20 White.

21 A: All right.

22 Q: Did you have an opportunity to review DHEC's
23 decision letter, I guess, from the time it came
24 out?

25 A: Yes.

1 Q: What were your thoughts about DHEC's decision
2 to deny Grand Strand a linear accelerator?

3 A: Well, I'd have to sit here and re-review it to
4 know how I felt about their comments related to
5 our application. I was more focused on the
6 fact that they -- that DHEC had chosen to
7 approve a center -- I mean, a linac to be done
8 over in Conway and not give what I felt to be
9 good consideration to our desire to offer this
10 service on the hospital campus.

11 Q: Okay. That's fine. I mean, that's generally
12 what I was asking you, your thoughts.

13 A: Okay.

14 Q: Based on your interaction with Coastal Cancer
15 Center, do you expect that practice to favor
16 Grand Strand over other providers like CRCC and
17 GMH?

18 A: No.

19 Q: I want to show you something, and I think we've
20 got a notebook over here, it's Respondent
21 Number 11.

22 MR. THOMAS: And it's 11, page 51, Roshel, that's in
23 terms of our identification. And it's Tolbert
24 12895, which is where we're going to go in the
25 document itself. And yeah, okay, we're there.

1 Q: And, Mr. White, I'm just going to ask you a
2 couple questions about this. This is an
3 exhibit referral analysis that CRCC did,
4 identification Respondent's Number 11, when
5 they made a determination of where certain
6 physicians may decide to refer their ---

7 MR. LONG: Objection, Your Honor, he needs to ask --
8 he needs to do it properly. He needs to ask
9 him if he knows anything about the document; if
10 he knows what it is. He doesn't need to
11 educate him on what the document is. If he
12 says he doesn't know anything about it, he
13 might be able to ask him a question, but he
14 really can't ask him questions about the
15 document. I mean, he needs to ---

16 THE COURT: Interesting because, normally, I would
17 sustain that objection because he can't ask
18 about anything until it's in the record. Y'all
19 have got this Federal rule thing going on here.
20 But I guess by making your objection it's not
21 in the record.

22 MR. LONG: No, Your Honor, it is in the record. I'm
23 not objecting to the document. I'm objecting
24 to him asking a question that basically is a
25 leading, compound question that educates the

1 witness ---

2 THE COURT: About ---

3 MR. LONG: --- on the document. That's my

4 objection.

5 MR. THOMAS: Here's what I'm getting at, Your Honor

6 ---

7 MR. LONG: He's just asking him ---

8 THE COURT: He can publish the document.

9 MR. LONG: He can ask him to read it, but he's

10 putting in the record now his characterization

11 of what it is.

12 THE COURT: Well, I missed that point.

13 MR. THOMAS: I'm not. What I'm doing is I

14 identified, okay, I got this document, I was

15 able to depose their expert about this document

16 yesterday, so I'm identifying it for Mr. White

17 in the record, and then I'm going to ask him

18 some questions about what it -- you know, about

19 some of the names of these physicians.

20 THE COURT: If that's what he's doing, I'll let him

21 proceed.

22 MR. LONG: Okay.

23 THE COURT: And I missed the point that you were

24 making too when I heard his question.

25 MR. LONG: Thank you, Your Honor.

1 Q: So, Mr. White, this is the document that CRCC's
2 expert indicated they did a referral analysis,
3 okay, and where these physicians may refer if
4 Grand Strand gets a linear accelerator and
5 that's -- I mean, a linear accelerator machine.
6 What I'm going to ask you is just a couple
7 questions about the names within the documents.
8 And I'd like you to go down where it says
9 number four, it says GS committed. Do you see
10 that in the left-hand column?

11 A: Yes.

12 Q: Okay. Do you know who Anand K. Sharma is?

13 A: Never heard of him.

14 Q: Okay. In fact, do you know it's a he?

15 A: Or her, I'm sorry. No, I don't know if it's a
16 he or a she.

17 Q: Do you know who Dr. Joseph Jenrette is?

18 A: Can't -- no, I don't.

19 Q: Okay. I'd like you to turn the page over for
20 me to Tolbert 12896.

21 THE COURT: What was that last name?

22 MR. THOMAS: Oh, I'm sorry. Jenrette. And for the
23 record, Your Honor, it's Joseph N. Jenrette, J-
24 E-N-R-E-T-T-E.

25 THE COURT: All right.

1 Q: Are you on the next page?

2 A: Yes, sir.

3 Q: Mr. White, do you see something that say 8-

4 Other-Support CRCC GS and Ford. For the

5 record, I believe that means Francis Ford

6 Cancer Center.

7 A: Okay.

8 Q: And there's a couple pages. And I want you to

9 take, just take a couple seconds and go down

10 that line there and see if you recognize the

11 names of any of those doctors, those referral

12 sources to CRCC?

13 A: Let's see.

14 Q: If any of them show ---

15 A: No, I'll just go down and if I see any I

16 recognize ---

17 Q: Yes.

18 A: --- sing them out.

19 Q: That's fine.

20 A: Okay. Belcher, Benjamin, Benz ---

21 Q: And you don't even have to call them out. When

22 you recognize one, that's the name I want you

23 to call out.

24 A: Okay. Belcher.

25 Q: Okay.

1 A: Benjamin.

2 Q: Good.

3 A: Benz, Bondy, Botse, Butler, Chambers, Cornnell,
4 Cozart, Dargan, De Grood, Devenyi, Ellis,
5 Epperson, Goh, G-O-H, Gordon, Grubb.

6 Q: Let me stop you there at Grubb. How many of
7 those were just on Grand Strand's medical
8 staff?

9 A: I'd have to go back and look.

10 Q: So that's not an analysis you've done?

11 A: No.

12 Q: Okay. Were a lot of them of Grand Strand's
13 medical staff; do you know?

14 A: A lot? What do you mean?

15 Q: Well, of the names that you were calling out,
16 were any of them on Grand Strand's medical
17 staff?

18 A: Some are; some aren't.

19 Q: Okay. And do you know what other medical
20 staffs the ones that aren't are on?

21 A: You've got to ask that again.

22 Q: The ones that you said that were not on the
23 medical staff, do you know which medical staffs
24 those physicians are on?

25 A: Some I do; most I don't.

1 Q: Okay. That's fine. All right. In terms of --
2 I want you to go back to 12895 for me.
3 A: Okay.
4 Q: And look at the first category, AUC CRCC. It
5 says 100 percent to CRCC.
6 A: Uh-huh (affirmative response).
7 Q: Are all of those physicians members of Grand
8 Strand's medical staff?
9 A: No.
10 Q: Okay. Do you know which ones they are? And
11 first of all, what does AUC stand for?
12 A: Atlantic Urology Clinic.
13 Q: And can you -- can you go down and identify the
14 doctors on that list that are on the Grand
15 Strand Medical staff?
16 A: It may not be perfect, but with 98 percent
17 confidence I can say, Bogache, Krzyzaniak,
18 Roberts, Shore, are all on our medical staff.
19 Q: All right. And in terms of number four, GS
20 Committed, I know one of these, I think it's
21 Anand Sharma, you didn't recognize that
22 person's name.
23 A: No.
24 Q: Do you recognize the other names there?
25 A: I don't know who Harper is.

1 Q: Okay.

2 A: The other three I do recognize.

3 Q: Okay. And the other three, let's see if we can
4 see here. I'm having problems reading this
5 print myself. The other three if I pull it up
6 on the -- there's a grand total category on the
7 far right-hand side. How about Giddens,
8 Borowicz, and Anderson, are any of those
9 doctors employed by Grand Strand?

10 A: Anderson and Giddens are employed
11 neurosurgeons.

12 Q: Okay. Those are the employed neurosurgeons.
13 So they account, if we go to the far right-hand
14 column, they account for eight treatment plans,
15 correct? Am I looking at that right?

16 A: Yeah.

17 Q: Okay. Any of these other doctors -- those
18 doctors I had you to name in the other
19 category, were any of those employed doctors?

20 A: I'd have to look again.

21 Q: Okay. I'm sorry. I should have asked you the
22 first time.

23 A: Benjamin.

24 Q: And what kind of doctor is he?

25 A: Neurologist.

1 Q: Okay.

2 A: Let's see.

3 Q: Had y'all -- did Grand Strand employ a
4 neurology group?

5 A: You've got to let me finish.

6 Q: Okay.

7 A: Let's see, Benjamin, he's the only one on that
8 page that's employed, I'm pretty sure.

9 Q: Okay. And I'm saying ---

10 A: I'm sorry.

11 Q: --- for the record, he did one treatment plan.

12 Okay. And could you ---

13 A: What was the other question?

14 Q: I'm sorry. It looks like if I look at
15 Benjamin, the neurologist, and pull it all the
16 way over, he did, it looks like, one treatment
17 plan on the far right-hand corner?

18 A: Yes.

19 Q: I know it's difficult to read.

20 A: Yes. Yes.

21 Q: And on the second page of Tolbert 12897, if you
22 would just turn to that one.

23 A: Okay.

24 Q: Can you go through and see if there are any
25 employed physicians there?

1 A: Dr. Hoang, the first line, was employed, but
2 he's been gone quite a while.

3 Q: Okay. So no longer with Grand Strand?

4 A: Karcic, same thing, he's been gone a long time.

5 Q: Okay.

6 A: McIntyre is an employed CV -- cardiovascular
7 surgeon.

8 Q: And for the record, one treatment plan,
9 correct?

10 A: Yes. And I don't see any other employed docs
11 on there.

12 Q: Okay. And the top five names on the next page?

13 A: None of those are employed.

14 Q: Okay. On the other list that you read, you
15 read about the first names ---

16 A: What page?

17 Q: On 12896.

18 A: Okay.

19 Q: Can you think of any reason these physicians
20 would abandon CRCC and just start referring 40
21 percent of their patients to Grand Strand if
22 Grand Strand were approved for a linear
23 accelerator?

24 A: I cannot imagine why any of them would, nor
25 would I anticipate them abandoning CRCC.

1 Q: Okay. Let me ask you this. How does Grand
2 Strand intend to reach its utilization goals
3 that's set forth in the CON application?

4 A: Well, I'd like to figure out Dr. Francke's
5 secret for improving provider relations if it
6 means anything other than employing them and
7 giving them a financial incentive to refer.
8 But more realistically, I would expect that
9 it's the old fashioned way of, number one,
10 providing a high quality service, giving them
11 input into aspects of the service that those
12 physicians might be involved in, going out and
13 marketing the product or the service line to
14 potential referral sources that we have good
15 reason to believe might be in a position to
16 refer patients to us, market to the public and
17 encourage them to -- give better understanding
18 of our plans for a comprehensive cancer center
19 and how the care would be enhanced if they need
20 to be in the hospital or need to have other
21 therapy or diagnostics done that are available
22 in the hospital, you know, the advantage of
23 doing it under one roof.

24 Q: Let me ask you this, that all those kind of
25 efforts that you talked about, are those

1 efforts that only Grand Strand can undertake in
2 the market?

3 A: I think any hospital should do it and, you
4 know, CRCC has done a pretty good job over the
5 years with marketing their services and they've
6 got a good product.

7 Q: Let me ask you this. At one point did you --
8 was there a consideration for opposing
9 Georgetown's relocation to Murrells Inlet?

10 A: We briefly considered it. I don't remember the
11 details as to why, but we elected to not oppose
12 it.

13 Q: Let me see what notebook you have over here.
14 Why don't you go to Respondent's 79. It's the
15 last one in this notebook, Mr. White.

16 A: Okay. Okay.

17 Q: Can you just identify the document for the
18 record?

19 A: That's the 2012 Business Plan for Grand Strand
20 Regional Medical Center that I'm sure we did in
21 early -- or I mean late 2011.

22 Q: And would you have had input into this
23 document?

24 A: Yes, sir.

25 Q: Would you have reviewed it?

1 A: Absolutely.

2 Q: And is this something y'all present to anyone?

3 A: We present it to our -- my supervisor or boss
4 down in Charleston, Jamie Thomas. We also
5 provide an overview to managers and to our
6 board of trustees.

7 Q: Okay. Would you turn over to page, it looks
8 like it's going to be Grand Strand Regional
9 Medical Center Bates 3194.

10 A: Okay.

11 Q: All right. There's a section here that says
12 oncology under 2012 Action Plans. Would you
13 read those bullets into the record.

14 A: It says Linear Accelerator CON application July
15 -- or excuse me, submitted July 2011. Open new
16 linear accelerator program with support from
17 local medical oncologists. Partner with Sarah
18 Cannon Center and developing inpatient cancer
19 center protocols; and determine feasibility of
20 GYN/oncology recruitment.

21 Q: Okay. And of these, let me ask you about that
22 third bullet point there. What is Sarah Cannon
23 Center?

24 A: Sarah Cannon Center is a comprehensive cancer
25 center that HCA is either part owners or full

1 owners of, I'm not sure which, in Nashville.
2 They provide a lot of information and research
3 and analysis for clinical protocols surrounding
4 care of cancer patients to HCA facilities and
5 non-HCA facilities alike. It's a well known
6 cancer center sort of like MD Anderson down in
7 Houston.

8 Q: Is that a resource for Grand Strand?

9 A: Very much so, yes, for cancer care.

10 Q: All right. And I'm interested in the last
11 bullet too, determine feasibility of GYN/ONC
12 recruitment. What does that mean?

13 A: Well, it's a trained gynecologic surgeon who
14 specializes in cancer care for women. And the
15 recruitment of one is really something a
16 hospital has to carefully approach, primarily
17 because it takes a large population base to
18 support a GYN/ONC surgeon because they are
19 fairly difficult to recruit, they make a
20 relatively high income and need a good base of
21 patients. Without a comprehensive cancer
22 center, or at least the promise of one
23 developing within a facility, it would be very,
24 very difficult to attract a good quality
25 gyn/oncology surgeon. But nevertheless, that's

1 in our plans going forward as we develop the
2 center.

3 Q: Have you started on that process of recruiting
4 the gyn/oncologist?

5 A: No, have never -- never talked to a candidate
6 and never had a head hunter looking for one.

7 Q: You're waiting for the -- for the approval of
8 a linac to do it?

9 A: Correct.

10 Q: Okay. At one point, did Grand Strand send
11 inpatients in need of radiation therapy to
12 CRCC?

13 A: For years. For decades we did.

14 Q: Do you recall generally when the hospital
15 stopped that process?

16 A: Early this year; I believe it was January.

17 Q: Okay. And can you -- can you explain why the
18 hospital decided to stop sending inpatients to
19 CRCC?

20 A: Sure, two reasons. First of all, when we
21 realized that CRCC and 21st Century were
22 ardently opposing our efforts to develop a
23 linear accelerator program, at the same time
24 expecting us to continue having patients that
25 physicians were ordering radiation therapy for

1 who were inpatients in the hospital for a
2 different reason other than their primary
3 cancer diagnosis in most cases, we were putting
4 them in an ambulance, ten-minute ambulance ride
5 down to the Carolina Regional Cancer Center,
6 taking them off the -- out of the ambulance,
7 off the stretcher, onto the linac, have a
8 treatment, back on the stretcher, back in the
9 ambulance, ten-minute ride back, out of the
10 ambulance, in the hall elevator, upstairs, back
11 in the bed. Number one, it seemed extremely
12 stupid of the hospital to be sending patients
13 and paying for the care of those patients to an
14 entity who was obviously committed to keeping
15 us from being able to provide that service in
16 our hospital to these same patients. So just
17 at a gut level, there seemed something
18 terribly, terribly irrational and wrong about
19 doing it. And the decision was made for the
20 care of the patient and to ensure that they are
21 going to get the optimal care they need for
22 whatever diagnosis they've got in a hospital,
23 and if they needed radiation therapy, that the
24 attending physicians or admitting physicians
25 needed to consider that before they put them in

1 the hospital and send them to a hospital that
2 offered linear accelerator services as an
3 inpatient service if they thought the patient
4 was going to need inpatient radiation therapy.

5 Q: Well, if the hospital had decided to locate the
6 radiation therapy center on Dr. Holt's
7 property, what would that have meant for those
8 inpatients?

9 A: Well, it would have meant a much, much, much
10 shorter ambulance ride. It still would not be
11 optimal for the care of those patients because
12 they'd still have to do the stretcher ride,
13 ambulance, off onto the table. Again, the Dr.
14 Holt location was never given any real serious
15 consideration as a site for us to build this
16 linear accelerator, and to be perfectly frank,
17 I don't think I recall a whole lot of
18 conversation about inpatients and, you know,
19 the advantage of going over there versus going
20 to CRCC. It would still not be optimal, but it
21 would be a much shorter ambulance ride and an
22 easier process.

23 Q: Well, by virtue of putting in the hospital,
24 that's not even an option, correct?

25 A: That's correct.

1 Q: Mr. White, can you explain just kind of
2 generally to the Court while Grand Strand
3 should prevail over CRCC if the Court is not a
4 obliged to approve two linear accelerators that
5 have been identified in the State Health Plan?

6 A: Well, I would hope that the Court would
7 consider the fact that, number one, CRCC does
8 have a monopoly and has had a monopoly in Horry
9 County, granted not the planning area but in
10 Horry County, for 30 plus years for linear
11 accelerator services. Number two, our data
12 clearly shows that it would not have the
13 significant adverse impact on the volume of
14 services provided by CRCC. The ability of the
15 hospital to ever add linear accelerator
16 radiation therapy services to our complement of
17 services as a tertiary facility is absolutely
18 dead in the water if we don't have a linear
19 accelerator in the facility. I wish that the
20 Health Plan differentiated between
21 freestanding, high profit margin, physician
22 owned, physician incentivized radiation therapy
23 centers versus a hospital comprehensive care
24 cancer care center linear accelerator, but it
25 doesn't. But in my mind, they're night and

1 day. They're two very different operations.
2 This is going to enable us to have the services
3 that we hear about daily in the hospital,
4 patients going to MUSC for, going to Duke for,
5 going to Hollings Cancer Center, like my next-
6 door neighbor did as he did of melanoma,
7 because we don't have all the services
8 available under one roof to care for those
9 patients. Specialists, equipment, technology,
10 expertise, ancillary services, research, a
11 number of -- a number of things that are there
12 for the -- for the making if we can get this
13 basic building block started. And I would just
14 implore the Court to consider that, you know,
15 it's a -- it's a very, very much needed new
16 service in Horry County, and the fact that
17 Georgetown has one next to their hospital in
18 Georgetown and is going to move it up to
19 Waccamaw Hospital a half mile from where DHEC
20 has approved CRCC to have one, is not a factor.
21 I mean, it may be in the Health Plan, but in
22 reality, it's not a factor as to why we would
23 want to build one on our campus to offer this
24 service to our residents.

25 Q: Thank you very much, Mr. White. Please answer

1 any questions that Mr. Long has for you.

2 A: Okay.

3 MR. LONG: Can we take a short break then before we
4 begin?

5 THE COURT: We may.

6 (Break from 2:46 p.m. until 2:55 p.m.)

7 MR. LONG: Your Honor, if it pleases the Court.

8 THE COURT: Go ahead.

9 MR. LONG: Are we back on the record?

10 MR. WHITE - CROSS-EXAMINATION BY MR. LONG:

11 Q: Mr. White, I'm Jimmy Long. We met at your
12 deposition back in the summer. Now, you've
13 been the CEO at HCA for 22 years, right?
14 You've been a CEO at the hospital there for 22
15 years, right?

16 A: No, sir, I've been here 18 and a half years.

17 Q: At HCA? You were a CEO before you came to
18 Grand Strand too, right?

19 A: Yes, I'll need to -- if you give me a minute,
20 I'll have to count how many years I was CEO in
21 Florida.

22 Q: I think you told me it was '91 to '95.

23 A: That's right, four -- so that's 22 plus years,
24 yes, sir.

25 Q: And then you've been at Grand Strand since

1 1995, so almost 18 years? A little over 18
2 years, right?

3 A: Uh-huh (affirmative response).

4 Q: Now, neither one of those hospitals that you
5 were the CEO had radiation therapy, right?

6 A: Correct.

7 Q: And all during the time that you've been at
8 Grand Strand, there have been applications
9 filed for linear accelerators, but Grand Strand
10 has never applied for a linear accelerator
11 before this application, correct?

12 A: The second part of your question I'll say
13 correct. I can't attest to there have been
14 other applications for linear accelerators
15 because we haven't been involved in it.

16 Q: Well, you certainly recall the linear
17 accelerator application litigation that
18 involved Dr. Bass and the urologists several
19 years ago, right?

20 A: No, sir.

21 Q: You don't recall anything about that?

22 A: I recall them having litigation. I was unaware
23 of who filed the application and who contested
24 or what the nuts and bolts of that were.

25 Q: Aren't you aware that there was animosity

1 between the urologists in Horry County and Dr.
2 Bass over the litigation over a linear
3 accelerator?

4 A: Yes.

5 Q: You're aware of that, right?

6 A: Yes, sir.

7 Q: And you've actually personally witnessed the
8 animosity between the urologists and Dr. Bass?
9 You saw it yourself, didn't you?

10 A: I saw the -- I heard and saw the animosity
11 expressed by the urologists, and I heard and
12 saw it from Dr. Bass on occasion.

13 Q: And you yourself have categorized that
14 relationship between the urologists and Dr.
15 Bass as nasty?

16 A: Nasty's a good description.

17 Q: And it is not good, is it, for the patients and
18 the community for the physicians to have a poor
19 relationship as nasty, is it? That's not good
20 for patients, is it?

21 A: It's not necessarily bad for patients. There's
22 a lot of nasty relationships existing in every
23 medical community in the country, I would
24 think.

25 Q: And you think that's ---

1 A: And where patients may not be impacted.

2 Q: And you think it has no impact on patients?

3 A: I didn't say that. You said it's not good for
4 patients, and I'm not going to categorize every
5 nasty relationship as being bad for patients.

6 Q: Do you think the relationship between the
7 urologists and Dr. Bass was good for the
8 patients in Horry -- in Horry and Georgetown
9 Counties?

10 A: No.

11 Q: All right. Let me ask you a couple of quick
12 questions about the CON application that you
13 testified about. You delegated all the
14 responsibility for the preparation of the CON,
15 right?

16 A: Correct.

17 Q: So you didn't have anything to do with the
18 length -- the choice of the machine, did you?

19 A: No.

20 Q: You didn't talk to anybody at the Sarah Cancer
21 Center -- I mean Sarah Cannon Center in
22 Nashville, right?

23 A: Not once.

24 Q: Do you know who Sarah Cannon is?

25 A: No.

1 Q: Mr. Mullins just told me. It's Minnie Pearl.
2 A: No, really?
3 Q: It is.
4 A: My Mom's from Nashville. I should know that.
5 Q: You thought you didn't know that. Okay.
6 A: Please don't let my the Court tell my Mom.
7 She'll be devastated. I didn't know that.
8 Q: There's been no work -- you didn't do -- you
9 delegated the need analysis, right?
10 A: Yes, sir.
11 Q: As a matter of fact, in your deposition, you
12 weren't sure if you'd ever even met Dan
13 Sullivan, were you?
14 A: At the time I was not sure, but when I saw him
15 yesterday, I was -- I had met Dan before on a
16 couple different occasions.
17 Q: But you didn't recall that in January -- in
18 July, I'm sorry, or June.
19 A: I sure didn't.
20 Q: You had nothing -- you had no role with the
21 financial projections, right?
22 A: Correct.
23 Q: You delegated the capital asset management tool
24 that y'all have internally, right?
25 A: Yes, sir.

1 Q: And also the request for capital documents,
2 correct?

3 A: No, sir. I reviewed all those documents, but
4 I did not prepare them and I delegated the
5 preparation.

6 Q: And let me talk about what those are. The
7 certificate of need application is prepared and
8 filed for DHEC, right?

9 A: Yes, sir.

10 Q: That's a public document that's read by your
11 competitors and other people; anybody can get
12 access to it, right?

13 A: That's my understanding.

14 Q: Internally at HCA and HCA, of course, owns
15 Grand Strand, right?

16 A: Yes, sir.

17 Q: Internally at HCA, y'all prepare a document you
18 call a CAM, Capital Asset Management tool.
19 It's an Excel spreadsheet that contains a lot
20 of financial information and projections about
21 the project, right?

22 A: I don't even know what an Excel spreadsheet is.
23 Never have done one and wouldn't know an Excel
24 from an inale spreadsheet.

25 Q: But you've seen at a CAM before, right?

- 1 A: I've seen the printout where it shows internal
2 rate of return on the front lower part of the
3 page.
- 4 Q: And contains a lot of financial information ---
- 5 A: Yes, sir.
- 6 Q: --- projections and things like that, right?
- 7 A: Correct. For multiple years.
- 8 Q: For multiple years in the future; it's part of
9 the projection for the project?
- 10 A: Correct.
- 11 Q: There's also a second document that you prepare
12 internally that ties to the CAM, and that's
13 called a Request for Capital, right?
- 14 A: Okay.
- 15 Q: You've seen that before?
- 16 A: Yes, sir.
- 17 Q: And it's a Word document. In other words, it's
18 in narrative form? It has questions and
19 answers, right?
- 20 A: Okay.
- 21 Q: You've seen that?
- 22 A: Would not recognize one if you put one beside
23 a fake, but I'm generally familiar with
24 reviewing them once they're done.
- 25 Q: And those documents have to prepared at the

1 hospital and submitted to -- at the division
2 level and at the group level before a project,
3 a capital project can be approved, right?

4 A: Yes. Yes, sir.

5 Q: And that would certainly be the case on a
6 project that was as expensive as this project?

7 A: Yes, sir. I don't know the dollar limit, but
8 for this one, absolutely.

9 Q: And let me -- let's go over a couple of the
10 people who when we look at some of these emails
11 and stuff later so we know who they are. At
12 the hospital level at Grand Strand, you are the
13 CEO, right?

14 A: Uh-huh (affirmative response). Yes.

15 Q: And Adam Rudd, who is here in the courtroom
16 today, is your chief operating officer, right?

17 A: Correct.

18 Q: Okay. And Robert Grace, who will be here
19 tomorrow, is your chief financial officer?

20 A: Yes, sir.

21 Q: And the three of y'all have the basic
22 management positions at Grand Strand, right?

23 A: In addition to a chief nursing officer, and
24 that position is vacant right now. We have an
25 interim non-corporate person in that role.

1 Q: All right. Now, t the next level up, the
2 person you report to is a gentleman named Jamie
3 Thomas, right?

4 A: Yes, sir.

5 Q: And at that level is what y'all call the
6 division level, and in this area of the
7 country, the division is South Carolina and
8 Jacksonville, right?

9 A: Yes, sir.

10 Q: And at that level, Jamie Thomas is the head of
11 the division, right?

12 A: Yes, sir.

13 Q: And then there's also a CFO person there who
14 during this process was Rodney VanPelt, right?

15 A: Correct. Yes, sir.

16 Q: So Rodney VanPelt and Jamie Thomas are at the
17 division level. Their offices are actually in
18 Charleston?

19 A: Correct.

20 Q: And they're responsible and you report directly
21 to them?

22 A: Yes, sir.

23 Q: And then they report at the group level, and
24 the key players there that were involved in
25 this project are a man named Chuck Hall, who is

1 the group president, right?

2 A: Yes, sir. Yes, sir.

3 Q: The chief financial officer at the group level
4 is a man named Mike Marks, right?

5 A: Yes, sir.

6 Q: And then there was a controller named Jerry
7 Rooker?

8 A: Jerry -- yes, sir.

9 Q: Jerry Rooker. And so those three individuals
10 are in Nashville at that level. I think
11 Rooker's moved to a different position or
12 whatever, but at this time he was the
13 controller?

14 A: I'm not sure. I'm not sure about that, but he
15 was the controller then.

16 Q: All right. So you delegated the preparation of
17 the CAM and the Request for Capital documents
18 to be sent to the people -- to the division
19 office and then on -- would all -- go on to
20 Nashville to get this project approved, right?

21 A: No, sir. I did not delegate them to be sent.
22 I delegated them to be prepared. I reviewed
23 them prior to them being sent.

24 Q: Okay. All right. Now, the narrative portion
25 of the application, you did not draft it,

1 right?

2 A: No, sir.

3 Q: Who actually compiled all the information that
4 goes in a CON application; do you know?

5 A: The financial information was compiled by
6 Robert Grace. I'm not sure what degree of
7 assistance he had from our consultant, Dan.
8 Adam Rudd did the vast majority of the data
9 gathering inside the hospital and had to rely
10 upon design and construction at the corporate
11 office, the equipment people at the corporate
12 office, telecommunications people, IT people
13 at the corporate office and relied upon Dan
14 Sullivan as well for detailed information
15 regarding projected demand and need and that
16 sort of thing.

17 Q: And Mr. Thomas was involved too, right? Will
18 Thomas, the lawyer?

19 A: Involved in what?

20 Q: The preparation of the CON.

21 A: At some ---

22 MR. THOMAS: Objection, Your Honor. He's calling --
23 I just don't want him to get into
24 attorney/client privilege

25 MR. LONG: I didn't ask him for attorney/client, Your

1 Honor.

2 A: I could not be ---

3 THE COURT: Hold on a second.

4 MR. WHITE: I'm sorry.

5 THE COURT: Let me rule on that. I overrule it just

6 on the general question he's asked now, but if

7 he goes any further, I'll sustain it.

8 A: He was involved in it, yes. To what degree, I

9 can't recall because so much of the actual

10 groundwork was done by other people other than

11 me, but I know Will was involved.

12 Q: Now let me go back and follow up on a couple of

13 questions I just asked you about the

14 relationship between the urologists and Dr..

15 Bass and their history.

16 A: Okay.

17 Q: In 2010, when 21st Century acquired Dr. Bass'

18 practice in 2010, within a short period of time

19 thereafter he retired, didn't he?

20 A: Yes, sir.

21 Q: So he no longer practices in Horry County,

22 correct?

23 A: To the best of my knowledge, he does not.

24 Q: And the nastiness that you saw was between the

25 urologists and Dr. Bass right? It was personal

1 between them, wasn't it?

2 A: I would have to categorize it as being nasty,
3 and to what level it was personal versus
4 business, I couldn't be the judge.

5 Q: Okay.

6 A: I don't think one of them would've helped the
7 other on the side of the road on a rainy
8 night.

9 Q: Okay. That's a good way to describe it. All
10 right. Let's talk a little bit about your
11 personal and your hospital's history with the
12 CON program, okay?

13 A: Okay.

14 Q: Now, you would certainly agree that it's
15 important for the Department to deny CON
16 applications that are not needed, isn't it?

17 A: Yes, sir.

18 Q: And your hospital has certainly taken that
19 position if you felt the Department approved an
20 application that was not warranted, haven't
21 you?

22 A: Yes, sir.

23 Q: You've opposed Georgetown's attempt to get open
24 heart surgery, their application, right?

25 A: Yes, sir.

1 Q: And you're the only open heart provider in
2 Georgetown or really in that whole little area
3 of the state until you get to Florence, right?

4 A: Yes, sir.

5 Q: Okay. And you think that caused a -- and don't
6 you believe that causes you to have a higher
7 quality facility to have that monopoly in that
8 area?

9 A: Absolutely. Just like you did when you
10 represented Providence to try to keep Lexington
11 from getting open heart surgery.

12 Q: That's correct. Now, do you -- you also were
13 involved in litigation in this courtroom when
14 you testified here, not in this courtroom,
15 maybe down the hall a little bit, when Loris
16 Hospital tried to open Seacoast Hospital in
17 Little River, right?

18 A: Sure. Certainly did.

19 Q: Okay. And in your deposition, you described
20 Loris Hospital to me as a hospital of mediocre
21 quality, low volume, lacking in any specialty
22 care with no notable reputation that has
23 financially struggled for years; do you recall
24 telling me that?

25 A: No, sir, but I would say it again.

1 Q: You don't disagree with any of those
2 descriptions, do you?

3 A: I certainly don't.

4 Q: Okay. And Loris is located in the worst payer
5 mix in Horry County, isn't it?

6 A: I haven't looked at the payer mix in Loris, but
7 it's a relatively poor part of the county.

8 Q: Okay. And Little River is a more wealthy part
9 of the county, isn't it?

10 A: Hence the reason they wanted to have a facility
11 over there.

12 Q: Right. But Grand Strand does get patients from
13 Little river, don't they?

14 A: Yes, sir.

15 Q: Okay.

16 A: As a matter of fact, we get more patients from
17 Little River now than we did before the
18 hospital, that Seacoast was built.

19 Q: And so you opposed that hospital at Seacoast
20 even after the Department had approved it,
21 right?

22 A: Absolutely.

23 Q: And one of the reasons that you opposed it is
24 because you thought it would have an adverse
25 impact on Grand Strand?

1 A: That was one of the reasons. Other than it not
2 being necessary, which it's proven to be true;
3 it wasn't necessary.

4 Q: And going back to the payer mix, Loris is one
5 of the poorer areas of the county. It's one of
6 the worst payer mixes. Now ---

7 A: Yes, sir..

8 Q: You agree with that. And when we talk about
9 payer mix, what we're talking about is the
10 people who live there's ability to pay for
11 healthcare services, right?

12 A: Not only the people that live there, but the
13 people who visit there, which not very many
14 oceanfront hotels in Loris get visited.

15 Q: Good point.

16 A: So generally speaking, it's poor agricultural,
17 low-end manufacturing, Medicaid, Medicare
18 population.

19 Q: And people who live in poorer areas of South
20 Carolina tend to be people who may not have
21 insurance, right?

22 A: They tend to have a higher Medicaid proportion
23 of the population, but I would say that would
24 be -- I can't really speak to that. We have a
25 huge amount of working poor with no insurance

1 in Myrtle Beach, people who have cell phones
2 and drive nice cars that come to our hospital
3 that don't have any insurance who are poor --
4 poor insurance ---

5 Q: Mr. White, I just want to -- I'm just going to
6 ask you, maybe I'll just ask you to describe it
7 in your words. What does payer mix mean?

8 A: Payer mix means as a total percent of one's
9 patient population, what portion is covered by
10 what type of -- certain types of insurance,
11 Medicare, Medicaid, Champus, commercial
12 insurance, VA insurance, no insurance, and we
13 even break down those with no insurance into
14 bad debt versus charity via an application that
15 assesses their ability to pay even if they
16 don't have insurance.

17 Q: And if someone has a better payer mix or an
18 area has a better payer mix than another area,
19 it's because the people who live there tend to
20 have better either insurance coverage or access
21 to ability to pay for healthcare, right?

22 A: And the people who visit there.

23 Q: And as you told me in your deposition, Loris is
24 probably the worst, but Myrtle Beach is the
25 best, right, payer mix?

1 A: Yes, sir.

2 Q: Now, when these applications were going through
3 the review process, you expected the Department
4 to only prove -- to approve only one, didn't
5 you? That's what you expected?

6 A: Initially that's what I expected until we
7 started seeing the data and the draft State
8 Health Plan coming out for the new plan which
9 indeed showed that there was going to be a need
10 for two. But initially, you're correct.

11 Q: And you have -- the reason that Grand Strand
12 has not dropped this lawsuit and applied under
13 the new health plan for a linear accelerator is
14 because you think that CRCC may apply also;
15 isn't that right? Isn't that what you told me
16 in your deposition?

17 A: If you say I said it, I'm sure I said it. I
18 don't recall saying it. It makes sense that we
19 should attempt to show the Court why it would
20 be prudent to approve a second one now rather
21 than start the process over. Given CRCC's
22 history of maintaining a monopoly in Horry
23 County, I would fully anticipate them fighting
24 us if we were to file an application subsequent
25 to this one.

1 Q: Because -- and of course, if you were to drop
2 this lawsuit and applied for a new one under
3 the new State Health Plan, you would have to
4 compete for that which you're trying to avoid
5 in this lawsuit; isn't that correct?

6 MR. THOMAS: Your Honor, I'm going to object. For
7 one thing, he's badgering the witness. He
8 asked him questions regarding legal conclusions
9 and, you know, Mr. White's not a lawyer, okay.
10 And that's exactly what Mr. Long is asking him,
11 legal conclusions under ---

12 THE COURT: Legal ---

13 MR. THOMAS: And I put up the statute up there.

14 THE COURT: He said that he would have to compete.

15 MR. THOMAS: No, no, no. I'm talking about the
16 whole concept of, you know, whether or not this
17 Court can approve, you know, one versus two.
18 And you know what the statute says. Mr.
19 White's not familiar with that statute, but
20 you're allowed to consider the State Health
21 Plan in effect at the time. And this is
22 Hematology Oncology associates. This is that
23 case, Your Honor.

24 MR. LONG: Your Honor ---

25 MR. THOMAS: And you've already ruled on this in a

1 motion for summary judgment, and I just don't
2 think this is proper testimony for Mr. White.

3 MR. LONG: Your Honor, that's not what I asked him.

4 And Mr. Thomas, and I'd hope Your Honor can
5 help me on this today. But it's inappropriate
6 for him to stand up and make that kind of
7 speaking objection in an attempt to educate the
8 witness on what the questions are about. My
9 question was very simple to him: why have not
10 you not dropped this -- this case and applied
11 under the new health plan, and the reason is
12 because they don't want to compete for it.
13 That's what I was asking him. And I meant
14 compete, not as in competing applications. I
15 meant compete to see who would get the CON.
16 That's my question. It wasn't badgering
17 either.

18 THE COURT: Well, I think that that was the original
19 objection. I'll overrule your objection at
20 this point in time. Ask it again though to
21 make sure I -- so I can make sure I hear it.

22 Q: Mr. White, the reason you haven't filed, the
23 reason you haven't dropped this lawsuit and
24 filed under the new State Health Plan is
25 because you do not want to have to compete with

1 other applicants for that linear accelerator --
2 for another linear accelerator to be
3 designated; you just want the Court to give it
4 to you in this lawsuit? Isn't that correct?

5 A: I would love for the Court to give it to us,
6 but that's not why we're drop -- not dropping
7 this action and going through the whole process
8 of applying. It's not to avoid competition,
9 counselor. It is to achieve the goal of
10 providing a comprehensive cancer center on the
11 campus of Grand Strand Regional Medical Center.
12 We're a tertiary facility, and we want it
13 sooner than later. It's to our benefit that
14 there happens to be two in the new State Health
15 Plan, which gives the Court an opportunity to
16 give it to us. That's -- I'm not a lawyer, I'm
17 just telling you the truth. That's why we're
18 not waiting. I never -- I don't recall any
19 discussion about waiting, should we wait,
20 should we not. Get it done.

21 Q: Do you think this area can hold -- that it has
22 a need for three new linear accelerators?

23 A: I haven't reviewed the data to know, but I know
24 the new State Health Plan says there's a need
25 for another one in addition to the one CRCC has

1 that hasn't even started yet.

2 Q: Didn't you tell me in your deposition that if
3 you got a linear accelerator at Grand Strand
4 and somebody wanted to open a linear
5 accelerator at Dr. Holt's property that you
6 would oppose that?

7 A: If that -- if it -- if there was no need for
8 one in the State Health Plan, absolutely we
9 would oppose it. And if we made the investment
10 of nine million dollars in a linear accelerator
11 on campus 200 yards from Dr. Holt's campus, I
12 think it would be very prudent for us to oppose
13 it.

14 Q: Well, don't you think 21st Century has made a
15 substantial investment in linear accelerator
16 services here in Horry County and in Georgetown
17 and this service area?

18 A: They sure have, and they've made a ton of money
19 too.

20 Q: As a matter of fact, your organization, HCA,
21 attempted to purchase Dr. Bass' practice too,
22 didn't it?

23 A: Several times.

24 Q: And you made a substantial offer to him that
25 was rejected?

1 A: It sure was, because 21st Century offered
2 substantially more than our substantial offer.
3 And Dr. Bass did the wise thing and took the
4 biggest offer.

5 Q: Now, HCA employs physicians that practice
6 primarily at your hospital, right?

7 A: In our market, yes, sir.

8 Q: Yeah. And -- well, they practice at your
9 hospital. These neurologists and neurosurgeons
10 practice at Grand Strand, right?

11 A: Yes, sir.

12 Q: And they are employed. And you also employ
13 trauma surgeons and regular surgeons, right?

14 A: Yes, sir.

15 Q: And you also have some primary care physicians
16 that are employed in the -- in the area?

17 A: Yes, sir.

18 Q: And all of those physicians send their patients
19 to Grand Strand, don't they?

20 A: No, sir.

21 Q: You're telling me the neurosurgeons and these
22 other physicians send -- practice at these
23 other hospitals that are employed by HCA ---

24 A: You're asking three different questions. First

25 ---

1 Q: Okay. Explain it to me.

2 A: --- you said do they all send them all to your
3 hospital. The answer's no. Some of the
4 primary care docs actually send patients to
5 other facilities that are not HCA, but patient
6 requests.

7 Q: Uh-huh.

8 A: You also asked me do they practice at other
9 hospitals. No, they're not on the medical
10 staff of other hospitals, but they can send
11 patients there without being on staff. But
12 generally speaking, yes, sir, the majority of
13 their referrals come to Grand Strand, but not
14 all.

15 Q: And it's more than just the majority; it's like
16 almost all of them, isn't it, except for
17 patient requests?

18 A: Well I can't -- yes, sir, majority. Vast
19 majority or whatever adjective you want to use
20 to describe it. Most.

21 Q: I want to try to show you -- we've done a
22 couple of exhibits here.

23 MR. LONG: Let's pull up Exhibit Number -- let's
24 show Exhibit Number 1 on the screen.

25 Q: And you can look at them either on the screen

1 or on these boards that we've done. Here, get
2 this you. Here's Number 1. Now, Number 1, as
3 you can see, is a map of the service area, it
4 says Total Population by Zip Code 2010. You
5 and I spent some time in your deposition going
6 through the zip codes in Horry County and in
7 your market, and you're very familiar with the
8 zip codes in your area, aren't you?

9 A: I'm very familiar with zip codes in Myrtle
10 Beach. I'm not very familiar with zip codes in
11 other parts of the county.

12 Q: Well, you talked to me ---

13 A: I am looking at a list, I can get -- I can --
14 I can relate to the town quicker than I can
15 relate to the zip code for the area.

16 Q: But you and I talked during your deposition,
17 you were able to describe for me a number of
18 different facts about these zip codes. I just
19 want to go over these with you if I could.

20 A: Okay. Okay.

21 Q: All right. Now, your facility, let's start
22 right here with zip code 29577. That
23 encompasses the town of Myrtle Beach; you see
24 that?

25 A: Yes, sir.

1 Q: And that's where CRCC's located, in that zip
2 code, correct?

3 A: I believe so, yes, sir.

4 Q: And the hospital is actually just north of that
5 line. You're actually in 29572?

6 A: Correct.

7 Q: But you're right on the zip code line, aren't
8 you? You're just a little north of it, right?

9 A: It's pretty close yes, sir.

10 Q: Pretty close. Now, 29572 is the Dunes area of
11 ---

12 A: Myrtle Beach.

13 Q: --- Myrtle Beach?

14 A: Yes, sir.

15 Q: It's very affluent, isn't it?

16 A: Oh, yes.

17 Q: And a little bit smaller population. The three
18 counties in Horry -- the three zip codes in
19 Horry County that have the largest populations
20 are ---

21 MS. ELLINGTON: I'm try to fix this.

22 MR. LONG: Okay.

23 MR. WHITE: It's okay. I can see -- well everybody
24 else will probably ---

25 MR. LONG: Well, we can probably hand it up to the

1 Judge.

2 THE COURT: I've got it blown up on my computer.

3 MR. WHITE: Well this one's pretty darn fuzzy. So I
4 can't read the zip codes.

5 MR. LONG: That's why we've got the board. But you
6 can see it, Your Honor, on the screen in here?

7 THE COURT: She gave me that thumb drive, I pulled
8 it up.

9 MR. LONG: Okay. Great.

10 THE COURT: And it didn't do an OCR scan to my
11 dissatisfaction, but that's okay.

12 Q: All right. The three zip codes in Horry County
13 that have the largest populations are 29577,
14 which is Myrtle Beach; 29588, which is a little
15 bit to the west of that, which also has --
16 well, you tell me. What's the 29588? Tell me
17 about that zip code.

18 A: That's -- can step aside just a little bit.

19 Q: Sure.

20 A: I'm pretty sure that's the southern end of the
21 Conway area and Socastee area of the county,
22 which is a substantial bedroom community and
23 pretty blue collar, but pretty substantial
24 number, and fastest growing part of the county
25 in raw numbers.

1 Q: That's what you told me in the deposition.

2 A: Yes, sir.

3 Q: This is the fastest growing zip code. It's
4 number two in population, but it's the fastest
5 growing, right?

6 A: Yes, sir.

7 Q: And then, and it's right to the south of
8 Conway?

9 A: Right.

10 Q: And then Conway is 29526 and it is actually the
11 largest zip -- I mean, the largest population
12 in the County, isn't it?

13 A: Okay. I didn't realize that.

14 Q: All right. And then, of course, the Georgetown
15 zip code is also -- has a heavy population,
16 right?

17 A: Yes, sir. Yes, sir.

18 Q: All right. Let me ---

19 MR. LONG: Let's pull up, if we could, Exhibit 76
20 and 77 on the screen.

21 A: All right. I can't read this at all. Is it in
22 here?

23 Q: Let me try -- let me blow up first.

24 A: Mr. Long ---

25 Q: Yeah, it's in the book if you want to look at

1 it. She's trying to blow it up on the screen
2 too if she can.

3 A: You know, my eyes are dry from sitting in here
4 and I -- well I can -- yeah, I can see that.
5 What's the number?

6 Q: 76.

7 A: 76. Mr. Long --

8 MR. LONG: Your Honor, this is Exhibit CRCC or
9 Respondent's Exhibit Number 1 that we were
10 looking at earlier. Now we're looking at
11 Respondent's Exhibit 77, 76 and 77.

12 Q: These are your discharges that we received from
13 you for 2010, 2011, and 2012. These are
14 inpatient discharges for Grand Strand.

15 A: Okay.

16 Q: Okay. Just looking at the 2012 numbers for
17 right now. Those are the first -- those top
18 five counties are your five biggest counties
19 for discharge -- I mean, five biggest zip codes
20 for discharges, right?

21 A: Yes, sir.

22 Q: Okay. It's 29577, which is Myrtle Beach;
23 29588, which we just talked about is the
24 Socastee area; 29579, which is Carolina Forest,
25 isn't it, in between these two, that's 29579?

1 A: Correct.

2 Q: That's Carolina Forest, then North Myrtle
3 Beach, which is up near -- which we were
4 talking about earlier, the Little River area,
5 and then Conway, right?

6 A: Yes, sir.

7 Q: Those are your five biggest zip codes for
8 discharges.

9 A: Uh-huh (affirmative response).

10 Q: And what we've done on this map here, if you
11 look at Exhibit Number 2, CRCC Exhibit Number
12 -- I'm sorry. I think this is 3. I wrote
13 down 2 but I think it's going to be 3. The
14 discharge map.

15 THE COURT: I think it's 3.

16 Q: This is CRCC Exhibit 3. To make it a little
17 easier to see, we put the discharges on the
18 map, and so you can see the five largest, the
19 five zip codes that give you the most patients
20 at your hospital, right?

21 A: Okay.

22 Q: And it tracks very closely with this population
23 map, doesn't it?

24 A: It appears to if your numbers and art is
25 correct.

1 Q: And so now I want to show you, if I could, CRCC
2 Exhibit Number 4. What we did was we took Mr.
3 Sullivan's projections in the CON, you recall
4 you testified about those just a minute ago and
5 you said you thought they were reasonable as to
6 where your patients were going to come from; do
7 you recall you testified on that on direct?

8 A: Yes.

9 MR. LONG: That's not the right one. Sorry Your
10 Honor, I grabbed the wrong one. I need CRCC 4.

11 Q: All right. We took Mr. Sullivan's projections
12 in the CON application and we put them on a
13 board to show where he said your patients were
14 going to come from if you got a linear
15 accelerator.

16 A: Yes, sir.

17 Q: At Myrtle Beach.

18 A: Yes, sir.

19 Q: And he projects that in one of your top zip
20 codes over here, 29526, that you're only going
21 to get four patients.

22 A: Uh-huh (affirmative response).

23 Q: Do you have any idea as to why you're only
24 going to get four patients from Conway?

25 A: Sure. Sure, very easily explainable. You're

1 imputing that the general market share of the
2 hospital is going to be reflected in where we
3 would expect to get patients for the linear
4 accelerator, and it's apples and oranges. I
5 mean most -- most of this is going to be
6 outpatient service to start with. So the
7 physicians in Conway traditionally will avoid
8 referring patients to Grand Strand for any
9 service that they can obtain somewhere else
10 because we're competitors. We don't share
11 medical staff members, hardly any, and it's
12 absurd to think that the market share for
13 radiation therapy is going to be
14 proportionately equal the market share of
15 general acute care admissions.

16 Q: When you -- what would you compare it to then?

17 A: I don't understand the question.

18 Q: On the market share. I mean you're -- there
19 will be no other -- there will be no other
20 hospitals in Horry County that will be offering
21 this service, right?

22 A: Yeah, and there are none now.

23 Q: Right. And so therefore, if a physician was
24 going to refer a patient for radiation therapy
25 services, Conway, Loris, those other hospitals

1 are not an option, are they?

2 A: No, they don't -- they don't have a hospital
3 option now.

4 Q: Right.

5 A: Why do you think all of a sudden Conway would
6 start referring -- Conway's doctors would start
7 referring linear accelerator patients to Grand
8 Strand just because they send heart patients to
9 us and services that they don't provide there
10 and no other hospital or outpatient provider
11 provides.

12 Q: You get no heart patients out of Conway?

13 A: We get a third of our heart patients from
14 Conway.

15 Q: Right. But you don't think you're going to get
16 a lot of patients from Conway for radiation
17 therapy?

18 A: No, sir. You know why? Phil Clayton has told
19 me that we won't. He's the CEO of Conway
20 Medical Center. Years ago he's told me that,
21 don't expect our docs to refer to your hospital
22 if you ever get a linear accelerator.

23 Q: But they don't offer it?

24 A: I can't respond to that. I can just tell you
25 the truth, the fact of the matter. So it's far

1 out to think that it's reflective of the
2 inpatient market share.

3 Q: Let's take a look at -- let's go to Exhibit
4 Number 24.

5 A: What is that ---

6 Q: CRCC Exhibit 24 on the screen.

7 A: Is that in this book?

8 Q: You can look at it in the book if you want.

9 A: Oh, okay, the map.

10 Q: We looked at this I know on direct, so I won't
11 be long with it. But this is a picture of a
12 Google Earth shot of the hospital which is in
13 white, correct?

14 A: Yes, sir. Yes, sir.

15 Q: And then those parking lots around there to the
16 west of the trees, the -- I'm sorry I mean to
17 the north, I mean to the upper part of the
18 photograph of the trees are parking lots of the
19 hospital, right?

20 A: Yes, sir, they're all parking lots.

21 Q: Can you tell me where on that map the linear
22 accelerator that you're proposing to build is
23 going to be located?

24 A: I can tell you.

25 THE COURT: You can actually touch the screen and

1 mark it if you want.

2 MR. WHITE: On here?

3 THE COURT: Yeah.

4 A: Ooh, okay. All right. Okay. We need to move
5 the whole thing down because you really can't
6 get to the top. Where's the ---

7 Q: Is it going to be above the picture?

8 A: Yes, sir.

9 Q: So it's not reflected on this picture?

10 A: It -- you can get just a hair of it. But I'm
11 going to touch this screen. Hot dog. Well,
12 you look there, Your Honor, above that mark and
13 to the left, that brown part is actually the
14 cardiac rehab section end of the hospital. It
15 doesn't have a white roof like the rest of the
16 building does; you follow me Mr. Moore (sic)?
17 That -- it's white and then you see the brown.
18 That's a brown roof instead of a white roof.

19 Q: At the very top of the picture?

20 A: Yes, sir.

21 Q: Okay. Now, that building in the bottom part of
22 the picture in red ---

23 A: Yes, sir.

24 Q: --- that Dr. Holt's office, isn't it?

25 A: I'm sorry. The actual site of the linear

1 accelerator on the campus is above that little
2 white box and it's going to be about right --
3 well, probably -- I'm sorry, more over here ---
4 Q: Okay.
5 A: --- where that arrow's pointing.
6 Q: All right. And Dr. Holt, his office is that
7 building towards the bottom in red, with the
8 red ---
9 A: Yes, sir.
10 Q: --- roof, right?
11 A: Yes, sir.
12 Q: And then, of course, there are trees between
13 his -- the back of his building and the parking
14 lot, right?
15 A: Yes, sir.
16 Q: And so you cannot drive a vehicle from his
17 parking lot to your parking lot?
18 A: You cannot.
19 Q: You cannot. And his address is on a different
20 street than yours, right?
21 A: Yes. Yes, sir.
22 Q: Now, in regards to the -- the comments earlier.
23 MR. LONG: Can we pull up their CON application,
24 Grand Strand CON application page 135?
25 THE COURT: You said 35?

1 MR. LONG: 135, the application. And there in the

2 Grand Strand CON application, which is Exhibit

3 Number 2, Joint Exhibit 2, page 135.

4 A: Mr. Long, you've got to -- will you help me out

5 here? Do I -- do I have that?

6 Q: You don't have it right there.

7 A: I can't read this, that's for sure.

8 Q: It's right here.

9 A: Okay.

10 Q: Page 35. I'm sorry, page 135.

11 A: Bate stamped 135?

12 Q: Yes, Bates stamped 135.

13 A: I apologize. All right. I've got it.

14 Q: Okay. This is -- Thomas Miller and Partners

15 are your architecturs -- architect and

16 construction team, right?

17 A: On this project and many other projects, yes,

18 they are.

19 Q: Marc Rowland is the individual who worked with

20 y'all on this, right?

21 A: Okay. Yes, sir.

22 Q: Look at the third paragraph, second sentence

23 and read that to me if you could. It starts

24 with this edition is designed.

25 A: A -- oh, I'm sorry. "This edition is designed

1 to accommodate a future linear accelerator
2 addition on the northwest corner of the
3 building while maintaining use of the required
4 support spaces as designed."

5 Q: Okay. Let's look over on the next page 136.

6 A: Okay.

7 Q: This is also a letter ---

8 A: Okay.

9 Q: --- from your construction people.

10 A: Okay.

11 Q: And if you'll look down first paragraph under
12 the -- this is the same letter, structural
13 narrative.

14 A: Yes, sir. You want me to read that?

15 Q: If you would. You can start with the sentence
16 that says, the proposed addition, in the top
17 paragraph.

18 A: In the last paragraph?

19 Q: No, in the top paragraph under structural
20 narrative.

21 A: Oh, okay.

22 Q: Page 136.

23 A: "The proposed addition has been configured to
24 allow the addition of a second future linear
25 accelerator vault adjacent to the original

1 vault."

2 Q: And what the actual plans are is you have left
3 that space green right next to the vault so
4 that in the future you can build a second vault
5 and use the same concrete wall and you only
6 have to build three walls; isn't that right?

7 A: That's brilliant. I hadn't thought of that,
8 but I knew it was going to be on the outside of
9 the existing print of the -- footprint of the
10 building.

11 Q: All right. Let's look, if we can, at Exhibit
12 Number 82.

13 A: Honestly, I had never thought of the two brick
14 walls as being contiguous that could be used
15 for a new one. That's pretty -- pretty good.

16 Q: CRCC Exhibit Number 82.

17 A: Okay.

18 Q: Okay. You were asked a couple of questions
19 about this exhibit earlier on your direct exam.

20 A: I'm sorry, I don't think I've seen that.

21 Q: You're in the CON application.

22 A: I'm sorry.

23 Q: This is CRCC Exhibit Number 82. And ---

24 A: Oh, is it in this one?

25 Q: This book right here. Okay.

1 A: Sorry.

2 Q: 82. All right. Prior to November 10, 2010,
3 Grand Strand had now sought to add linear
4 accelerator radiation therapy services in the
5 service area, had they? This is the first time
6 that y'all really talk about it with Mr. Thomas
7 and Jamie Thomas sent you this email, right?

8 A: No, sir. We talked about it many times, as I
9 testified earlier, about buying Dr. Bass'
10 linear accelerator business.

11 Q: First time you ever talked about applying for
12 yourself, right?

13 A: Yes, sir.

14 Q: And so in his initial email to you, okay?

15 A: Okay.

16 Q: He mentions that Dr. Holt's group is estranged
17 from 21st Century, right?

18 A: Yes, sir.

19 Q: And you testified that information came from
20 you?

21 A: Yes, sir, it did.

22 Q: And that y'all might oppose Georgetown's move
23 to Waccamaw, right?

24 A: Yes, sir.

25 Q: And that he was ---

1 A: Well, no, he said that; I didn't say that.

2 Q: He said that.

3 A: Yeah.

4 Q: And he also said that y'all might consider
5 employing Dr. Holt's group, right?

6 A: Might be, yes, sir. Might be a part.

7 Q: Because you said earlier on your direct, if you
8 don't have the referrals from Dr. Holt's group,
9 then there's no justification for the project,
10 right?

11 A: No, sir, I didn't.

12 Q: You did not say that?

13 A: I said if you don't have part of their
14 referrals. If you can't count on them for some
15 of your referrals, it's not worth doing the
16 project. We never believed for a second that
17 we would -- and I don't think our projections
18 anticipate or project that we get all of Dr.
19 Holt's referrals. I would love to have all of
20 Dr. Holt's referrals and his group, but I doubt
21 that's going to happen.

22 Q: All right. Let's look at CRCC Exhibit 83. You
23 want to turn the ---

24 A: Yes, sir.

25 Q: This is the same day as your email from Jamie

1 Thomas and you're responding to him, may we
2 proceed to use David Summer to develop this CON
3 application ---
4 A: Yes, sir.
5 Q: --- right?
6 A: Yes, sir.
7 Q: And that'd be Parker Poe's law firm?
8 A: Yes, sir.
9 THE COURT: What's that exhibit again? I can't ...
10 MR. LONG: This is 83, Your Honor.
11 THE COURT: Okay. Thanks.
12 MR. LONG: These are pretty much going to run in
13 order. There are one or two that I'll have to
14 go back on Your Honor.
15 Q: Next Exhibit, CRCC 90.
16 A: Okay.
17 Q: We're now up to January of 2011. We've got an
18 email from David Was to you talking about the
19 need to move to talk to Dr. Holt, right?
20 A: Yes, sir.
21 Q: Okay. And you wrote Mr. Was back and said he
22 is behind it. He is Dr. Holt, right?
23 A: Yes, sir.
24 Q: We need to meet with him at first, hold for a
25 couple of days; I talked to him today, right?

1 A: Yes, sir.

2 Q: So now you're talking to Dr. Holt about the
3 project, right?

4 A: Yes, sir.

5 Q: All right. Let's look over at Exhibit Number
6 91. That's ten days later, and you're sending
7 off a email -- you're sending off asking for
8 plans ---

9 MR. THOMAS: Your Honor, I need to object to this
10 one. I don't see Mr. White's name on it. Is
11 it 91?

12 MR. LONG: 91.

13 MR. THOMAS: Am I missing something? I see K. Hall,
14 Jason Whinham and M. Rowland ---

15 A: I wasn't on this one.

16 Q: Okay. Let me ask you this. Did you instruct
17 the architects and construction people to
18 design plans for a freestanding option?

19 A: Absolutely not.

20 Q: For Grand Strand?

21 A: Absolutely not.

22 Q: You did not?

23 A: No, sir.

24 Q: Who would have done that?

25 A: Probably either Adam or Jamie Thomas or Chuck

1 Hall or Rodney VanPelt or Mike Marks or Jerry
2 Rooker, because I don't have the authority to
3 tell an architect to draw plans, and neither
4 does Adam, without the group approving it
5 first.

6 Q: Okay.

7 A: But someone did.

8 Q: But someone told them to do that because they
9 immediately started drawing plans for a
10 freestanding option; that is an option not
11 connected to the hospital, right?

12 A: That was an option we looked at very briefly
13 that was not in our -- is not in our
14 application as even a thought.

15 Q: Just looked at it briefly; that's what you're
16 testifying as?

17 A: On the grand scale of things from January 2010
18 to today, yes, sir, it was very briefly.

19 Q: How about the grand scale of January to July
20 when you filed the application, is that brief?

21 A: We ---

22 Q: Would you say you looked at it briefly?

23 A: It was not -- yeah, I still say briefly,
24 because it was a flash in the pan idea, just
25 like South Strand was and it never flew.

1 Q: Okay. Look at Exhibit Number 92.

2 A: Okay.

3 Q: And this is an email from you to Adam Rudd, Jim
4 Rardin, and Robert Grace.

5 A: Uh-huh (affirmative response).

6 Q: And it's dated February 17. And you said Loris
7 and McLeod had their linac public notice today.
8 What are our next steps to getting an architect
9 to draw the project on the lot adjacent to the
10 medical oncology office, right?

11 A: No, sir. What are our next steps to getting
12 approval to have an architect draw the plans?

13 Q: And what you were asking to do was to draw
14 plans to put it in the -- when you say adjacent
15 to the medical oncology office, you're talking
16 about in the parking lot of Dr. Holt's
17 property; that's what that means, right?

18 A: Buying a piece of property adjacent to Dr.
19 Holt's office and getting plans to put a linear
20 accelerator building there.

21 Q: And that's January 17th ---

22 MR. THOMAS: Your Honor, can I object just for a
23 second? This testimony seems to be awfully
24 cumulative. We've already gone through this
25 and this was, as you recall, at the status

1 conference on Monday, we already admitted that
2 we considered this -- this option, the witness
3 has. And I'm just wondering are we going to go
4 through every single email that talks about
5 this when we know and the Court knows that the
6 application is for it to be at the hospital.

7 THE COURT: He's on cross, so he's got wide
8 latitude. So I'm going to let him continue.

9 MR. THOMAS: Thank you.

10 MR. LONG: I'm moving quickly, Your Honor. We've
11 got them organized well. It won't be
12 cumulative. Each email's different. 62,
13 please.

14 A: 62. You had me on a roll. I was already to
15 93.

16 Q: Okay?

17 A: Yes, sir.

18 Q: If you would, turn to the second page of
19 Exhibit 62.

20 A: Second page, okay.

21 Q: That's a letter that you sent to Sissy Price in
22 March, correct?

23 A: Yes, sir.

24 Q: It's dated March 4th, 2011, right?

25 A: Uh-huh (affirmative response).

1 Q: Now, that letter that you sent to Ms. Price,
2 where does it say that the facility is going to
3 be located?

4 A: It says on property adjacent to the hospital's
5 campus. That would be on property we'd buy
6 from Dr. Holt's office. Again, flash in the
7 pan idea that didn't stick.

8 Q: Now we're up to March 4th. Okay. Let's take
9 a look at Number 93, CRCC Exhibit 93.

10 A: Okay. I'm there. By the way, she didn't give
11 me the letter that I asked for. Okay. I'm at
12 93.

13 Q: This is an email from you to other people, the
14 architects and others saying here are the site
15 plans that you've received from Dr. Holt. Says
16 he is anxious to talk with us and our planners
17 about this ASAP. Chuck is here next week.
18 Chuck is Chuck Hall, isn't it?

19 A: Yes, sir.

20 Q: And he will -- and will want to know, right?

21 A: Yes, sir.

22 Q: So March 10th, you're moving forward with plans
23 for Dr. Holt's property, right?

24 A: No, sir. We're looking at that as an option at
25 this point; not with plans.

1 Q: CRCC Exhibit Number 94.

2 A: Okay.

3 Q: Dr. Holt on March 10 gives you three places on
4 his property that he thinks you can put the
5 machine, right?

6 A: Yes, sir.

7 Q: And you're raising the option of putting the
8 closed loop with the hospital, right? That's
9 a closed road that you talked about on direct?

10 A: Yes, sir. Yes, sir.

11 Q: Okay. CRCC Exhibit 95.

12 A: All right.

13 Q: Same day. You're having conversations with the
14 architects and the design team about coming up
15 with plans for the options that Dr. Holt has
16 suggested to you, right?

17 A: No, sir. I'm responding to Jason's email where
18 he is discussing those things.

19 Q: Right. You forwarded the site plans to him?

20 A: The email we already looked at.

21 Q: Right.

22 A: Okay.

23 Q: And he writes you back and says we'll start
24 work on these, right?

25 A: And come up with different options, we already

1 know -- yeah, he's looking at the same email.

2 Q: Yeah.

3 A: And I just said thanks, let me know if you need

4 anything.

5 Q: Right. And the options are the three options

6 that Dr. Holt proposed to you about the three

7 places on his land, right? There were three

8 places that Dr. Holt suggested would be places

9 where you could potentially locate ---

10 A: I think that's a big assumption ---

11 Q: --- the freestanding building?

12 A: --- to make. I don't know that that's -- that

13 were the options that they ended up drawing

14 out, if they did. May well be, but I don't

15 know at this point if that's the options

16 they're talking about.

17 Q: Turn back to 94.

18 A: All right.

19 Q: Exhibit Number 94.

20 A: Okay.

21 Q: Just look at Dr. Holt's email again.

22 A: Okay. Got it.

23 Q: And he suggested three places to you on his

24 property ---

25 A: Yes, sir.

1 Q: --- to add it, right?

2 A: Right.

3 Q: Those are the options, right?

4 A: Right.

5 Q: Let's take a look at ---

6 A: The closed loop connection was not one of the
7 options that he suggested.

8 Q: Well, that was something you suggested ---

9 A: Yes, sir.

10 Q: --- so you could basically get from your
11 parking lot ---

12 A: Right. Right.

13 Q: --- to his parking lot without having to go out
14 on the road?

15 A: It was to give closer -- the closest possible
16 connection to the hospital campus, yes.

17 Q: Because all the time that you're talking to
18 them about building a freestanding center in
19 Dr. Holt's parking lot, you knew that your
20 inpatients were going to have to be put in an
21 ambulance and driven over there for treatment?

22 A: Never thought that deeply into it because it
23 was never given real serious consideration. It
24 was an option we were looking at because ---

25 Q: Okay.

1 A: --- it was one of the three options we had at
2 the time.

3 Q: Look at Exhibit Number 96.

4 A: All right.

5 Q: Take a look at these. This is him responding
6 to you the next day talking to you about
7 questions and things that he would need to draw
8 plans on Dr. Holt's property, right?

9 A: Yes, sir.

10 Q: And in any of these emails that we've just
11 looked at, there's no discussion of any other
12 locations on the hospital property, is there?

13 A: Why would there be? We're talking about that
14 single option. There's no discussion of about
15 what South Strand option is either.

16 Q: Let's look at Exhibit Number 97. Now this is
17 the Eastern Group Visit, right?

18 A: Yes, sir. It's a presentation we gave when
19 they visited our hospital.

20 Q: And did you describe it to me in your
21 deposition as a long arduous process to prevent
22 -- to present information to Mr. Hall and Mr.
23 Marks? They come to Myrtle Beach and meet with
24 you for most of the day, right?

25 A: Yes, sir.

1 Q: And y'all give them a PowerPoint presentation
2 that's very lengthy. We didn't put the whole
3 thing in here, because most of it's redacted,
4 but it's a 60, 70 page PowerPoint or more,
5 right?

6 A: Grueling.

7 Q: And you practice it actually, right?

8 A: Over and over and over.

9 Q: And it deals with strategy and performance and
10 quality and satisfaction ---

11 A: Earnings.

12 Q: --- everything about the hospital? Earnings?

13 A: Everything.

14 Q: Okay. Let's turn over if we could to page 381.

15 A: Okay. Where would that be?

16 Q: It's going to be about the -- I'm sorry. Let's
17 go to -- 3122.

18 A: What book ---

19 Q: Which is going to be -- you're just going to
20 turn like three pages over. We'll just do all
21 of them. You can see the bottom.

22 A: Where's 320 ---

23 Q: You see the bottom? 3122?

24 A: 3060. I see 3060 on this one.

25 Q: 398.

1 A: Sir?

2 Q: Keep turning over ---

3 A: These are all in black.

4 Q: Right.

5 A: Myrtle Beach at night.

6 Q: Oh, I think it has an entire one. You can look

7 at it on the screen if you want to. We're

8 going to 3122.

9 A: Where do you see 31 --

10 Q: It's GSRMC 3122.

11 A: Oh, okay. 3122. In other words. that's not

12 it. All right.

13 Q: And this is the presentation that you made to

14 Mr. Hall and Mr. Marks. And how many hospitals

15 does Mr. Hall have under him?

16 A: I don't know, probably 60 or 70.

17 Q: And there's another -- he's under the national

18 group, then there's the American group's about

19 60 or 70 too, also, right?

20 A: Well, at the time, Mr. Long, he would -- this

21 was the Eastern Group. Since that time they've

22 reorganized and now it's the National Group.

23 At the time we had the Eastern Group and

24 Western Group. And now there's the National

25 Group, the American Group and the Central

1 Group.

2 Q: And Mr. Hall has a lot of hospitals that he's
3 in charge of, right?

4 A: He sure does.

5 Q: Okay. And looking at this page, this is where
6 -- this is the part of the presentation where
7 you talked about oncology, right?

8 A: Yes, sir.

9 Q: And what did you tell him in the PowerPoint?
10 That you were going to place a linear
11 accelerator on the campus of the medical
12 oncology group property? That's what you told
13 him, right?

14 A: Let me clarify this. Part of the purpose of
15 this strategic ---

16 MR. LONG: Your Honor, if I could just pause. Could
17 he answer the question and then explain it.

18 A: Okay. No.

19 Q: You did not tell him that in the PowerPoint?

20 A: No, sir, I did not.

21 Q: That does not say place linear accelerator on
22 campus of medical oncology group property?

23 A: That's what it said, but that doesn't mean at
24 all what you're saying.

25 Q: Okay.

1 THE COURT: You can explain.

2 A: Okay. Thank you. The purpose of the strategic
3 plan is for us to plan strategy with the group
4 officials and the division officials. And Mr.
5 Long, when we present information to that
6 group, as I said, it's an arduous process. The
7 main reason it's arduous is that a large
8 percentage of our proposed strategy that we put
9 in the form of a plan with sentences like place
10 linear accelerator on campus on medical
11 oncology group property is subject to being
12 shot down, criticized, knocked down, altered,
13 removed or agreed upon by the group at the time
14 of the presentation. This is not us telling
15 the officials in Nashville who fly in on the
16 corporate jet to review this thing for a few
17 hours what we're going to do with their assets
18 in Horry County; it's us proposing to them what
19 we would like to do, and from there, we get
20 guidance.

21 Q: Exactly.

22 A: Correct. So yes we ---

23 Q: So you ---

24 A: This was a -- an idea we had at the time when
25 they came. And as you know, it didn't fly, we

1 -- we took it off the table as a possibility,
2 and it's not what we are applying to do.

3 Q: But it's what you wanted to do, isn't it?

4 A: No, it's not.

5 Q: Let's look at the page -- the other things you
6 told him: you wanted a covered walkway from the
7 building to their office, right?

8 A: That's what we said, yes.

9 Q: And you were going to have to buy and lease the
10 land, right?

11 A: Correct.

12 Q: There's nothing on this page or anywhere in
13 this PowerPoint about putting that linear
14 accelerator at the hospital, is there?

15 A: No.

16 Q: And there's nothing on that page or in this
17 PowerPoint about the need to have a linear
18 accelerator attached to the hospital, is there?

19 A: No, that's not what we're applying to do.

20 Q: And there's nothing on this PowerPoint or on
21 this page about South Strand, right?

22 A: No.

23 Q: Now let's look at page number 398 in the
24 PowerPoint.

25 A: Three ---

1 Q: 3,098.

2 A: Oh, I'm sorry.

3 Q: GSRMC 3098.

4 THE COURT: What exhibit are you in right now?

5 MR. LONG: Same exhibit, Your Honor. It's Exhibit
6 Number 97, CRCC 97.

7 Q: And of course the blacked out part, that's the
8 way it was produced to us. We, of course,
9 didn't do that, but what did you say about
10 oncology on the key tactics on the strategic
11 plan?

12 A: The linear accelerator program plan with
13 medical oncologists.

14 Q: Which would be Dr. Holt's group, right?

15 A: Yes, sir.

16 Q: Let's look over at 3081. This is not about Dr.
17 Holt but it's some information that I want to
18 make sure that we see. A big part of your
19 discussion, of course, once you get there.

20 A: All right.

21 Q: A big part of your discussion with Mr. Hall
22 when he does his visits is market share, right?

23 A: Very big part, yes, sir.

24 Q: At the very top line is the market share by
25 inpatient -- it's your total market share,

1 right?

2 A: Hold on here, let me look. Inpatient, this --
3 this is likely inpatient market share only, not
4 total market share. Total inpatient market
5 share.

6 Q: Okay. So it's inpatient market share is 35
7 percent in 2009, right?

8 A: Yes, sir.

9 Q: And it's been very consistent on the years you
10 lay out there, right?

11 A: Slightly increasing on the -- on the -- on a
12 curve.

13 Q: Trend is up?

14 A: Uh-huh (affirmative response).

15 Q: And then you also give the market share for
16 oncology, right?

17 A: Correct.

18 Q: And it's 29 percent in 2009, right?

19 A: 29 ---

20 Q: 29.03?

21 A: Yes. Yes.

22 Q: But it has been as high as 35 percent, right?

23 A: Correct.

24 Q: And it's also trending up?

25 A: Correct. Keeping in mind these are

1 dramatically lower numbers we're talking about,
2 apples and bananas. Total market share versus
3 the oncology market share.

4 Q: The percentages though are very -- very close?

5 A: Percentages mean nothing if you're talking
6 about dramatically different volumes.

7 Q: It is very different volumes, but it's also the
8 -- okay. I won't try to convince you about
9 that.

10 A: I'm sorry.

11 Q: All right. Let's move to CRCC Exhibit Number
12 98.

13 A: 98.

14 Q: And just remember, that visit from Mr. Hall is
15 dated March 16th, 2011, right?

16 A: The presentation?

17 Q: The presentation, right?

18 A: Okay. I'll stipulate that.

19 Q: And we're now at least a couple of months from
20 when you first started our first email. We've
21 yet to see an email from you when y'all started
22 work on this in January, right? So you're
23 about two months into it, right?

24 A: Two or three, yeah.

25 Q: Okay. We've yet to see an email from you

1 talking about putting the linear accelerator at
2 the campus, have we?

3 A: I don't know that one exists or not, but no, we
4 haven't looked -- we haven't looked at one in
5 my time on the stand.

6 Q: And we certainly have not looked at one that
7 said anything about South Strand, have we?

8 A: No. Don't think we've looked at one that
9 talked about doing it on a portable trailer
10 either.

11 Q: Let's look at CRCC Exhibit 98.

12 A: Even though we had a discussion about it.

13 Q: This is the next day.

14 A: Okay. This is marked 2897, is that?

15 Q: Right.

16 A: Okay.

17 Q: Is this CRCC Exhibit 98, the next day after the
18 Eastern Group visit, you're exchanging emails
19 again with the architects about the options,
20 right?

21 A: No, sir, not exchanging emails.

22 Q: He's sending you the options, right?

23 A: He sent me an email. I wouldn't call that
24 exchanging emails.

25 Q: Okay. He sent you an email. And those emails

1 show three options?

2 A: Okay.

3 Q: One of them is in the southern part of the
4 parking lot, way down towards the trees, right?
5 Or is it on the other side of the trees?

6 A: I'd have to read this. Which option is that?

7 Q: Option number one.

8 A: Okay.

9 Q: That's actually the southern parking lot. It
10 says a building on existing southern parking
11 lot of the hospital campus. So you're going to
12 build it right down next to the trees and then
13 build a covered walkway to Dr. Holt, right?

14 A: Let me -- can I take a second to read this?

15 Q: Sure.

16 A: Okay. That's what that option is.

17 Q: Right. The other options are on -- on the lot
18 of the existing MOB, that's Dr. Holt is the
19 MOB, right?

20 A: Yes, sir.

21 Q: Okay. Let's move on then to Exhibit CRCC 99.
22 Design and construction sending you an email,
23 Attached are the revised site plans reflecting
24 the addition of an access road to the linac
25 project. All the discussion with this, which

1 is about putting it on the property of Dr.
2 Holt, right?
3 A: No, it's on the property we would buy from Dr.
4 Holt.
5 Q: Property you would ---
6 A: And by the way, Mr. Long, we've spent more time
7 in depositions and court talking about this
8 option than we did in Myrtle Beach talking
9 about the option.
10 Q: We still are no emails on you on the hospital
11 though and we're up to April 22nd.
12 A: That's correct.
13 Q: Okay. Now, we if could, let's look at the
14 Exhibit Number -- let's look at Exhibit Number
15 70.
16 A: Is that the same book, Mr. Long?
17 Q: I think it's going to be in another book.
18 A: All right. Which book, Mr. Long, do we ---
19 Q: I'm sorry, it's the one -- it's CRCC Exhibit
20 Number 70. Should be right here.
21 A: All right.
22 Q: This is the -- this is the Request for Capital
23 document we discussed in the beginning?
24 A: Yes, sir.
25 Q: Correct?

1 A: Okay.

2 Q: I would ask that you turn to pages 1339, 1341.

3 A: This is from February 2007?

4 Q: No, sir.

5 A: That's what the page says.

6 Q: I know but ---

7 A: Okay. That's just the form, I guess.

8 Q: That's the form.

9 A: Sorry. What page?

10 Q: 1339.

11 A: All right.

12 Q: This is the Request for Capital document that

13 would be sent to the district -- to the

14 division office and then on to group, right?

15 A: Yes, sir.

16 Q: Office?

17 A: Yes, sir.

18 Q: I would ask that you read about halfway down,

19 right below those numbers.

20 A: Okay.

21 Q: About in the upper third. And below that a

22 little bit, right where those four numbers are.

23 And the paragraph under -- no above that.

24 Right there. Right there. Okay.

25 A: Okay.

1 Q: This document says, "We received the project
2 budget from Thomas, Miller and Partners on May
3 18, 2011, and imputed those numbers into the
4 CAMS document and request." So this Request
5 for Capital document is an ongoing document
6 you're working on the entire time that the CON
7 -- during this process, right?

8 A: Yes, sir.

9 Q: And so people go in and make changes to it,
10 right?

11 A: Robert would go in and make changes to it, or
12 he would be directed to make changes to it by
13 Rodney VanPelt or the controller at group
14 office of Mike Marks or the planner might be
15 consulted and suggest making changes.

16 Q: And you would certainly agree with me that this
17 version was written after May 18, 2011, right?
18 Since it says right there, we received the
19 budget on May 18, 2011, it would have had to
20 been written after May 18 right? Isn't that
21 correct? I mean, he could not have known
22 before May 18 that he was going to receive the
23 budget on May 18. He had not already received
24 it, right?

25 A: Is that a question or you're stating this?

1 Q: I'm just asking if you agree with me.

2 A: Yeah, I agree.

3 Q: Okay. And so this would have been done after
4 May 18th, and what does it have up there in
5 regards to the cost of the project beside the
6 land?

7 A: One million 400 thousand. That's how much it
8 would have costed if we decided to go with the
9 option of buying land from Dr. Holt.

10 Q: Okay. And let's turn over quickly to 1341.

11 A: Okay.

12 Q: Two pages over. This doesn't have to do with
13 that particular issue, but what does the
14 document say in regards to where the volumes
15 came from that are in the document? If you
16 look at right below that Exhibit 14, it says
17 outpatient volumes. Where does it say that the
18 utilization data came from?

19 A: Outpatient volumes based on the projected
20 utilization data provided by Parker Poe, LLC,
21 a consultant hired to analyze the radiation
22 therapy market in Myrtle Beach.

23 Q: Okay. It says Parker Poe, right? All right,
24 let's turn over if you would to Exhibit Number
25 113, CRCC 113.

1 A: Hold on. Where would that be?

2 Q: I'm sorry, my exhibit book.

3 A: Different book?

4 Q: Yes, if you can get this one.

5 A: You can just tell me to go grab another book.

6 All right.

7 Q: 113.

8 A: Yes, sir.

9 Q: This email is May 25th.

10 A: Okay.

11 Q: This is you telling Mr. Rowland that Jamie, as

12 in Jamie Thomas, wants an alternate plan for

13 the linear accelerator connected to the

14 hospital, right?

15 A: Yes, sir.

16 Q: So on May 25th is when y'all started looking at

17 putting it at the hospital, right?

18 A: Yes -- no. That's the second time we started

19 looking at putting it at the hospital.

20 Q: Okay.

21 A: That's where originally we were going to put

22 it.

23 Q: That's the first email I've seen from you on

24 that. Let's look at ---

25 A: Well, we discussed it and it wasn't in an