

THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

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SC Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
The Honorable S. Phillip Lenski, Administrative Law Judge

Appellate Case No. 2015-000056

Amisub of South Carolina, Inc., d/b/a Piedmont Medical Center,
d/b/a Fort Mill Medical Center Petitioner,

v.

South Carolina Department of Health and Environmental Control
and The Charlotte Mecklenburg Hospital Authority, d/b/a Carolinas
Medical Center-Fort Mill Respondents,

Of whom The Charlotte Mecklenburg Hospital Authority, d/b/a Carolinas
Medical Center-Fort Mill, is Appellant.

**RETURN TO APPELLANT'S SUPPLEMENTAL BRIEF AND AMENDMENT OF
MOTION FOR RELIEF FROM BOND AND PETITION FOR SUPERSEDEAS**

Petitioner Amisub of South Carolina, Inc., d/b/a Piedmont Medical Center, d/b/a Fort Mill Medical Center ("Piedmont"), files this Return in Opposition to Appellant's Supplemental Brief and Amendment of Motion for Relief from Bond and Petition for Supersedeas ("Amended Motion"). For the reasons set forth below, Appellant's Amended Motion should be denied.

A decade has passed since Piedmont first applied for a Certificate of Need ("CON") to build a hospital in Fort Mill. For a decade the citizens of the Fort Mill area have waited for a needed hospital. This process has involved two agency reviews, two lengthy trials before the Administrative Law Court ("ALC"), and now an appeal to this Court. *See Amisub of S.C., Inc. v. S.C. Dept. of Health and Environmental Control*, Docket No. 11-ALJ-07-0575-CC, at 2-4 (S.C. Admin. L. Ct. Dec. 15, 2014), ("Amended Final Order"), attached as **Exhibit A**. In its Amended Motion, Appellant The Charlotte Mecklenburg Hospital Authority, d/b/a Carolinas Medical Center - Fort Mill ("CHS" or "Appellant") (1) seeks relief from the bond required by S.C. Code § 44-7-220(B) on the ground that the statute is unconstitutional on its face, and (2) seeks to stay Piedmont from proceeding with its hospital project.

I. OPPOSITION TO RELIEF FROM BOND

A. Section 44-7-220(B) is Constitutional Pursuant to this Court's decision in *Grand Strand*.

Less than one month ago, this Court ruled on a CON appeal and specifically found that Section 44-7-220(B) "is constitutional as written." *See Grand Strand Regional Center v. South Carolina Dept. of Health and Environmental Control*, App. Case No. 2014-000973, at *5 (S.C. Ct. App. March 19, 2015), attached as **Exhibit B**. In so holding, this Court addressed

the exact same constitutional challenges to Section 44-7-220(B) as advanced by Appellant in the instant case – separation of powers, equal protection, and due process. *Id.*, at 3-4.

Appellant goes to great lengths to distinguish the facts and arguments of the instant case from those in *Grand Strand*. However, the alleged distinctions between the two cases are simply irrelevant. This Court had the opportunity to strike down Section 44-7-220(B) in *Grand Strand* but specifically chose otherwise. The outcome of a facial constitutional analysis is not dependent upon the facts and circumstances of a particular case. A statute is either constitutional or it is not, and this Court has already decided that question in regard to Section 44-7-220(B).

B. Section 44-7-220(B) is Constitutional Even in the Absence of the *Grand Strand* Decision.

Even in the absence of the *Grand Strand* decision, the Appellant's constitutional challenges to Section 44-7-220(B) fail.

A legislative enactment will be sustained against constitutional attack if there is any reasonable hypothesis to support it [w]hen the issue is the constitutionality of a statute, every presumption will be made in favor of its validity and no statute will be declared unconstitutional unless its invalidity appears so clearly as to leave no doubt that it conflicts with the constitution. A legislative act will not be declared unconstitutional unless its repugnance to the constitution is clear and beyond a reasonable doubt.

Sloan v S.C. Bd. of Phys. Therapy Examiners, 370 S.C. 452, 480-81, 636, S.E.2d 598, 613 (2006) (citations omitted).

Appellant fails to cite to a single case where a statutory appeal bond such as the one in this case was invalidated. Nevertheless, Appellant argues that Section 44-7-220(b) violates the separation of powers doctrine, equal protection, and due process. Each of these arguments is addressed in turn.

1. Separation of Powers

“[A] usurpation of powers exists, for purposes of [the] constitutional separation of powers doctrine, when there is a significant interference by one branch of government with the operations of another branch.” 16A Am.Jur.2d *Constitutional Law* § 246. This rule is not fixed and immutable, however, as there are grey areas which are “tolerated in complex areas of government.” *McInnis*, 278 S.C. at 313, 295 S.E.2d at 636 (1982). There consequently is “some overlap of authority and some encroachment to a limited degree.” *Id.*; *see also* 16A Am.Jur.2d *Constitutional Law* § 244. (“Separation of powers does not require that the branches of government be hermetically sealed; the doctrine of separation requires a cooperative accommodation among the three branches of government; a rigid and inflexible classification of powers would render government unworkable.”). At its core, the doctrine therefore “is directed only to those powers which belong exclusively to a single branch of government. 16A Am.Jur.2d *Constitutional Law* § 246.

State v. Langford, 400 S.C. 421, 434-35, 735 S.E.2d 471, 478 (2012.)

Appellant argues that Section 44-7-220(B) violates the separation of powers doctrine because it conflicts with portions of Rule 203 and 241, SCACR. In support for this argument, the Appellant relies on a 1982 South Carolina Supreme Court order, which explained that the General Assembly cannot invade the Supreme Court's power to promulgate rules of judicial practice and procedure. *See In re Circuit Court Rule 102*, 1982 LEXIS 483 (S.Ct. Aug. 31, 1982). However, unlike the present case, *In re Circuit Court Rule 102* addressed a direct and existing conflict. The statute at issue required an answer to be served within twenty days of the complaint, while a circuit court rule provided for a thirty day answer period. Applying the principle that the General Assembly cannot intrude upon the court's authority to promulgate rules of procedure, the Supreme Court invalidated the conflicting statute. *See id.* at * 8.

This case presents no such conflict. Rules 203(b)(6),(d)(2), and (e)(2) govern the procedure for CON appeals, but are silent on the issue of bonds. Rule 241 simply provides that the Court may require a bond as a condition for the granting of supersedeas or lifting of the

automatic stay. Section 44-7-220(B) does not conflict with either Rule 203 or 241. *In re Circuit Court Rule 102* is therefore inapplicable.

None of the cases cited by Appellant involves a statutory appeal bond such as Section 44-7-220(B). *Rutherford v. Rutherford*, 307 S.C. 199, 414 S.E.2d 157 (1992) did not even involve a separation of powers issue, but, rather, a statute limiting the scope of review in domestic cases that was “clearly in conflict” with the language of Article V, Section 5 of the South Carolina Constitution. *Id.*, 307 S.C. at 203, 414 S.E.2d at 159-60. In *Elk Horn Coal Corp v. Cheyenne Res. Inc.*, 163 S.W.3d 408 (Ky. 2005), the court addressed the constitutionality of a statutory penalty for second appeals in damages cases, not a statutory appeal bond. *Id.*, 163 S.W.3d at 410. Finally, the court in *Consumers Gas Co. v. Illinois Commerce Comm'n*, 493 N.E.2d 1148, 1152 (Ill. Ct. App. 1986) held that certain statutory procedures for an obtaining an appeal bond were unconstitutional, but only to the extent they conflicted with state supreme court rules. *Id.* As explained, Section 44-7-220(B) does not conflict with any court rules, and, therefore, *Consumers Gas Co.* is inapplicable.

2. Equal Protection

To satisfy the equal protection clause, a classification not involving a fundamental right or a suspect class must (1) bear a reasonable relation to the legislative purpose sought to be achieved, (2) members of the class must be treated alike under similar circumstances, and (3) the classification must rest on some rational basis. *Sloan*, 370 S.C. at 480, 636 S.E.2d at 613. A court “must give great deference to a legislative body’s classification decisions because it presumably debated and weighed the advantages and disadvantages of the legislation at issue.” *Sloan*, 370 S.C. at 480-81, 636 S.E.2d at 613. Furthermore, “[t]he classification does not need to completely accomplish the legislative purpose with delicate precision in order to

survive a constitutional challenge.” *Id.* (quoting *Foster v. S.C. Dept. of Highways Pub. Transp.*, 306 S.C. 519, 526, 413 S.E.2d 31, 36 (1992)).

Appellant argues that Section 44-7-220(B) treats CON appellants differently from other appellants by requiring CON appellants to post an appeal bond, with no rational basis for the distinction. In *Grand Strand*, however, this Court found that “there is a rational basis for [Section 44-7-220(B)’s] provision awarding a respondent the appeal bond if the ALC’s decision is upheld, and this provision is related to a legitimate government interest.” *Grand Strand* at 4. The legitimate government interest behind Section 44-7-220(B) is the need “to reserve some funds to compensate a respondent harmed by the delay of its approved project during the pendency of the appeal.” *Id.*

Appellant relies heavily on *Lindsey v. Normet*, 405 U.S. 56 (1972) and *O’Day v. George Arakelian Farms, Inc.* 536 F.2d 856 (9th Cir. 1976), neither of which addressed an appeal bond like Section 44-7-220(B). Instead, both *Lindsey* and *O’Day* invalidated statutes with a “double bond” requirement, holding that no rational basis supported requiring a double bond to effectuate an appeal.¹ *Lindsey*, 405 U.S. at 76-77; *O’Day*, 536 F.2d at 860. Appellant also relies on *Elk Horn*, which involved a statutory penalty for a second appeal, intended to deter frivolous appeals. 163 S.W.3d at 415. The *Elk Horn* court held the statute at issue violated equal protection because it had the effect of deterring both frivolous and meritorious appeals and thus lacked a rational basis. *Id.*, at 421-22.

Section 44-7-220(B) does not require a double bond nor impose a penalty, like the cases relied upon by Appellant. Moreover, unlike the statutes at issue in *Lindsey*, *O’Day*, and *Elk*

¹ It is important to note that the Court in *Lindsey* specifically recognized the validity of a statutory appeal bond requirement, stating that a “State may properly take steps to insure that an appellant post adequate security before an appeal. . . .” *Id.* at 77-78.

Horn, Section 44-7-220(B)'s bond provision bears a reasonable relation to a legitimate government purpose and its classifications rest on a rational basis. *See Grand Strand* at 4.

3. Due Process

Finally, Appellant argues that the bond requirement in Section 44-7-220(B) violates due process because it burdens access to judicial review. "The fundamental requirements of due process under the United States Constitution and the South Carolina Constitution include notice, an opportunity to be heard in a meaningful way, and judicial review." *Grand Strand* at 4 (quoting *Harbit v. City of Charleston*, 382 S.C. 383, 393, 675 S.E. 2d 776, 781 (Ct. App. 2009)). What this Court noted about the Appellant in *Grand Strand* applies equally to the Appellant in the present appeal: "Appellant has successfully initiated its appeal of the ALC's decision, and this Court will soon give Appellant its judicial review." *Grand Strand* at 4. "We find there has been no impairment of Appellant's right to judicial review under Article 1, Section 22 of the South Carolina Constitution, nor has there been a violation of its right to procedural due process." *Id.* at 3-4.²

To the extent Appellant contends that Section 44-7-220(B) violates substantive due process, that issue was also decided in *Grand Strand*: "[W]e find Appellant has not demonstrated an equal protection or substantive due process violation because there is a rational basis for [Section 44-7-220(B)'s] provisions awarding a respondent the appeal bond if the ALC's decision is upheld, and this provision is related to a legitimate government interest." *Grand Strand* at 4.

² In support of its due process argument, Appellant cites *Boddie v. Connecticut*, 401 U.S. 371 (1971). In *Boddie*, indigent appellants argued that a state statute requiring certain court fees and costs was unconstitutional as applied to them, in that it restricted their access to the courts to bring a divorce action. 401 U.S. at 372. *Boddie* is clearly distinguishable from the present case.

II. OPPOSITION TO SUPERSEDEAS

In its original motion, Appellant argued that a stay was appropriate pursuant to Section 44-7-220(B) and Rule 241(c), ALR. To the extent Appellant still asserts arguments based on Section 44-7-220(B) and Rule 241(e), Piedmont will address them briefly.

In *Grand Strand* this Court emphasized that Section 44-7-220(B) contains no stay requirement “and we decline to insert such a requirement in the statute.” *Grand Strand* at 3. Rule 241(c)(2) provides that “[in] determining whether [a supersedeas] should issue. . . [the court] should consider whether such an order is necessary to preserve jurisdiction of the appeal or to prevent a contested issue from becoming moot.” In *Grand Strand* the Court found:

We find there is no danger the court will lose jurisdiction or the issues on appeal will become moot if Grand Strand is allowed to proceed with its project. See *S.C. Ret. Sys. Inv. Comm’n v. Loftis*, 402 S.C. 382, 384, 741 S.E.2d 757, 758 (2013) (“A case is moot where a judgment rendered by the [c]ourt will have no practical legal effect upon an existing controversy because an intervening event renders any grant of effectual relief impossible for the [c]ourt.”). Grand Strand acknowledges that if it were to proceed with construction of its facility, it would have to cease all operations related to its project if this court reverses the ALC’s decision approving its CON. Therefore, whether Grand Strand proceeds with construction and operation of its facility will not moot the issues on appeal or strip this court of jurisdiction.

Grand Strand at 2. Similarly, Piedmont acknowledges that it would be required to cease operations on its Fort Mill hospital project should the ALC’s decision be reversed.

In its Amended Motion, CHS argues this Court should preliminarily enjoin Piedmont from starting work on its Fort Mill hospital during the appeal, pursuant to S.C. Code §1-23-380 and SCRCP 65. Section 1-23-380(1) of the South Carolina Administrative Procedures Act provides that “[p]roceedings for review are instituted by filing a petition” Section 1-23-380(2) then adds: “The filing of the petition does not itself stay enforcement of the agency

decision. The agency may grant, or the reviewing court may order, a stay upon appropriate terms, upon the filing of a petition under Rule 65 of the South Carolina Rules of Civil Procedure.”

Piedmont is unaware of any case in which Rule 65 has been applied to a petition for supersedeas, filed pursuant to SCACR 241(c), during the pendency of an appeal, following a final evidentiary hearing. Moreover, CHS has not filed a petition under Rule 65. *See Grand Strand* at 3, 5 (noting that Appellant CRCC had not filed a Rule 65 petition). Even if Rule 65 were to apply to a petition for supersedeas, one should not be granted to CHS. Issuance of a preliminary injunction requires the movant to satisfy three criteria: irreparable harm, a likelihood of success on the merits, and no adequate remedy at law. *Poyntner Investments, Inc. v. Century Builders of Piedmont, Inc.* 387 S.C. 583, 586-87, 694 S.E.2d 15, 17 (2010).

1. Irreparable Harm

Appellant CHS contends that failure to impose a stay would cause it to lose market share and revenue. The ALC’s decision to award the CON to Piedmont was based on its finding that, for years, Piedmont has lost market share to CHS due to CHS’s CPN physician network referring patients exclusively to CHS hospitals located outside of York County. *Order Denying Respondent’s Motion to Stay/Supersedeas Pending Appeal* at 5 (attached as **Exhibit C**). Permitting CHS to build a hospital in York County “would accelerate [Piedmont’s] loss of market share, erode its payor mix, and would put at risk the quality of medical care available to York County patients” *Id.* The ALC further noted that CHS’s present position is inconsistent with the position it asserted at trial:

Additionally, the court finds it curious that the Respondent is now asserting that it will lose market share to the Petitioner if it is permitted to build its hospital in Northern York County. During the trial in this matter, it was the Respondent's position that its proposed Northern York County hospital's function would primarily be to relieve the high patient volume at its other hospitals and accommodate existing patients that were currently receiving care at those other CHS facilities outside of the county. The Respondent's position was that building its proposed hospital in Northern York County would allow it to manage its existing York County patient base better. Therefore, this court fails to understand how permitting the Petitioner to build its hospital will have any effect on the Respondent's existing market share which is currently being cared for at the Respondent's other hospitals.

Ex. C at 5.

The ALC's Amended Final Order found that the establishment of Piedmont's Fort Mill hospital "could" restore Piedmont's market share in the Fort Mill area to what it had been in 2003-2004, before CHS began taking significant market share from Piedmont. Ex. A, Findings of Fact 20-26, 79. It is unreasonable to believe, however, that the restoration of Piedmont's market share will occur overnight. Even after the new hospital is constructed, it could take years for Piedmont to recapture the market share it lost to CHS from 2005-2012. *See id.*

Even if CHS could demonstrate that Fort Mill Medical Center were likely to cause it some immediate economic loss, such a loss would be insufficient to constitute irreparable harm. "Generally, pure economic loss is not sufficient to satisfy the requirement of showing an irreparable harm where an adequate an adequate remedy is available at law." *Professional Wiring Installers, Inc. v. Sims*, 2008 WL 9840409 (S.C. App. 2008) (UNPUBLISHED), citing *MailSource, LLC v. M.A. Bailey & Assocs.* 356 S.C. 363, 370, 588 S.E.2d 635, 639 (Ct. App. 2003). The exception to the general rule is that pure economic loss may constitute

irreparable harm when it causes the “complete loss” of a business. *Peek v. Spartanburg Reg. Healthcare Syst.*, 367 S.C. 450-455, 626 S.E.2d 34, 37 (Ct. App. 2005) (“The complete loss of a professional practice can be an irreparable harm”); *Levine v. Spartanburg Reg. Servs. Dist.*, 367 S.C. 458, 465, 626 S.E.2d 38, 42 (Ct. App. 2005) (“loss of . . . professional practice and career . . . can be an irreparable harm.”); *Dist. of Columbia v. E. Trans-Waste of Md., Inc.*, 758 A.2d 1, 15 (D.C. 2000) (“While economic loss does not, in and of itself, constitute irreparable harm, such harm will be found if economic loss threatens the very existence of [plaintiff’s] business.”); *Campbell Inns, Inc. v. Banholzer, Turnure & Co.*, 148 Vt.1, 527 A.2d 1142, 1146 (1987) (“The potential loss of a business satisfies the irreparable harm requirement . . .”).

CHS is a public hospital system based in Charlotte that owns or manages 42 hospitals, in addition to various other healthcare facilities and a large physician network. Ex. A, Findings of Fact 4, 23. According to its own witness, in 2011 CHS had net assets of \$3.5 billion. Trial Trans. at 1849:18-1850:4, attached as **Exhibit D**. It is undisputed that CHS was doing well financially prior to 2005, when it began taking significant market share from Piedmont. It is undisputed that CHS is doing well financially today. There is absolutely no risk that a 100-bed hospital in Fort Mill could threaten CHS’s existence or, therefore, cause it irreparable harm.

Any change in referral patterns generated by operation of Fort Mill Medical Center would revert back if CHS were successful on appeal. Moreover, Piedmont has not yet begun its project, which is scheduled to take 26 months to complete. Piedmont Updated CON Application, Project Timeline (Revised 2010), attached as **Exhibit E**.³ Therefore, even if

³ The timeline optimistically assumed a start date of April 2013 and a completion date of July 2015.

Piedmont were to begin its project today, “this court will likely decide the merits of the appeal before completion of [Piedmont’s] project and thus, well before area doctors begin to change their referral patterns.” See *Grand Strand* at 3 (noting that the Grand Strand project was expected to take 18 months.) If the Court imposes a stay and Piedmont prevails, months will be added to the time necessary for the appeals process, depriving citizens in the service area even longer of a new hospital.

2. Likelihood of Success on the Merits

CHS cites *Williams v Jones*, 92 S.C. 342, 348, 75 S.E. 705, 710 (1912) for the proposition that CHS need only raise a “fair question” as to its likelihood of success. It further cites *Transcontinental Gas Pipe Line Corp v. Porter*, 252 S.C. 478, 481, 167 S.E. 2d 313, 315 (1969) for the principle that simply a prima facie showing in the complaint of entitlement to injunctive relief is all that is required to show a likelihood of success.

Both *Williams* and *Transcontinental* involved preliminary injunctions issued by a trial court before a trial was held. At such an early stage of litigation, before any evidence has been submitted or even before any discovery has been conducted, it would be inappropriate for the court to consider the merits of the case. At that stage of litigation, the only way to demonstrate a likelihood of success is by establishing a prima facie case in the complaint.

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That, however, is not the situation in the present case. A fifteen-day trial has been held, following years of litigation. The ALC has issued a Final Order and an Amended Final Order. Appellant asks this Court to don blinders and ignore the findings and conclusions of the ALC's 53-page Amended Final Order, which meticulously analyzes the merits of CHS's case and finds it lacking. CHS offers no authority to support its argument that in a petition for supersedeas in a post-trial appeal, the likelihood of success on the merits should be analyzed by whether the Appellant established a prima facie case in its initial pleading.⁴ *See Ex. C* at 6.

3. Adequate Remedy at Law


CHS clearly has an adequate remedy at law – the appeal it has just filed. If CHS wins the appeal, Piedmont will have to cease development of its hospital project. The purpose of a temporary injunction is to preserve the status quo. *Peek*, 367 S.C. at 456, 626 S.E.2d at 37. If Piedmont ceases construction or operation of Fort Mill Medical Center, the status quo will be preserved.

⁴ The principal issue on which Appellant bases its hopes of success relates to an alleged violation of the dormant commerce clause. The Amended Final Order addresses CHS's dormant commerce clause argument in a lengthy footnote. *Ex. A* at 2, n.2. The Court observes that the same State Health Plan, project review criteria, and analysis would have been used in the Amended Final Order "regardless of whether competing applicants were out-of-state or in-state providers." *Id.* In fact, "the same plan, criterion and analysis have been applied in similar cases in which CHS has been awarded a CON in South Carolina. The decision of the court has been the result of an extended process commencing prior to 2006 when DHEC issued its first Decision. The court was permitted to make its own findings of fact by a preponderance based on the evidence presented. Because the court chose to accept or reject certain testimony and assign different weight and credibility to the evidence presented by the parties in the *de novo* hearing does not mean that its decision violates the Dormant Commerce Clause or the Commerce Clause. Similarly, merely because CHS disagrees with the court's ruling, does not render its analysis in violation of the Dormant Commerce Clause." *Id.*

III. CONCLUSION

Less than one month ago this Court expressly held that Section 44-7-220(B) “is constitutional as written.” *Grand Strand* at 5. To the extent SCRCP 65 applies to this appeal, Appellant cannot show irreparable harm, likelihood of success, or an inadequate remedy at law. For these reasons, the Amended Motion should be denied.

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Columbia, South Carolina

April 13, 2015

CERTIFICATE OF SERVICE

I, the undersigned administrative assistant of the law offices of Nelson Mullins Riley & Scarborough LLP, attorneys for Amisub of South Carolina, Inc., d/b/a Piedmont Medical Center, d/b/a Fort Mill Medical Center do hereby certify that I have served all counsel in this action with a copy of the pleading(s) hereinbelow specified by placing same in the United States mail, postage prepaid, to the following address(es):

Pleadings: **RETURN TO APPELLANT'S SUPPLEMENTAL MOTION FOR RELIEF FROM BOND AND PETITION FOR SUPERSEDEAS**

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April 13, 2015

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Amisub of South Carolina, Inc. d/b/a)
Piedmont Medical Center d/b/a Fort Mill)
Medical Center,)
)
Petitioner,)
)
v.)
)
South Carolina Department of Health and)
Environmental Control and The Charlotte-)
Mecklenburg Hospital Authority d/b/a)
Carolinas Medical Center-Fort Mill,)
)
Respondents.)

Docket No. 11-ALJ-07-0575-CC

AMENDED FINAL ORDER

APPEARANCES: Stuart M. Andrews, Jr., Esquire and Daniel J. Westbrook, Esquire for
Petitioner Amisub of South Carolina, Inc., d/b/a Piedmont Medical Center,
d/b/a Fort Mill Medical Center

Douglas M. Muller, Esquire, Trudy H. Robertson, Esquire, and E.
Brandon Gaskins, Esquire for Respondent The Charlotte-Mecklenburg
Hospital Authority, d/b/a Carolinas Medical Center-Fort Mill,

Ashley C. Biggers, Esquire for Respondent South Carolina Department of
Health and Environmental Control

STATEMENT OF THE CASE

This matter is before the Administrative Law Court (ALC or court) pursuant to the request for a contested case hearing filed by Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center (Piedmont). Piedmont is challenging the decision of the South Carolina Department of Health and Environmental Control (DHEC or the Department) to grant a certificate of need (CON) to The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas Medical Center-Fort Mill Carolinas Healthcare System (CHS) to build a general acute care hospital in York County, South Carolina. The hearing was held over the course of fifteen (15) days between April 8, 2013, and May 7, 2013. The court issued its Final Order and Decision in the matter on March 31, 2013. Upon a Motion for Reconsideration filed by CHS, the court issued an Order vacating the March 31, 2013 Final Order and Decision. For the reasons set forth

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in this Amended Final Order, the court concludes that the CON application should be granted to Piedmont for the purpose of building a one hundred (100) bed general acute care hospital in York County, South Carolina.^{1,2}

BACKGROUND

York County, South Carolina is among the fastest growing counties in the state. *Jt. Ex. 1-B at 1004*. One of the fastest growing and most affluent parts of York County is the area surrounding the town of Fort Mill in Northern York County. *Tr. 215:12-16; 1235:14-19*. The western part of the county (Western York County) is more rural, less populous, and less affluent. *Tr. 1236:14 - 1238:12*.

The 2004-2005 South Carolina Health Plan (State Health Plan or Plan) identified a need for 64 additional acute care hospital beds in York County. Based on the need identified in the Plan, DHEC received four applications for a Certificate of Need (CON) to build a hospital near the town of Fort Mill. The four applicants were Piedmont, CHS, Presbyterian Healthcare System (Presbyterian), and Hospital Partners of America, Inc. (HPA). In January 2005, Piedmont applied to construct and operate a sixty-four (64) bed hospital. On March 11, 2005, CHS, Presbyterian, and HPA each filed competing applications to construct and operate a 64 bed hospital. On October 6, 2005, Piedmont withdrew its January 2005 application and submitted a

¹ In their Petition for Rehearing as to the original Final Order and Decision issued on March 31, 2014 and subsequently vacated on May 2, 2014, CHS argued that the three (3) physicians that testified were not "independent" as they were affiliated with Piedmont. The use of the word, "independent," was utilized in the sense that those physicians were not contractually bound by any employment agreement to refer patients to any particular facility. To avoid further misinterpretation, the word, "independent" has been removed. CHS also argues that the court erred in allowing these physicians to testify at the contested case hearing on the basis that they testified beyond the scope of their deposition testimony. The admission of testimony and the weight and credibility assigned to the same is within the purview of the court. The court does not believe that there was any abuse of discretion in allowing the admission such testimony. *Hill v. S.C. Carolina Dept. of Health & Envtl. Control*, 389 S.C. 1; 698 S.E.2d 612 (2010). CHS also had a full and fair opportunity to cross-examine these witnesses at the contested case hearing and did not request additional time to prepare for further examination during the course of the hearing.

² In their Petition for Rehearing as to the original Order, CHS argues that the court's opinion violates the Dormant Commerce Clause. Upon review of the applicable case law, the parties' briefs and both the original and Amended Orders, the court does not believe it violated the Dormant Commerce Clause in its analysis and application of the State Health Plan or Project Review Criterion in the original or amended decisions. The same plan, criterion and analysis would have been utilized regardless of whether competing applicants were out-of-state or in-state providers. In fact, the same plan, criterion and analysis have been applied in similar cases in which CHS has been awarded a CON in South Carolina. The decision of the court has been the result of an extended process commencing prior to 2006 when DHEC issued its first Decision. The court was permitted to make its own findings of fact by a preponderance based on the evidence presented. Because the court chose to accept or reject certain testimony and assign different weight and credibility to the evidence presented by the parties in the *de novo* hearing does not mean that its decision violates the Dormant Commerce Clause or the Commerce Clause. Similarly, merely because CHS disagrees with the court's ruling, does not render its analysis in violation of the Dormant Commerce Clause.

new application for a 100 bed hospital. The 100 bed hospital would include 64 general acute care hospital beds for which the Plan showed a need as well as thirty-six (36) licensed general acute care hospital beds that were to be transferred from the Piedmont Medical Center in Rock Hill to a new facility in Fort Mill. Piedmont's proposed hospital would be called Fort Mill Medical Center (FMMC). CHS' proposed hospital would be called Carolinas Medical Center – Fort Mill (CMC-FM).

By decision letters dated May 30, 2006, DHEC approved Piedmont's application to construct a 100 bed general acute hospital in York County and denied the applications of Presbyterian, CHS, and HPA for 64 bed hospitals. In response to DHEC's decision, CHS and Presbyterian filed separate requests for contested case hearings at the ALC.³ The cases were assigned to the Honorable Carolyn C. Matthews and consolidated into *The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System and Presbyterian Healthcare System d/b/a Presbyterian Hospital-York, LLC v. South Carolina Department of Health and Environmental Control and Amisub of South Carolina, Inc. d/b/a Piedmont Healthcare System d/b/a Fort Mill Medical Center*, Docket No. 06-ALJ-07-0713-CC.

The contested case hearing was held in September 2009. At the conclusion of the presentation of evidence by Petitioners CHS and Presbyterian, both parties moved for summary judgment, arguing that DHEC erred in interpreting the Plan in such a manner as to allow only Piedmont, as the existing facility in York County for which the Plan designated additional beds, to be approved and to require the denial of all other applicants. Piedmont moved for partial summary judgment on the issue of whether it was a "competing applicant." On December 9, 2009, Judge Matthews issued an Order that upheld DHEC's finding that Piedmont was a competing applicant for the CON at issue in this matter. However, Judge Matthews found that DHEC erroneously interpreted the Plan to allow only existing providers—in this case, Piedmont Medical Center—to obtain a CON. Based on this finding, Judge Matthews remanded the matter to DHEC with instructions:

1. Review the Presbyterian, Carolinas [CHS], and FMMC [Piedmont] CON applications to determine "which of the applicants, if any, most fully complies with the requirements, goals, and purposes of this article and the State Health Plan, Project Review Criteria, and the regulations adopted by the department" as required by S.C. Code Ann. § 44-7-210(C).

....

³ HPA did not appeal DHEC's 2006 decision and is not a party to the matter currently pending before this court.

7. The Department's decisions must be made based upon the fact that each of the parties is in equal compliance with 24A S.C. Code Reg. 61-15 § 802.1. The Department's decisions must be accompanied by written findings as to each applicant's compliance with the relevant Project Review Criteria and which party best meets each project review criterion and the basis thereof.

Charlotte-Mecklenburg Hosp. Auth. v. S.C. Dep't of Health & Envtl. Control, Docket No. 06-ALJ-07-0713-CC (Dec. 9, 2009), pp. 27-28 (emphasis in original). On appeal, the South Carolina Supreme Court concluded that the Order of December 9, 2009, was interlocutory because a final determination as to the CON had not been made. *Charlotte-Mecklenburg Hosp. Auth. v. S.C. Dep't of Health & Envtl. Control*, 387 S.C. 265, 692 S.E.2d 894 (2010).⁴ The parties, therefore, proceeded with the remand instructions.

The parties consented to a deadline of October 4, 2010, for filing updated information with DHEC. All three parties submitted supplemental information to update their previous CON applications. During the ensuing eleven months, each applicant submitted additional information concerning its CON application to DHEC, either on its own initiative or in response to numerous requests by DHEC staff for additional information. The volume of material submitted by the applicants to DHEC during this period was extensive. DHEC held a Project Review Meeting on June 29, 2011, which provided the opportunity for each applicant to make a presentation and answer questions posed by DHEC staff.

On September 9, 2011, DHEC issued three (3) decision letters, this time granting CHS' application and denying the applications of Presbyterian and Piedmont. Each decision letter included three or four numbered paragraphs highlighting the basis for the decision contained therein, and they also referenced the Project Review Criteria Analysis that was attached to all three decisions. The ten-page Project Review Criteria Analysis, along with the Project Review Summary for each applicant, serves as the Summary of Staff Findings.

After the DHEC Board denied the request for a final review conference, the decision letters of September 9, 2011 became the final decisions of DHEC. Presbyterian and Piedmont timely requested contested case review of these decision letters. This court consolidated the cases on January 31, 2012. Pursuant to its motion to withdraw, this court dismissed Presbyterian as a party by Order dated February 1, 2013.

⁴ For purposes of this Amended Order, the court will defer to Judge Matthews' finding that Piedmont's application qualified as a competing application and that all of the applicants were in equal compliance with S.C. Code Ann. Regs. 61-15 § 802.1.

STANDARD OF REVIEW

This Court reviews contested case actions *de novo*. *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). Petitioner bears the burden of proof by a preponderance of the evidence. *Nat'l Health Corp. v. S.C. Dep't. of Health & Envtl. Control*, 298 S.C. 373, 379, 380 S.E.2d 841, 844 (Ct. App. 1989).

FINDINGS OF FACT

Having carefully considered all testimony, exhibits, and arguments presented at the hearing of this matter, and taking into account the credibility of the witnesses and the reliability of the evidence, I make the following findings of fact by a preponderance of the evidence:

1. Piedmont is an existing two-hundred-eighty-eight (288) bed acute care hospital located in Rock Hill, York County, South Carolina.⁵ Piedmont is operated by Amisub of South Carolina, Inc., which is a subsidiary of Tenet Healthcare Corporation (Tenet). Tenet is a for-profit, publicly traded company that is headquartered in Dallas, Texas and owns forty-nine (49) hospitals in ten (10) states. Tr. 177:20-23; 193:5-16. Piedmont has a medical staff of approximately three hundred fifty (350) physicians and employs more than one thousand five hundred (1,500) persons, including six hundred seventeen (617) nurses, one hundred forty-one (141) of which live in Northern York County or Mecklenburg County, North County. Tr. 186:3-12, 187:9-16. In addition to standard community hospital services, Piedmont Medical Center provides specialized services not usually offered by a hospital its size, including open heart surgery, neurosurgery, cardiac catheterization, vascular surgery, neonatal intensive care, specialized women's and pediatric services, and behavioral health. Tr. 184:3, 185:10.

2. Piedmont Medical Center has won a number of quality awards in recent years. In 2013 and 2010 it was named Distinguished Hospital of the Year in South Carolina for cardiovascular disease and stroke services by DHEC and the American Heart Association (AHA). Tr. 189:1-10. In 2013 the AHA also awarded Piedmont Medical Center the Gold Plus Achievement Award for treatment of heart failure and stroke. Tr. 189:21 - 190:1. In 2011 Piedmont was one of four hospitals in the state cited by the Joint Commission of Accreditation of Healthcare Organizations (Joint Commission) as a Top Performer on Key Quality Measures of

⁵ Piedmont Medical Center has 288 beds, which includes 268 acute care beds and 20 beds for psychiatric services. This case focuses on the addition of 64 acute care beds. As a result, most of the discussion pertains to the 268 acute care beds, rather than the psychiatric beds.

heart attack, heart failure, pneumonia, and surgical care. Tr. 190:3-21. Piedmont also has a number of certifications and accreditations, as well as payor recognitions for quality of care. Tr. 191:19 - 193:4.

3. Amisub pays local, state, and federal taxes. Tr. 952:20 - 953:2. Operating as a division of Amisub, Piedmont's proposed FMMC is projected to pay over \$4,000,000 per year in local property taxes, including taxes levied by York County school districts. Tr. 493:9 - 15.

4. CHS is a public hospital system created by North Carolina statute and headquartered in Charlotte, North Carolina. Tr. 1682:1-10. CHS owns or manages forty-two (42) hospitals, in addition to various healthcare facilities. Tr. 1778:16-20. CHS' largest hospital is Carolinas Medical Center (CMC-Main), located in Charlotte, North Carolina. CMC-Main has more than eight hundred (800) beds and provides highly specialized tertiary and quaternary services. Tr. 200:14-20. The closest CHS hospital to Piedmont Medical Center is CMC-Pineville, located just across the state line in Pineville, North Carolina, an approximately twenty-five (25) minute drive from Rock Hill. Tr. 198:20-21. From 2002 to 2013, CHS spent more than \$300,000,000 expanding CMC-Pineville from ninety-seven (97) to two hundred six (206) beds. Tr. 1188:2-23. During this period CHS also expanded CMC-Pineville's services to include specialized tertiary services similar to those provided at Piedmont Medical Center. Tr. 1191:23 - 1192:9.

5. CHS has also been recognized for the quality of its clinical services. For example, CHS' 42 hospitals have been awarded a combined twenty-one (21) Joint Commission certifications. Like Piedmont, CHS has been party to a contract with its home county, under which Mecklenburg County reimbursed it over \$16,000,000 annually to provide certain charity care services. Tr. 492:4-12. In 2012, however, the contract was terminated. *Id.* From January 2007 - July 21, 2012, CHS filed over nine thousand seven hundred (9,700) collection actions against patients for not paying their bills. Piedmont Ex. 114 at 17. As a result, CHS obtained nearly five thousand (5,000) liens on patient homes. *Id.*; Tr. 1748:13-17.

6. DHEC is a state agency charged with, among other things, implementing South Carolina's CON regulatory program, which includes licensing standards for the establishment of acute care hospitals. S.C. Code Ann. § 44-7-140. By statute, DHEC is "the sole agency for control and administration of the granting of [CONs] and licensure of health facilities." *Id.* As part of its duties, DHEC is required to publish, at least every other year, a South Carolina Health

Plan, outlining the need for medical facilities and services in the State. The South Carolina Health Plan includes an inventory of existing facilities and services, projections of need for additional facilities and services, standards for distribution of facilities and services, and general statements regarding project review criteria for consideration of CON applications. S.C. Code Ann. § 44-7-180(B).

7. The original CON applications in this case were based on the need identified in the 2004-2005 South Carolina Health Plan. In that Plan, DHEC projected the population in York County would grow from 172,090 in 2003 to 192,300 in 2010. The Plan also recognized that the occupancy rate at Piedmont Medical Center, the only general acute care hospital in York County, had increased from sixty-five and two-tenths (65.2) percent in 2001 to seventy-five and one-tenth (75.1) percent in 2003. Based on historical occupancy rates at Piedmont Medical Center, and the projected growth of the York County population, DHEC identified a need for three hundred thirty-two (332) acute care beds in York County. The Plan, therefore, identified a need for an additional 64 acute care hospital beds over and above Piedmont Medical Center's existing two hundred sixty-eight (268) acute care beds.

8. The other relevant plan is the 2012-2013 South Carolina Health Plan, which became effective November 9, 2012, and is currently in effect. In that plan, DHEC revealed that the occupancy rate at Piedmont Medical Center, the only existing acute care hospital in York County, decreased from 75.1 percent in 2003 to fifty-seven and one-tenth (57.1) percent in 2009. Although the occupancy rate subsequently increased to fifty-eight (58) percent in 2010 and sixty-two and one-tenth (62.1) percent in 2011, it still has not returned to its 2001 occupancy rate. DHEC also projected that the population of York County would increase from 229,600 in 2011 to 253,900 in 2018.

9. CHS proposes to construct a 64 bed hospital to be located in Fort Mill, South Carolina, at a total project cost of \$79,101,360. Joint-A-CHS-001.0143. CHS intends to serve patients that are already aligned with its system. The proposed CHS Fort Mill hospital is a smaller acute care hospital that will serve a different acuity level of patients than Piedmont's larger, tertiary hospital. Redirecting a sizeable portion of the CHS-aligned patients in Northern York County to a new CHS hospital in Fort Mill will cause the new hospital to be well-utilized.

10. Piedmont proposes to construct a 100 bed hospital to be located in Fort Mill, South Carolina, at a total project cost of \$119,808,964, without financing, or \$146,522,042,

which includes financing costs during construction. Joint-B-PMC-001.0010. Piedmont's proposal envisions transferring 36 beds from Piedmont Medical Center, its existing hospital in Rock Hill, to its new hospital in Fort Mill, and adding those to 64 beds for which a need is recognized in the 2004-2005 South Carolina Health Plan for York County. Currently, Piedmont Medical Center in Rock Hill has a daily census of one hundred eighty (180) beds, meaning that on any given day the facility has one hundred (100) or more empty beds. Of the 36 beds it proposes to transfer from Piedmont Medical Center to its Fort Mill facility, nineteen (19) were not being staffed or used for patient care. By transferring the beds, Piedmont intends to redeploy resources from Rock Hill to the Fort Mill area where there is a greater need for them.

11. At the time of the review of the CON applications on remand, Beverly Brandt was the DHEC Chief of Bureau of Health Facilities and Services Development. Ms. Brandt, who was not involved in the original review in 2006, relied on the ranking of the Project Review Criteria that was established by DHEC during its original 2006 review. (Tr. 873:6 – 20; 1376:20 – 1377: 10). In a letter from Mary Fechtel dated March 27, 2006, DHEC established the relative importance of the project review criteria, listing the most important criteria first, as follows:

- Rank 1 Compliance with the State Plan (1)
- Rank 2 Community Need Documentation (2a-2e)
Distribution (Accessibility) (3a-3g)
Distribution (22)
- Rank 3 Projected Revenues (6a, 6b)
Projected Expenses (7)
Net Income (9)
Financial Feasibility (15)
Cost Containment (16a-16c)
Efficiency (17)
- Rank 4 Record of the Applicant (13a, 13b, 13d)
Acceptability (4a-4c)
Adverse Effects on Other Facilities (23a, 23b)

Resp. Ex. 2C, 000697; Resp. Ex. 4B, 000592. These criteria are grouped in the DHEC regulation in the general categories of Need for the Proposed Project, Economic Consideration, and Health System Resources. § 801(1). Thus, DHEC's ranking established that these categories would be the focus of its review of the CON applications for building a hospital in Fort Mill. DHEC also established that all other relevant criteria would be given equal importance. The remaining criteria are grouped in the DHEC regulation in the general categories of Site Suitability and Special Consideration. § 801(1).

The York County Contract

12. Since 1980 Piedmont has been party to a contract with York County (the York County Contract) that does not expire until 2045. Tr. 193:24 – 194:13. The contract has been amended numerous times over the years, and the parties are currently negotiating the tenth addendum to the contract. Tr. 957: 19 – 24. In the Ninth Addendum, the parties expressed their intent that the terms and conditions of the contract, including the various amendments, would apply to FMHC. Tr. 957:13 – 18. The York County Contract restricts how much Piedmont can charge for services, requires quarterly and annual public financial reports to the county, and further requires Piedmont to make certain annual capital investments in facilities or equipment. The contract also requires Piedmont to provide various non-hospital based services, including county-wide ambulance services at no charge to the County and an urgent care center in Western York County. Tr. 945: 5 – 10; 195:9 – 196:5.

13. Piedmont provides some of these services at a loss. For example, it operates the county-wide ambulance service at a loss of approximately \$4,000,000 - \$4,500,000 per year, and the service transports a significant number of patients to hospitals other than Piedmont located outside of York County. Tr. 944: 4 – 7. In addition, Piedmont agreed under the Ninth Addendum to the contract to provide full-time (24/7) physician coverage at its urgent care center in Western York County. Tr. 954:16 – 955:13. Because of the limited demand for urgent care services in Western York County, Piedmont lost \$800,000 a year for each of the five (5) years it staffed the center at the level requested by York County. Tr. 956:5 – 11. Under the Sixth Addendum, Piedmont undertook to pay an indigent care tax to the state of approximately \$450,000 per year that would otherwise be assumed by York County. Tr. 950: 11 – 15.

14. David S. Levitt, the healthcare planning consultant who drafted Piedmont's application and has provided CON services in over four hundred fifty (450) matters throughout South Carolina and the northeast and southeast, testified that he is aware of no other hospital that has assumed comparable contractual responsibilities to the counties in which they are located. Tr. 491:23 – 492:3. Piedmont's commitment to the York County community, as expressed through this long-standing contract, is impressive. The citizens of York County derive innumerable benefits as a result of the transparency and enforceable obligations of the contract. While Piedmont could have withdrawn from the contract at points during the past three decades, Piedmont has continued to maintain its commitment to reasonable pricing, capital reinvestment,

ambulance services that operate at a substantial loss to Piedmont, and comprehensive annual reports on the operation of the hospital and its performance under the contract.

15. Piedmont's interest in establishing a hospital to serve the Northern York County and Fort Mill area began several years before it filed its initial CON application in November 2004. Tr. 960:1-6; 449:1-4. In 1999, Piedmont recognized Northern York County as one of the fastest growing areas of the state and developed plans to establish a medical presence in the area. Tr. 961:5-12. Charles F. Miller, Piedmont's chief executive officer from 1998-2013, testified that Piedmont hoped to meet the growing demand for healthcare services and to reduce the outmigration of York County residents to out of county hospitals by establishing a hospital in the Fort Mill area. Tr. 961:15 – 962:1.

16. During this period of time, Piedmont was notified by a local developer, Clear Springs Development Company (Clear Springs), of its interest in the establishment of a series of planned communities in the Fort Mill area that would incorporate a broad range of healthcare services and facilities. Tr. 960:10-24; 963:2-16. Clear Springs became the development vehicle used by the Close family to convert its Fort Mill area holdings into various planned communities. Tr. 962:19-23. In April 1999, Clear Springs issued a request for proposals RFP) to Piedmont, CHS, and Presbyterian seeking proposals for the development of healthcare services in Baxter Village. Piedmont and Presbyterian submitted proposals; CHS did not. Tr. 436:12 – 437:17. In October 1999, Piedmont was selected by Clear Springs to develop the healthcare services that would be located on the Baxter Medical Campus in Fort Mill. *Id.* These services included physician practices, urgent care services, an imaging center, and ultimately a hospital.⁶ Tr. 436:5-8.

17. By letter dated October 5, 2000, Mr. Miller requested, and subsequently received, Tenet's approval to enter into an agreement with Clear Springs to develop the proposed Baxter Village healthcare services. Tr. 965:3 – *see* Piedmont Ex. 25. In that letter, Mr. Miller stated: "A major portion of Piedmont Healthcare System's strategic plan for the last decade has been centered on initiatives to reduce outmigration from York County to Charlotte-based facilities." Tr. 965:24 – 966:3.

⁶ The parties acknowledged that the establishment of the hospital and other healthcare facilities would be subject to CON review. Tr. 969:1-9. Clear Springs and Piedmont also agreed to change the location of the proposed hospital site from Baxter Village to a site adjacent to Clear Springs' Kingsley North project that included plans for 1200 residences, one million square feet of commercial office space, and a three hundred (300) room hotel. Tr. 970:9 – 971:18.

18. The Fort Mill satellite hospital has been the centerpiece of Piedmont's long-term plan to serve York County. The hospital would create a presence in Northern York County and would provide local services to a growing population that has historically travelled outside of York County, mostly to the Charlotte area, for a wide range of needs, including employment, shopping, entertainment, and healthcare. Tr. 966:13 – 967:2. By reducing outmigration of patients from the Northern York County and Fort Mill area, the satellite hospital would also strengthen Piedmont's services to residents throughout York County by increasing the number of patients treated at Piedmont's Rock Hill facility. Tr. 439:15-18.

19. The agreement between Piedmont and Clear Springs to develop the Baxter Village Medical Campus provided for a ten (10) year period to establish a hospital. Tr. 968:17-19. When the 2004-2005 State Health Plan was published showing a need for 64 beds, and after taking into consideration the time necessary to process the CON application and to design, develop, and construct the hospital, Mr. Miller believed that the FMMC would open on schedule in 2010. Tr. 968:2-5; 17-25.

Utilization

20. From 1997 to 2005, the utilization of Piedmont by York County residents increased forty (40) percent, from approximately ten thousand (10,000) to fourteen thousand (14,000) inpatient discharges. Tr. 433: 10 – 15. During that period, Piedmont's market share of York County patients who received inpatient hospital services was generally flat, registering a high of sixty-seven (67) percent in 2002 to a low of sixty-four (64) percent in 2005. Tr. 434: 4 - 12. The utilization increase Piedmont experienced in the period occurred proportionately during this period with other hospitals serving York County residents. Tr. 434:13 – 17.

21. Several significant developments occurred between the time of the filing of the Fort Mill area CON applications in 2005 and the filing of the updated applications in 2010 following the remand of this case. Tr. 450:13 – 17. The first was the decrease in utilization of Piedmont by York County residents. During this period, Piedmont's utilization dropped from approximately fourteen thousand (14,000) to eleven thousand (11,000) discharges. Tr. 451:15 – 21; Piedmont Ex. 136. This decline in patient volume nearly erased the growth in utilization Piedmont experienced from 1997 to 2005. Piedmont's market share of York County inpatient hospital services dropped from 64 percent in 2005 to fifty-five (55) percent in 2011. Tr. 453:20

– 25. This decline in patient volume occurred during a period when York County's population grew twenty-two (22) percent. Tr. 205:11 – 22.

22. The utilization data during this period reflect a direct correlation between Piedmont's York County patient loss and CHS' gain. From 2005 to 2010, Piedmont lost approximately two thousand two hundred (2,200) York County patient discharges. During the same period, Carolinas Medical Center and Mercy-Pineville increased York County discharges by a combined one thousand eight hundred (1,800) patients. Tr. 454:11 – 18. Thus, over eighty (80) percent of Piedmont's loss in York County patient volume from 2005 to 2010 was absorbed by CHS facilities. Tr. 455:2-9.

23. CHS owns a large network of employed physicians known as the Carolinas Physician Network (CPN). In February 2005 prior to the filing of CHS' CON application in this case, CPN employed twenty-five (25) physicians with offices in York County. Tr. 456:2 – 5. Within one month following CHS' submission of its application, in April of 2005, CPN added twelve (12) physicians to its network, bringing its total of employed physicians in York County to thirty-seven (37). Tr. 456:5 – 7. By 2012 the number of York County doctors working for CPN had grown to sixty-six (66), and at the time of the final hearing, the total number of CPN physicians employed in York County was between seventy and ninety (70 – 90). Tr. 214: 10 – 11; 1751:1 – 4.

24. CPN physicians enter a uniform employment agreement that establishes the following requirements concerning patient referral practices:

Referrals to CMHA Facilities. As a condition to the receipt of consideration provided for in this Agreement, Physician agrees to refer all patients in need of hospitalization, diagnosis or treatment on an outpatient or an inpatient basis to a facility owned, operated or managed, directly or indirectly, by CMHA and/or to a practitioner who is a member of the medical staff of any such facility (or any such practitioner's group practice) unless: (a) the patient expresses a preference for a different facility or practitioner; (b) the patient's insurer determines the facility or practitioner; or (c) the referral is not in the patient's best medical interests according to Physician's judgment. The above requirement shall not apply with respect to any ambulatory surgery center owned in part, directly or indirectly, by CMHA and in part by practitioners or group practices.

Piedmont ex. 25 at 1. In the absence of the above listed express exceptions, CPN physicians must refer their patients to CHS facilities or to physicians on the medical staffs of such facilities

who agree to admit the patients to such facilities. Tr. 457:6 – 11. During the period from 2009 to 2012, CPN referrals to CHS facilities and services increased more than four (4) times, from one thousand two hundred (1,200) referrals in 2009 to more than five thousand (5,000) in 2012. Tr. 462:3 – 5. Four CPN primary care offices in York County accounted for more than eighty (80) percent of the CHS referrals between 2009 and 2012. Tr. 463:7 – 15. One CPN cardiology practice in York County doubled its referrals to CHS hospitals from 1,200 cases in 2009 to two thousand four hundred (2,400) cases in 2012. Tr. 462:18 – 25.

25. After CHS filed its CON applications in April 2005, changes in their physician network strategies became evident.⁷ CHS, which had owned physician practices in York County for an extended period, quickly expanded its employed physician network and began the process of changing physician referral patterns. Tr. 981:11 – 982:23. Many physicians resigned their staff privileges at Piedmont, including several who had held leadership positions. Tr. 986:4 – 982:21; Piedmont Ex. 26. By 2011, nearly all CPN physicians had resigned from Piedmont's medical staff. Tr. 285: 16-20; see Piedmont Ex. 27.

26. Piedmont utilization records demonstrate a direct correlation between these changes in CPN physician referral patterns and the reduction of services at Piedmont between 2005 and 2011. Piedmont's overall market share of inpatient acute hospital services for York County residents dropped eleven (11) percentage points from sixty-three (63) percent in 2005 to fifty-two (52) percent in 2011. In contrast, the market share for CHS facilities grew by twelve (12) percentage points, increasing from twenty (20) to thirty-two (32) percent. Tr. 486:10 – 18. Piedmont's market share of complex cases for more severely ill York County patients shows even greater changes. From 2005 to 2011, Piedmont's share fell from fifty (50) percent to thirty-six (36) percent. During that same period, CHS market share grew from approximately thirty (30) percent to forty-two (42) percent, reflecting the increasing number of CPN practice referrals discussed above. Tr. 487:7 – 22. As a result, by 2011 more residents of York County than stayed to receive complex services. Tr. 487: 22 – 24.

Impact of Proposed Projects

27. Piedmont projects a fifty-eight (58) percent occupancy rate for FMMC by its third year of operations. Tr. 1229:20-23. The projected occupancy rates of FMMC are consistent

⁷ Presbyterian also altered its physician network strategies, however, because it has withdrawn as a party from this matter, this order makes no findings in that regard.

with similar facilities in the service area and the state. The only hospital in the service area is Piedmont Medical Center, whose occupancy rates for 2009 to 2011 were fifty-seven (57), fifty-eight (58), and sixty-two (62) percent, respectively. According to the 2012-2013 State Health Plan, the average occupancy rate for South Carolina hospitals from 2009 to 2011 was less than 58 percent, as was the average rate for hospitals in Region II, the region that includes York County. In addition to transferring some of Piedmont's existing patients to the new facility, Piedmont seeks to halt outmigration by expanding its emergency department, recruiting physicians, and building FMMC. Tr. 215:4 – 23.

28. CHS contends it will fill CMC-FM's beds by shifting York County patients it already serves at its existing facilities outside York County to its new facility. By shifting patients from its North Carolina hospitals to CMC-FM, CHS asserts it will take no additional patient volume or market share from Piedmont and have no other impact on Piedmont. Jt. Ex. 1-A at 20 (S-CHS-474); at 1232 (S-CHS0995); Tr. 1763:25 – 1764:7. Del Murphy, CHS' executive who drafted the CMC-FM application, testified that CHS' goal is not to increase its York County market share, but merely to maintain its current market share. Tr. 1764:13 – 22. In his trial testimony, Mr. Murphy attempted to make the distinction between a shift of market share and a shift of patients. Tr. 1759:11 – 1760:20. However, in his deposition, which was read into the record, Mr. Murphy blurred this distinction.

Q: Is it Carolina's position that they will not take any more patients from Piedmont than they are currently taking? And your answer was what?

A. Correct.

Tr. 1761:7-11. Additionally, CHS' expert, Dawn Carter, conceded that the assumption that CMC-FM would take no additional patients from Piedmont was "the basis of the projection in the [CHS] application." Tr. 2492:3-10.

29. The court finds CHS' assumption that it would take no patients or market share from Piedmont by operation of CMC-FM unreliable. Even if CHS had no desire to serve new patients, which seems implausible, it would not have the ability to control patient admissions into its proposed Fort Mill hospital. In addition to patients being admitted by its CHS-employed physicians, CMC-FM would also admit patients through its emergency department, as well as

through non-CHS physicians who would join hospital's medical staff and other independent physicians who would become exclusively affiliated with CHS. Tr. 521:7 – 23.

30. In 2012, the percent of emergency department admissions in CHS Charlotte area hospitals ranged from forty-five (45) percent at CMC-Mercy to approximately eighty (80) percent at CMC-Lincoln. Tr. 523:2 – 8. Roughly fifty (50) percent of the patients at CHS' hospital in Pineville, North Carolina (CMC-Pineville) were admitted through the emergency department. Tr. 523:8. These data demonstrate that, like other hospitals, CHS has no control over who presents at the emergency departments of its hospitals. Undoubtedly, some patients who will present at CMC-FM will be individuals who have historically used Piedmont. As CHS expert Dawn Carter acknowledged, "Usually a majority of inpatient admissions come through the emergency department." Tr. 2493:8 – 10. The proximity of CMC-FM's emergency department to Rock Hill would certainly attract Fort Mill patients who would otherwise go to Piedmont's existing facility and be admitted there.

31. Another way that Piedmont patients would shift to CMC-FM would be if non-aligned physicians who practice at Piedmont become aligned with CHS by employment or otherwise. Each of the three (3) physicians who are not contractually bound to any particular health care facility called as witnesses by Piedmont testified that they would obtain privileges at CMC-FM if it were approved. Although these physicians testified that they have had privileges at Piedmont for years and supported the approval of its application, they believed that patients they had served at Piedmont would want to be served at any new hospital that would be built in the Fort Mill area, irrespective of who established it. Tr. 148:13 – 149:8 (Adlakha); 296:4 – 15 (Taylor); 767:4 – 768:8 (Singhi). In order to maintain their relationship with those patients, the physicians expect to obtain privileges at the new facility so they can continue to serve the patients they have treated at Piedmont, even if the shift of patients to CMC-FM would have an adverse affect on Piedmont. *Id.* The testimony of these three practitioners was consistent with the reports received from Piedmont medical staff members by Piedmont experts David S. Levitt and Daniel J. Sullivan. Tr. 524:11 – 17.

32. The potential risk that Piedmont patients would shift to CMC-FM if non-contractually bound physicians who practice at Piedmont become aligned with CHS by employment or otherwise is more than merely speculative. One physician who testified at the hearing, Dr. Taylor, stated that his group, the oldest OB/GYN practice in York County,

discussed the prospects of employment with CHS, Piedmont, and other healthcare systems. Dr. Taylor continued by testifying that if his group, which provides over ninety-five (95) percent of Piedmont's OB/GYN services became employed with CHS, all of the group's patients, which are currently being treated at Piedmont, would be shifted to CMC-FM and other CHS facilities. Tr. 299:18 - 21. Similarly, another physician, Dr. Singhi, stated that his cardiology practice, Carolina Cardiology, has considered employment by both CHS and Piedmont. Tr. 773:19 - 774:21. Carolina Cardiology furnishes between eighty (80) and ninety (90) percent of the cardiology services at Piedmont. Dr. Singhi recognized the challenges that would exist if CMC-FM was approved that would not permit his practice to maintain its present status (e.g. being able to refer and admit patients to any facility to his choosing at which he has privileges). Tr. 773:19 - 774:7. If the Carolina Cardiology physicians become employed by CHS, Dr. Singhi acknowledged that CHS would expect his group to comply with the CPN physician network referral policy and transfer patients from Piedmont to CHS facilities. Tr. 778:11 - 25.

33. To the extent that CHS can control the facilities to which its affiliated physicians' patients are treated, the court finds that there is little incentive for CHS to simply shift existing patients to CMC-FM. CHS spent \$300,000,000 recently doubling CMC-Pineville's bed size and adding many specialty services that duplicate Piedmont's. In its 2007 CON application in North Carolina, part of CMC-Pineville's justification for expanding was that it projected that over twenty (20) percent of its admissions would come from York County. Tr. 1189:1 - 20. From that, it is impossible not to recognize that CHS has every incentive to recoup its multi-million dollar capital investment by maximizing utilization at CMC-Pineville, and not shifting those patients to CMC-FM.

34. It would also be untenable for CHS to seek little or no incremental increase in utilization of its facilities in return for its more than \$75,000,000 projected investment in CMC-FM. Merely serving the same patients that CHS already attends does not reflect sound business or healthcare planning principles. Tr. 518:5 - 12. This court cannot conclude that CHS, a highly successful business, would establish a new multi-million dollar facility in a new market without intending to serve any new patients, many of whom would inevitably be existing Piedmont patients. To conclude otherwise would be capricious.

35. CHS identified its incentive for establishing CMC-FM as not economic, but rather the need for additional capacity to relieve the utilization demands on the CHS Charlotte area

facilities. Tr. 2695:7 – 2696:25. Ms. Carter testified that CMC-FM would enable CHS to "decompress" utilization at CHS facilities, particularly CMC-Main. Tr. 2413:2 – 12. Mr. Levitt, however, countered that the effect of any relief provided to CHS' Charlotte area facilities by the redirection of York County patients to CMC-FM would be insignificant. Tr. 2696:11 – 25. Considering the effect on CMC-Main alone, the shift of York County patients from that facility to CMC-FM would affect only two and two-tenths (2.2) percent of the patient demand at CMC-Main. *Id.*

36. The evidence presented suggests that superior alternatives are available to CHS to decompress utilization at some of its facilities such as CMC-Main. Tr. 2697:12 – 19. Six (6) of the CHS Charlotte area hospitals consistently have had capacity to relieve CHS of its capacity constraints at CMC-Main. Tr. 2697:12-14. In 2009, CMC-Mercy was only forty-six (46) percent occupied. Tr. 2697:15-16. That same year, CMC-University, which is located in Charlotte very close to CMC-Main, was operating at forty-seven (47) percent capacity. Tr. 2698:3-7. Similarly, in 2011, the combined occupancy for CMC-Mercy and CMC-Pineville was 65 percent. Tr. 2697:16-17. The 2011 occupancy of CMC-University was 43 percent. Tr. 2698:6-7. Because CMC-Main draws from a large area, patients receiving care there from the communities served by CMC-Union, CMC-Kings Mountain, and CMC-Cleveland Regional⁸ could be redirected to those facilities in the same way CHS is proposing to shift patients to CMC-FM. Tr. 2698:9-20. If the objective of CHS is to decompress utilization at CMC-Main, the availability of excess capacity at other CHS facilities is a superior alternative to expending large amounts of capital to construct a hospital in Fort Mill. Tr. 2698:24 – 2699:10.

Adverse Impact

37. Experts for Piedmont and CHS testified about two alternative methods for analyzing impact; the incremental (with and without) method, and the "lookback" method. The incremental method projects an existing provider's utilization and income at a future date under two alternative circumstances: first, with a new operational provider; and second, without a new provider. The lookback method reviews the existing provider's projected utilization and income at a certain future date, assuming the presence of the new provider's projected utilization and income at a certain date in the future, and assuming the presence of a new provider. Then, an

⁸ In 2009, CMC-Cleveland Regional operated at 38 percent and CMC-Kings Mountain at twenty-eight (28) percent. Tr. 2552:25; 2554:12; 2557:18; 2558:9.

analyst looks back to the existing provider's utilization and income data at a specific point in time. Future projections are compared with the historical data to determine whether adverse impact would occur.

38. Piedmont's expert, Mr. Levitt, used the incremental approach in his adverse impact analysis. Mr. Levitt projected Piedmont's utilization and income in 2017 if CMC-FM were approved and operational. He compared those projections to Piedmont's projected utilization and income in 2017 without CMC-FM. He concluded that CMC-FM would cause an impact of three thousand seventy-six (3,076) fewer cases annually and \$12,087,942 less annual income for Piedmont. Piedmont Ex. 104.

39. CHS experts argued that because of the proposed patient shift from CHS facilities in North Carolina to CMC-FM, construction of CMC-FM would have no impact on Piedmont. Alternatively, however, they advocated using the lookback method for analyzing impact. Employing that approach, Ms. Carter, one of CHS' experts, testified that CMC-FM would have no adverse impact on Piedmont. Tr. 2346:22 - 2348:13.

40. Mr. Sullivan, another of Piedmont's experts, criticized the lookback approach for failing to give effect to population growth.⁹ By way of example, he discussed a hypothetical existing hospital (Hospital A) with a twenty (20) percent occupancy rate. A CON application for a new hospital (Hospital B) was approved in Hospital A's service area and, five (5) years later, Hospital A's occupancy rate remained at 20 percent. The lookback approach would conclude that no adverse impact had occurred, even though Hospital A's occupancy rate would have been forty (40) percent without Hospital B, due to high population growth in the service area. The incremental approach would take that fact into account and conclude Hospital A had been adversely impacted. Tr. 2834:2 - 2835:18.

41. Mr. Levitt's incremental method adverse impact analysis projecting a reduction in Piedmont's utilization of over three thousand (3,000) inpatient cases annually and over

⁹ CHS questioned Mr. Sullivan's credibility because in March 2005 he was engaged by CHS to conduct a technical review of the 2005 CMC-FM application before it was submitted to DHEC. Tr. 1256 - 1263. Mr. Sullivan's role was very limited, however. Tr. 1261:25 - 1262:17. Moreover, the application he reviewed differed significantly from the application DHEC approved in 2011. For example, the 2005 application did not propose to shift all patients to be served at CMC-FM from existing CHS facilities. Tr. 1290:17 - 1291:4 (Sullivan); Tr. 1675:8 - 1676:11, 1677:11 - 1679:3; 1680:9 - 1681:11 (Murphy). Ms. Carter also contended that Mr. Sullivan's testimony was inconsistent with his testimony in a North Carolina CON case. The court finds that, based on Mr. Sullivan's explanation, the two cases are distinguishable and his testimony not inconsistent. Tr. 2843:1 - 2847:10.

\$12,000,000 less annual income for Piedmont was based on an assumption that sixty-seven (67) percent of CMC-FM's patients would come from Piedmont. Tr. 649:21 – 650:4. Mr. Levitt also forecast the effect if half of CMC-FM's patients were to come from Piedmont. Under that scenario, the impact on Piedmont would be a loss of some two thousand (2,000) inpatient cases a year that would reduce Piedmont's income by approximately \$8,000,000 annually. Tr. 2703:24 – 2704; see Piedmont Ex. 107.

42. CHS expert Kathryn Platt produced a similar result when she applied the incremental adverse impact model, although her assumption that Piedmont's losses would be proportionate to its market share reduced the degree of the adverse impact in comparison to Mr. Levitt's analysis. Under Ms. Platt's incremental analysis, Piedmont would lose one thousand six hundred twenty-three (1,623) patient cases a year, and suffer a negative financial impact of \$6,500,000 annually. Tr. 2704:23 – 2271:8. Assuming CHS would shift existing patients to CMC-FM, Ms. Platt characterized her incremental analysis as a worst case scenario for Piedmont. Tr. 2270:23 – 2271:8. Ms. Platt also prepared a lookback adverse impact analysis that compared Piedmont's projected performance in 2017 with what it was in 2009. Under this analysis, which does not give effect to growth in demand or growth in population, Piedmont was projected to have only sixty-two (62) fewer patients in 2017 than it did in 2009. Tr. 2705:1-8.

43. Ms. Carter performed a similar lookback analysis, using more current baseline data from 2011 instead of 2009. Under Ms. Carter's lookback projection, Piedmont would lose six hundred seventy-six (676) inpatient cases each year that would have an adverse financial impact on Piedmont of \$2,700,000 annually. Tr. 2705:10-19. Ms. Carter testified that even if Piedmont incurred losses projected by Mr. Levitt, that the impact would not be adverse, determining that the adjusted margins of two and one-tenth (2.1) percent to five and four-tenths (5.4) percent were within an acceptable range. Tr. 2436:14 – 2437:11. However, Ms. Carter's analysis only took into consideration the financial effect of Piedmont's loss of inpatient cases. In rebuttal, Mr. Levitt testified that the inpatient financial losses were so great that he did not quantify the additional loss of outpatient services Piedmont would incur. Tr. 2707: 6 – 15. However, after Ms. Carter testified that the financial impact of the projected inpatient losses was insignificant, Mr. Levitt calculated the additional loss of outpatient services. Using the same assumptions he applied to his original adverse impact analysis, Mr. Levitt determined that the outpatient impact ranged from a low of \$5,500,000 applied to Ms. Platt's projection to a high of

\$10,500,000. Tr. 2707:23 – 2708:10. When considered in the aggregate, the negative impact ranges from \$12,100,000 for Ms. Platt's model to \$22,300,000 for the highest projected loss calculated by Mr. Levitt. Tr. 2708:13 – 24.

44. Mr. Levitt measured the effect of these combined inpatient and outpatient financial losses against Piedmont's pre-tax income for 2009, 2011, and 2012. He used three (3) projected total losses: \$22,300,000, based on the assumption that CMC-FM would take sixty-seven (67) percent of its patients from Piedmont; \$15,000,000, based on the assumption that CMC-FM would take fifty (50) percent of its patients from Piedmont; and \$12,100,000, based on the analysis performed by Ms. Platt that assumes Piedmont's losses would be proportional to its market share. Tr. 2709:10 – 2710:22. Mr. Levitt then applied those projected losses against Piedmont's pre-tax income, which was approximately \$28,000,000 in 2009, \$24,700,000 in 2011, and \$36,000,000 in 2012, to determine the following percentages that the total projected losses represented of pre-tax income. Tr. 2709:15 – 21.

<u>Financial Impact as a Percentage of Piedmont's Pre-Tax Income</u>			
<u>Projected Total Losses</u>	<u>2009</u>	<u>2011</u>	<u>2012</u>
\$22,300,000	80%	90%	62%
\$15,000,000	53.2%	60.2%	41.3%
\$12,100,000	43.4%	49.1%	33.7%

Tr. 2709:22 – 2711:1.

Each of these sets of projections represents what this court finds would be a substantial and adverse impact on Piedmont. Tr. 2711:24 – 2712:1. The calculations, however, do not account for all of the potential adverse financial impact on Piedmont. They do not include effect of the loss of complex cases, such as cardiac and neurosurgical cases. Additionally, these projected losses are based on pre-tax income from 2009–2012. They are not adjusted for inflation to reflect the full extent of the projected losses in the event CMC-FM became operational after 2017. Tr. 2711:16 – 24. Ms. Carter criticized other aspects of Mr. Levitt's adverse impact analysis and projections.¹⁰ One basis was her belief that Mr. Levitt overstated Piedmont's

¹⁰ Though qualified as an expert in health planning, Ms. Carter could not recall ever doing an adverse impact

projected expenses for 2020, thereby decreasing its projected 2020 income and exaggerating the adverse impact. Tr. 2430:8 – 2432:17. Ms. Carter concluded that Piedmont projected a twenty-five (25) percent increase from its actual 2009 to its projected 2020 expenses at a time when its projected volume remained flat. Tr. 2431:11-16. However, in comparing Piedmont's 2009 actual expenses to its 2020 projected expenses, she mistakenly included bad debt as an expense item for 2020, but not for 2009.¹¹ Tr. 2783:22 - 2785:8; 2787:16 - 2788:4 (Masterton); Tr. 2510 - 2518 (Carter). As a result, Piedmont's expenses increased only fourteen (14) percent instead of 25 percent. Tr. 2789:2 - 2795:25. Once Ms. Carter's calculation errors taken into account, Mr. Masterton testified that the increase in expenses from 2009 to 2020 demonstrates Piedmont's ability to manage costs well. Tr. 2793:21 - 2794:2. Moreover, the corrections result in a projected annual after-tax loss for Piedmont in 2020 of approximately \$18,000, a decrease from 2009 of over one hundred (100) percent. Tr. 2794:3-22.

45. Ms. Carter further criticized Mr. Levitt's adverse impact analysis by comparing York County with other South Carolina counties, where, according to Ms. Carter, hospitals were thriving. Tr. 2443:7-25. Ms. Carter contended that Piedmont would similarly thrive, despite the presence of CMC-FM. *Id.* However, as Ms. Carter conceded, one of the two hospitals in Spartanburg County is "less than well utilized." Tr. 2529:24 - 2530:25. The two existing hospitals in Anderson County are not competitors and historical outmigration from Anderson County is far less than in York County. Tr. 2524:1 - 2525:24, Piedmont Ex. 15. Lexington County, unlike York County (assuming CMC-FM is approved), has only one hospital. Tr. 2527:19-22. Moreover, Ms. Carter testified that was she unaware whether any providers in any of those counties had extensive physician networks comparable to the CHS network in York County. Tr. 2526:11-17; 2528:2-7; 2529:15-19; 2531:22 - 2532:5. Mr. Levitt and Mr. Sullivan testified that CMC-FM, in combination with CHS' growing physician network, would result in continued outmigration, particularly for specialty patients with complex medical needs who would be referred to CHS network hospitals such as CMC-Pineville and CMC-Main. Mr. Levitt testified that he analyzed the changes in Piedmont's market share in the complex cases of various product lines from 2005 to 2011. Tr. 506:22 – 507:21. These are cases that would be less likely

analysis herself or even working on another case in which adverse impact was a major issue. Tr. 2504:10-20.

¹¹ Ms. Carter conceded she also mistakenly used \$24,914,730 as the amount of Piedmont's 2009 bad debt, when the correct number was \$26,292,000. Tr. 2507:3-2509:16 (Carter); Tr. 2785:9-13 (Masterton).

to be performed at small community hospitals, and would instead be referred to larger facilities such as the CHS-Charlotte area hospitals or Piedmont.

46. For complex cardiac catheterization and electrophysiology cases during this period, Piedmont's share dropped from seventy-six (76) percent to forty-two (42) percent, while CHS' more than doubled from fifteen (15) percent to forty (40) percent. Tr. 512:16 - 22. Similarly, an analysis of all complex heart-related procedures in 2005, including open heart surgeries, shows that Piedmont's market share was sixty (60) percent and CHS' was twenty-one (21) percent. By 2011, their market share was identical. Tr. 513:24 - 514:7. A review of complex surgery cases from the same time period shows a similar trend. Piedmont had a fifty (50) percent market share that was nearly twice that of CHS' share of twenty-eight (28) percent. By 2011, however, CHS' share of complex surgeries performed on York County residents exceeded Piedmont's share. Tr. 515:6 - 16. In six (6) separate service lines involving complex cases, including cardiac catheterization and electrophysiology, neurosurgery, vascular surgery, gynecological surgery, plastic surgery, and ENT surgery, Piedmont lost at least fifty (50) percent of its volume from 2005 to 2011. Tr. 516:3 - 22. In several other service areas, including cardiovascular medicine, Piedmont lost more than twenty-five (25) percent of its volume. Tr. 516:22 - 25.

47. The testimony of Arun Adlakha, M.D., in describing his practice's experience, is illustrative of the nature of the adverse impact that would occur on a broader scale to Piedmont and existing York County providers, including specialty physicians, if the CON were awarded to CMC-FM. Dr. Adlakha is a pulmonologist and a sleep disorder intensivist who is a partner in a Rock Hill-based pulmonology group. Tr. 116:17 - 118:12. Dr. Adlakha had a robust practice in 2009. Tr. 123:19. The demand for services was so strong that Dr. Adlakha planned to develop a lung cancer center at Piedmont, which he expected to be an extension of the services he provided with navigational bronchoscopy, a new invasive technology Piedmont acquired in 2009 at Dr. Adlakha's request. Tr. 132:6 - 134:7. The instrument, which cost \$150,000, was the first in the greater Charlotte area and only the third in South Carolina. *Id.* When the equipment was first put into operation, Dr. Adlakha performed eight (8) to ten (10) procedures a month with it. Tr. 134:24. Shortly after the unit was put into service, however, the consults and referrals for patients who needed the procedure dropped significantly, reducing the number of cases to one or two a month. Tr. 134:9-13. The patient volume never returned. Dr. Adlakha made the decision

to terminate the use of the instrument as he found it "very difficult to maintain [his] proficiency and justify keeping it for so long." Tr. 134:13-15.

48. Dr. Adlakha's dramatic decline in demand for navigational bronchoscopy in 2009 coincided with an abrupt change in referral patterns that resulted in a drop of twenty-five to thirty (25 - 30) percent in total bronchoscopies. Tr. 126:20-24. The loss in referrals was attributable to the practices owned by the CHS physician network. Tr. 129:20-23. Dr. Adlakha's practice received no notice of the change in the referral practices, even though the members of Dr. Adlakha's practice had close professional and personal relationships with many CHS physicians. Tr. 130:11-17. Carolina Pulmonary Physicians had been the primary resource for the pulmonary and sleep consults for the CHS York County practices. Tr. 130:17-19. There was no other reasonable explanation that would account for the change in the CHS physicians' referral practices. Tr. 130:20-25.

49. The loss in so much volume of Piedmont's complex cases from 2005 - 2011, such as navigational bronchoscopy, lies in the changed relationships and referral patterns among CHS' York County primary care physicians. As Ms. Carter testified, "the most important factor in determining where a patient goes for specialty physician services is referral by their primary care physician." Tr. 2499:7-11. With its recent expansion, CMC-Pineville's specialty services now duplicate those of Piedmont's. Since 2005 CHS has increased the number of physicians it employs in York County by eighty-nine (89) percent. Tr. 214:4-14. Ms. Carter anticipates CHS will continue to acquire physician practices in York County if CMC-FM is constructed. Tr. 2494:13-22. Ms. Carter further testified that hospital systems employ physicians because they are referral sources. Tr. 2500:19 - 2501:3; 2501:12-17; 2502:12-18. CHS will be highly incentivized to encourage its employed physicians to continue to refer patients to CHS facilities and specialists, and have no inducement to refer patients to Piedmont facilities and specialists who have privileges with and practice at Piedmont. Tr. 2500:19 - 2501:17; 2502:12-18.

50. If CHS established CMC-FM, outmigration of complex specialty services such as Dr. Adlakha experienced would not only continue, but also would likely accelerate as a result of CPN physician referral practices. Piedmont's specialty programs, which require certain minimum volume levels to maintain quality and proficiency, as well as economic viability, would be jeopardized. Tr. 1202:16-19. Piedmont's CEO, William Masterton, testified that continued outmigration and patient volume loss could force Piedmont to reduce or eliminate

specialty programs and services as well as abate its workforce. Loss or paring of Piedmont's specialty programs would be detrimental to York County citizens, especially those living in the western, more rural part of the county farther away from CHS specialty facilities in North Carolina. Tr. 225:19 - 226:7; 1202:25 - 1203:7.

51. The court listened to extensive testimony about how hospitals profit through managed care, commercial insurance patients. Medicare is a parsimonious payor, Medicaid often pays providers below cost, and self-pay patients (uninsured patients whose income levels do not permit them to qualify for charity care), typically pay little or nothing. Tr. 1207:10 - 1208:5. Mr. Masterton testified that hospitals must use the margins they achieve from managed care, or privately insured, patients to subsidize the services they provide to uninsured and Medicaid patients.

52. Mr. Levitt testified that a hospital's payor mix is the key to its ability to cover the costs of services for those patients who are uninsured or whose insurers, such as Medicaid, pay limited reimbursement. To maintain services to medically underserved groups and to sustain profitability, a hospital must have a strong base of managed care and commercial patients. Tr. 640:4-20. From 2005 to 2011, Piedmont's payor mix changed significantly as CHS' market share of York County patients expanded. During that period, Piedmont's managed care patients declined sixteen (16) percent, while the number of Medicaid patients increased by the same 16 percent and charity care doubled. Tr. 639:9-23. The exchange of profitable patients for those whose insurance, if they have any, pays less than the costs of delivering services has a direct effect on a facility's profitability.

53. The construction of CMC-FM would further erode Piedmont's payor mix, as CHS physicians directed managed care patients from the relatively affluent Fort Mill area to CMC-FM and other CHS facilities, leaving a disproportionate number of uninsured, Medicaid, and Medicare patients for Piedmont and independent York County physicians. The effect on Piedmont and non-CHS practitioners would be to lower their profit margins and reduce resources thus jeopardizing their ability to care for medically underserved individuals and maintain their current level of services and job. Tr. 1205:22 - 1208:5.

54. During the staff review, fifty-nine (59) physicians practicing in York County who were not employed by an applicant submitted letters of support. Of these, forty-five (45) expressed support for Piedmont while one did for CHS. Tr. 681:5 - 10. Many of the physicians

who supported Piedmont also expressed concern about the effect of CMC-FM on Piedmont. Mr. Levitt reviewed these letters and interviewed, along with Mr. Sullivan, a number of the physicians who authored the letters. The following shared concerns were expressed by the physicians: (1) Piedmont's ability to maintain high standards of patient quality would be compromised; (2) CMC-FM and CHS physicians would refer patients needing specialized care to CHS physicians and facilities outside of York County; (3) the payor mix of Piedmont and its medical staff would be degraded; and (4) the healthcare delivery system in York County, including Piedmont and its medical staff, would be weakened. Tr. 683:16 – 685:1.

55. Three (3) York County physicians, who are not employed by or contractually bound to either applicant but who refer a majority of their patients to Piedmont, testified that if CMC-FM were constructed, it would adversely affect Piedmont. Dr. Adlakha testified that construction of CMC-FM would cause an even greater increase in the loss of Piedmont's outpatient and inpatient services than it has experienced in recent years. Tr. 146:11 – 19. He also testified that in his opinion the quality of care would be adversely affected: "the quality of any hospital or any individual [physician] is dependent on the quantity that they see, as well as the quality of cases that they see." Tr. 147:14 – 17. As a result, it would be difficult to maintain the same scope and quality of pulmonary services at Piedmont if CMC-FM were approved. Tr. 146:23 – 147:2.

56. Another physician, Dr. Norman Taylor, testified that the approval of CMC-FM would cause a further deterioration of Piedmont's payor mix as well as the payor mix of his practice thereby decreasing the percentage of patients who are payors. Tr. 292:5 – 7. Under such circumstances, the quality of care at Piedmont would suffer and the ability to recruit new physicians would be impaired. Tr. 289:1 – 290:1; 291:22 – 292:5.

57. Among the greatest threats to Piedmont is that if CMC-FM were approved it would reduce the volume of services referred to non-contractually bound specialists on the Piedmont medical staff and degrade the payor mix of those practices to the point where the practitioners would have little choice but to join the CPN network to maintain their financial viability. Doctors Taylor and Singhi testified that their practices would have to give serious consideration to becoming employed by the CHS physician network if CMC-FM was constructed. Tr. 778:11 – 25. Dr. Taylor further testified that since his practice is the principal provider of OB/GYN services at Piedmont, if the physicians in his practice became employed by

or contractually bound to CHS and shifted their patients to CMC-FM and other CHS facilities, it would likely force the closure of Piedmont's Women's Tower, which would cause the hospital to lose its neonatal service. Tr. 299:18 – 300:3. Mr. Masterson testified that the affiliation of more noncontractually bound physicians currently practicing at Piedmont with CHS would be devastating to Piedmont's utilization. Tr. 223:8 – 224:3.

58. Mr. Levitt testified that as Piedmont lost patient volume to CMC-FM, its cost per unit of service would increase. While Piedmont could reduce some costs tied directly to the delivery of services that it would no longer provide, such as supplies and medications, it would be unable to control other fixed costs. Lower patient utilization would cause an increase in the cost per unit of services to cover Piedmont's fixed costs. Tr. 686:15 - 24.

59. Mr. Masterton testified that building FMMC was the crucial in Piedmont's strategy to halt to halt outmigration of patients out of York County, Tr. 253:4-12. Mr. Sullivan agreed:

Without Piedmont having a physical presence in the Fort Mill market, I don't see them being able to effectively reverse the outmigration that's occurred over the last seven years CHS . . . has dramatically expanded Pineville. It offers a broad range of services equivalent to what Piedmont does. They've effectively penetrated the physician market [W]ithout having a physical presence [in Fort Mill] that would attract patients to the facility and give Piedmont a base on which to recruit additional physicians . . . I don't think that any other strategy is going to have any significant impacts in terms of changing the outmigration problem.

Tr. 1200:2-18.

60. Ms. Brandt disagreed with Piedmont's strategy, opining that FMMC would actually harm Piedmont, while CMC-FM would not. Tr. Ex. 1-B at 1011. The court finds no support for Ms. Brandt's position. Piedmont has experienced a significant amount of its market share shift to CHS since 2005 without a CHS hospital in Fort Mill. The court is persuaded by Mr. Sullivan's opinion that CMC-FM would effectively segregate much of Northern York County from Piedmont. Tr. 1198:8-13. Allowing the construction of FMMC versus CMC-FM, thereby permitting FMMC to shift some of its patients there along with 36 of Piedmont's unused beds, would result in reversing much of the ongoing outmigration from York County and would be a far better outcome for all York County residents who would have even easier accessibility to healthcare in the county without and degradation in existing services. Tr. 1197:10 - 1199:11.

Bed Need and Projections

61. The methodology by which acute care hospital bed need is determined in the State Health Plan is a function of the utilization of particular hospitals, and not the utilization of residents of a county. Tr. 442:17 – 25. In the 2004-2005 Health Plan, DHEC projected York County would need two hundred eighty-eight (288) beds, including two hundred sixty-eight (268) acute beds plus twenty (20) beds for psychiatric services. Tr. 484:1 – 3. Because of considerable outmigration, the bed need for all York County residents is greater than the bed need for patients who receive care at Piedmont. Adjusting the methodology in the Health Plan to take into consideration the use by York County residents of hospital services, regardless of where they received the services, results in a need for four hundred ninety-one (491) beds. Tr. 481:18 – 483:25. After taking into consideration the 288 Piedmont beds, a need exists for two hundred three (203) additional beds to serve York County residents who have been leaving the county for hospital services.

62. Piedmont and CHS base their respective projections of bed need on similar assumptions about the distribution of utilization throughout York County. Tr. 2674:3 – 11. Piedmont assumed twenty-nine (29) percent of its beds would be used by residents of the Northern York County area; CHS assumed thirty (30) percent. Both parties assumed twenty-three (23) percent of their beds would be used by residents from the greater Rock Hill area. CHS projected a somewhat greater utilization by residents of the Western York area: eight and one-tenth (8.1) percent compared to three (3) percent for Piedmont. Tr. 2674:11 – 23. Based on these assumptions, projections of the bed need distribution within York County relied on by each applicant are consistent. Tr. 2674:23 – 25.

63. CHS relied on its utilization projections to demonstrate the need for its 64 bed facility. The critical element of its projections was the assumption that it would redirect substantial portions of its market share of York County patients to CMC-FM – seventy-five (75) percent of Northern York County, eighty-five (85) percent of greater Rock Hill, and fifty (50) percent of Western York County. Tr. 675:21 – 2677:5. To calculate the projected utilization, CHS applied its 2009 market share to the CMC-FM utilization forecasts. Tr. 2676:5 – 6. Mr. Levitt testified that even if CHS' assumptions were accurate, applying CHS' more recent market share would show that the 64 bed facility would be inadequate. From 2009 to 2011, CHS' market share of York County patients continued to grow. Tr. 2676:15 – 16. Applying the higher

2011 market share to CHS' assumptions about the extent to which it expected patients to be redirected to CMC-FM would result in an occupancy rate of over eighty-eight (88) percent by 2017. Under CHS' utilization model, occupancy would exceed ninety (96) percent by 2020. Tr. 2676:16 – 20.

64. Based on this updated calculation, CHS would need ninety-five (95) beds at CMC-FM. Tr. 2677:19 – 23. If, however, CMC-FM were to take market share from Piedmont, which this court has found is a reasonable eventuality, it would need even more beds. To illustrate the point, Mr. Levitt testified that if CMC-FM were to increase its market share by five (5) points, the facility would be one hundred eight (108) percent occupied by 2017. Tr. 2679:20 – 21. The proposed 64 bed CMC-FM facility would be inadequate to meet the projected bed need.

65. Because of the growth projections in Northern York County, the hospital in Fort Mill should be designed to respond to the increased demands that will be placed on the facility over time. FMMC is designed to accommodate up to two hundred fifty (250) beds. Tr. 2667:6 – 22. CMC-FM's design, however, envisions a potential future expansion of only eighteen (18) to twenty (20) beds. Tr. 2628:5 – 20. The CMC-FM design contains no empty space reserved for future expansion (shell space). Tr. 2567:24 – 2568:3. CHS presented no evidence of other space it could convert to accommodate additional space in the event of expansion. Adding additional beds would require construction, which would be expensive and potentially disruptive. Tr. 1228:15 – 17. Adding beds would also require an additional CON, which could be expensive and time-consuming. Tr. 2568:15 – 2569:3.

66. Piedmont's proposal is intended primarily to meet the needs of residents leaving the county by establishing 100 beds at FMMC. Even with the transfer of the 36 beds, Piedmont would have more than seventy (70) empty beds available on an average day. Piedmont, therefore, would be able to accommodate significant spikes and fluctuations in occupancy that occur in York County throughout the year. Tr. 1224:21 – 1225:19.

67. During the DHEC staff review, CHS presented a model in support of its contention that a 64 bed facility was needed in the Fort Mill area, and not the 100 bed hospital Piedmont proposed. Based on the data it presented, CHS argued that Piedmont's transfer of 36 beds to FMMC in Northern York County results in a "tremendous maldistribution" of hospital

beds in York County with a disproportionate number of beds in Northern York County that would restrict access for patients in the rest of the county. Tr. 2659:23 – 2660:1.

68. Beverly Brandt, DHEC's CON Director at the time of the agency's decision, relied heavily on CHS' maldistribution model in presenting the grounds for her decision, stating that she was concerned with the effect of Piedmont's proposal on the "balance of the distribution [of beds] to the target population." Tr. 2663:20 – 2664:3. Her analysis of the applications used virtually the same language advanced by CHS in finding that "the replacement/relocation of the 36 beds in Northern York County does not appear to equitably distribute beds within the county and reduces accessibility to greater Rock Hill and Western York." Tr. 2662:12 – 16; Jt. Ex. 1-B at 1007.

69. Mr. Sullivan identified two principal flaws in the CHS model. First, at the time the model was prepared the 2010 census data was not published. Tr. 1220:7 – 22. Additionally, Mr. Sullivan noted that Ms. Platt failed to incorporate a new Northern York County zip code, 29707, that would be part of the new hospital's primary service area. Tr. 1219:12 – 1220:7. Since the development of CHS' model projections, the 2010 census shows that its model understated the population in Northern York County. Tr. 1220:5 – 7. The updated census shows the population in the Fort Mill area to be significantly higher in 2015 than the assumptions upon which CHS and DHEC were relying in finding a 100-bed facility would disproportionately allocate beds to Northern York County. Tr. 1220:12 – 1222:10.

70. The more reasonable period for projecting the bed-to-population ratio would be in 2020, not 2015. Tr. 1221:3 – 22. Updated population estimates based on the most recent census project that the three zip codes in Northern York County are expected to grow at over twice the rate of the greater Rock Hill and Western York County areas. Tr. 2664:25 – 2665:18. These official population projections demonstrate that the location of a 100-bed hospital in Northern York County would result in an equitable distribution of beds and will better meet the need for a new hospital in the Fort Mill area.

71. Piedmont projects a fifty-eight (58) percent occupancy rate for FMMC by its third year of operations. Tr. 1229:20-23. Ms. Carter testified this occupancy rate was too low to justify project approval. Tr. 2549:19-22. However, CHS itself operates several facilities at occupancy rates below 58 percent. Tr. 2552:25; 2554:12; 2557:18; 2558:9. Mr. Carter, as well as another CHS expert, Mr. Murphy, agreed that all of these CHS hospitals were successful. Tr.

1693:25 - 1694:2; 2558:21-24. It is clear that hospitals can operate efficiently and in a financially feasible manner at a 58 percent occupancy rate. Tr. 1230:13-16. Moreover, Northern York County is a higher growth area with an expanding population that will result in an increased demand for hospital services in the future. Tr. 1230:21 - 1231:8.

72. The projected occupancy rates of FMHC are consistent with similar facilities in the service area and the state. The only hospital in the service area is Piedmont Medical Center, whose occupancy rates for 2009 to 2011 were fifty-seven (57), fifty-eight (58), and sixty-two (62) percent, respectively. Tr. 694:12-16. According to the 2012-2013 State Health Plan, the average occupancy rate for South Carolina hospitals from 2009 to 2011 was less than 58 percent, as was the average rate for hospitals in Region 2, which includes York County. Tr. 2549:24 - 2551:9; 694:4-7.

73. Piedmont's projected occupancy rate is more reasonable than CHS', which projects that CMC-FM will achieve a third-year occupancy rate of sixty-eight (68) percent. Tr. 1228:19-20. A seventy (70) percent occupancy rate is an indicator that expansion may be needed, especially in a smaller hospital. Tr. 1228:23 - 1229:10. A 64-bed hospital with a 70 percent occupancy rate has only 18 beds to accommodate occupancy spikes and fluctuations in need. Tr. 1228:3-10.

74. Piedmont's representatives testified that its strategy to halt outmigration has three (3) components: expand its emergency department, recruit physicians, and, most importantly, build FMHC. Tr. 215:4-23. The emergency department is significant because sixty-nine (69) percent of Piedmont's inpatients access the hospital through its emergency room. Tr. 218:8-11. DHEC recently approved a CON for Piedmont to double the size of its ER, a project that will be completed in 2014. Tr. 218:1-21. Physician referrals are another important source of inpatient volume. Tr. 213:19-20. Piedmont currently employs thirty-two (32) physicians and plans to recruit fourteen (14) more in 2013. Tr. 217:5-10.

75. FMHC would provide Piedmont with a second emergency department and would enhance Piedmont's ability to recruit physicians. Tr. 217:11-21. Prior to accepting the CEO position at Piedmont, Mr. Masterton served as CEO for Coastal Carolina Hospital (Coastal) in Hardeeville. Tr. 179:12-14. Tenet acquired Coastal with the goal of halting outmigration and that goal was accomplished. Tr. 253:1-14. Like FMHC, Coastal is located near an interstate close to a county line and state border. Tr. 2797:17 - 2798:16. Just over the county line are

competing hospital systems in the area of Savannah, Georgia. Tr. 2798:16-20. During Mr. Masterton's three (3) year tenure at Coastal, outmigration declined and Coastal's market share increased over fifty (50) percent. Tr. 181:8-21; 2799:2-5.

76. Coastal's experience is typical of that of other satellite hospitals in South Carolina. Virtually all of the parent facilities of satellites in South Carolina are tertiary hospitals that provide specialized services, as does Piedmont. Tr. 1074:20 - 1075:11. Parent facilities develop satellites as a strategy to recover or grow market share, just as Piedmont plans to do with FMMC. Tr. 1073:17 - 1074:14; 539:2-19.

77. Georgetown Hospital System (Georgetown) is an example of how satellite hospitals can strengthen a parent hospital's performance. Georgetown opened Waccamaw Community Hospital (Waccamaw) in 2003 in Northern Horry County to stem outmigration and the loss of market share to Horry County facilities. Tr. 542:18-12. According to Mr. Levitt, who serves as a healthcare planning consultant for Georgetown, Waccamaw has had a "tremendous positive impact" on Georgetown. Tr. 541:8-11; 547:1-14. That effect was achieved as a result of the increased utilization of the system as a whole. It was also due to the increase in referrals of Waccamaw area patients to Georgetown for more complex services not provided at Waccamaw. Tr. 547:18 - 548:3. As a result of the high demand in northern Georgetown County, Waccamaw grew from a forty (40) bed facility when it opened in 2003 to one hundred twenty-four (124) beds in 2008. Tr. 553:14-22; 557:19-23.

78. The parallels between the market pressures faced by Georgetown and Piedmont are remarkable. Both hospitals were losing market share in a high growth and affluent region of their respective county to larger urban centers. Tr. 557:23 - 558:3. Both hospitals faced competition from larger and more sophisticated healthcare systems that were aggressively pursuing strategies to increase the shift of market share. Tr. 556:4-16. Like Georgetown, Piedmont has recognized that by establishing a satellite hospital in the community where outmigration was occurring, it would improve accessibility, meet the growing needs of the area, and, through that community presence, recover the market share it had lost. Tr. 558:4 - 559:19.

79. Piedmont's projected market share assumes that with the presence of FMHC in Northern York County that it could return approximately to the share it had in 2003-2004. Tr. 559:8-12; 561:1-7. The only material differences in the historic and projected market shares are in the three zip codes in Northern York County where Piedmont historically has not had a large market share. Tr. 563:17. With the location of FMHC in Northern York County, Piedmont assumed that would change, projecting shares comparable to the market share Piedmont has in the immediate area where it is located. Tr. 563:19 – 564:9.

80. CHS argued that Piedmont's projected market shares for FMHC were unreasonable, contending that patients from Rock Hill zip codes (29730 and 29732) would not go to FMHC. Jt. Ex. 1-A at 56-57 (S-CHS-53-54). Ms. Brandt agreed, noting it was unreasonable "to assume a patient choosing to use Piedmont's services will drive past the main hospital to receive care at FMHC." Jt. Ex. 1-B at 1007. However, in many portions of 29730 and 29732 residents could travel to FMHC without having to drive past Piedmont. Ex 111. Robert Walsh, Piedmont's transportation engineering expert, testified that the most expeditious route for residents of these zip codes to take to FMHC was I-77. Tr. 241:9 - 343:22. Mr. Walsh conducted a series of travel time studies that showed that for a large portion of 29730 and a small portion of 29732 it took less driving time to drive to FMHC than Piedmont. Piedmont Ex. 111; Tr. 349:14 - 352:2. Mr. Walsh also found that while the drive to Piedmont would be quicker for significant portions of the zip code, the time saved would be ten minutes or less.¹² Tr. 349:14 – 352:2.

81. Overall, Piedmont's market share assumptions are reasonable and achievable. Tr. 564:20 – 565:2. The court finds reasonable its assumption that with the addition of its new Fort Mill area hospital, it will be able to restore the market share it lost since 2004.

Access to Medically Underserved

82. DHEC requires CON applicants to project the level of charity care they will provide to be expressed as a percentage of its projected gross revenue. 24A S.C. Code Ann. Regs. 61-15 § 202(2)(c)(1)(d). After a CON is approved and a project is implemented, however, DHEC does not verify whether the applicant actually meets its charity care projections. Tr. 1241:25 – 1242:11.

¹² On cross, CHS counsel suggested Mr. Walsh had inappropriately conducted travel time studies on Memorial Day, but Mr. Walsh clarified that, while his staff had conducted some of the studies during the month of May, they had not conducted any on Memorial Day. Tr. 420:11-21.

83. In their 2005 submissions, the applicants projected charity care levels consistent with one another. Piedmont projected it would provide charity care valued at three (3) percent of its gross revenue.¹³ Tr. 1246:9. CHS projected charity care for CMC-FM that equaled three and five-tenths (3.5) percent of its gross revenue. Tr. 1244:7 – 13. In its October 4, 2010 updated application, Piedmont again projected 3 percent. However, when CHS submitted its updated projections in December 2010, it increased CMC-FM's charity care projection to six and three-tenths (6.3) percent. Tr. 1244:15 – 17.

84. Northern York County is the most affluent area of one of the most affluent counties in the state. Tr. 1235:16 – 19. For example, the percentage of patients from Northern York County on Medicaid is less than one-half that of Medicaid patients from the rest of the county. Tr. 1236:14 – 25. In 2011, only five and five-tenths (5.5) percent of the hospital patients from Northern York County were self-pay or charity patients, as opposed to nine and five-tenths (9.5) percent from the rest of York County. Tr. 1237:16 – 1238:12; Piedmont Dx 234.

85. Donald G. Stewart, the CHS planner who developed the 6.3 percent projection, testified that he based the new projection on 2009 internal financial reports of CMC-Pineville and CMC-University, another CHS hospital. Tr. 1860:18 – 1861:4. Mr. Stewart did not consider York County employment data, income data, CPN physician data, data from recently built South Carolina hospitals, or data from cost reports. Tr. 1863:7 – 1866:12.

86. The internal data on which Mr. Stewart relied showed CMC-Pineville's 2009 gross revenue to be \$385,034,797. Piedmont Ex. 83 at 3 (S-CHS-1205). The 2009 gross revenue for CMC-University was \$382,847,000. S-CHS-1293. Mr. Stewart testified that the same data showed that in 2009, CMC-Pineville provided \$19,486,000 in charity care [five and one-tenth (5.1) percent of its gross revenue] and CMC-University provided \$31,042,000 in charity care [eight and one tenth (8.1) percent of its gross revenue]. Tr. 1829:21 – 22. The weighted average of these percentages was 6.3 percent, the number Mr. Stewart projected for CMC-FM. Tr. 1860:24 – 1861:15.

87. The source of the data Mr. Stewart relied upon were reports by CHS' vendor, PeopleSoft. Tr. 1875:10 – 21; 1883:5 – 9. The PeopleSoft reports showed different charity care amounts than those used by Mr. Stewart. PeopleSoft reported CMS-Pineville's 2009 charity care

¹³ In 2011, Piedmont's actual charity care equaled three and eight-tenths (3.8) percent of its gross revenue.

at only \$510,847. Tr. 1878:10 – 11. Similarly, the PeopleSoft report for CMC-University listed its 2009 charity care at only \$2,173,922. CHS 1293.

88. The PeopleSoft reports classified uncompensated care into five (5) different categories: charity care, Mecklenburg County inpatient contractual adjustments, bad debt expense, bad debt recovery, and self-pay discount. Tr. 1876:20 – 1877:1. CHS later reclassified the status of many patients from bad debt or self-pay amounts to charity care. CHS made these reclassifications at various times. Sometimes CHS would reclassify a patient as charity care during his or her hospital stay, and at other times the reclassification did not occur until after discharge. Tr. 1877:23 – 1878:9; 1878:23 – 1879:3; Tr. 1880:11 – 20; 1881:18 – 24; 1883:14 – 1884:5. After the reclassifications, CMC-Pineville's 2009 charity care jumped from \$510,847 to \$19,486,000 and CMC-University's from \$2,173,922 to \$31,042,000. Tr. 1829:21 – 22; 1878:10 – 16.

89. Federal law requires all health care providers who participate in the Medicare program to submit an annual cost report. Tr. 1239:3-5. The provider must certify the accuracy of the information in the report and there are civil and criminal penalties associated with providing false information. Tr. 1239:18-24. Cost reports are prepared after the end of the reporting year, following any reclassification of accounts. Tr. 2848:14-22. Table S10 in the cost report shows the provider's gross revenue and gross charity care. Tr. 1240:2-8.

90. CMC-Pineville and another CHS facility, CMC-Mercy, operate under a single license and therefore file a consolidated cost report. Tr. 1240:12-17. On the Pineville-Mercy consolidated cost report, those two facilities reported \$1,213,654,912 of gross revenue and \$30,948,212 of charity care. Piedmont Exs. 75-78, 81, Piedmont Dx 200. The charity care amount for inpatients and outpatients combined is only two and six-tenths (2.6) percent of the gross revenue reported. *Id.*; Tr. 1240:21-23; Tr. 2850:18-24.

91. DHEC accepted CHS' projection that 6.3 percent of CMC-FM's gross revenue would be provided to charity care patients. In accepting CHS' charity care projection for CMC-FM, Ms. Brandt gave no weight to the historical experience of CMC-Pineville or CMC-Mercy, or to the demographics of York County.

92. Piedmont introduced evidence from multiple sources that showed CHS physicians based in York County place restrictions on the acceptance of medically underserved patients. These patients include uninsured patients, Medicaid patients, and, in some cases, Medicare

patients. The effect of these restrictions by CHS-owned physician practices has not only limited access of medically underserved individuals to primary medical care but also, would limit access of those same individuals to non-emergency admissions at CMC-FM, which would be heavily dependent on CHS-employed physicians. Tr. 577:9 – 12; 17 – 24.

93. This court is persuaded by the illustrative evidence demonstrating the relatively low provision of Medicaid and uninsured care by CHS York County practices. CHS records reflect that in 2012, Medicaid patients of Medical Associates of Fort Mill represented only three-tenths (0.3) percent of all patients of the office. For Medical Associates of Rock Hill in 2012, Medicaid patients represented a mere one-tenth (0.1) percent of all patients of that office. A similar pattern exists at Shiland Family Practice, another York County primary care CPN practice: one (1) percent Medicaid patients at the Rock Hill office and six-tenths (0.6) percent Medicaid patients in Shiland Family Practice's Fort Mill office. Similarly, the percentage of Medicaid patients of the Sanger Clinic, a CHS-owned cardiology group that serves York County patients, was equally low and consisted of one and five-tenths (1.5) percent in its Fort Mill office and one and six-tenths (1.6) percent in its Rock Hill office. The percentage of uninsured patients served in these practices in 2012 was significantly below the 6.3 percent charity care projection provided by CHS for the CMC-FM facility, which actually ranged from one and three-tenths (1.3) to two and five-tenths (2.5) percent.

94. In contrast, the current Medicaid participation of Dr. Adlakha's pulmonology practice is fifteen (15) percent and of Dr. Taylor's OB/GYN practice is fifty (50) percent. Piedmont's payor mix reflects the heavier charity and Medicaid load that its medical staff members carry. In 2011, nearly eleven (11) percent of Piedmont's patients were classified as self-pay or charity in contrast to six (6) percent of York County patients served by CHS who were self-pay or charity. The pattern is substantially the same for Medicaid patients from York County, which constituted eleven (11) percent of the payor mix for CHS in 2011, and eighteen (18) percent for Piedmont. Based on the evidence provided, this court finds little support for CHS' projected charity care as 6.3 percent. First, CHS nearly doubled its projection for charity care from 3.5 percent in 2005 to 6.3 percent in 2010. Second, the CHS hospitals have an average charity care of approximately four and five-tenths (4.5) percent, with the highest being five (5) percent at CMC-Main in Charlotte. York County has one of the highest median household incomes in South Carolina and Fort Mill is the most affluent area within York County based on

median household income. Given that CMC-FM will be situated in this affluent area, it is not realistic to believe that CMC-FM's charity care percentage in Fort Mill would be higher than the charity care percentage at its main hospital in downtown Charlotte.

95. Telephone surveys of CHS primary care physician practices conducted by Mr. Levitt in July 2011 and again in February 2013 produced results demonstrating the restrictions on the acceptance of medically underserved patients by those CHS practices. The July 2011 survey focused on the two CHS York County primary care physician practices, Shiland Family Medicine and Medical Associates of Rock Hill and Fort Mill. These practices operate in four (4) locations in Rock Hill and Fort Mill and represent eighty (80) percent of the York County patient referrals to CHS facilities. Tr. 580:25 – 581:10. The 2011 survey revealed that Shiland Family Practice was not accepting new uninsured, Medicaid, or Medicare patients. Tr. 581:10-14. *Also see* Jt. Ex. 1B, p. 782. The survey also showed that Medical Associates of Rock Hill and Fort Mill were not accepting new uninsured patients unless the patient paid in advance seventy (70) percent of a new patient charge that ranged from two hundred ninety dollars (\$290) to eight hundred dollars (\$800). Tr. 581:14-20. Mr. Levitt's February 2013 survey revealed no changes at the practices, which were still not scheduling appointments for new Medicaid or Medicare patients. Tr. 599:16 – 600.

96. The information obtained from CHS primary care offices was also consistent with records produced by CHS that show relatively low percentages of Medicaid and uninsured care by CHS York County practices. CHS records show that in 2012, Medicaid patients of Medical Associates of Fort Mill represented three-tenths (.3) percent of all patients of the office. Tr. 604:1 – 5; CHS Ex. 27 at 1 (S-CHS-9841). For Medical Associates of Rock Hill in 2012, Medicaid patients represented one-tenth (.1) percent of all patients of that office. Tr. 604:6 – 8; CHS Ex. 27 at 1. A similar pattern exists in the other CPN York County primary care practice, Shiland Family Practice: one (1) percent Medicaid patients at the Rock Hill office and six-tenths (.6) percent Medicaid patients in Shiland's Fort Mill office. Tr. 604:9 – 14; CHS Ex. 27 at 1. Similarly, the percentage of Medicaid patients of the Sanger Clinic, a CHS-owned cardiology group that serves York County patients, was equally low, consisting of one and one-half (1.5) percent in its Fort Mill office and one and six-tenths (1.6) percent in its Rock Hill office. Tr. 605:2-13; CHS Ex. 27 at 1. The percentage of uninsured patients these same practices served in

2012 was also low, ranging from one and three-tenths (1.3) to two and one half (2.5) percent. CHS Ex. 27 at 1.

97. The number of Medicaid patients served by these York County CHS physician practices is substantially lower than it would be in the absence of restrictive patient-acceptance practices. Tr. 607:1 – 608:3. For example, the current Medicaid participation of Dr. Adlakha's pulmonology practice is fifteen (15) percent and of Dr. Taylor's OB/GYN practice is fifty (50) percent. Tr. 127:19-24 (Adlakha); 263:13 – 264:1 (Taylor).

98. Piedmont's payor mix reflects the heavier charity and Medicaid load that its medical staff members carry. In 2011, nearly eleven (11) percent of Piedmont's patients were classified as self-pay or charity in contrast to six (6) percent of York County patients served by CHS who were self-pay or charity. Tr. 621:1-17.

99. Because the CHS primary care practices are not accepting new Medicaid patients and have not accepted them for at least two years, York County Medicaid patients would not have access to CHS primary care physicians. Tr. 609:23 – 610:3. These Medicaid patients would also not be in a position to receive referrals to CHS specialty physicians who would be responsible for admitting patients to CMC-Fort Mill. Tr. 610:3-4. The CHS primary care physicians would function as the gatekeepers for CMC-Fort Mill. Tr. 610:4-6. If the flow of medically underserved patients into CHS primary care offices is restricted, the referrals and ultimate admissions of those individuals into CMC-Fort Mill would be restricted as well.

Financial Considerations

100. Joel Grice, a thirty (30) year veteran and former director of DHEC's CON division, testified that the function of the financial project review criteria has been to evaluate the financial feasibility of proposed projects by considering the reasonableness of proposed revenues and expenses. Instead of measuring applicants' projections against each other because of the variability of assumptions and the potential for one applicant making adjustments in *pro forma* budgets to gain a competitive advantage over another, DHEC has historically evaluated the reasonableness of financial projections based on existing projects it has approved. Tr. 1133:22 – 1137:16.

101. DHEC found that Piedmont and CHS' proposed charges that were comparable to other facilities in the service area or the state. Mr. Levitt and Mr. Grice testified that they agreed with DHEC's finding. Tr. 692:1 – 4; 1133:2 – 9.

102. In identifying total capital costs for FMMC, Piedmont projected its costs differently from CHS. To accurately compare the projected costs of the two projects, they needed to be based on the same factors. Mr. Levitt testified that he made the following adjustments to FMMC's total project costs to achieve that effect: (1) he excluded capitalized interest as had CHC; (2) he eliminated an inflationary factor for future construction cost that CHS had not included; and (3) he applied a large volume purchaser discount on medical equipment available to Tenet or CHS, rather than list equipment cost at retail charges. The adjusted total capital cost for FMMC was reduced from \$146,000,000 to \$119,800,000. Tr. 702:2 - 4.

103. The total project cost per bed for the 100 bed FMMC is \$1,200,000 per bed. For CMC-FM, the total project cost per bed is \$1,200,000. The costs per bed proposed by Piedmont and CHS are consistent with those experienced by similar facilities constructing new satellite and replacement hospitals. In 2008, Ms. Brandt, as director of the CON division, approved applications for two satellite hospitals, Trident-Berkeley and Roper-Berkeley, at a projected cost of \$2,300,000 per bed. Tr. 703:7 - 8. CHS is an owner of the Roper St. Francis HealthSystem that filed the Roper-Berkeley CON application. Another CHS-affiliated satellite hospital, Roper Mt. Pleasant, was approved in 2005 at a cost of \$1,500,000 per bed. Tr. 703:17 - 25. Without adjusting for inflation, the cost per bed for some new hospitals have been lower than those projected by Piedmont and CHS, but overall the capital costs of the proposed projects are reasonable when compared with the costs of similar facilities. Tr. 703:6. Neither DHEC nor CHS presented any evidence that addressed the issue of whether the total capital costs of the proposed projects are consistent with those of similar facilities.

104. Mr. Levitt also compared the proposed operating costs of FMMC and CMC-FM with other satellite hospitals that have been approved by DHEC. He demonstrated how CMC-FM's projected 2010 operating costs are comparable to those approved for Roper Mt. Pleasant in 2005, without adjusting for inflation. Mr. Levitt also demonstrated how FMMC's 2010 proposed operating costs without adjusting for inflation were consistent with the 2006 operating costs of Palmetto Parkridge. Mr. Levitt concluded that the projected total operating costs were reasonable and consistent with those approved for existing facilities. Tr. 709:7 - 13. CHS presented no evidence addressing the operating costs of similar facilities other than its own.

105. DHEC found, and this court agrees, that Piedmont and CHS' proposed charges were comparable to other facilities in the service area or state.

106. FMMC and CMC-FM respective proposed budgets reflect a positive increase in each hospital's financial performance over the first three years of operation. FMMC's financial performance improves from a deficit of \$5,400,000 in the first year of operation to more than \$300,000 in net income by its third year of operation. CMC-FM projects net income of \$663,000 in its first year, climbing to over \$2,700,000 by its third year of operation. Tr. 711:15 - 22.

107. Mr. Levitt compared the projected financial performance of Roper-Berkeley and Trident-Berkeley, the two hospitals whose CON applications were most recently approved, with FMMC and CMC-FM. The projected performances of these projects are comparable to FMMC's projected performance, but not to CMC-FM's projected financial performance. Roper-Berkeley, a project of Roper St. Francis HealthSystem that is owned in part and managed by CHS, actually showed a loss of nearly \$15,000,000 over its first three years of operation, far greater than those projected by FMMC. However, DHEC found the Roper-Berkeley project had sufficient net income and was financially feasible. Tr. 712:14 - 24. Trident-Berkeley's financial performance projections were consistent with those projected by FMMC, and were likewise found to be financially feasible by DHEC. Tr. 712:1 - 7.

108. Mr. Grice examined a broader selection of projects, including all new hospital CON applications filed and approved since 2005. He testified that it is very common for new hospitals to incur losses in the first year or two of operation. Tr. 1150:15 - 25. In reviewing competing applications, Mr. Grice testified that he has never found one applicant more financially feasible than another if it shows a positive trend by the third year. Tr. 1151:23 - 1152:10. There is no issue as to whether either applicant will be able to build and sustain their respective projects. Tr. 1152:11 - 17.

109. Both applicants appear to be committed to funding their respective projects. CHS proposed to use cash to finance the construction of CMC-FM. Tr. 715:17 - 20. Piedmont presented a letter from its parent corporation, Tenet Healthcare Corporation, stating that the company would fund the project and finance it "with the most appropriate and cost-effective capital structure at the time utilizing existing cash reserves, existing lines of credit, or the

issuance of debt or equity." Tr. 714:13 – 715:1. Both financing proposals are reasonable, and both applicants are financially able to build the projects.

110. This court finds that it is more efficient to build a 100 bed hospital capable of meeting future need for services than to build a 64 bed facility that requires expansion within a few years of opening. When expansion is needed to accommodate the projected growth in Northern York County, FMMC would be in the better position to respond. FMMC is designed for a capacity of up to 250 beds. Tr. 2667:6 – 22. CMC-FM's design, however, would permit expansion of no more than 20 beds for a total of 84 beds. Tr. 2628:5 – 20. Without the availability of shell space to accommodate the growth, bed expansion at CMC-FM would be more expensive and less efficient than at FMMC. Tr. 2567:25 – 2568:3; 2568:15 – 2569:3.

111. CHS argues that its proposal is more efficient because it projects fewer Full Time Equivalent (FTE) staff per adjusted occupied bed (AOB) than Piedmont. Tr. 2603:19 – 2604:3. CHS contends that CMC-FM will employ only three and one-tenth (3.1) total (clinical and non-clinical) FTEs per AOB while FMMC will employ four and two-tenths (4.2). Tr. 2603:19 – 2604:3. However, CHS would employ an unknown number of offsite staff that would provide services to CMC-FM. In calculating its FTEs per AOB, CHS failed to take into account the additional cost of this offsite staff. Tr. 1892:1 – 22; 2604:4 – 15; 2605:8 – 23; 2607:6 – 11.

112. Ms. Carter testified that CMC-FM's proposal was also more efficient because it had a higher percentage of patient care space than Piedmont's facility. Tr. 2596:17 – 2597:7. There is no standard definition of what constitutes patient care space versus non-patient care space, and Ms. Carter could not recall whether certain areas were classified as one or the other, although she testified that kitchens, chapels, and shell space could be examples of non-patient care space. Tr. 2597:8 – 2598:11. Therefore, under Ms. Carter's approach, hospitals with no kitchens, chapels or shell space would be considered more efficient than hospitals with such areas. This court finds this proposition incongruous.

Public Support and Opposition

113. DHEC received more than five thousand (5,000) letters of support for Piedmont, and thirty-four (34) letters of opposition. Ex. 1-B at 1011; Tr. 2611:17 – 22. A number of the Piedmont support letters were critical of CHS, but were not counted by DHEC as opposition letters to CHS. DHEC also received more than five thousand (5,000) support letters for CHS and

no letters of opposition. Tr. 2612:3 – 12. Some of the CHS letters of support were critical of Piedmont, however, these were likewise not counted by DHEC as opposition letters to Piedmont.

CONCLUSIONS OF LAW

Based upon the above findings of fact, the court concludes the following as a matter of law:

1. The ALC has jurisdiction over this contested case proceeding pursuant to S.C. Code Ann. § 44-1-60(F) (Supp. 2006) and § 1-23-600(A) (2005). In DHEC permitting cases, the Administrative Law Judge is the finder of fact. *Brown v. S.C. Dep't of Health & Env'tl. Control*, 348 S.C. 507, 560 S.E.2d 410 (2002). This court's review of a DHEC decision on a CON application is *de novo*. *Marlboro Park Hosp. v. S.C. Dep't of Health & Env'tl. Control*, 358 S.C. 573, 595 S.E.2d 851 (Ct. App. 2004).
2. The State Certification of Need and Health Facility Licensure Act, S.C. Code Ann. §§ 44-7-110 to -394 (CON Act), requires a person or health care facility to obtain a CON before undertaking the construction or establishment of a new health care facility, including a hospital. S.C. Code Ann. §§ 44-7-130(10), -160(1) (Supp. 2010).
3. The purposes of the CON Act 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 (2002).
4. DHEC is responsible for administering the CON program in South Carolina. S.C. Code Ann. § 44-7-140 (2002). As such, DHEC's duties include promulgating regulations, S.C. Code Ann. § 44-7-150(3) (2002), and preparing a South Carolina Health Plan, S.C. Code Ann. § 44-7-180(B) (Supp. 2010).
5. DHEC promulgated Regulation 61-15 in order to administer the CON program to achieve the purpose of the CON Act. Regulation 61-15 § 802 sets forth thirty-three (33) project review criteria applicable to CON applications. These criteria fall into five (5) general categories: (1) need for the proposed project; (2) economic considerations of the project; (3) the project's impact on the resources of the health care system; (4) suitability of the site of the project; and (5) certain special circumstances. S.C. Reg. 61-15 §§ 801-802. During the application review process, DHEC establishes the relative importance of these project review

criteria and notifies each applicant of the ranking. S.C. Code Ann. Regs. 61-15 §§ 304, 801(2). While a project does not have to satisfy every project review criterion to be approved, no project may be approved unless it is consistent with the South Carolina Health Plan. S.C. Code Ann. Regs. 61-15 § 801(3); *see also* S.C. Code Ann. Regs. 61-15 § 802(1) (“proposal shall not be approved unless it is in compliance with the South Carolina Health Plan”).

6. In determining whether to grant or deny a CON application, DHEC evaluates the proposed project under the project review criteria found in Regulation 61-15 § 802 and under the policies and standards in the applicable State Health Plan. S.C. Code Ann. § 44-7-210(C). 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.” S.C. Code Ann. § 44-7-210(C); *see also MRI at Belfair, LLC v. S.C. Dep’t of Health & Envtl. Control*, 379 S.C. 1, 9, 664 S.E.2d 471, 475 (2008) (holding that compliance with the State Health Plan and the Project Review Criteria are independent requirements for approval of a CON).

7. In the case of competing applications, DHEC must award the CON, if appropriate, to the applicant who most fully complies with the requirements, goals, and purposes of the CON Act, the State Health Plan, the project review criteria, and other applicable regulations. S.C. Code Ann. § 44-7-210(B); S.C. Code Ann. Regs. 61-15 § 307(2). Here, Piedmont, CHS, Presbyterian, and HPA filed competing CON applications to provide similar services or facilities in the same service area. *See* S.C. Code Ann. § 44-7-130(5) (2002); S.C. Code Ann. Regs. 61-15 § 103(6). DHEC granted CHS’ application to construct a 64 bed general acute hospital in York County.

8. Piedmont timely filed a request for contested case hearing challenging DHEC’s decision to approve CHS’ CON application. As a result, Piedmont, as the moving party, bears the burden of proof in this contested case. *See Leventis v. S.C. Dep’t of Health & Envtl. Control*, 340 S.C. 118, 132-33, 530 S.E.2d 643, 651 (Ct. App. 2000) (holding that the burden of proof in administrative proceedings generally rests upon the party asserting the affirmative of an issue). Therefore, Piedmont must prove by a preponderance of the evidence that DHEC erred in approving CHS’ CON application. *See Anonymous v. State Bd. of Med. Exam’rs*, 329 S.C. 371, 375, 496 S.E.2d 17, 19 (1998) (holding that the standard of proof in an administrative proceeding is generally the preponderance of the evidence); *Nat’l Health Corp. v. S.C. Dep’t of Health &*

Envtl. Control, 298 S.C. 373, 379, 380 S.E.2d 841, 844 (Ct. App. 1989) (stating that the preponderance of the evidence standard applies in CON disputes).

9. At the contested case hearing before this court, the issues to be considered are limited to those presented to or considered by DHEC during the staff review and decision-making process. S.C. Code Ann. § 44-7-210(E). As long as no new issues are considered in these contested case proceedings, any evidence pertinent to the issues considered by DHEC staff may be considered by this court. *Marlboro Park Hosp. v. S.C. Dep't of Health & Envtl. Control*, 358 S.C. 573, 578-79, 595 S.E.2d 851, 854 (Ct. App. 2004).

10. This court must consider the South Carolina Health Plan in effect at the time the CON applications were filed and may also consider the South Carolina Health Plan in effect at the time of this decision. S.C. Code Ann. § 44-7-225 (Supp. 2010). Thus, this court must consider the 2004-2005 South Carolina Health Plan and may also consider the 2012-2013 South Carolina Health Plan. Both of these plans were admitted as evidence at the contested case hearing.

11. The weight and credibility assigned to evidence presented at the hearing of a matter is within the province of the trier of fact. *See S.C. Cable Television Ass'n v. S. Bell Tel. & Tel. Co.*, 308 S.C. 216, 222, 417 S.E.2d 586, 589 (1992). Furthermore, a trial judge who observes a witness is in the best position to judge the witness's demeanor and veracity and to evaluate the credibility of his testimony. *See, e.g., Woodall v. Woodall*, 322 S.C. 7, 10, 471 S.E.2d 154, 157 (1996); *Wallace v. Milliken & Co.*, 300 S.C. 553, 556, 389 S.E.2d 448, 450 (Ct. App. 1990).

12. Under Rule 702 of the South Carolina Rules of Evidence, “[i]f scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise.” An expert is granted wide latitude in determining the basis of his opinion, and where an expert's testimony is based upon facts sufficient to form an opinion, the trier of fact must weigh its probative value. *Small v. Pioneer Mach., Inc.*, 329 S.C. 448, 470, 494 S.E.2d 835, 846 (Ct. App. 1997).

13. “[E]xpert testimony is essential in cases which involve a subject of special technical science, skill, or occupation of which the members of the jury or the trial court are not presumed to be specially informed.” 32A C.J.S. *Evidence* § 729, at 85 (1996). For example, the

South Carolina Supreme Court has held that in medical malpractice cases “the plaintiff must use expert testimony . . . unless the subject matter lies within the ambit of common knowledge and experience, so that no special learning is needed to evaluate the conduct of the defendant.” *Pederson v. Gould*, 288 S.C. 141, 143, 341 S.E.2d 633, 634 (1986).

14. In general, “expert opinion evidence is to be considered or weighed by the triers of the facts like any other testimony or evidence . . . [;] the triers of fact cannot, and are not required to, arbitrarily or lightly disregard, or capriciously reject, the testimony of experts or skilled witnesses, and make an unsupported finding to the contrary of the opinion.” 32A C.J.S. *Evidence* § 727, at 82-83 (1996). However, the trier of fact may 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, 72-73, 425 S.E.2d 61, 63 (Ct. App. 1992). Further, the trier of fact may accept the testimony of one expert over that of another. *See S.C. Cable Television Ass’n v. S. Bell Tel. & Tel. Co.*, 308 S.C. 216, 417 S.E.2d 586 (1992).

15. The parties do not dispute DHEC’s findings that Piedmont and CHS equally meet the following project review criteria:

- 1 Compliance with the State Health Plan
- 3c Location allows for timely delivery of necessary support services at a reasonable cost
- 3e Documentation of means by which persons will access services
- 6a Proposed/comparable charges
- 7 Consistent with similar facilities
- 13a Successful operations and management experience
- 13b Ability to obtain financing
- 13d Record of compliance
- 4a Support of affected persons
- 4c Possible transfer agreements

With there being no evidence in the record to the contrary, the court concludes that DHEC did not err in finding that Piedmont and CHS equally met these Project Review Criteria.

Need (2a, 2b, 2c, 2d, 2e, 3a)

16. Project Review Criteria 2a requires identification of the target population while Criteria 2b requires projections of anticipated population changes to be reasonable and based upon accepted methodologies.

17. Project Review Criteria 2c requires that the proposed project provide services that meet an identified need of the target population, and Project Review Criteria 2e provides that the projected utilization should be sufficient to justify the implementation of the proposed service.

18. Expert witnesses presented by both parties agreed on one core issue: a need exists for a new hospital in Northern York County. No consensus was reached, however, on the fundamental question presented whether that need is for CHS' 64 bed facility or Piedmont's 100 bed facility. As noted in the Findings of Fact, this court was persuaded that Piedmont proved by a preponderance of the evidence that a 100 bed hospital would better meet the needs of the residents of York County than the 64 bed facility CHS proposed. CHS relied on its maldistribution theory during staff review as the primary basis for challenging the need for Piedmont's larger facility. However, when updated census data were applied to its methodology during trial, it revealed that the beds in York County would be more equitably distributed through the FMMC 100 bed hospital than they would by the construction of CMC-FM. FMMC's capacity to expand to 250 beds in the future also demonstrates that it would be better positioned to meet the needs of the rapidly growing Fort Mill area than CMC-FM. CMC-FM's own projections show that, by the third year of operation, it would be operating at an occupancy level that would justify the approval of new beds, but with little shell space available to it for expansion. These projections are further evidence that CHS' proposed facility would be too small to fully meet the demand.

19. In addition to meeting the need for new hospital services, Piedmont's application was specifically intended to strengthen the York County healthcare system by reducing outmigration from York County. While patients have sought medical services outside of York County for years, primarily in the Charlotte area, the outmigration accelerated from 2005 to 2011. The effects of the outmigration, which are detailed in the relevant Findings of Fact and are incorporated herein, reduced the ability of Piedmont and many of the independent physicians on Piedmont's medical staff to meet the healthcare needs of York County residents. Piedmont demonstrated by a preponderance of the evidence that the establishment of FMMC would strengthen the capacity of existing York County providers to meet those needs. For these reasons, Piedmont best meets § 802.2 (a, b, c, e).

20. Project Review Criteria 2d addresses the reduction, relocation, or elimination of a facility or service. Since only Piedmont's application proposes to relocate beds, the applicability of this criterion is limited to Piedmont. The court finds that the transfer of 36 beds to FMMC will not adversely affect the population served at Piedmont because even with the transfer of the

36 beds, Piedmont would have more than 70 available beds on an average day. The court further finds that these beds will be better utilized at FMCC.

21. Project Review Criteria 3a provides that unnecessary duplication of services will not be approved. The court concludes that Piedmont's transfer of 36 beds would not unnecessarily duplicate services, but rather it would redeploy beds to an area of greater need in the county. Therefore, the court concludes that both applicants equally meet this criteria.

Access to Medically Underserved (3b, 3d, 3f, 3g)

22. DHEC accepted CHS' projections that CMC-FM would provide charity care equaling 6.3 percent of its gross revenue. The State Health Plan defines indigent care, also referred to as charity care, as

medical care (measured in dollars) provided to an individual who has been determined to be unable to pay for this care prior to admission in non-emergency situations, and as soon as possible but before the discharge in emergency situations and for which only one billing has occurred and no other efforts have been undertaken to collect such debt. Indigent care does not include debt; contractual adjustments; or care that is reimbursed by a governmental program (Medicare, Medicaid, County indigent care program), church, or philanthropic organizations.

2004-2005 State Health Plan at I-5, I-6.

23. Project Review Criterion 3b requires that the project should be located so that it may serve medically underserved areas. The court concurs with the Department that both applicants equally meet this criteria.

24. Project Review Criterion 3d requires that the proposed facility should not restrict admissions. DHEC found that Piedmont and CHS equally met this criterion. However, CPN internal records suggest CPN practices in York County limit access for indigent, Medicaid, and even Medicare patients. Whereas Piedmont and the non-contractually bound physicians who have privileges there do not. The court finds that this criteria is best met by Piedmont.

25. Project Review Criterion 3f directs that applicants should address the extent to which all residents of the area, particularly low income and medically underserved residents are likely to have access to the proposed facility.

26. CHS' proposed charity care does not meet the definition quoted above. Mr. Stewart's testimony and CHS internal documents reveal that CHS' charity care projections include large amounts of bad debt that CHS reclassifies as charity care. Contrary to the State Health Plan's requirements, these reclassifications occurred before, during, and after patients' hospital stays.

27. As discussed in the Findings of Fact, the greater weight of the evidence suggests CMC-FM's charity care will be significantly less than 6.3 percent of its gross revenue. This is substantiated by past cost reports filed by CHS for CMC-Pineville and CMC-Mercy, indicating those hospitals provided charity care valued at 2.6 percent of gross revenue.

28. Additionally, while the court finds that both applicants addressed the issue of availability of care for indigent residents in the county, the Findings of Fact reflect the court's concern that the practices of physicians affiliated with CHS via CPN would limit non-emergency access to CMC-FM. Therefore, the court finds that Piedmont better meets Criteria 3f.

29. Project Criteria 3g requires applicants to ensure that individuals in need of treatment have access to appropriate care, regardless of their ability to pay. The court finds that both applicants meet this criteria.

Adverse Impact (16c, 22, 23a, 23b, 3h)

30. The most heavily disputed application of the Project Review Criteria relates to DHEC's analysis of the Project Review Criteria on adverse impact.

31. At trial, Piedmont's witnesses objected to DHEC's exclusion of Criteria 3h and the relative low ranking that DHEC gave Criteria 23a and 23b. S.C. Code Ann. § 44-7-210(E) limits the issues to be considered at the contested case hearing to those presented to or considered by DHEC during the staff review and decision-making process. By failing to raise the issues related to the exclusion and importance of certain Project Review Criteria to DHEC prior to the contested case, Piedmont cannot raise these objections in the contested case. Accordingly, the court rejects Piedmont's arguments that DHEC erred in failing to consider Criterion 3h and in ranking Criteria 23a and 23b as among the least important criteria in its review. As a result, the court will consider these criteria according to the ranking established by DHEC in its letter of March 27, 2006. This does not require the court to ignore Criterion 3h but

rather, that the court should give no greater weight to this criterion than it does to any of the other criteria that were not specifically listed in DHEC's ranking.¹⁴

32. The effect on Piedmont of the loss of over one thousand (1000) patients and millions of dollars a year will make it more difficult for the hospital to recoup its fixed costs. Its associated per unit cost per unit of services associated would increase. As a result, the operation of CMC-FM would have an adverse effect on existing providers. For that reason, Piedmont best meets § 802.16(c).

33. Project Review Criterion 22 requires that the proposed project's effect on the distribution of health services should be carefully considered to functionally balance the distribution to the target population. The court concludes that the operation of CMC-FM would have an adverse effect on the distribution of services provided by existing healthcare providers to the residents of York County. Section 802.22 calls for an evaluation of the effect of the proposed facility or service not only on Piedmont but also on other healthcare providers. Letters from over forty (40) physicians to DHEC during its staff review as well as the testimony of the three physicians is compelling evidence that the ability of existing York County healthcare providers to serve residents of the county would be jeopardized by the operation of CMC-FM. Piedmont best meets § 802.22.

34. Criterion 23a requires the consideration of the impact on the current and projected occupancy rates or use rates of existing facilities and services, weighed against the increased accessibility offered by the proposed services. 803(23)(a). For reasons detailed in the Findings of Fact of this Order, this court finds the position asserted by CHS and DHEC that by shifting patients from CHS facilities outside of York County, CMC-FM will cause little, if any, adverse impact on Piedmont to be unsound. CHS lacks both the incentive and the ability to accomplish such a shift or to control admissions to CMC-FM. Although CMC-FM will undoubtedly serve CHS patients, the court finds Piedmont has proven, by a preponderance of the evidence, that CHS would continue to acquire market share from Piedmont if CMC-FM were established. This would be accomplished through services provided by CMC-FM, as well as by the increased outmigration of patients to CHS facilities outside of York County for more specialized services.

¹⁴ Ms. Fechtel's letter of March 27, 2006, explained that all other relevant criteria—the criteria not specifically listed in the letter—would be given equal importance. Thus, any criteria that was not listed but was relevant to consideration of the CON applications would be given equal importance.

35. Given the rapid population growth projected for Northern York County, the court concludes that the incremental approach is more reliable than the lookback approach in calculating CMC-FM's impact on Piedmont. Under the incremental approach, Piedmont would lose from one thousand six hundred (1,600) to three thousand (3,000) inpatients per year. When the loss of outpatients is projected, the total annual lost income caused by the operation of CMC-FM would range from \$12,000,000 to \$22,000,000, depending upon which expert's analysis is considered. This court is persuaded by the analysis of other courts which have found that significantly smaller losses constitute adverse impact. *See e.g., Lexington County Health Servs. Dist., Inc. v. DHEC*, 04-ALJ-07-0365-CC, 2006 WL 2899943 (ALC Sept. 15, 2006) (\$3.2-\$4.5 million annual loss to Palmetto Health is adverse impact); *Edisto Surgery Center v. DHEC*, 1998 WL 404373 at 17 (ALC, July 2, 1998) (annual loss of \$2.7 - \$3.1 million would be substantial negative impact on The Regional Medical Center of Orangeburg and Calhoun Counties). Moreover, Piedmont's projected loss represents between thirty-three (33) and ninety (90) percent of its annual pretax income. *See Marlboro Park Hosp. v. DHEC*, 2000 WL1274366 at 9 (ALC, July 27, 2000) [a thirty-two (32) percent reduction in pretax income constitutes substantial adverse impact]; *see id.* (a reasonable profit is necessary for hospitals to make capital investments such as new equipment).

36. The court finds that CHS's proposal does not meet Project Review Criterion 23a and that Piedmont's does meet it.

37. Criterion 23b requires that the staffing of the proposed hospital should be provided without unnecessarily depleting the staffing of existing hospitals or services. Piedmont presented evidence CMC-FM would have a negative impact on Piedmont's ability to staff its existing facility. It argued that because a large percentage of Piedmont's staff, especially nursing staff, currently live in Northern York County or Mecklenburg County, CMC-FM's relative proximity to their homes could pose a significant threat to Piedmont's ability to retain or recruit a substantial portion of its workforce. Tr. 224:4-23; 688:8-15. However, none of the witnesses testifying for Piedmont on this issue could provide the court with specific examples of what staff might be depleted, or the degree they might be depleted. Mr. Masterton, Piedmont's witness, acknowledged that he could not quantify what, if expenses, salaries, staff, and services might have to be reduced. Tr. 224:4 - 226:7; 2830:25 - 2831:6. The court finds that the position

of Piedmont too speculative to support a finding that the construction of CMC-FM would deplete its staff. Therefore, both parties equally meet Criterion 23b.

Financial Feasibility (6b, 9, 15, 16a, 17)

38. The court concludes that Piedmont and CHS equally meet Regulation 61-15 § 802(6)(a), as the proposed changes of both applicants are "comparable to those changes established by other facilities for similar services within the service area or state." Piedmont and CHS also equally satisfy Regulation 61-15 § 802(7), as their projected expenses are "consistent with those experienced by similar facilities." The court also agrees with Piedmont and CHS that Project Review Criterion 16b is not applicable.

39. Project Review Criterion 6b requires that projected levels of utilization should be consistent with those experienced by similar facilities and consistent with the need of the target population. As described in the court's Findings of Fact, CMC-FM will be well-utilized, however, with its smaller size and a projected occupancy rate approaching seventy (70) percent in its third year of operation, CMC-FM may need to expand to meet the growing needs of rapidly expanding Northern York County. FMMC's projected levels of utilization are lower, with a projected occupancy rate of 58 percent in its third year of operation. However, evidence was presented that FMMC's projected occupancy rates were consistent with similar facilities in the service area and the State. Additionally, FMMC's proposed larger size, created by the transfer of 36 beds from Piedmont to FMMC, places it in a better position to accommodate the expanding population of fast growing Northern York County. For these reasons, this court concludes that both Piedmont and CHS equally meet Project Review Criterion 6b.

40. Both applicants equally satisfy Regulation 61-15 § 802(9), as both show an improvement in net revenue over the course of time. Both equally satisfy Regulation 61-15 § 802(15), as both have projected the immediate and long-term financial feasibility of their projects. Id. Both applicants equally satisfy Regulation 61-15 § 802(16)(a), in that both have identified feasible methods of funding.

41. Section 802(17) provides that "[t]he proposed project should improve efficiency by avoiding duplication of services, promoting shared services, and fostering economies of scale." Piedmont better satisfies this criterion because its proposal fosters economies of scale by spreading costs over a greater number of beds. Not only will FMMC's 100 beds better accommodate future growth, FMMC is better designed for expansion than is CMC-FM.

Public Support and Opposition (4b)

42. Both applicants equally comply with Regulation 61-15 § 802(4)(b), which requires consideration of whether documented opposition exists to a proposed project. Both submitted over 5,000 letters of support. While DHEC counted 34 letters of opposition to Piedmont, it did not count as opposition a number of letters from physicians both supporting FMMC and opposing CHS.

Conclusion

43. Piedmont and CHS both presented outstanding cases. DHEC conducted a thorough review process for the applications. DHEC staff asked numerous questions of both applicants seeking additional information and held a project review meeting to thoroughly discuss and understand the proposed projects. The Project Review Criteria Analysis was thorough and detailed. This court finds that the Department properly reviewed and analyzed both applications. To the extent that the court disagrees with certain aspects of Ms. Brandt's analysis, it was persuaded by the testimony of Mr. Grice, an expert with three decades of institutional knowledge and history with DHEC's CON program.

44. This court concludes that either hospital would promote cost containment. Both applicants have the ability to access cash to build its facility. Although the total cost to build FMMC is higher than the cost to build CMC-FM, the court concludes the per bed cost of the two facilities is comparable. Because the need for 100 beds has been established, the greater cost necessary for the construction of the larger facility is an imperative expenditure that meets the public need. Another factor contributing to the greater cost required to construct FMMC is that it is designed to accommodate growth of up to 250 beds, while CMC-FM is designed to add no more than 20 beds.

45. This court concludes that neither proposed Fort Mill area hospital would unnecessarily duplicate the services provided by Piedmont. Moreover, Piedmont has justified the transfer of 36 beds as a reasonable use of those resources to address the growing demand for healthcare services in Northern York County.

46. This court concludes that the establishment of FMMC will best serve the public needs by reducing the outmigration of York County residents to hospitals beyond York County, and in so doing, will strengthen the existing healthcare system in York County that consists largely of Piedmont Medical Center and non-contractually bound physicians on the Piedmont

medical staff. Approval of Piedmont's application will help stem outmigration and maintain quality of care, while approval of CHS' will escalate outmigration and lead to an erosion of quality of care in York County, especially for specialty services. For all these reasons, FMMC will better serve public needs than CMC-FM.

47. This court concludes that either applicant would be capable of providing high quality healthcare services at its proposed Fort Mill area hospital. One of the principal differences between the applicants is that the approval of CMC-FM would have the effect of causing the erosion of quality of care at Piedmont and among specialists practicing there as a result of the diminution in the volume of patients and the degradation of the payor mix of the patients who would continue to be seen at Piedmont. Consequently, there would be no hospital in York County providing many of the high quality and tertiary services that Piedmont has added. Alternatively, the establishment of FMMC will ensure that high quality services continue to be provided and added within York County.

48. Piedmont made a proffer of evidence on the "bed need" issue identified in this court's Order on Motion in Limine date April 5, 2013 and Piedmont's argument in the prior contested case hearing before Judge Matthews. I conclude that Judge Matthews' prior ruling is dispositive of this issue.

49. CHS made a proffer of evidence on the "competing applicant" issue identified in this court's Order on Motion in Limine dated April 5, 2013 and CHS' argument in the prior contested case before Judge Matthews. I conclude that Judge Matthews' prior ruling is dispositive of this issue.

50. Due to the enormous amount of discovery involved in this case, the large volume of evidence gathered and presented, and the occurrence of unforeseen but unavoidable delays associated with the hearing, the court finds substantial cause justifying the issuance of the final decision in this matter falling outside of the eighteen (18) month timeline set forth in S.C. Code Ann. §44-76-220(g)(Supp. 2013).

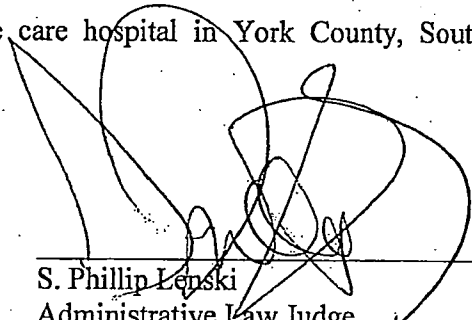
ORDER

After careful review of the evidence presented in this matter, and based upon the findings of fact and conclusions of law stated above, the court finds that Piedmont's application to establish FMMC most fully complies with the State Health Plan, the Project Review Criteria, and

the purposes of the CON Act and, therefore, should be approved while CHS' application to construct CMC-FM should be denied.

IT IS HEREBY ORDERED that the Department shall issue the CON application to Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center d/b/a Fort Mill Medical Center for the purpose of building a 100 bed general acute care hospital in York County, South Carolina.

AND IT IS SO ORDERED.¹⁵



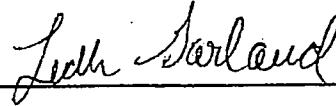
S. Phillip Lepski
Administrative Law Judge

December 15, 2014
Columbia, South Carolina

¹⁵ The court gave careful consideration to all of the issues raised by CHS in its Motion for Reconsideration in drafting this Amended Final Order. To the extent that any issues raised in the Motion for Reconsideration are not specifically addressed in this Amended Final Order, the court found them to be without merit.

CERTIFICATE OF SERVICE

I, Leah E. Garland, 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).



Leah E. Garland
Judicial Law Clerk

December 15, 2014
Columbia, South Carolina

FILED

DEC 15 2014

SC ADMIN. LAW COURT

The South Carolina Court of Appeals

Grand Strand Regional Medical Center, LLC,
Respondent,

v.

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

Grand Strand Regional Medical Center, LLC,
Respondent,

v.

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

of whom Carolina Regional Cancer Center is the
Appellant.

Appellate Case No. 2014-000973

ORDER

The South Carolina Department of Health and Environmental Control (DHEC) granted Carolina Regional Cancer Center (Appellant) a Certificate of Need (CON) to add a linear accelerator to a proposed radiation cancer treatment facility in Conway. At the same time, DHEC found competing—and denied—a CON application by Respondent, Grand Strand Regional Medical Center, LLC, seeking to add a linear accelerator facility to its hospital campus in Myrtle Beach. On appeal to the Administrative Law Court (ALC), the ALC reversed DHEC's decision in part, finding the applications were not competing and both Appellant and Grand Strand should be granted a CON.

Appellant appealed the ALC's decision granting Grand Strand's CON. As required by section 44-7-220(B) of the South Carolina Code (Supp. 2014), Appellant posted a bond with this court in the amount of \$489,431.25, which represents an amount equal to five percent of the total cost of Grand Strand's project. Section 44-7-220(B) further provides, "If the Court of Appeals affirms the [ALC]'s decision or dismisses the appeal, the Court of Appeals shall award to the party whose project is the subject of the appeal all of the bond and also may award reasonable attorney's fees and costs incurred in the appeal."

Appellant subsequently filed a petition for supersedeas and requested panel review of a single judge's order denying the petition. We granted panel review and held a hearing on February 25, 2015. Appellant asks the court to stay the ALC's order granting a CON to Grand Strand pending the resolution of the appeal. In its filings and in its arguments before the court, Appellant argued (1) it was entitled to a stay under Rule 241(c)(2), SCACR; (2) this court should read a mandatory stay into section 44-7-220(B) because without a stay, the statute produces absurd results contrary to the CON Act's purposes; and (3) unless a stay is imposed the appeal bond provision unconstitutionally curtails Appellant's right to judicial review, violates procedural and substantive due process, and violates the constitutional guarantee of equal protection. After careful consideration, we deny the petition for supersedeas.

Appeals from administrative tribunals are exceptions to the automatic stay requirement of Rule 241(a) of the South Carolina Appellate Court Rules. Rule 241(b)(11), SCACR. However, a supersedeas may be ordered pursuant to Rule 241(c), SCACR. The rule provides that "[i]n determining whether [a supersedeas] should issue . . . [we] should consider whether such an order is necessary to preserve jurisdiction of the appeal or to prevent a contested issue from becoming moot." Rule 241(c)(2), SCACR. We find there is no danger the court will lose jurisdiction or the issues on appeal will become moot if Grand Strand is allowed to proceed with its project. *See S.C. Ret. Sys. Inv. Comm'n v. Loftis*, 402 S.C. 382, 384, 741 S.E.2d 757, 758 (2013) ("A case is moot where a judgment rendered by the [c]ourt will have no practical legal effect upon an existing controversy because an intervening event renders any grant of effectual relief impossible for the [c]ourt."). Grand Strand acknowledges that if it were to proceed with construction of its facility, it would have to cease all operations related to its project if this court reverses the ALC's decision approving its CON. Therefore, whether Grand Strand proceeds with construction and operation of its facility will not moot the issues on appeal or strip this court of jurisdiction.

Appellant asserts it will face "severe consequences" if Grand Strand is allowed to begin operating its linear accelerator services on its hospital campus "just three miles away from Appellant's existing operations" because referral patterns among doctors in the area will change. We find Appellant has not established that a stay is necessary to prevent irreparable harm to its referral base. Briefing is complete in the case and Grand Strand confirmed during the hearing that it has not yet begun its project, which is scheduled to take eighteen months. Therefore, even if Grand Strand were to begin its project today, this court will likely decide the merits of the appeal before the completion of Grand Strand's project and thus, well before area doctors begin to change their referral patterns.

Appellant further argues section 44-7-220(B) yields an absurd result, contrary to the CON Act's purpose, if a mandatory stay is not required in exchange for it posting a bond, "[d]espite the lack of the word 'stay' in the . . . bond provision." However, our rules of statutory construction do not allow courts "to add the words [the legislature] omitted, nor to interpolate them on conceits of symmetry and policy." *Consumer Advocate for the State of S.C. v. S.C. Dep't of Ins.*, 397 S.C. 599, 602, 725 S.E.2d 708, 710 (Ct. App. 2012) (alteration in original) (quoting *Kinard v. Moore*, 220 S.C. 376, 388, 68 S.E.2d 321, 325 (1951)). Section 44-7-220(B) contains no requirement that a mandatory stay be issued in conjunction with the filing of the appeal bond, and we decline to insert such a requirement into the statute.

Appellant also asserts this court may reject the plain language of the statute if abiding by it would render it unconstitutional. *See Kiriakides v. United Artists Commc'ns, Inc.*, 312 S.C. 271, 275, 440 S.E.2d 364, 366 (1994) ("However plain the ordinary meaning of the words used in a statute may be, the courts will reject that meaning when to accept it would lead to a result so plainly absurd that it could not possibly have been intended by the [l]egislature or would defeat the plain legislative intention."). Here, Appellant argues there can be only two justifications for awarding the appeal bond to Grand Strand if its CON is upheld: (1) to compensate Grand Strand for delay costs caused by the appeal, or (2) to deter and punish Appellant for appealing. If Grand Strand proceeds with its project, unencumbered by a stay, it will incur no delay costs, and in that situation, Appellant argues the appeal bond provision becomes punitive, violating its constitutional right to judicial review, procedural due process, substantive due process, and equal protection.

We find there has been no impairment of Appellant's right to judicial review under Article 1, Section 22 of the South Carolina Constitution, nor has there been a

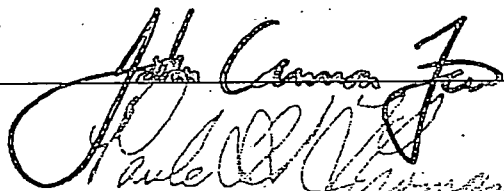
violation of its right to procedural due process. See S. C. Const. art. I, 22 (providing "[n]o person shall be finally bound by a judicial or quasi-judicial decision of an administrative agency affecting private rights except on due notice and an opportunity to be heard . . . and he shall have in all such instances the right to judicial review"); *Harbit v. City of Charleston*, 382 S.C. 383, 393, 675 S.E.2d 776, 781 (Ct. App. 2009) ("The fundamental requirements of due process under the United States Constitution and the South Carolina Constitution include notice, an opportunity to be heard in a meaningful way, and judicial review."). Appellant has successfully initiated its appeal of the ALC's decision, and this court will soon give Appellant its judicial review. Appellant has never claimed it was unable to afford the appeal bond or that the appeal bond otherwise deterred it from filing its appeal. Further, because Appellant will receive its judicial review, we decline to find that the legislature's decision to impose the appeal bond violated the separation of powers doctrine by attempting to curtail judicial review and make the ALC, an executive branch agency, the final arbiter in CON cases.

Second, we find Appellant has not demonstrated an equal protection or substantive due process violation because there is a rational basis for the statute's provision awarding a respondent the appeal bond if the ALC's decision is upheld, and this provision is related to a legitimate government interest. See *Sloan v. S.C. Bd. of Physical Therapy Examiners*, 370 S.C. 452, 480, 636 S.E.2d 598, 613 (2006) ("To satisfy the equal protection clause, a classification must (1) bear a reasonable relation to the legislative purpose sought to be achieved, (2) members of the class must be treated alike under similar circumstances, and (3) the classification must rest on some rational basis."); *id.* at 483, 636 S.E.2d at 614 ("[T]he standard for reviewing all substantive due process challenges to state statutes . . . is whether the statute bears a reasonable relationship to any legitimate interest of government."). As we read the statute, the legislature imposed the appeal bond on CON appellants to reserve some funds to compensate a respondent harmed by the delay of its approved project during the pendency of the appeal. We believe that is a legitimate government purpose.

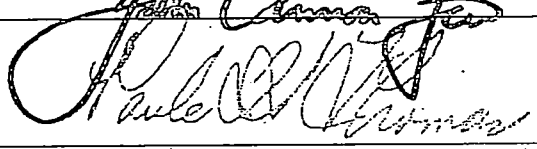
We acknowledge that in some instances, adherence to the statute as written may produce imperfect results; however, we do not believe this invalidates the statute. See *Bodman v. State*, 403 S.C. 60, 70, 742 S.E.2d 363, 368 (2013) (stating that in the equal protection analysis, "[t]he classification also does not need to completely achieve its purpose to withstand constitutional scrutiny" nor does "[t]he fact that the classification may result in some inequity" make the classification unconstitutional (internal quotation marks omitted)). For example, if Grand Strand chose not to delay its project during the appeal and we affirm the ALC's decision,

Grand Strand may be entitled to receive the appeal bond without having suffered any delay costs. In that event, depending on how and whether this court awards costs and attorney's fees, the award of the appeal bond to Grand Strand could constitute a windfall. On the other hand, if we impose a stay or if Grand Strand chooses to delay its project during the appeal process and we affirm the ALC's decision, the award of the appeal bond may not fully compensate Grand Strand, resulting in a shortfall. In that case, the appeal would have harmed Grand Strand's economic interests. The statute may be understood to balance these two potential outcomes within the larger statutory framework of the CON Act, which seeks to efficiently regulate the construction of health facilities. *See* S.C. Code Ann. § 44-7-120 (2002) (stating two of the purposes of the CON Act are to "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"). Accordingly, we believe section 44-7-220(B) is constitutional as written, and it is not necessary to grant Appellant a stay to render the statute valid.

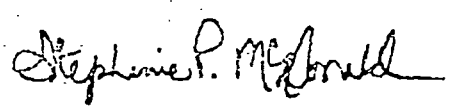
Therefore, for these reasons noted above, we deny Appellant's petition for supersedeas.



CJ.



J.



J.

Columbia, South Carolina.

cc: William R. Thomas, Esquire
Walter Hammond Cartin, Esquire
Ashley Caroline Biggers, Esquire
Vito Michael Wicevic, Esquire
Amber B. Carter, Esquire

FILED

March 19, 2015 jak

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Amisub of South Carolina, Inc., d/b/a
Piedmont Healthcare System d/b/a Fort Mill
Medical Center,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control and The Charlotte-
Mecklenburg Hospital Authority d/b/a
Carolina Medical Center-Fort Mill,

Respondents.

Docket No.: 11-ALJ-07-0575-CC

**ORDER DENYING RESPONDENT'S
MOTION TO STAY/SUPERSEDEAS
PENDING APPEAL**

This matter is before the court on the Respondent's, The Charlotte Mecklenburg Hospital Authority d/b/a Carolina Medical Center-Fort Mill (Respondent or CHS), Motion to Stay/Supersedeas Pending Appeal and Memorandum in Support filed on January 28, 2015. The Respondent seeks to stay the December 15, 2015 Amended Final Order of the South Carolina Administrative Law Court ("ALC" or "court") granting the contested Certificate of Need (CON) to Amisub of South Carolina, Inc., d/b/a Piedmont Healthcare System d/b/a Fort Mill Medical Center (Petitioner or Piedmont) pending the outcome of the appeal filed by the Respondent in the South Carolina Court of Appeals. The court issued an Order Granting Motion to Stay Pending Appeal on February 10, 2015. However, the court vacated that Order on February 12, 2015 when it became aware that responsive pleadings that had been submitted by the Petitioner, had been misrouted to another judge on the ALC and had not been considered when the court issued its February 10, 2015 Order. Having reviewed the Petitioner's Memorandum in Opposition to Respondent's Motion to Stay/Supersedeas Pending Appeal, as well as the Respondent's Reply Memorandum, the court denies the Respondent's Motion to Stay/Supersedeas Pending Appeal.

FILED

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SC ADMIN. LAW COURT

This CON contested case was initiated by the Petitioner on November 15, 2011. After a hearing on the merits, this court issued a Final Order dated March 31, 2014 (Final Order) which granted a CON to the Petitioner and denied a CON to the Respondent. The Respondent received written notice of the entry of the Final Order on March 31, 2014. On April 9, 2014, the Respondent timely filed a Motion to Alter or Amend the Final Order pursuant to ALC Rule 29(d) and Rule 59, South Carolina Rules of Civil Procedure (SCRCP). On May 2, 2014, the court vacated the Final Order. On December 15, 2014, the court issued an Amended Final Order. The Respondent received written notice of the entry of the Amended Final Order on December 15, 2014 and filed a Notice of Appeal with the South Carolina Court of Appeals on January 14, 2015. The Respondent subsequently filed a cash bond, pursuant to S.C. Code Ann. § 44-7-220(B), with the Clerk of the South Carolina Court of Appeals in the sum of One Million Five Hundred Thousand and no/100 Dollars (\$1,500,000.00), which is the maximum amount payable by statute.

JURISDICTION

The ALC has jurisdiction to rule on the Respondent's Motion to Stay pursuant to Rule 241, South Carolina Appellate Court Rules (SCAPCR). Rule 241(d) provides:

Except where extraordinary circumstances make it impracticable, an application for an order lifting the automatic stay or for supersedeas must first be made to the lower court or administrative tribunal which entered the order or decision on appeal. The issuance of an ex parte order or decision, or an unnecessary delay by the lower court or administrative tribunal in ruling on this application shall constitute an extraordinary circumstance.

Similarly, Rule 205, SCACR, provides:

Upon the service of the notice of appeal, the appellate court shall have exclusive jurisdiction over the appeal; the lower court or administrative tribunal shall have jurisdiction to entertain petitions for writs of supersedeas as provided by Rule 241. Nothing in these Rules shall prohibit the lower court, commission or tribunal from proceeding with matters not affected by the appeal.

Therefore, the ALC has jurisdiction to consider any motion for a stay/supersedeas after a Notice of Appeal is filed, and the Court of Appeals may only consider it after the ALC has ruled or under “extraordinary circumstances.” Pursuant to S.C. Code Ann. § 1-23-380(2), the ALC may grant a stay requested by a party “upon appropriate terms.” Pursuant to S.C. Code Ann. § 44-7-220(B), a party seeking a reversal of the ALC’s decision to approve a CON application must deposit a bond with the Clerk of the Court of Appeals up to a maximum of \$1,500,000.00. Here, the Respondent has deposited the required bond pursuant to § 44-7-220(B).

DISCUSSION

The Respondent argues that it this court should grant a stay as a result of posting the bond pursuant to S.C. Code Ann. §44-7-220(B) (Supp. 2012). Alternatively, the Respondent argues that an equitable stay should be granted pursuant to S.C. Code Ann. § 1-23-380(2) (Supp. 2013) regarding the ability of an agency or reviewing court to grant a stay pending appeal. The court will address each argument in turn.

S.C. Code Ann. § 44-7-220(B)

In its motion filed on January 28, 2015, the Respondent asserts that on January 14, 2015, it posted a cash bond with the Clerk of the South Carolina Court of Appeals in the amount of \$1,500,000.00, which is the maximum amount payable pursuant to S.C. Code Ann. § 44-7-220(B). As acknowledged in the Respondent’s motion, the statute is silent on whether the posting of a bond will be accompanied by a stay of the underlying judgment. The Respondent asks the court to adopt the rationale in Melton v. Walker, 209 S.C. 330, 40 S.E.2d 161 (1946) and find that the posting of the bond justifies this court issuing a stay. However, the court finds this case unpersuasive. Furthermore, in a much more recent case, the South Carolina Court of Appeals addressed this exact issue and denied a party’s request for a stay based on arguments similar to those proposed by the Respondent. In Grand Strand Regional Medical Center v. S.C. Department of Health and Environmental Control, App. Case No. 22014-000973 (S.C. Ct. App., Dec 16, 2014), the South Carolina Court of Appeals denied the petition for a stay of Carolina Regional Cancer Center (CRCC). In that case, two applicants (CRCC and Grand Strand Regional Medical Center) were seeking certificates of need to provide radiation therapy services in the Myrtle Beach area. The

Administrative Law Court ruled that the applications were not competing and approved both. CRCC appealed the decision to the Court of Appeals, posting a bond pursuant to S.C. Code Ann. §44-70220(B). CRCC then filed a petition for supersedeas to stay implementation of Grand Strand's radiation therapy project.

The Court of Appeals denied CRCC's petition. In its opinion, the Court of Appeals held:

Appeals from administrative tribunals are exceptions to the automatic stay requirement of Rule 241(a) of the South Carolina Appellate Court Rules. Rule 241(b)(11), SCAR. However, a supersedeas may be ordered pursuant to Rule 241(c), SCAR. The rule provides that "[i]n determining whether such an order is necessary to preserve jurisdiction of the appeal or to prevent a contested issue from becoming moot." Rule 241(c)(2), SCAR. We find there is no danger the court will lose jurisdiction or the issues on appeal become moot if Grand Strand is allowed to proceed with its project. See S.C. Ret. Sys. Inv. Comm'n v. Loftis, 402 S.C. 382, 384, 741 S.E.2d 757, 758 (2013) ("A case is moot where a judgment rendered by the [c]ourt will have no practical legal effect upon an existing controversy because an intervening event renders any grant of effectual relief impossible for the [c]ourt."). Grand Strand acknowledges it would have to cease operations at its facility if this court reverses the ALC's decision approving its CON. Therefore, whether Grand Strand proceeds with construction and operation of its facility will not moot the issues on appeal or strip this court of jurisdiction.

This court finds the holding in Grand Strand to be dispositive of this issue. The Court of Appeals will not lose jurisdiction of this matter irrespective of whether the Petitioner is permitted to begin construction of its facility. Furthermore, in its Motion in Opposition, the Petitioner acknowledges, as did Grand Strand, that it would have to cease operations at Fort Mill Medical Center if the Court of Appeals were to reverse this court's decision approving its CON.

Equitable Stay

In the alternative, the Respondent argues that this court should grant an equitable stay to the Respondent during the pendency of its appeal under S.C. Code Ann. § 1-23-380(2). Section 1-23-380(2) provides that "serving and filing of the notice of appeal does not itself stay enforcement of the agency decision. . ." However, the ALC may, "upon appropriate terms," order a stay "upon the filing of a petition under Rule 65 of the South Carolina Rules of Civil Procedure.," Although the Respondent has not filed a petition under Rule 65, SCRCR, it argues that Rule 65 is incorporated into the Administrative Procedures Act (APA) by § 1-23-380(2) and that this court should issue a preliminary injunction to preserve the *status quo ante* and because

the Respondent (1) will suffer irreparable harm without such relief; (2) has a likelihood on the merits; and (3) there is no adequate remedy at law. Poynter Invs. V. Century Builders of Piedmont, 387 S.C. 583, 586-87, 694 S.E.2d 15, 17 (2010).

1. Irreparable Harm

The Respondent asserts that it will lose significant revenue in Northern York County if the Petitioner is permitted to begin constructing its hospital because it will take market share from the Respondent. The court disagrees.

First, the court disagrees with the Respondent's assertion that it would lose market share to the Petitioner if the Petitioner were to be permitted to build its hospital. This court's decision to award the CON to the Petitioner was in part based on its finding that the Petitioner was consistently losing market share to the Respondent because of the Respondent's practices that ensured that patients seen by physicians within the Respondent's CPN network who needed hospital services were being referred exclusively to the Respondent's network of hospitals located outside of York County, and not to the Petitioner's existing hospital located within the county. Permitting the Respondent to build a hospital in Northern York County would accelerate the Petitioner's loss of market share, erode its payor mix, and would put at risk the quality of medical care available to York County residents, especially in the area of tertiary services, as the Respondent would continue to refer patients needing tertiary care to its out of county hospital network, and not to the Petitioner's Rock Hill hospital.

Additionally, the court finds it curious that the Respondent is now asserting that it will lose market share to the Petitioner if it is permitted to build its hospital in Northern York County. During the trial in this matter, it was the Respondent's position that its proposed Northern York County hospital's function would primarily be to relieve the high patient volume at its other hospitals and accommodate existing patients that were currently receiving care at those other CHS facilities outside of the county. The Respondent's position was that building its proposed hospital in Northern York County would allow it to manage its existing York County patient base better. Therefore, this court fails to understand how permitting the Petitioner to build its hospital will have any effect on the Respondent's existing market share which is currently being cared for at the Respondent's other hospitals.

Furthermore, even if the Respondent could establish that the construction of the Petitioner's hospital would cause some immediate economic loss, it would not rise to the level of

irreparable harm. Pure economic loss is generally insufficient to satisfy the irreparable harm prong of the test for obtaining a stay where an adequate remedy is available at law. Professional Wiring Installers, Inc. v. Sims, 2008 WL 9840409 (S.C. App. 2008) (Unpublished), citing MailSource, LLC v. M.A. Bailey and Associates, 356 S.C. 363, 370, 588 S.E.2d 635, 639 (Ct. App. 2003). The only exception to this general rule is when the economic loss would cause a complete loss of the business. Peck v. Spartanburg Regional Healthcare Systems, 3678 S.C. 450-455, 626 S.E.2d 34, 37 (Ct. App. 2005); Levine v. Spartanburg Regional Services District, 367 S.C. 458, 465, 626 S.E.2d 38, 42 (Ct. App. 2005); District of Columbia v. E. Trans-Waste of Maryland, Inc., 758 A.2d 1, 15 (D.C. 2000); Campbell Inns, Inc. v. Banholzer, Turnure and Company, 148 Vt. 1, 527 A.2d 1142, 1146 (1987). As was demonstrated at the hearing, the Respondent is a large hospital system with forty-two (42) hospitals and other healthcare facilities, as well as a significant physician network. The economic loss posed by the Petitioner's One Hundred (100) bed hospital in Northern York County cannot be said to threaten the existence of the Respondent's business, and therefore, cannot be said to pose irreparable harm to the Respondent.

Finally, any change in referral patterns that may occur because of the construction and operation of the Petitioner's hospital would revert to the Respondent if it is successful on appeal.

2. Likelihood of Success on the Merits

The court disagrees with the Respondent that it only needs to raise a fair question as to its likelihood of success on appeal. Both cases cited by the Respondent in support of its position, Transcontinental Gas Pipe Line Corporation v. Porter, 252 S.C. 478, 481, 167 S.E.2d 313, 315 (1969), and Williams v. Jones, 92 S.C. 342, 348, 75 S.E. 705, 710 (1912), involves preliminary injunctions issued by a court before the trial occurred. In those cases, the court held that simply a prima facie showing in the complaint was all that was required to establish the likelihood of success prong of the test for injunctive relief. The court finds the holdings in those cases to be inapplicable here, where this case was in litigation for years, was subjected to a fifteen day trial, and where the court issued a detailed Amended Final Order.

Furthermore, the court respectfully disagrees, for reasons set forth in its Amended Final Order, that the Respondent is likely to succeed in its appeal on any of the grounds set forth in its motion.

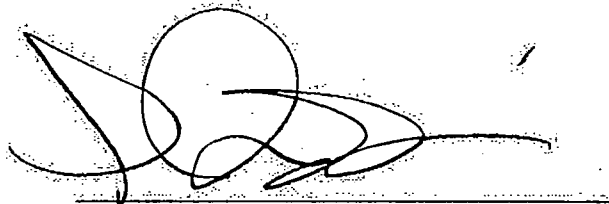
3. Adequate Remedy at Law

The last prong of the test for obtaining a stay requires the party to demonstrate that it has no adequate remedy at law. The Respondent's Motion to Stay/Supersedeas Pending Appeal fails to establish this. The Respondent's remedy at law is the appeal it has already filed. If it prevails, then the Petitioner will be required to stop the construction or the operation of its hospital.

ORDER

IT IS THEREFORE ORDERED that the Respondent's Motion to Stay/Supersedeas Pending Appeal is **DENIED**.

AND IT IS SO ORDERED.

A handwritten signature in black ink, appearing to read 'S. Phillip Lenski', written over a horizontal line.

S. Phillip Lenski
Administrative Law Judge

February 20, 2015
Columbia, South Carolina

CERTIFICATE OF SERVICE

I, Leah E. Garland, 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).



Leah E. Garland
Judicial Law Clerk

February 20, 2015
Columbia, South Carolina

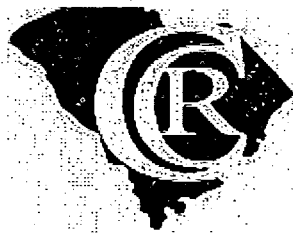
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FEB 20 2015

SC ADMIN. LAW COURT

Transcript of the Testimony of
AMISUB OF SC V. SC DHEC

Date: April 8, 2013



CREEL COURT REPORTING, INC.
Condensed Transcript and Word Index

1230 Richland Street
Columbia, SC 29201
Phone: (803) 252-3445 / (800) 822-0896
Fax: (803) 799-5668
Email: contact@creelreporting.com
Internet: www.creelreporting.com

1 It is from the 2011 audited financial
2 statements which includes results from 2011 and
3 2010.

4 Q: Okay. All right. And the very last line there
5 is the end of year net assets, is that right?

6 The last line item; end of year net assets?

7 A: Yes.

8 Q: Is that what that says?

9 A: Yes.

10 Q: It's hard for me to read it from here, and I
11 can't read it on my monitor. And for 2011, the
12 total reporting -- what does headline -- that
13 heading on that column says total reporting
14 entity; is that what it says?

15 A: I'm not sure which -- it's primary enterprise
16 or are you looking above the primary
17 enterprise?

18 Q: Well, let's start with 2011. At the top of the
19 columns in bold face, each one of them says
20 primary enterprise, the second one says
21 combined component units. And what does the
22 third one say?

23 A: Total reporting entity.

24 Q: Okay. For the total reporting entity column,
25 what's the end of the year net assets? Can you

1 read that, please?

2 A: Not really. I think it's --

3 Q: Is it 3 billion and something.

4 A: It's -- yeah, it's 3 point, I think 5 billion.

5 Q: All right. And for the combined component
6 units, what is it? Can you read that? Is it
7 800? I just can't see that.

8 A: I'm not sure what number you are looking at.

9 Q: I was looking at the combined component units
10 end of the year net assets. So it's the very
11 bottom of that column.

12 A: Oh, yeah, the middle column.

13 Q: Yeah, the middle column.

14 A: It looks like it's about \$800 million.

15 Q: About \$800 million?

16 A: Uh-huh (affirmative response).

17 Q: And for the primary enterprise, is that 2 point
18 something?

19 A: Yes, \$2.9 billion.

20 Q: \$2.9 billion. Okay, thank you.

21 MR. WESTBROOK: Now, let's -- Dan, can I ask you to
22 pull up, please, CHS-511. This is a -- I think
23 you will recognize, Mr. Stewart, this is
24 something from the CHS-Application. It says at
25 the top "CMC-Fort Mill assumptions for

ATTACHMENT E
PROJECT TIMELINE (REVISED)

**Piedmont Medical Center
Fort Mill Medical Center
Fort Mill Medical Center Proposal to Construct 100-Bed Hospital**

Project Timeline

Phase	Anticipated Date (Month/Year)
Drawings submitted to City/State	April 2013
Agency Reviews Complete	June 2013
Construction Start	July 2013
Construction complete	May 2015
Occupancy	July 2015

Nelson Mullins

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April 13, 2015

Hand Delivered

The Honorable Jenny Abbott Kitchings
Clerk of Court
South Carolina Court of Appeals
1015 Sumter Street
Columbia, SC 29201

RECEIVED

APR 13 2015

SC Court of Appeals

RE: Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center d/b/a Fort Mill
Medical Center vs. South Carolina Department of Health and Env. Control, et al
Appellate Case No. 2015-000056
Our File No. 05946/01509

Dear Ms. Kitchings:

I am enclosing an original and seven copies of **Return To Appellant's Supplemental Motion For Relief From Bond And Petition For Supersedeas** for filing. Please return a stamped copy to our office via our courier.

By copy of this letter, I am serving opposing counsel with these pleadings.

Very truly yours,



Daniel J. Westbrook

DJW:myb

Enclosures

cc: Ashley C. Biggers, Esq.
Vito M. Wicevic, Esq.
Douglas M. Muller, Esq.
Trudy H. Robertson, Esq.
E. Brandon Gaskins, Esq.