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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

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

Appellate Case No. 2015-000056
Lower Court Docket No. 11-ALJ-07-0575-CC

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S.C. SUPREME COURT

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

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.

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STATE OF SOUTH CAROLINA

BEFORE THE ADMINISTRATIVE LAW COURT

The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System and Presbyterian Healthcare System d/b/a Presbyterian Hospital-York, LLC, Petitioners, 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, Respondents.	Civil Action No. 06-ALJ-07-0713-CC **ORDER** **1. GRANTING RESPONDENT AMISUB'S MOTION FOR PARTIAL SUMMARY JUDGMENT AND** **2. GRANTING PETITIONERS' MOTION FOR SUMMARY JUDGMENT AND REMANDING CASE**

THE HONORABLE CAROLYN C. MATTHEWS

DECEMBER 9, 2009

FILED

DEC 9 2009

SC ADMIN. LAW COURT

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I. RESPONDENT AMISUB'S MOTION FOR PARTIAL SUMMARY JUDGMENT

A. Issue: Is Amisub a "competing applicant" in this case?

Regulation 61-15 § 103(6) provides that "[a]ll applications received by the Department within fifteen (15) days of publication of the Notice of Affected Persons in the State Register of the first application(s) will be considered to be competing." On January 24, 2005, Amisub filed its CON application for 64 beds. On March 11, 2005, Presbyterian, Carolinas, and Hospital Partners of America ("HPA") filed 64-bed applications within the regulatory time frame, so that there were then four competing applicants. On September 23, 2005, Notice of Affected Persons was published in the State Register for Presbyterian, Carolinas, and HPA.

After discussions with DHEC staff, on October 6, 2005, Amisub withdrew its application. When this occurred, the other three applicants succeeded Amisub and automatically became the first applicants in the competitive review process. Also on October 6, 2005, Amisub submitted a replacement application for a 100 bed hospital. Because the filing of the 100-bed application occurred within 15 days of the State Register notice on September 23, Amisub satisfied the regulatory requirements necessary to be considered a competing application.

B. The Department Considered and Rejected Petitioners' Argument.

Petitioners' contention that Amisub's application should be disregarded is not new. Presbyterian raised it during the staff's review. Nancy S. Layman, the Department's Chief Attorney for Health Regulation, responded with a legal opinion rejecting Presbyterian's argument. Presbyterian raised it again in its request for review to the Department's Board, a request the Board

declined. Finally, both Presbyterian and Carolinas raised it before this Court in their previous summary judgment motions.

Amisub did not withdraw its 64-bed application and re-file without discussing the issue thoroughly with staff. During these discussions, the staff explained the Department's practice of applying Regulation 61-15 § 103(6) to pending CON applications in order to make determinations about competing applicants. The staff also explained how withdrawals and re-filings may affect such determinations. Amisub representatives inquired specifically whether the Department would accept and consider their application "competing" if Amisub withdrew its 64-bed application and simultaneously submitred a 100-bed application. Amisub was informed it would be consistent with the Department's practice to accept the application and consider it a competing application with those of Carolinas, Presbyterian, and HPA, as long as Amisub's application was filed within 15 days of notice being published in the State Register that the other applications had been deemed complete.

Amisub relied heavily on these discussions with staff in deciding to withdraw its 64-bed application and replace it with a 100-bed application. Had the staff not taken the position that it would permit Amisub to withdraw and re-file an application that the Department would treat as competitive with the other three applications, Amisub would not have elected that course of action.

In a letter dated November 10, 2005, Ms. Layman set forth the Department's legal position concerning the effect of the withdrawal of an applicant that filed prior to the submission of competing applicants and then re-filed:

> In a situation like this, it is the Department's position that the remaining applicant(s) succeed the one that has withdrawn and now automatically become the first applicant(s) in the competitive review process. Any other entity now has 15 days from the date the succeeding applicant(s) were published in a subsequent State Register. In this particular case, no one else applied except FMMC, which re-applied with another CON application to include the needed 64 beds plus additional beds. FMMC continues to meet

the definition of "*competing applicant*" as defined in R. 61-15 § 103.6 since it submitted an application within 15 days of the prior applicants.

DHEC witnesses' testimony is consistent with the legal position set forth in Ms. Layman's letter. Mary Fechtel, Assistant Deputy Commissioner of Health Regulation and CON reviewer in this case, testified that she agreed with the position provided in Ms. Layman's November 10, 2005 letter and verified that it is the position of the Department. Ms. Fechtel testified further that when Amisub withdrew its 64-bed application, it was no longer part of the process and the other York County applications became the first applicants:

Ms. Fechtel: Once its (sic) withdrawn, it's no longer a part of the process.

Mr. Westbrook: It's dead, right?

Ms. Fechtel: It's dead.

Mr. Westbrook: All right. And at that point in time, consistent with Ms. Layman's letter, what succeeds as the first application in the review process?

Ms. Fechtel: The other three applications.

Mr. Westbrook: Since they all filed on the same day?

Ms. Fechtel: At the same time.

Joel Grice, retired Bureau of Health Facilities and Services Development, testified that it was the Department's practice to allow an applicant to withdraw and re-file its application. Furthermore, Ms. Fechtel recalled the meeting during which the withdrawal issue was discussed with Mr. Grice:

Ms. Crum: Ms. Fechtel, when did you first find out that FMMC was going to withdraw its January 2005 64-bed CON application and submit a 100-bed application?

Ms. Fechtel: Probably a week or so before they did it.

Ms. Crum: So sometime right after the Notice to Affected Persons was published in the State Register on September 23, 2005?

Ms. Fechtel: Right. They came in to discuss it with Mr. Grice, and I remember thinking in my mind, I don't know how anybody's going to get an application done and make this time line.

Ms. Crum: Did they actually discuss it with you, the fact –

Ms. Fechtel: I was – I was in the office with Mr. Grice when it was discussed, yes.

. . .

Ms. Fechtel: That was the only conversation I remember. I vaguely remember Mr. Stewart saying – Mr. Stewart – Mr. Andrews giving – saying they were giving that some consideration and asking Mr. Grice his opinion of doing that and he told them they could do that.

Lastly, when asked about the timeline of events related to the application filings and notice in the State Register, Leon Frishman, retired Deputy Commissioner for Health Regulations, replied that he could not testify to the issue because he did not know and that Mr. Grice or Ms. Fechtel should be asked instead.

Therefore, based upon Regulation 61-15 § 103(6), Ms. Layman's letter interpreting the Regulation, and the testimony of the DHEC witnesses, Amisub's 100-bed application meets the definition of "competing applicant." Upon its withdrawal of the 64-bed application, Amisub was no longer the first applicant. Because Amisub submitted its 100-bed application within 15 days of the State Register notice on September 23, its application was properly deemed to be "competing."

C. **DHEC's Interpretation of Its Own Regulation is entitled to deference.**

The Department's position reflects a reasonable construction of the regulation. Moreover, it is an interpretation DHEC applied in a previously contested matter. The decisions of a state agency with respect to interpreting its own regulations are entitled to great deference. *White v. S.C. Dep't of Health and Envtl. Control*, No. 04-ALJ-07-03570-CC, 2005 WL 3694238 at *3 (Dec. 30, 2005); *see also S.C. Coastal Conservation League v. S.C. Dep't of Health and Envtl. Control*, 380 S.C. 349, 362, 669 S.E.2d 899, 906 (Ct. App. 2008) ("This Court, although not bound by the decision, will ordinarily defer to the opinion of a state agency as to the interpretation of a statute it is charged with

the duty of enforcing."); *Open MRI of Charlotte, Inc. v. S.C. Dep't of Health and Envtl. Control*, No. 97-ALJ-07-0706-CC, 1999 WL 186848 (March 5, 1999) ("DHEC is the sole state agency responsible for implementation of the CON program, its interpretations of the Plan and regulations concerning administration of the Certificate of Need Program must be accorded great deference and will not be overruled absent compelling reasons."); *Safety Disposal Systems, Inc. v. S.C. Dep't of Health and Envtl. Control*, No. 01-ALJ-07-0122-CC, 2002 WL 1354623 at *26 (June 5, 2002) (quoting *Lloyd v. South Carolina Dep't of Health and Envtl. Control*, 328 S.C. 419, 428-29, 491 S.E.2d 592, 597 (Ct. App. 1999)) ("'It is well established that construction of a statute by the agency charged with its administration will be accorded the most respectful consideration and will not be overruled absent compelling reasons.'"); *Joe's Custom Brickwork, Inc. v. S.C. Dep't of Revenue*, No. 05-ALJ-17-0112-CC, 2005 WL 2277955 at *4 (Aug. 23, 2005) (holding that the same deference applied to an agency's construction of a statute should apply to the implementation of the agency's practice, absent any specific restrictions to the contrary, or a clear abuse of discretion.).

DHEC's decision to issue the permits must be given deference. "Courts defer to the relevant administrative agency's decisions with respect to its own regulations unless there is a compelling reason to differ." *Brownlee v. South Carolina Dept. of Health and Environmental Control*, 382 S.C. 129, 676 S.E.2d 116 (S.C.,2009). The decisions of a state agency with respect to interpreting its own regulations are entitled to great deference. *See S.C. Coastal Conservation League v. S.C. Dep't of Health and Envtl. Control*, 380 S.C. 349, 362, 669 S.E.2d 899, 906 (Ct. App. 2008) ("This Court, although not bound by the decision, will ordinarily defer to the opinion of a state agency as to the interpretation of a statute it is charged with the duty of enforcing."); *Lloyd v. South Carolina Dep't of Health and Envtl. Control*, 328 S.C. 419, 428-29, 491 S.E.2d 592, 597 (Ct. App. 1999)) ("It is well

established that construction of a statute by the agency charged with its administration will be accorded the most respectful consideration and will not be overruled absent compelling reasons.'").

A reviewing court "may not substitute its judgment for the judgment of the agency as to the weight of the evidence on questions of fact." S.C. Code Ann. § 1-23-380(5) (Supp. 2008). The DHEC Board's findings are presumptively correct, and therefore, the challenging party bears the burden of proving its decision was erroneous in view of the substantial evidence in the record. *Leventis v. S.C. Dep't of Health & Envtl. Control,* 340 S.C. 118, 136, 530 S.E.2d 643, 653 (Ct. App. 2000). *See also*; *Too Tacky Partnership v. South Carolina Department of Health and Environmental Control and Mayo Read, Jr.,* Op. No. 4616 (S.C. Sup. Ct. filed September 9, 2009) (Shearhouse Adv. Sh. No. 40 at 78).

CONCLUSION

Based on the above analysis, Respondent Amisub is a competing applicant in this Certificate of Need case and its Motion for Partial Summary Judgment is **Granted.**

II. PETITIONERS' MOTION FOR SUMMARY JUDGMENT

STATEMENT OF THE CASE

This contested case arises from decisions by the South Carolina Department of Health and Environmental Control ("Department" or "DHEC") to approve a Certificate of Need ("CON") for one applicant to construct a proposed hospital in Fort Mill, South Carolina, and to deny Certificates of Need to the other applicants. The legal issue is whether the 2004-2005 South Carolina State

Health Plan[1] ("Plan") was properly interpreted by the Department to allow only the existing hospital to access the additional general acute hospital bed need identified in the Plan and apply to construct a new hospital, to the exclusion of all other applicants.

After hearing testimony, reviewing exhibits and hearing legal argument, I find that there are no genuine issues of material fact and conclude, as a matter of law, that the Department committed a error of law and exceeded its statutory authority by its application of the Plan. Further, I find that the error of law was so pervasive that it infected the entire decision-making process. Thus, a remand to the Department is the appropriate remedy under the circumstances.

PROCEDURAL HISTORY

On November 22, 2004, Fort Mill Medical Center, Inc. ("FMMC") filed a CON application under the Plan for the construction of a sixty-four (64) bed acute-care hospital to include one (1) diagnostic cardiac catheterization laboratory, one (1) magnetic resonance imaging ("MRI") unit and one (1) computed tomography ("CT") scanner, to be located at the intersection of SC Highway 160 and Highway 21 Bypass, Fort Mill, South Carolina ("2004 Application"). On January 25, 2005, the 2004 Application was withdrawn without being deemed complete, without notice to affected parties being filed in the State Register and without any other party filing a competing application.

On January 25, 2005, — the same day that the 2004 Application was withdrawn — Amisub of South Carolina, Inc. ("Amisub") d/b/a FMMC filed its application to construct and operate a sixty-four (64) bed acute-care hospital ("First 2005 Application") in Fort Mill, York County. On February 25, 2005, a notice to affected persons was published in the State Register stating that the First 2005 Application had been deemed complete.

On March 11, 2005, three (3) applicants filed competing applications to construct and operate

[1] The applications were filed under the Plan. Regulation 61-15 § 504 provides that the applications will be reviewed under the plan in effect when the applications are filed.

a sixty-four (64) bed hospital in York County. These three (3) applicants were Petitioner Presbyterian Healthcare System d/b/a Presbyterian Hospital York, LLC ("Presbyterian"); Petitioner The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas HealthCare System ("Carolinas"); and Hospital Partners of America[2] ("HPA"). Presbyterian's CON application, Carolinas' CON application and HPA's CON application were subsequently deemed by the Department to be "competing" with the First 2005 Application. On September 23, 2005, a notice to affected persons was published in the State Register, which indicated that the three (3) CON applications of Presbyterian, Carolinas and HPA were deemed complete.

On October 6, 2005, FMMC withdrew its First 2005 Application, and submitted on the same day a CON application for a one hundred (100) bed hospital in York County, consisting of sixty-four (64) general acute-care hospital beds and thirty-six (36) licensed general acute hospital beds to be transferred from Piedmont Medical Center in Rock Hill to the new, proposed facility in Fort Mill ("Second 2005 Application").

On May 30, 2006, the Department issued four (4) substantially identical decision letters ("Decision Letters") to the applicants. In these Decision Letters, the Department indicated that it was granting a CON to FMMC for a one hundred (100) bed hospital and denying the applications of Presbyterian, Carolinas and HPA for sixty-four (64) bed hospitals. The Department's decisions regarding FMMC, Presbyterian and Carolinas are the subject of this contested case.

After extensive discovery and several pre-trial hearings on various motions filed by all the parties, including previous Motions for Summary Judgment, the case proceeded to a contested case hearing beginning on September 9, 2009. After the conclusion of the Petitioners' collective cases in chief, on September 28, 2009, Presbyterian filed its Renewed Motion for Summary Judgment and on

[2] HPA did not seek contested case review of the Department's decision.

September 29, 2009, Carolinas filed its Renewed Motion for Summary Judgment. On October 6, 2009, Respondents filed a Motion for Involuntary Non-suit. These motions were heard before the Court on October 19, 2009, at which time I denied Respondents' Motion for Involuntary Non-suit and granted Petitioners' Renewed Motions for Summary Judgment. The basis for my ruling is set forth below.

FACTS

The following facts are undisputed. Amisub is a South Carolina corporation and the licensee of Piedmont Medical Center in Rock Hill, South Carolina. Amisub's sole shareholder is Tenet Medical Systems, Inc. Tenet Medical Systems, Inc. is ultimately owned by Tenet Healthcare Corporation, a Delaware corporation ("Tenet"). Tenet is a for-profit health care system publicly traded on the New York Stock Exchange. Piedmont Medical Center is an existing two-hundred and eighty-eight (288) bed general acute-care hospital located at 222 South Herlong Avenue, Rock Hill, York County, South Carolina. Piedmont Medical Center is the only general acute-care hospital located in York County.

Presbyterian is a South Carolina not-for-profit limited liability corporation. Presbyterian is wholly owned by Novant Health, Southern Piedmont Region, LLC, a North Carolina not-for-profit corporation which, in turn, is wholly owned by Novant Health, Inc., a North Carolina not-for-profit corporation.

Carolinas is a public entity existing and organized pursuant to the North Carolina Hospital Authorities Act, N.C. Gen. Stat. § 131E-15 et seq. and is a body politic and corporate.

The Department is an agency of the State of South Carolina, overseen by the Board of Health and Environmental Control ("Board"). The Board and Department are established pursuant to S.C. Code Ann. § 44-1-20 (Rev. 2002).

The CON decisions that are the subject of this contested case were all made under the Plan. The bed need methodology for determining whether there is a need for additional general acute hospital beds is set forth in section G.1.(A)(4)(a)-(c) of the Plan. The Plan shows a general acute-care hospital bed need of sixty-four (64) additional acute-care beds ("Bed Need") for Piedmont Medical Center, the only hospital in York County. Regarding the Bed Need in York County, the parties have stipulated as follows:

> The Plan shows a bed need for 64 additional acute care hospital beds for Piedmont Medical Center in York County. The parties agree that there is a bed need for 64 acute care hospital beds but disagree as to who is entitled under the Plan to be awarded those beds, irrespective of other Reg. 61-15 § 802 project review criteria.

Therefore, there is an undisputed need for sixty-four (64) additional acute-care beds in York County, South Carolina.

The Department's Decision Letters found:

> [T]he proposal submitted for the Fort Mill Medical Center is the only project of the competing CON applications that is consistent with the hospital bed need methodology as specifically outlined in the 2004-2005 S.C. Health Plan (sic). The aforementioned Plan uses individual facilities as the unit calculation of bed need instead of the county. Therefore, the bed need for York County, as indicated in the 2004-2005 S.C. Health Plan (sic), is based on Piedmont Medical Center as the planning unit, not York County. The number of beds needed is based on the service area and market share of Piedmont Medical Center, not the entire medical patient population in York County.

The Department determined that because Amisub was the licensee of Piedmont Medical Center and would be the licensee of only FMMC, FMMC complied with the Plan Bed Need. The FMMC hospital facility would have to be separately licensed. Dennis Gibbs, the Department's Director of the Division of Health Licensing, testified that the Fort Mill Medical Center proposed by Amisub in the Second 2005 Application was a distinct "facility" that would have to be separately licensed from the existing Piedmont Medical Center in Rock Hill and that it would be a distinct facility from the existing Piedmont facility in Rock Hill.

Finally, the Department found that, with the exception of 24A S.C. Code Reg. 61-15 § 802.1 (compliance with the Plan), FMMC, Presbyterian and Carolinas each complied with all of the other Project Review Criteria applicable to the projects.

STANDARD OF REVIEW

It is settled law in this State that the denial of a summary judgment motion is interlocutory, and the trial court is entitled to reconsider its initial denial of summary judgment or it can entertain a subsequent motion for summary judgment. See Blyth v. Marcus, 335 S.C. 363, 367, 517 S.E.2d 433, 434 (1999). The denial of a motion for summary judgment does not establish the law of the case. Brown v. Pearson, 326 S.C. 409, 416-17, 483 S.E.2d 477, 481-82 (Ct. App. 1997).

Rule 68, RPALC, provides that "[t]he South Carolina Rules of Civil Procedure may, where practicable, be applied in proceedings before the Court to resolve questions not addressed by these rules." Rule 56, SCRCP, provides that summary judgment shall be granted if it is shown" that there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law." See also Gadson v. Hembree, 364 S.C. 316, 613 S.E.2d 533 (2005).

The issue of interpretation of a statute[3] is a question of law for the court. Charleston County Parks & Recreation Comm'n v. Somers, 319 S.C. 65, 67, 459 S.E.2d 841, 843 (1995) ("The determination of legislative intent is a matter of law"). In MRI at Belfair, LLC v. S.C. Dep't of Health and Envtl. Control, 379 S.C. 1, 664 S.E.2d 471 (2008), the South Carolina Supreme Court found that "[t]he issue whether the Plan standards satisfy the statutory requirements is a legal conclusion based on statutory interpretation principles. Thus, no factual findings are necessary to

[3] The Court recognized that the Plan itself is not a statute or regulation, having never been subject to the General Assembly's review. However, as discussed below, the Plan is adopted by the Board pursuant to the requirements of the CON Act and CON Regs.

determine compliance with § 44-7-180(B)." 379 S.C. 1, 7 n.4, 664 S.E.2d 471, 474 n.4. All parties have conceded that the interpretation of the Plan is a matter of law.

DISCUSSION

Petitioners assert that they are entitled to judgment as a matter of law because the Department's May 30, 2006 decisions violate the State Certificate of Need and Health Facility Licensure Act, S.C. Code Ann. § 44-7-110, et seq. (Rev. 2002) ("CON Act") and 24A S.C. Code Reg. 61-15 (Supp. 2009) ("CON Regs") and exceed DHEC's authority because there is no authority for the Department, through its Board, to adopt, interpret and apply the Plan so that only existing licensed hospitals in South Carolina are in compliance with the Plan. Such an interpretation would preclude the existence of competing applicants from which that the Department can choose the applicant that most fully complies with the goals and purposes of the CON Act and CON Regs, including the Project Review Criteria and other regulations, as required by the CON Act and CON Regs.

A. Purposes And Requirements Of The CON Act

The CON Act provides:

> The purpose of this article is to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State. To achieve these purposes, this article requires:
>
> (1) the issuance of a Certificate of Need before undertaking a project prescribed by this article;
> (2) adoption of procedures and criteria for submittal of an application and appropriate review before issuance of a Certificate of Need;
> (3) preparation and publication of a State Health Plan;
> (4) the licensure of facilities rendering medical, nursing, and other health care.

S.C. Code Ann. § 44-7-120 (Rev. 2002) (emphasis added). The Department is designated as the sole state agency for control and administration of the granting of CONs, licensure of health care

facilities and other activities necessary to be carried out under the CON Act. See S.C. Code Ann. § 44-7-140 (Rev. 2002).

Pursuant to the CON Act, the Department is required to promulgate "substantive and procedural regulations considered necessary by the department . . . to carry out the department's licensure and Certificate of Need duties under this article, including regulations to deal with competing applications... ." S.C. Code Ann. § 44-7-150(3) (Rev. 2002) (emphasis added). The CON Act also provides for the adoption and content of the Plan. "The plan at a minimum must include: (1) an inventory of existing health care facilities, beds.... (2) projections of need for additional health care facilities, beds ... ." S.C. Code Ann. § 44-7-180(B) (Rev. 2002) (emphasis added).

No application can be approved unless it complies with the State Health Plan. 24A S.C. Code Ann. Reg. 61-15 § 802.1 (Supp. 2009); see also S.C. Code Ann. § 44-7-210(C) (Rev. 2002). The CON Act requires preparation and publication of a State Health Plan. See S.C. Code § 44-7-120(3) (Rev. 2002).

In the recent case of Dema v. Tenet Physician Services - Hilton Head, Inc., the South Carolina Supreme Court opined that the CON Act does not create a private right of action so that a civil suit can be brought against a hospital for injury resulting from DHEC's finding a violation of the CON Act. The Court found that "[i]f the overall purpose of the statute is to aid society and the public in general, the statute is not enacted for the special benefit of a private party." Dema, 383 S.C. 115, 121-122, 678 S.E.2d 430, 433 (citation omitted). The expressly stated clear legislative intent of the CON Act is "to advance the quality of healthcare provided in this State for all people receiving the care, not for a particular individual." Id. Likewise, the need here is for all people receiving hospital care, not for those receiving care at a particular hospital. I find that the clear and

unambiguous legislative purpose of the CON Act is to serve the people of South Carolina. The CON Act was not enacted for the benefit of any single health care provider; thus, an interpretation of the Plan that the Bed Need is for a specific existing hospital, not the general public, is contrary to the legislative purposes of the CON Act.

B. Definition Of "Competing Applicants" Under The CON Act

The CON Act defines "competing applicants" as "two or more ... health care facilities as defined in this article who apply for Certificates of Need to provide ... facilities in the same service area within a time frame as established by departmental regulations and whose applications, if approved, would exceed the need for services or facilities." S.C. Code Ann. § 44-7-130(5) (Rev. 2002) (emphasis added). In other words, to be considered a competing application, the applications have to meet the criteria of S.C. Code Ann. Section 44-7-130(5), which includes being approvable under the Plan.

"Compete" is defined as: "To strive or contend with another or others, as for profit or a prize ..." American Heritage Dictionary, 2nd College Ed. (1985). Merriam-Webster Online defines "competing" as: "to strive consciously or unconsciously for an objective (as position, profit, or a prize): be in a state of rivalry. <companies competing for customers>." http://www.merriam-webster.com/dictionary/competing (September 28, 2009).

Section 44-7-210(C) provides, in pertinent part: "In the case of competing applications, the department shall award a Certificate of Need, if appropriate, on the basis of which, if any, most fully complies with the requirements, goals, and purposes of this article and the State Health Plan, Project Review Criteria, and the regulations adopted by the department." (Emphasis added). If only Piedmont Medical Center can be approved under the Plan, as DHEC found in the Decision letters,

there could never be competing applications for the York County Bed Need from which the Department could make a choice to award a CON.

A clear and unambiguous statutory requirement of the CON Act is to allow applicants to compete for the Bed Need identified in the Plan so the Department can determine, through review under the Project Review Criteria contained in the CON Regs, which competing applicant, 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", and I so conclude. In other words, it is the Department's statutory responsibility under the CON Act to choose which application offers a hospital that will "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." Moreover, the Department must determine which will comply with the CON Regs, including the Project Review Criteria.

I find that the Department's interpretation of the Plan in which only an existing hospital (or one affiliated with that hospital) can comply with the Plan is contrary to the CON Act's and CON Regs' requirement that applicants be allowed to compete for the public need for the Bed Need in the Plan.

C. The Scope Of The Department's Authority Under The Act

As an agency of the State and a creature of statute, DHEC's authority is dependent upon statute – in this case, the CON Act and the CON Regs. As creatures of statute, the Department, its Board and this Court are possessed only with those powers specifically delineated or necessarily implied in their enabling legislation. See City of Columbia v. Bd. of Health and Envtl. Control, 292

S.C. 199, 355 S.E.2d 536 (1987). Respondents argue that the Department was exercising its implied authority under the CON Act in adopting and interpreting the plan so that only an existing hospital could comply with the Bed Need methodology and satisfy the Bed Need shown in the Plan.

When determining what powers or authority an agency possesses by necessary implication, the basic premise is that:

> [s]uch implication, inference, or presumption, as the fact may be, is always indulged to supply a deficiency, and is never permitted to contradict the act, grant, or instrument whatsoever involved.

See Sutherland Statutes and Statutory Construction, § 55:3 (emphasis added). Any implication which is inconsistent with the spirit and purpose of the CON Act must be denied. Id. at § 55.4. In Mungo v. Smith, the South Carolina Supreme Court held:

> Such (administrative) bodies, being unknown to the common law, and deriving their authority wholly from constitutional and statutory provisions, will be held to possess only such powers as are conferred, expressly or by reasonably necessary implication, or such as are merely incidental to the powers expressly granted. See 51 C.J. 36, 37, where among other things it is said: "Any reasonable doubt of the existence in the commission of any particular power should ordinarily be resolved against its exercise of the power."

Mungo v. Smith, 289 S.C. 560, 564, 347 S.E.2d 514, 517 (1986) (emphasis in original) (emphasis added).

There is no language in either the CON Act or the CON Regs which makes it "reasonably necessary" for the Department to interpret the Plan so that only Piedmont Medical Center complies with the Bed Need. The Department's power under the CON Act does not (1) authorize it to interpret the Plan's Bed Need methodology so that only existing hospitals comply with that methodology and (2) allow Piedmont Medical Center, as the existing hospital, to serve as the gatekeeper that will determine the single applicant that the Department approves. Because the Department interpreted the Plan so that only Piedmont Medical Center and FMMC comply with the

Plan Bed Need, the interpretation conferred a special benefit upon Piedmont Medical Center and FMMC in contravention of the CON Act's stated purposes to determine public need; thus, that interpretation exceeds the agency's statutory authority.

D. Petitioners Are Entitled To Judgment As A Matter Of Law Because The Department's Decisions Are Affected By Error Of Law.

The Department's Decision Letters interpreting and applying the Plan's Bed Need methodology are affected by error of law and the Department exceeded its statutory authority by interpreting the Plan so that only Piedmont Medical Center, as the existing hospital in York County, complied with the Plan Bed Need methodology so that only FMMC was eligible to be approved. The Plan, as a matter of law, must be construed so that Carolinas, Presbyterian and FMMC each comply equally with the Plan's Bed Need and 24 S.C. Code Reg. 61-15 § 802(1).

The cardinal rule of statutory construction is that the legislative intent must be ascertained and it must prevail. Gardner v. Biggart, 308 S.C. 331, 417 S.E.2d 858 (1992). In Hitachi Data Sys. Corp. v. Leatherman, a case involving a statutory interpretation of the South Carolina Code, the South Carolina Supreme Court found that:

> In construing statutes, we seek to effectuate legislative intent. The cardinal rule of statutory construction is that words used therein must be given their plain and ordinary meaning without resort to subtle or forced construction to limit or expand its operations. The language must also be read in a sense which harmonizes with its subject matter and accords with its general purpose.

309 S.C. 174, 178, 420 S.E.2d 843, 846 (1992) (citations omitted). "On the other hand, where a statute is ambiguous, the Court must construe the terms of the statute." Wade v. Berkeley County, 348 S.C. 224, 229, 559, S.E.2d 586, 588 (2002) (citations omitted). "If the language of an act gives rise to doubt or uncertainty as to legislative intent, the construing court may search for that intent beyond the borders of the act itself .... An ambiguity in a statute should be resolved in favor of a just, beneficial, and equitable operation of the law, ... [and i]n light of its manifest purpose.

Georgia-Carolina Bail Bonds, Inc. v. County of Aiken, 354 S.C. 18, 25, 579 S.E.2d 334, 337-38 (Ct. App. 2003) (citations omitted).

In this case, the legislative purposes and intent are clear, and the CON Act requires that the Plan be consistent with the legislative purposes of the CON Act. See S.C. Code Ann. § 44-7-120(3) (Rev. 2002). Based upon the legislative purposes of the CON Act and CON Regs discussed above, the clear and unambiguous requirement of the CON Act is to allow applicants to compete for the public Bed Need identified in the Plan so the Department can determine, through review under the Project Review Criteria contained in the CON Regs, which competing applicant "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." The Department committed an error of law by interpreting the Plan in a manner contrary to the CON Act and CON Regs.

1. The Plan Language Is Ambiguous. I find that the Bed Need methodology in the Plan is ambiguous, as evidenced by the face of the Plan and by the varying Department staff Plan interpretations discussed below. When there is an ambiguity in the Plan and one interpretation complies with the legislative purposes and statutory requirements and the other does not, pursuant to Section 44-7-120(3) and to the principles of statutory construction, to the extent they provide guidance to this Court, the interpretation of the Plan must be that which complies with the purposes and requirements of the CON Act and CON Regs.

On its face, the Plan states that it calculates general acute care hospital Bed Need for individual hospitals, but the calculation formula uses the projected total population growth for each county to calculate the Bed Need for the hospital. Piedmont Medical Center is the only hospital in York County. The column labeled "Facility/County in the Plan on page II-14, which refers to "York Co" contains the stated Bed Need for 64 beds. Id. Based on the fact that the total population in

York County is used to determine Bed Need for the only hospital in a county, on the face of the Plan, one could conclude that the Bed Need in York County is for the entire county and any applicant seeking a CON to construct and operate a 64-bed hospital is in compliance with the Bed Need in the Plan.

Further, the testimony of the Department's witnesses demonstrates the ambiguities in the Plan. Prior to the 2003 South Carolina Health Plan ("2003 Plan"), the planning unit for additional general acute hospital Bed Need was the county. In the 2003 Plan, the planning unit was changed to the individual hospital, a change which was carried forward to the Plan. Mr. Whiteside, former Director of the Department Division of Planning and CON, testified that the Bed Need methodology sections of the 2003 Plan were changed in response to requests by several hospitals which focused on a provision in the 2001 South Carolina Health Plan ("2001 Plan") that allowed existing hospitals to add up to an additional fifty (50) beds as an "efficient addition" exception to the general rules requiring demonstration of county need. In response, the Department's health planning staff recommended changes to the language in the draft 2003 Plan that addressed general hospital Bed Need, primarily to address what Mr. Whiteside termed the "Florence Rule."

Using Florence County as an example, Mr. Whiteside testified that in some counties with multiple hospitals, the entire county might show that no beds were needed, while a particular facility within that County might have a demonstrated need. To address the "Florence issue," the formula for calculating Bed Need was unchanged, but changes were made to the text of the 2003 Plan to replace references to the county as the unit planning and to make individual hospitals the planning unit.

As Mr. Whiteside testified, the "county-wide" Bed Need formula used prior to 2003, in the 2001 Plan, is identical to the hospital Bed Need formula used in the Plan. The number of hospital

beds needed is calculated in the same manner. The only changes to the State Health Plan from 2001 to 2004-2005 were changes in some of the terminology; there was no change in the fundamental manner in which Bed Need was calculated.

In single hospital counties such as York County, the calculation for hospital Bed Need in 2001 is identical to the calculation made in 2004-2005, other than the fact that the variable numbers (such as projected population growth and occupancy rates) changed. In effect, the formula used to calculate hospital Bed Need methodology was unchanged from the 2001 Plan to the 2004-2005 Plan.

Mr. Frishman, the Department's Deputy Commissioner when the decisions were made, testified that he thought the Plan was ambiguous; that it was "silent" on the treatment of new hospitals; and that it should be interpreted so that any one of the applicants could comply with the Plan Bed Need.

Joel Grice, the former Director of the Department's Bureau of Health Facilities and Services Development, was ultimately responsible for making CON decisions (awards and denials) in South Carolina. Mr. Grice took the following actions regarding interpretation of the Plan during the review process:

1) issued a memorandum on January 25, 2005, in which he interpreted the Plan as stating that: "[a] CON for the net hospital bed need in a county may be requested and approved for any existing hospital located in the county, or for any other entity/applicant, for the development of a new hospital or an addition to an existing hospital within that county." At the direction of the Commissioner, this memorandum was rescinded.

2) told the news media that any applicant could apply and be approved for the Bed Need in the Plan.

3) testified that he changed his mind a couple of weeks before the May 30, 2006 Decision Letters and concluded that the Plan could only be interpreted to allow Piedmont Medical Center to be approved for the Bed Need.

Ultimately, at the conclusion of the review process, Mr. Grice issued the Decision Letters interpreting the Plan so that FMMC, through Piedmont Medical Center, was the only applicant that complied with the Plan Bed Need.

I find that, based both upon both the face of the Plan and the disparate interpretations the various Department witnesses had as to the interpretation of the Plan, the Bed Need methodology is ambiguous and must be interpreted in a manner that complies with the purposes and requirements of the CON Act and CON Regs.

2. Deference to the Agency Is Not Appropriate In This Case. Although deference is usually given to an agency's interpretation of its own statute and regulations, an agency's interpretation will be rejected if it conflicts with the language of the statute or regulation. Brown v. Bi-Lo, Inc., 354 S.C. 436, 440, 581 S.E.2d 836, 838 (2003). South Carolina courts have long held that however clear the language is in a statute, the courts will not apply a construction that reaches an absurd result the Legislature clearly did not intend. See Kiriakides v. United Artists Communications, Inc., 312 S.C. 271, 275, 440 S.E.2d 364, 366 (1994) ("If possible, the court will construe the statute so as to escape the absurdity and carry the intention into effect."); Catawba Indian Tribe of South Carolina v. State of South Carolina, 372 S.C. 519, 527, 642 S.E.2d 751, 755 (2007) (citations omitted). Respondents argue that the plain meaning of the words in the Plan provide that the Bed Need was generated by Piedmont Medical Center and therefore, only Piedmont Medical Center and FMMC can comply with the Plan.

In this case, the record is replete with evidence that there is no uniformity among the Department witnesses in terms of their interpretation of the Plan. While both Mr. Grice and Ms. Fechtel ultimately testified they believed it was clear that only Piedmont Medical Center (and, in turn, FMMC) complies with the Plan's Bed Need under Regulation 61-15 § 802.1, it took them well

over a year to arrive at that conclusion. As discussed above, Mr. Grice, with the approval of Mr. Frishman, as well as with the approval of the Department's Commissioner and General Counsel, issued a memorandum construing the Plan in such a manner that any hospital-applicant could comply with the Plan.

Mr. Grice later withdrew that memorandum, but Mr. Frishman continued to believe that it was the correct interpretation of the Plan. Some sixteen (16) months later, Mr. Grice finally made the determination that only FMMC, through Piedmont Medical Center's Bed Need, complied with the Plan. Significantly, Ms. Fechtel did not consult with either of the Department's health planners, Mr. Whiteside or Les Shelton, before making her recommendation to Mr. Grice that Presbyterian and Carolinas did not comply with the Plan, and Mr. Shelton testified that Mr. Grice never consulted with him before making this decision.

As discussed above, Mr. Frishman testified that the Plan should be interpreted so that any one of the applicants complied with the Plan Bed Need. Mr. Whiteside, who was responsible for the drafting and approval of the Plan, also testified that any applicant was approvable under the Plan, and further testified that "when we developed the Plan it was never designed to exclude anybody from being able to apply and/or be approved." While deferring to Mr. Whiteside,[4] Mr. Shelton also testified that it was never the intent of the Plan to exclude applicants from complying with the Plan need.

The Department's interpretation of the Plan nullifies the public need purpose of the CON Act and vitiates the "competing applicant" requirements. The Department's witnesses admitted at trial that, under the Plan as interpreted by the Department, there could never be competing applicants for additional acute hospital Bed Need. Mr. Frishman testified that if the only hospital which could

[4] Mr. Shelton testified that he deferred to his superior in the Department, Mr. Whiteside, in terms of the proper interpretation of the Plan.

meet the need in the Plan was Piedmont Medical Center, then there could never be competing applicants. Mr. Grice, who issued the Decision Letters, also admitted that you could not have "competing applicants" under his interpretation of the Plan.

Ultimately, in the face of this ambiguity, the Department issued the May 30, 2006 Decision Letters and concluded that "the proposal submitted for the Fort Mill Medical Center is the only project of the competing CON applications that is consistent with the hospital Bed Need methodology as specifically outlined in the 2004-2005 S.C. Health Plan (sic)." The Decision Letters stated that because the sixty-four (64) additional Bed Need in the Plan was for Piedmont Medical Center, FMMC's application for a different hospital in a different location complied with the Plan.

In construing the Plan in the face of this ambiguity, it is compelling that both the CON Act and CON Regs define and contain provisions regarding the Department's responsibility to choose the competing applicant that best complies with the purposes and goals of the CON Act and the CON Regs. Clearly, the CON Act contemplates competition and the Department does not have the authority to interpret the Plan so that it nullifies the Department's statutory responsibility to choose among competing applicants.

As an agency of the State, the Department's interpretation and application of the Plan is bound by the legislative intent embodied in the clear and unambiguous language of the CON Act and the CON Regs. The Department's interpretation of the Plan vitiates the requirement that the Department review the CON applications, apply the Project Review Criteria and decide which competing applicant best complies with those criteria.

In fact, DHEC witness Mary Fechtel, the project reviewer for each applicant, testified that once she made the finding that only FMMC complied with the Plan, she did not address who best complied with the other Project Review Criteria. Ms. Fechtel specifically stated:

Q. Okay. Now, now once you made the finding that only Fort Mill Medical Center complied with the state plan, you didn't go back and make the finding as to who best complied with each of the other project review criteria, did you?

A. No, ma'am.

Ms. Fechtel's testimony makes it clear that the Department never conducted a true comparative analysis and did not make its determination "on the basis of which, 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 the CON Act. See S.C. Code Ann. § 44-7-210(C) (Rev. 2002) (emphasis added). Under the circumstances, I find that the Department committed an error of law and exceeded its statutory authority when it construed this ambiguous Plan so that only the existing hospital could comply with the Plan Bed Need.

Further, I find that the error of law was so pervasive that it infected the entire decision-making process. Ms. Fechtel testified that she was instructed to review the applications "competitively" and Mr. Grice testified that the applications were reviewed competitively. Yet, each witness decided that only the FMMC application could comply with the Plan; therefore, the Department did not make contemporaneous findings as to which applicant most fully complied with the purposes, goals and Project Review Criteria during the final decision making process.

This Court cannot evaluate the merits of which applicant best met the Project Review Criteria because the Department's Decision Letters failed to apply the Plan in accordance with the purposes, goals and requirements of the CON Act. Thus, the Department failed to carry out its statutory mandate under the CON Act and the CON Regs. to determine which applicant, 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." S.C. Code Ann. § 44-7-210(C) (emphasis added).

The Administrative Law Court, has the inherent power to remand a matter to the Department if it determines that there have been pervasive errors in the Department's review which would, if carried forward, unfairly place burdens on the party or parties affected by the error. See generally S.C. Code Ann. § 1-23-630 (Rev. 2005); 73A C.J.S. Public Administrative Law and Procedure § 461; 2 Am. Jur. 2d Administrative Law § 574; and South Carolina Baptist Hosp. v. S.C. Dep't of Health and Envtl. Control, 291 S.C. 267, 353 S.E.2d 277 (1987) (hearing officer's order of remand to the Department to develop criteria for proper review of competing applications). Accordingly, because I find that the Department's decisions were affected by error of law and exceeded the agency's authority, remand is appropriate in this case, so that the agency can make the determination as to which of the applicants "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." S.C. Code Ann. § 44-7-210(C).

E. Petitioners' Other Grounds for Renewed Summary Judgment

Having concluded that a remand of the applications in this case is appropriate so that the CON applications of FMMC, Presbyterian and Carolinas may all be reviewed equally under the Plan as competing applicants, and so that the Department, having already determined that each applicant complies with the remaining Project Review Criteria, can determine which applicant most fully complies with the CON Act purposes and the Project Review Criteria, I find it unnecessary to address the other issues raised by Petitioners in their respective Renewed Motions.

ORDER

Because the CON Act defines the parameters of the Department's authority and contemplates that applicants can freely apply and be approvable to compete for a new hospital to meet the public need and other purposes of the CON Act and the CON Regs, I find the Department committed an

error of law and exceeded its statutory authority in interpreting and applying the Plan. The Department's decisions were affected by an error of law and exceeded the agency's authority because the Department interpreted and applied the Plan in a manner that precluded competing applicants from being approved in this case.

Accordingly, **IT IS HEREBY ORDERED** that the Petitioners' **MOTIONS FOR SUMMARY JUDGMENT** are **GRANTED** and that this matter is **DISMISSED** and **REMANDED** to the Department to take action consistent with the following instructions:

1. Review the Presbyterian, Carolinas, and FMMC 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).
2. If any party wishes to provide information to the Department and update its application or provide information to address issues regarding changes concerning the other applicants (collectively, "Updated Information"), that Updated Information must be submitted not later than sixty (60) days from the date of this Order.
3. The Department has thirty (30) days from receipt of additional information from any party to request information from that party, and the party shall have thirty (30) days to provide the requested additional information to the Department. When the Department does not need any additional information for a party, it shall notify such party in writing within thirty (30) days of the submission of Updated Information.
4. The Department, at its sole election, may conduct a project review meeting to receive information and to question the parties.
5. The Department must reach decisions not more than sixty (60) days from the date that it

sent the last party a letter stating that the Department needs no additional information. However, in the spirit of 24A S.C. Code Reg. § 305 (2)(b), the review period may be extended by the Department for a maximum of sixty (60) days from the date of the last party letter.

6. Notice of the Department decisions must be served on counsel for each party the day of the decisions by hand, email, or facsimile to the addresses listed in each party's Prehearing Statement.

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.

AND IT IS SO ORDERED.

Carolyn C. Matthews
Administrative Law Judge

December 9, 2009
Columbia, South Carolina

This is a true and correct copy of the [illegible] served by the [illegible] on all parties to the [illegible] by the [illegible] interagency in the [illegible] Mail Service addressed to [illegible], their attorney(s).

This 9th day of December 2009

By Shelly A. Keith

The Supreme Court of South Carolina

The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System and Presbyterian Healthcare System d/b/a Presbyterian Hospital-York, LLC,	Petitioners,
Of whom Presbyterian Healthcare System d/b/a Presbyterian Hospital-York, LLC is	Appellant/Respondent,
and the Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Healthcare System is	Respondent/Appellant,
v.	
South Carolina Department of Health and Environmental Control,	Respondent,
and Amisub of South Carolina, Inc. d/b/a Piedmont Healthcare System d/b/a Fort Mill Medical Center,	Respondent/Appellant.

ORDER

Petitioners and Respondent/Appellant Amisub of South Carolina, Inc. filed notices of appeal in the Court of Appeals from an order of the Administrative Law Court (ALC) dated December 9, 2009. That order granted Amisub's motion for partial summary judgment, granted petitioners motion for summary judgment, and remanded the case to the Department of Health and Environmental Control (DHEC) for a determination as to which party, if any, was entitled to a certificate of need. The Court of Appeals consolidated the appeals.

Petitioner Presbyterian Healthcare System has now filed a motion to certify the appeals to this Court pursuant to Rule 204(b), SCACR, and a motion to expedite the proceedings. Neither Petitioner Charlotte-Mecklenburg Hospital Authority nor Amisub oppose the motions. We hereby certify the appeals to this Court pursuant to Rule 204(b), SCACR. However, we dismiss the appeals because the order of the ALC is not immediately appealable.

The right of appeal arises from and is controlled by statutory law. *Ex parte Capital U-Drive-It, Inc.*, 369 S.C. 1, 630 S.E.2d 464 (2006). South Carolina Code Ann. § 14-3-330(1) (1976) provides that an interlocutory order is immediately appealable if it involves the merits. However, where there is a

specialized statute, § 14-3-330 does not govern the right to review. *Ex parte Capital U-Drive-It, Inc., supra.*

South Carolina Code Ann. § 1-23-610(A)(1) (Supp. 2009) provides that judicial review may only be sought from a ***final*** decision of the ALC. Therefore, although § 14-3-330 permits appeals from interlocutory orders which involve the merits, that section is inapplicable in cases where a party seeks review of a decision of the ALC because the more specific statute, § 1-23-610, limits review to final decisions of the ALC. *Ex parte Capital U-Drive-It, Inc., supra. See also Spectre, LLC v. S.C. Carolina Dep't of Health and Envtl. Control*, 386 S.C. 357, 688 S.E.2d 844 (2010) (a specific statute prevails over a more general statute). To the extent *Canteen v. McLeod Reg'l Med. Ctr*, 384 S.C. 617, 682 S.E.2d 504 (Ct. App. 2009). and *Oakwood Landfill, Inc. v. S.C. Dep't of Health and Envtl. Control*, 381 S.C. 120, 671 S.E.2d 646 (Ct. App. 2009), rely on §14-3-330 to permit the appeal of interlocutory orders of the ALC or an administrative agency, those cases are overruled.

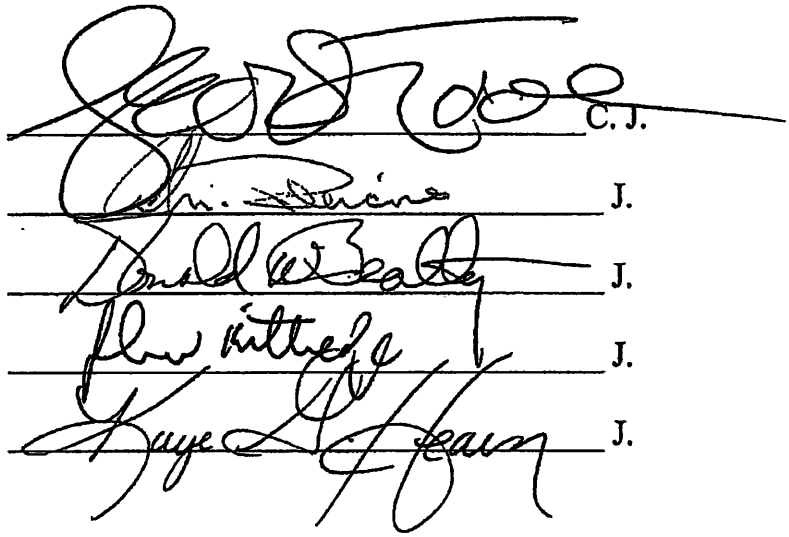
The order of the ALC in this case is not a final order. If there is some further act which must be done by the court prior to a determination of the rights of the parties, the order is interlocutory. *Hooper v. Rockwell*, 334

S.C. 281, 513 S.E.2d 358 (1999); *Mid-State Distributors, Inc. v. Century Importers, Inc.*, 310 S.C. 330, 426 S.E.2d 777 (1993); *Adickes v. Allison & Bratton*, 21 S.C. 245 (1884). A judgment which determines the applicable law, but leaves open questions of fact, is not a final judgment. *Hooper v. Rockwell, supra*; *Mid-State Distributors, Inc. v. Century Importers, Inc., supra*; *Good v. Hartford Accident & Indemnity Co.*, 201 S.C. 32, 21 S.E.2d 209 (1942). A final judgment disposes of the whole subject matter of the action or terminates the particular proceeding or action, leaving nothing to be done but to enforce by execution what has been determined. *Good v. Hartford Accident & Indemnity Co., supra.*

The ALC's order upholds DHEC's finding that Amisub was a competing applicant for the certificate of need at issue in this matter. However, the ALC found DHEC erroneously interpreted the State Health Plan to allow only existing providers to obtain a certificate of need. Based on this finding, the ALC remanded the matter to DHEC to determine whether any of the applicants were entitled to the certificate of need. Although the ALC decided questions of law involved in this matter, a final determination as to the certificate of need has not been made. Therefore, the order of the ALC is interlocutory and is not a final decision which is immediately

appealable under § 1-23-610. Accordingly, we dismiss this matter.

IT IS SO ORDERED.



C. J.

J.

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Columbia, South Carolina

April 8, 2010

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 **FINAL ORDER AND DECISION**

APPEARANCES: Stuart M. Andrews, Jr., Esquire and Daniel J. Westbrook, Esquire for Petitioner Amisub of South Carolina, Inc.

Douglas M. Muller, Esquire, Trudy H. Robertson, Esquire, and E. Brandon Gaskins, Esquire for Respondent The Charlotte-Mecklenburg Hospital Authority

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) 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 days between April 8, 2013, and May 7, 2013. For the reasons set forth herein, 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.

FILED
MAR 31 2014
SC ADMIN. LAW COURT

BACKGROUND

York County, South Carolina is among the fastest growing counties in the state. One of the fastest growing and most affluent parts of York County is the area near Charlotte surrounding the town of Fort Mill in Northern York County. The western part of the county (Western York County) is more rural, less populous, and less affluent.

The 2004-05 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 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 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's 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.[1] 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.

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

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).
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> . . . .
>
> 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).[2] 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

[2] For purposes of this 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.

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 decision letters, this time granting CHS's application and denying the applications of Presbyterian and Piedmont. The decision letters each 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.

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 accuracy of the evidence, I make the following findings of fact by a preponderance of the evidence:

1. Piedmont Medical Center is an existing two-hundred-eighty-eight (288) bed acute care hospital located in Rock Hill, York County, South Carolina.[3] Piedmont Medical Center 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. 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. 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,

[3] 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.

vascular surgery, neonatal intensive care, specialized women's and pediatric services, and behavioral health.

2. CHS is a public hospital system created by North Carolina statute and headquartered in Charlotte. CHS owns or manages forty-two (42) hospitals, in addition to various healthcare facilities. CHS's 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. 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. From 2002 to 2013, CHS spent more than $300 million expanding CMC-Pineville from ninety-seven (97) to two hundred six (206) beds. During this period CHS also expanded CMC-Pineville's services to include specialized tertiary services similar to those provided at Piedmont Medical Center.

3. 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).

4. The original CON applications in this case were based on the need identified in the 2004-05 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 percent (65.2%) in 2001 to seventy-five and one-tenth percent (75.1%) 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. 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.

5. The other relevant plan is the 2012-13 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 seventy-five and one-tenth percent (75.1%) in 2003 to fifty-seven and one-tenth percent (57.1%) in 2009. Although the occupancy rate subsequently increased to fifty-eight percent (58%) in 2010 and sixty-two and one-tenth percent (62.1%) 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. Based on historical occupancy rates at Piedmont Medical Center, and the projected growth of the York County population, DHEC identified a need for sixteen (16) acute care hospital beds in addition to the 332 acute care beds identified in the 2004-05 South Carolina Health Plan. Thus, DHEC's current plan identifies a need for a total of three hundred forty-eight (348) acute care beds in York County.

6. CHS proposes to construct a sixty-four (64) bed hospital to be located in Fort Mill, South Carolina, at a total project cost of $79,101,360. 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.

7. Piedmont proposes to construct a one hundred (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. In addition to the 64 beds for which a need is recognized in the 2004-2005 South Carolina Health Plan, Piedmont plans to transfer thirty-six (36) beds from Piedmont Medical Center, its existing hospital in Rock Hill, to its proposed hospital in Fort Mill. Currently, Piedmont Medical Center 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 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.

8. 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 review. 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	Need (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)

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).

York County Contract

9. Since 1980 Piedmont has been party to a contract with York County (York County Contract) that does not expire until 2045. The York County Contract places certain restrictions on 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. Over the years the parties have amended the contract on nine occasions and are currently negotiating a tenth addendum. In the

Ninth Addendum, the parties expressed their intent that the terms and conditions of the contract, including the various amendments, would apply to FMMC.

10. Piedmont provides some of these services at a loss. For example, it operates the county-wide ambulance service at a loss of approximately $4 - 4.5 million per year, even though the service transports a significant number of patients to hospitals other than Piedmont located outside of York County. 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. Because of the limited demand for urgent care services in Western York County, Piedmont lost $800,000 a year for each of the five years it staffed the center at the level requested by York County. 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.

11. This court is impressed with the commitment Piedmont has made to its community through the York County contract. 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.

Utilization

12. From 1997 to 2005, the utilization of Piedmont by York County residents increased forty (40) percent, from approximately 10,000 to 14,000 inpatient discharges. 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. The utilization increase Piedmont experienced in the period occurred proportionately during this period with other hospitals serving York County residents.

13. 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. The first was the decrease in utilization of Piedmont by York County residents. During this period, Piedmont's utilization dropped from approximately 14,000

to 11,000 discharges. 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. This decline in patient volume occurred during a period when York County's population grew twenty-two (22) percent.

14. The utilization data during this period reflect a direct correlation between Piedmont's York County patient loss and CHS's gain. From 2005 to 2010, Piedmont lost approximately 2,200 York County patient discharges. During the same period, Carolinas Medical Center and Mercy-Pineville increased York County discharges by a combined 1,800 patients. Over eighty (80) percent of Piedmont's decline in York County patient volume from 2005 to 2010 went to CHS facilities.

15. CHS owns a large network of employed physicians known as the Carolinas Physician Network (CPN). In February 2005 prior to the filing of CHS's CON application in this case, CPN employed twenty-five (25) physicians with offices in York County. By April, within a month following the submission of the CHS application, CPN added twelve (12) physicians to its network, bringing to thirty-seven (37) its total of employed physicians in York County. By 2012 the number of York County doctors working for CPN had grown to sixty-six (66). 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.

In the absence of the express exceptions listed, 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. During the period from 2009 to 2012, CPN referrals to CHS facilities and

services increased more than four times, from 1,200 referrals in 2009 to more than 5,000 in 2012. Four CPN primary care offices in York County accounted for more than eighty (80) percent of the CHS referrals between 2009 and 2012. A CPN cardiology practice in York County doubled its referrals to CHS hospitals from 1,200 cases in 2009 to 2,400 cases in 2012.

16. After CHS filed its CON applications in April 2005, changes in their physician network strategies became evident.[4] CHS, which had owned physician practices in York County for an extended period, quickly expanded their employed physician network and began the process of changing physician referral patterns. Many physicians resigned their staff privileges at Piedmont, including several who had held leadership positions. By 2011, nearly all CPN physicians had resigned from Piedmont's medical staff.

17. 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. An examination of Piedmont's market share of complex cases for sicker 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 (42) percent, reflecting the increasing number of CPN practice referrals discussed above. As a result, by 2011 more residents of York County left to receive complex services than stayed.

Impact of Proposed Projects

18. Piedmont's establishment of a satellite hospital in Fort Mill is the centerpiece of its long-term plan to serve York County. The satellite hospital's presence in Northern York County would provide local services to a growing population that has historically oriented to Charlotte instead of Rock Hill for a wide range of needs, including employment, shopping, entertainment, and healthcare. By reducing outmigration of patients from the Fort Mill Area, the

[4] 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.

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.

19. Piedmont projects a fifty-eight (58) percent occupancy rate for FMMC by its third year of operations. The projected occupancy rates of FMMC 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. 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.

20. 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. The emergency department is significant because sixty-nine (69) percent of Piedmont's inpatients access the hospital through its emergency room. DHEC recently approved a CON for Piedmont to double the size of its emergency room, a project that will be completed in 2014. FMMC would provide Piedmont with a second emergency department and would enhance Piedmont's ability to recruit physicians.

21. CHS contends it will fill CMC-FM's beds simply by shifting York County patients it already serves to the 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. CHS executive Del Murphy, who drafted the CMC-FM application, testified that CHS's goal is not to increase its York County market share, merely to maintain the market share it currently has. CHS's expert, Dawn Carter, also conceded that the assumption that CMC-FM would take no additional patients from Piedmont was "the basis of the projection in the [CHS] application."

22. The court finds CHS's 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 unlikely, 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 by non-CHS physicians who would join hospital's medical staff and other independent physicians who would become affiliated exclusively with CHS.

23. 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. Roughly fifty (50) percent of the patients at CHS's hospital in Pineville, North Carolina (CMC-Pineville) were admitted through the emergency department. These data show that, like other hospitals, CHS cannot control 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." The proximity of CMC-FM's emergency department to Rock Hill would certainly attract Fort Mill area patients who would otherwise go to Piedmont and be admitted there.

24. Each of the three independent physicians 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, whether the facility was established by CHS or Piedmont. 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. Otherwise, the practitioners would be at risk of losing their patients to CHS-employed physicians and others practicing at CMC-FM. The testimony of these three practitioners was consistent with the reports Piedmont experts David S. Levitt and Daniel J. Sullivan received from Piedmont medical staff members.

25. A third way Piedmont patients would shift to CMC-FM would be if independent physicians who practice at Piedmont become aligned with CHS by employment or otherwise. The court finds that this risk is more than merely speculative. Dr. Taylor testified that his group, the oldest OB/GYN practice in York County, has discussed the prospects of employment with CHS, Piedmont, and other healthcare systems. If his group became employed by CHS, Dr. Taylor testified that patients of his group, which provides over ninety-five (95) percent of Piedmont's OB/GYN services, would be shifted to CMC-FM and other CHS facilities. Similarly, Dr. Singhi stated that his cardiology practice, Carolina Cardiology, has considered employment by both CHS and Piedmont. Carolina Cardiology furnishes between eighty (80)

and ninety (90) percent of the cardiology services at Piedmont. Dr. Singhi recognized the demands that would exist if CMC-FM was approved, and which would not permit his practice to maintain its independent status. 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 move patients from Piedmont to CHS facilities.

26. To the extent that CHS can control where its patients go for services, the court finds that there is little incentive for CHS to simply shift existing patients to CMC-FM. CHS spent $300 million recently doubling CMC-Pineville's bed size and adding many specialty services that duplicate Piedmont's. In its 2007 CON application in North Carolina, CMC-Pineville justified its expansion, in part, by projecting that over twenty (20) percent of its admissions would come from York County. From that, it would appear that CHS would have every incentive to recoup its multi-million dollar capital investment by maximizing utilization at CMC-Pineville, and not shifting those patients to CMC-FM.

27. It would also be unreasonable for CHS to seek little or no incremental increase in utilization of its facilities in return for its more than $75 million projected investment in CMC-FM. Merely serving the same patients that CHS already serves does not reflect sound business or healthcare planning principles. This court finds it difficult to conclude that CHS, a highly successful organization, would establish a new facility in a new market without intending to serve any new patients, many of whom would inevitably come from Piedmont.

28. The incentive CHS identified for the establishment of CMC-FM was not economic, but the need for additional capacity to relieve the utilization demands on the CHS Charlotte-area facilities. Ms. Carter testified that CMC-FM would enable CHS to "decompress" utilization at CHS facilities, particularly CMC-Main. Mr. Levitt, however, countered that the effect of any relief provided to CHS's Charlotte-area facilities by the redirection of York County patients to CMC-FM would be insignificant. 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.

29. The evidence presented suggests that superior alternatives are available to CHS to decompress utilization at some of its facilities such as CMC-Main. Six of the CHS Charlotte area hospitals consistently have had capacity to relieve CHS of its capacity constraints at CMC-Main. In 2009, CMC-Mercy was only forty-six (46) percent occupied. That same year, CMC-

University, which is located in Charlotte near CMC-Main, was operating at forty-seven (47) percent capacity. Similarly, in 2011, the combined occupancy for CMC-Mercy and CMC-Pineville was sixty-five (65) percent. The 2011 occupancy of CMC-University was forty-three (43) percent. Because CMC-Main draws from a large geographic area, patients receiving care there from the communities served by CMC-Union, CMC-Kings Mountain, and CMC-Cleveland Regional[5] could be redirected to those facilities in the same way CHS is proposing to shift patients to CMC-FM. The availability of excess capacity at these CHS facilities is a superior alternative for reducing utilization at CMC-Main than the $75 million proposed capital expenditure required to construct a hospital in Fort Mill.

30. Mr. Levitt and Mr. Sullivan testified that CMC-FM, in combination with CHS's 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.

31. 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. These are cases that would be less likely to be performed at small community hospitals, and would be referred instead to larger facilities such as the CHS-Charlotte area hospitals or Piedmont.

32. 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's more than doubled from fifteen (15) percent to forty (40) percent. 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's was twenty-one (21) percent. By 2011, their market share was identical. 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's share of twenty-eight (28) percent. By 2011, however, CHS's share of complex surgeries performed on York County residents exceeded Piedmont's.

33. In six separate service lines involving complex cases, including cardiac cath/EP, neurosurgery, vascular surgery, gynecological surgery, plastic surgery, and ENT surgery, Piedmont lost at least fifty (50) percent of its volume from 2005 to 2011. In several other service

[5] In 2009, CMC-Cleveland Regional operated at thirty-eight (38) percent and CMC-Kings Mountain at twenty-eight (28) percent.

areas, including cardiovascular medicine, Piedmont lost more than twenty-five (25) percent of its volume.

34. Piedmont also presented evidence regarding the impact on its payor mix. Hospitals make a majority of their profits through managed care, commercial insurance patients. Medicare pays hospitals significantly less for patients covered under that program, and Medicaid often pays providers below their cost. Self-pay patients, irrespective of whether they qualify for charity care, typically pay little or nothing.[6] 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.

35. 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 such medically underserved groups and to maintain profitability, a hospital payor mix must contain a significant percentage of managed care and commercial patients. From 2005 to 2011, Piedmont's payor mix declined substantially as CHS's market share of York County patients grew. During that period, Piedmont's managed care patients fell sixteen (16) percent, while its Medicaid patients increased by the same amount and its charity care cases doubled.

Adverse Impact

36. Three independent York County physicians, not employed by either applicant but who refer a majority of their patients to Piedmont, testified that if CMC-FM were constructed, it would adversely affect Piedmont. One physician testified that CMC-FM would increase the loss of outpatient and inpatient services, particularly of complex cases that Piedmont has been experiencing in recent years. 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." As a result, it would be difficult to maintain the same scope and quality of pulmonary services at Piedmont if CMC-FM were approved.

37. Another physician 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, decreasing the

[6] Self-pay patients are uninsured patients whose income levels do not qualify for charity care. Tr. 1237:7-11.

percentage of patients who are payors. Under such circumstances, the quality of care at Piedmont would suffer and the ability to recruit new physicians into the area would be impaired.

38. Among the greatest threats to Piedmont is that if CMC-FM were approved it would reduce the volume of services referred to independent 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. Two doctors testified that their practices would have to give serious consideration to becoming employed by the CHS physician network if CMC-FM was constructed. One doctor testified that if the physicians in his practice, which is the principal provider of OB/GYN services at Piedmont, became employed by 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.

39. Experts for Piedmont and CHS testified about two alternative approaches for analyzing adverse impact. The incremental approach projects an existing provider's utilization and income at a future date under two alternative circumstances: a) with a new provider operational; and b) without the new provider. Under the alternative approach, called the lookback method, the analyst views the existing provider's projected utilization and income at a certain future date, assuming the presence of the new provider. The analyst then "looks back" to the existing provider's utilization and income data at a specific point in time. The future projections are compared with the historical data to determine whether adverse impact would occur.

40. Mr. Sullivan criticized the lookback approach for failing to give effect to population growth. 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 years later, Hospital A's occupancy rate remains at 20 percent. The lookback approach would conclude that no adverse impact had occurred at Hospital A, even though its occupancy rate would have been forty (40) percent had Hospital B not been built, due to high population growth in the service area. Alternatively, the incremental approach would take into account the high population grown in the area and conclude that Hospital A had been adversely impacted by the construction of Hospital B.

41. 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 3,076 fewer cases annually and $12,087,942 less annual income for Piedmont. This analysis was based on the assumption that sixty-seven (67) percent of CMC-FM's patients would come from Piedmont. 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 2,000 inpatient cases a year that would reduce Piedmont's income by approximately $8 million annually.

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 1,623 patient cases a year, constituting a negative financial impact of $6.5 million annually. Assuming CHS would shift existing patients to CMC-FM, Ms. Platt characterized her incremental analysis as a worst case scenario for Piedmont.

43. CHS experts argued that because CMC-FM would be utilized primarily by existing CHS patients who would be shifted from facilities in North Carolina, CMC-FM would have no adverse impact on Piedmont. As a fallback, however, CHS's experts also advocated a lookback approach. Ms. Platt prepared a lookback adverse impact analysis that compared Piedmont's projected performance in 2017 with what it was in 2009. Under her analysis, which did not give effect to growth in demand or growth in population, she projected that Piedmont would have only sixty-two (62) fewer patients in 2017 than it did in 2009. 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 $2.7 million annually.

44. 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 2.1 percent to 5.4 percent were within an acceptable range. 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. 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 $5.5 million applied to Ms. Platt's projection to a high of $10.5 million. When considered in the aggregate, the negative impact ranges from $12.1 million for Ms. Platt's model to $22.3 million for the highest projected loss calculated by Mr. Levitt.

45. 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 projected total losses: $22.3 million, based on the assumption that CMC-FM would take 67 percent of its patients from Piedmont; $15 million, based on the assumption that CMC-FM would take one-half of its patients from Piedmont; and $12.1 million, based on the analysis performed by Ms. Platt that assumes Piedmont's losses would be proportional to its market share. Mr. Levitt then applied those projected losses against Piedmont's pre-tax income, which was approximately $28 million in 2009, $24.7 million in 2011, and $36 million in 2012, to determine the following percentages that the total projected losses represented of pre-tax income.

Financial Impact as a Percentage of Piedmont's Pre-Tax Income

Projected Total Losses	2009	2011	2012
$22.3 million	80%	90%	62%
$15.0 million	53.2%	60.2%	41.3%
$12.1 million	43.4%	49.1%	33.7%

46. Each of these sets of projections represents what would be a substantial and adverse impact on Piedmont. 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.

Bed Need and Need Projections

47. 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, not the utilization of residents of a county. In the 2004-05 Health Plan, DHEC projected York County would need three hundred thirty-two (332) acute care beds by 2010. In the 2012-13 Health Plan, DHEC projected York County would need three hundred forty-eight (348) acute care beds by 2018.

48. Piedmont and CHS each base their projections of bed need on similar assumptions about the distribution of utilization throughout York County. 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 somewhat greater utilization by residents of the western York area, eight and one-tenth (8.1) percent compared to three (3) percent for Piedmont. Based on these assumptions, projections of the bed need distribution within York County relied on by each applicant are consistent.

49. 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. To calculate the projected utilization, CHS applied its 2009 market share to the CMC-FM utilization forecasts.

50. Mr. Levitt testified that even if CHS's assumptions were accurate, applying CHS's more recent market share would show that the 64 bed facility would be inadequate. From 2009 to 2011, CHS's market share of York County patients continued to grow. Applying the higher 2011 market share to CHS's 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. By 2020, under CHS's utilization model, occupancy would exceed ninety (96) percent.

51. Based on this updated calculation, CHS would need ninety-five (95) beds at CMC-FM. If, however, CMC-FM were to take market share from Piedmont, which this court has found is a reasonable assumption, 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 points, the facility

would be one hundred eight (108) percent occupied by 2017. The proposed 64 bed CMC-FM facility would be inadequate to meet the projected bed need.

52. 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. CMC-FM's design, however, envisions a potential future expansion of only eighteen (18) to twenty (20) beds. The CMC-FM design contains no empty space reserved for future expansion ("shell space"). CHS presented no evidence of other space it could convert to accommodate additional space in the event of expansion. Adding additional beds would therefore require construction, which is expensive and potentially disruptive. Adding beds would also require an additional CON, which could be expensive and time-consuming.

53. 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.

54. 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.

55. Beverly Brandt, DHEC's CON Director at the time of the agency's decision, relied heavily on CHS's 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." More specifically, in her analysis of the applications, Ms. Brandt 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."

56. Mr. Sullivan identified two principal flaws in the CHS model. First, that at the time the model was prepared the 2010 census data was not published. Additionally, Mr. Sullivan

noted that Ms. Platt failed to incorporate a new Northern York County zip code, 29707, that is part of FMMC's primary service area. Since the development of CHS's model projections, the 2010 census shows that its model understated the population in Northern York County. The updated census shows the population in the Fort Mill Area to be significantly higher in 2015 than the assumptions on which CHS and DHEC were relying in finding a 100-bed facility would disproportionately allocate beds to Northern York County.

57. The more reasonable period for projecting the bed-to-population ratio would be in 2020, not 2015. 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. 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.

Access to Medically Underserved

58. DHEC requires CON applicants to project the level of charity care they will provide, 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.

59. In the 2005 applications, 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.[7] CHS projected charity care for CMC-FM that equaled three and five-tenths (3.5) percent of its gross revenue. 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.

60. Northern York County is the most affluent area of one of the most affluent counties in the state. For example, the percentage of patients from Northern York County on Medicaid is less than half that of Medicaid patients from the rest of the county. In 2011, only five and five-tenths (5.5) percent of the hospital patients from Northern York County were self-

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

pay or charity patients, as opposed to nine and five-tenths (9.5) percent from the rest of York County.

61. 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 another CHS hospital, CMC-University. 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.

62. The internal data on which Mr. Stewart relied showed 2009 gross revenue for CMC-Pineville of $385,034,797. The 2009 gross revenue for CMC-University was $382,847,000. 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 $31,042,000 in charity care [eight and one tenth (8.1) percent of its gross revenue]. The weighted average of these percentages was 6.3 percent, the number Mr. Stewart projected for CMC-FM.

63. The source of the data Mr. Stewart relied on were reports by CHS's vendor, PeopleSoft. The PeopleSoft reports showed different charity care amounts than those used by Mr. Stewart. PeopleSoft reported CMS-Pineville's 2009 charity care at only $510,847. Similarly, the PeopleSoft report for CMC-University listed its 2009 charity care at only $2,173,922.

64. The PeopleSoft reports classified uncompensated care into five different categories: charity care, Mecklenburg County inpatient contractual adjustments, bad debt expense, bad debt recovery, and self-pay discount. CHS later reclassified portions of the bad debt and self pay amounts as charity care. 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. CHS reclassified the status of many patients from bad debt or self-pay 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, at other times the reclassification did not occur until after discharge.

65. DHEC accepted CHS's projection that 6.3 percent of its gross revenue would be provided to charity care patients. In accepting the 6.3 percent charity care projection for CMC-

FM, Ms. Brandt gave no weight to the historical experience of CMC-Pineville or CMC-University, or to the demographics of York County.

66. 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-owed physician practices has not only been to limit access of medically underserved individuals to primary medical care but would be to limit access of those same individuals to non-emergency admissions at CMC-FM, which would be heavily dependent on CHS-employed physicians.

67. This court is persuaded by the evidence showing relatively low percentages 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 three-tenths (0.3) percent of all patients of the office. For Medical Associates of Rock Hill in 2012, Medicaid patients represented one-tenth (0.1) percent of all patients of that office. 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 (0.6) percent Medicaid patients in Shiland'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, consisting 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 these practices served in 2012 was significantly below the 6.3 percent charity care projection provided by CHS for the CMC-FM facility, ranging from one and three-tenths (1.3) to two and five-tenths (2.5) percent.

68. 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.

69. Based on the evidence provided, this court finds little support for CHS's projected charity care as 6.3 percent is unreasonable. 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) 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 reasonable to believe that CMC-FM's charity care percentage would be higher than the charity care percentage at its main hospital in downtown Charlotte, North Carolina.

Financial Considerations

70. Joel Grice, a thirty 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.

71. In identifying total capital costs for FMMC, Piedmont projected its costs differently than CHS. To permit the projected costs of the two projects to be accurately compared, 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 affect: he excluded capitalized interest as CHS had; he eliminated an inflationary factor for future construction cost that CHS had not included; and 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 million to $119.8 million.

72. The total project cost per bed for the 100 bed FMMC is $1.2 million per bed. For CMC-FM, the total project cost per bed for the 64 bed, $77.5 million facility is $1.2 million. When the total project costs of these facilities are compared with the costs of recent CONs for new satellite and replacement hospitals, the costs per bed proposed by Piedmont and CHS are consistent with those experienced by similar facilities. 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 $2.3 million per bed. 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 $1.5 million per bed. The cost per bed for some new hospitals have been lower than those projected by Piedmont and CHS, without adjusting for inflation, but overall the capital costs of the proposed projects are reasonable when compared with the costs of similar facilities. 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.

73. 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 showed how FMMC's 2010 proposed operating costs were consistent with the 2006 operating costs of Palmetto Parkridge, without adjusting for inflation. Mr. Levitt concluded that the projected total operating costs were reasonable and consistent with those approved for existing facilities. CHS presented no evidence addressing the operating costs of similar facilities other than its own.

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

75. FMMC and CMC-FM proposed budgets each 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 $5.4 million in the first year of operation to more than $300,000 in net income by year three. CMC-FM projects net income of $663,000 in its first year, climbing to over $2.7 million by year three.

76. Mr. Levitt compared the projected financial performance of Roper-Berkeley and Trident-Berkeley, the two most recently approved new hospital CON applications, 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 nearly $15 million loss 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. Trident-Berkeley's financial performance projections were consistent with those projected by FMMC, and were again found to be financially feasible.

77. 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. In reviewing competing applications, Mr. Grice testified that he has never found one applicant more financially feasible than another if they show a positive trend by the third year. There is no issue as to whether either applicant will be able to build and sustain their respective projects.

78. CHS proposed to use cash to finance the construction of CMC-FM. 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." Both financing proposals are reasonable, and both applicants can afford to build the projects. Additionally, both applicants appear to be committed to funding their respective projects and both are capable of doing so.

79. 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. CMC-FM's design, however, would permit expansion of no more than 20 beds for a total of 84 beds. 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.

Public Support and Opposition

80. DHEC received more than 5,000 letters of support for Piedmont, and thirty-four (34) letters of opposition. 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 5,000 support letters for CHS and no letters of opposition. Some of the CHS letters of support were critical of Piedmont, however, these were not counted by DHEC as opposition letters to Piedmont.

Proposed Hospital Sites

81. The proposed site for FMMC is in Fort Mill near the intersection of S.C. Highway 160, which is four lanes, and U.S. Highway 21, which is two lanes. The capacity for S.C. 160 is 28,000 vehicles per day and its current traffic volume is approximately 17,000 vehicles per day. The capacity for U.S. 21 is 12,000 vehicles per day and the current volume is approximately 6,000. Three entrances to the hospital site are planned from U.S. 21 and a fourth entrance from S.C. 160. Piedmont offered unrebutted testimony[8] from an expert transportation engineer, Robert Walsh, that the Piedmont site posed no concerns related to safety or traffic congestion.

82. The proposed site for CMC-FM is located south of the FMMC site at the Sutton Road exit off of Interstate 77. There is a single entrance off of Sutton Road to the hospital site along a frontage road located three hundred (300) feet from the south bound ramp of I-77 and directly across from a large truck stop, Love's Plaza.[9]

83. The South Carolina Department of Transportation (DOT) requires that a distance of at least seven hundred fifty 750 feet separate a full access intersection and an interstate ramp. The purpose of the 750 foot requirement is to provide greater traffic safety and reduce traffic congestion. Although the DOT has authority to waive that requirement, no evidence has been presented that such a waiver has been granted for the CMC-FM site.

84. The CMC-FM site is a part of a larger development site known as the "Kanawha Site." When the Kanawha Site is developed, the DOT intends to put traffic signals at the I-77 ramps. DOT has no plans, however, to place traffic signals on the frontage road leading to CMC-FM's proposed site. Traffic signals at the interstate ramps are likely to result in greater congestion in the 300 feet between the southbound ramp and the frontage road. Mr. Walsh testified there is potential for traffic to back up along the road to the CMC-FM site. This congestion and safety concerns are heightened due to the heavy, slow-moving truck traffic accessing Love's Plaza.

CONCLUSIONS OF LAW

[8] Although CHS executive Del Murphy testified about the traffic volumes at both the Piedmont and CHS sites, he was not qualified as an expert in transportation engineering or in any other field. Moreover, Mr. Murphy conceded he had not checked the traffic capacity or current traffic volume at either site.

[9] CHS has proposed only one entrance to the proposed location, which is off a frontage road across from Love's Plaza truck stop. While CHS's counsel suggested on cross-examination of Mr. Murphy that additional or alternative entrances to the hospital could be developed, no evidence was presented of an alternate entrance or of the costs associated with developing it.

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 & Envtl. 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 & Envtl. 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 purpose of the CON Act "is to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State." 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 project review criteria applicable to CON applications. These criteria fall into five 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 Heath 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's 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's 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's 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 but also may 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 2004-05 South Carolina Health Plan and may also consider the 2012-13 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's 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. When updated census data were applied to its methodology during trial, however, 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 reflects the facility 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. These projections are further evidence that CHS's 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. While patients have sought medical services in the Charlotte area for years, the outmigration accelerated from 2005 to 2011. The effects of the outmigration, which are detailed in the Findings of Fact, have 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, this criterion applies to Piedmont only. 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 empty beds available on an average day. The court further finds that these beds will be better utilized at FMMC.

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.

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

22. DHEC accepted CHS's 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 philanthrophic organizations.

2004-05 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.

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.

25. Project Review Criterion 3f directs that the proposed facility should establish provisions to ensure that patients will receive treatment regardless of ability to pay, and Project Review Criterion 3g requires the consideration of whether the proposed project will have a potential negative impact upon the ability of existing providers to serve medically underserved groups.

26. CHS's proposed charity care does not meet the definition quoted above. Mr. Stewart's testimony and CHS internal documents reveal that CHS's 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 evidence includes past cost reports filed by CHS for CMC-Pineville and CMC-Mercy, showing those hospitals provided charity care valued at 2.6 percent of gross revenue.

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

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

29. 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 the court should give no greater weight to this criterion than it does to any of the other criteria that was not specifically listed in DHEC's ranking.[10]

30. The effect on Piedmont of the loss of over a thousand patients and millions of dollars a year will make it more difficult for the hospital to cover its fixed costs. Its cost per unit of services associated with such costs 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).

31. 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

[10] 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.

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 other healthcare providers. The testimony of the three physicians as well as the letters to DHEC during staff review from over forty (40) independent 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.

32. 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, this court finds unreasonable the position asserted by CHS and DHEC that by shifting patients from CHS facilities in North Carolina, CMC-FM will cause little, if any, adverse impact on Piedmont. 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 demonstrated, by a preponderance of the evidence, that CHS would continue to take market share from Piedmont if CMC-FM were established. It would do so through services provided by CMC-FM as well as by the increased outmigration of patients to CHS facilities in North Carolina for more specialized services.

33. Given the rapid population growth projected for Northern York County, the court concludes that the incremental approach is more reasonable than the lookback approach in calculating CMC-FM's impact on Piedmont. Under the incremental approach, Piedmont would lose from 1,600 to 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 to $22 million, 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) (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).

34. Criterion 23b requires that the staffing of the proposed hospital should be provided without unnecessarily depleting the staffing of existing hospitals or services. 23b. As discussed in the Findings of Fact, 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 on other healthcare providers as well. The testimony of three physicians in addition to the letters to DHEC during staff review from forty (40) independent 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. Therefore, this court finds that Piedmont best meets § 802.22.

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

35. 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.

36. Project Review Criterion 6b requires that projected levels of utilization should be reasonably 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 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% 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 Medical Center to FMMC, place 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.

37. Both applicants equally satisfy Regulation 61-15 § 802(9), as both show an improvement in net revenue over 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.

38. 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 CMC-FM.

Public Support and Opposition (4b)

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

Conclusion

40. 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 aspects of Ms. Brandt's analysis, it was persuaded by the testimony of Mr. Grice and Ms. Fechtel, both of whom worked within the CON program for many years and possessed greater experience and institutional knowledge.

41. This court concludes that either hospital would promote cost containment. Both applicants have the ability to use 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 a necessary 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.

42. 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.

43. This court concludes that the establishment of the FMMC will best serve the public needs by reducing the outmigration of York County residents to North Carolina hospitals and, in so doing, will strengthen the existing healthcare system in York County that consists largely of Piedmont Medical Center and independent physicians on the Piedmont medical staff. Approval of Piedmont's application will help stem outmigration, while approval of CHS's will escalate it, especially for specialty services. Furthermore, CHS's proposed hospital site presents traffic and safety concerns. For all these reasons, FMMC will better serve public needs than CMC-FM.

44. 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 two 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 added and provided within York County.

45. 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, but I conclude that Judge Matthews' prior ruling is dispositive of this issue.

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

47. 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 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's 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.

S. Phillip Lenski
Administrative Law Judge

March 31, 2014
Columbia, South Carolina

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 **ORDER**

A hearing was held in this matter over the course of fifteen days between April 8, 2013, and May 7, 2013 at the Administrative Law Court (ALC). This court issued a Final Order and Decision on March 31, 2014. Thereafter, on April 9, 2014, the Respondent Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center-Fort Mill filed a Motion for Reconsideration.

IT IS HEREBY ORDERED that this court's Final Order and Decision is hereby vacated pending a decision upon the Respondent's Motion.

AND IT IS SO ORDERED.

S. Phillip Lenski
Administrative Law Judge

May 2, 2014
Columbia, SC

FILED
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SC ADMIN. LAW COURT

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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SC ADMIN LAW COURT

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

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[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).
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> ....

[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 FMMC. 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 Regional[8] 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.

Financial Impact as a Percentage of Piedmont's Pre-Tax Income

Projected Total Losses	2009	2011	2012
$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

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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. 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. Jt. 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 FMMC 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 FMMC. 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. FMMC 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 FMMC, 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 FMMC 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 FMMC 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 FMMC were unreasonable, contending that patients from Rock Hill zip codes (29730 and 29732) would not go to FMMC. 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 FMMC." Jt. Ex. 1-B at 1007. However, in many portions of 29730 and 29732 residents could travel to FMMC 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 FMMC 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 FMMC 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-owed 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 & Envtl. 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 & Envtl. 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 Heath 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 FMMC.

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 philanthrophic 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 ion 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).

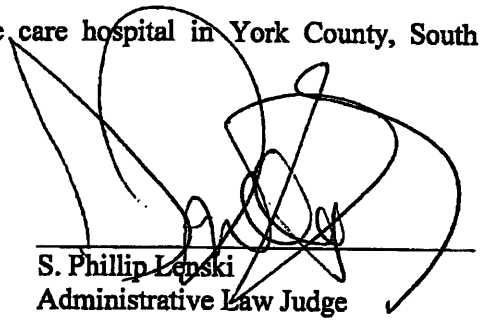
ORDER

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 Lenski
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.

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, Petitioners, v. South Carolina Department of Health and Environmental Control and The Charlotte Mecklenburg Hospital Authority, d/b/a Carolinas Medical Center-Fort Mill, Respondents.	Civil Action No. 11-ALJ-07-0575-CC **RESPONDENT CHS'S MOTION IN LIMINE TO EXCLUDE CERTAIN EVIDENCE TO BE OFFERED AT THE CONTESTED CASE HEARING AND MEMORANDUM IN SUPPORT**

Respondent, The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center-Fort Mill ("CHS"), hereby moves *in limine* to exclude certain evidence to be offered at the contested case hearing.

I. STATEMENT OF FACTS

A. Expert Testimony of Robert Walsh

Piedmont has identified Robert Walsh, P.E., as an expert witness who will testify about his opinions on "traffic engineering issues, including but not limited to drive time and traffic issues related to the applicants' proposed sites." (Piedmont Sec. Am. Designation of Expert Witnesses ¶ 6.) In Walsh's deposition, he stated two opinions regarding traffic issues relating to CHS's proposed hospital site off of Sutton Road: (1) the site is too close to Interstate 77 ("I-77") from a safety and congestion management perspective (Walsh Dep. 27:21-28:3); and (2) the site is too close to a Love's Plaza truck stop that has "a lot of truck traffic coming in and out" (Walsh Dep. 40:21-25). Walsh

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offered no other opinions regarding the proposed location of the CHS site. (Walsh Dep. 31:1-4.)

Walsh admitted that in reaching these opinions that he had not reviewed the plan for the CHS hospital site and did not know where its entrances will be: "I haven't seen a site plan for the [CHS] hospital, so I don't know where its proposed entrances really are." (Walsh Dep. 28:6-8.) Walsh could not specify which documents he reviewed in developing his opinions, except for a Google Earth photo of the site and a letter from the South Carolina Department of Transportation, which, admittedly, only pertained to the "site, and not to the hospital itself." (Walsh Dep. 29:10, 30:3-7.) He did not take any photographs of the traffic conditions. (Walsh Dep. 29:14-16.)

While Walsh claims that he has visited the proposed CHS site and monitored traffic conditions, he admits that he only made two short, general site visits and did nothing to record or quantify his observations:

> Q. Regarding your concerns about the proximity to the truck stop, did you collect any data about the truck traffic in and out of Love's?
>
> A. We did not record any traffic counts or collect any data of that sort. It's just strictly from visual observations.
>
> Q. And how long were you on the site to make these visual observations?
>
> A. I've been there on at least two occasions for 15 to 20 minutes.
>
> Q. 15 to 25 minutes. And during those two times for 15 to 20 minutes, were you only monitoring the truck traffic?
>
> A. No. I was observing not only the truck traffic but that was a predominant -- the predominant traffic was the stream of trucks coming in and out of Love's. Sutton Road itself doesn't carry a significant amount of traffic at this time.

Q. Did you take any notes to record your observations about the truck traffic?

A. No. I was also looking at the pavement conditions, various aspects of the roadways itself and the intersections.

Q. So you were doing other things than just watching the trucks coming in out and out of Love's?

A. Well, yeah, it was a general site visit.

(Walsh Dep. 41:11-42:11.) Based on these observations, Walsh could not give precise data or conclusions about the amount of truck traffic near the CHS site and Love's Plaza. Instead, he stated that "there's a lot of truck traffic coming in and out of Love's Plaza." (Walsh Dep. 41:2-3.) When asked to quantify what he meant by "a lot," Walsh responded: "Higher than average. . . . I think anybody could observe that it's a higher than normal truck traffic on a particular intersection or roadway." (Walsh Dep. 42:24-43:8.)

B. Testimony of Dr. Sushil Singhi

Piedmont has identified Sushil Singhi, M.D., as one of its witnesses in the hearing. Dr. Singhi is a cardiologist in Rock Hill. Although he is not affiliated with CHS, he is expected to testify about the referral practices of CHS physicians. During his deposition, Dr. Singhi admitted that his knowledge of the referral practices of CHS physicians is based on what he has been told by physicians, patients, and patients' families. (Singhi Dep. 68:14-24.) Dr. Singhi refused to disclose the identity of the physicians and patients who told him this information:

Q. And which primary care physicians have told you that?

A. That's also -- I will not mention it right now because that's my livelihood and I don't want to breach anything, my relationship with the primary care physicians, which I have for the last 20 years. . . .

Q. But these undisclosed physicians have told you that they are forced to send their patients?

A. Yes.

Q. And you are unwilling to tell us who those physicians are?

A. At this time, yes.

Q. How about patients -- which of your patients have told you they have been forced to go to a Charlotte area hospital?

A. I don't want to disclose that.

Q. How many patients have told you that?

A. Again, the quantity, I cannot tell you that, but I have heard over and over from patients and families.

(Singhi Dep. 68:23-69:4, 69:18-70:7.) Dr. Singhi also stated that he has received phone calls in which patients and patients' families have complained about being referred to hospitals and facilities in North Carolina. (Singhi Dep. 51:15-52:10.)

C. Testimony of Dr. Norman Taylor

Piedmont has identified Norman Taylor, M.D., as one of its witnesses in the hearing. Dr. Taylor is an OB/GYN physician in Rock Hill. Although he is not affiliated with CHS, he is expected to testify regarding CHS's practices relating to the acceptance and treatment of OB/GYN patients who are covered by Medicaid. During his deposition, Taylor admitted that he did not know CHS's OB/GYN policy regarding the acceptance of Medicaid patients. (Taylor Dep. 53:10-25.) He also testified that his practice has been accepting Medicaid patients who had been dropped by CHS. Taylor stated that these patients would tell him that other OB/GYN practices were not taking Medicaid patients. (Taylor Dep. 43:19-43:25.)

D. Expert Testimony of Dan Sullivan

Piedmont has identified Dan Sullivan as an expert in the area of healthcare planning and finance. (Piedmont Sec. Am. Designation of Expert Witnesses ¶ 5.) Sullivan's testimony is expected to include opinions regarding the outmigration of patients from York County and the referral practices of CHS physicians. During his deposition, Sullivan testified that during the course of his engagement as an expert in this matter that he had discussions with eleven physicians at Piedmont about CHS physicians being encouraged to refer patients to other CHS hospitals, facilities, and physicians instead of Piedmont's hospitals, facilities, and physicians. (Sullivan Dep. 20:23-27:22.) Sullivan did not speak directly with the CHS physicians whom were allegedly encouraged to refer their patients within the CHS network. Instead, Sullivan learned all of this through second-hard reports of Piedmont physicians. During his deposition, Sullivan admitted that the second-hand information that he received was hearsay:

> Q. So, in other words, these physicians are recounting to you conversations they had with unidentified CHS network physicians?
>
> A. Well, they identified them, but I don't recall their names. But they talked about specific doctors who they had personal relationships with and who they received significant referrals in the past. And when they asked them about it, this is what they recounted. I mean, I realize this is hearsay. I mean, I'm just telling you what I heard from the doctors.
>
> Q. Well, it's really double hearsay, isn't it?
>
> MR. WESTBROOK: Object to the form.
>
> THE WITNESS: Yeah.

(Sullivan Dep. 27:6-18.) Sullivan stated that there was no indication that the referral patterns of CHS physicians were being driven by CHS's organizational interests other than his discussions with the Piedmont doctors. (Sullivan Dep. 28:17-29:5.)

E. Expert Testimony of David Levitt

Piedmont has identified David S. Levitt as an expert who will testify to his opinions that "are contained in his deposition" and that Piedmont's application most fully complies with the CON Act. (Piedmont Sec. Am. Designation of Expert Witnesses ¶ 2.) Upon information and belief, Levitt served as an expert witness for Roper Hospital in a previous CON contested case for a new facility in Berkeley County. CHS owns 10% of and manages Roper Hospital. Levitt is expected to testify regarding CHS's CON application in comparison to the Roper-Berkeley CON application to discredit parts of CHS's application. (Levitt Dep. 95:3-12.)

Also, Levitt is expected to testify that CHS maintains a practice of not accepting patients covered under Medicaid and Medicare, among other things. Levitt bases this testimony on a "survey" in which he made phone calls to two primary care practices in the CHS network and an unidentified Piedmont employee made phone calls to two pediatric practices in the CHS network:

> Q. Were there any other restrictions on admissions? You know, there was some mention about that the CPN physician practices were not admitting new patients that weren't managed care patients. Do you have any reason to think that CMC-Fort Mill would do that?
>
> A. Yes.
>
> Q. Okay. Why do you say that?
>
> A. Because the physicians that would practice at Fort Mill, CMC-Fort Mill, don't accept Medicaid, Medicare, self-pay patients.
>
> Q. And what -- are those the practices that are referenced in your interview notes?

A. As well as the July 11 submission we submitted to DHEC. We had some information in there well about some research we had done about what the practice patterns were for those practices about admitting new patients. And then I personally called the CHS primary care physicians, and they told me they don't take Medicare or Medicaid patients.

Q. Do you recall who you -- what practices you called?

A. I called -- if we had a list. It's the one in Fort Mill and the one in Rock Hill owned by CHS. Not Shiland, the other one.

Q. It looks like the ones you identified in your July 11, 2011, comparative review analysis to DHEC --

A. Yes.

Q. -- are Shiland Family Physicians, Medical Associates of Fort Mill and Rock Hill, Palmetto Pediatrics and Rock Hill Pediatrics. Those are the ones that you personally called and were told those things?

A. I called Medical Associates of Fort Mill and Medical Associates of Rock Hill.

Q. And who called Shiland and Palmetto Pediatrics and Rock Hill Pediatrics?

A. An individual at Piedmont.

(Levitt Dep. 83:11-84:23.)

Levitt did not identify with whom he and the Piedmont employee spoke when inquiring into these alleged practices:

Q. Mr. Levitt, before we get into the adverse impact criteria, I just wanted to ask you a few follow-up questions from this morning. In terms of the survey that you -- that was performed on the CHS physicians in York County, how did you go about doing that? I mean, how did you make that call?

A. The calls I made, I called and asked if they were accepting new patients, asked if they accepted new patients if they were covered under Medicare. I asked if they accepted new patients if they were covered under Medicaid.

Q. And did you identify who you were?

A. No. They never asked. And that was usually the first question, "I would like to make an appointment, and are you accepting new patients?" "Yes. What's your insurance?" Both practices that was the first question they asked me, what was my insurance.

Q. And when you say both practices, were those --

A. Carolinas Family Care in Fort Mill and RockHill were the two I called.

Q. Was it the pediatric?

A. No. I didn't call the pediatric.

Q. Would this have been Medical Associates of Fort Mill in Rock Hill?

A. Yes, that's who I called.

Q. So you had called and just said, "I want to schedule an appointment," and then they asked for your details. And when you gave your details --

A. We didn't even get that far. They asked what my insurance was, and I said, "Well, if it was Medicaid, could I make an appointment?" And they said, "No, we're not taking any new Medicaid patients." I said, "Well, if it was Medicare, could I make an appointment?" "No. We're not taking any new medicare patients." . . .

Q. Was that pretty much the same way that the other surveyors would ask questions of the practice?

A. Yes.

Q. Did you keep any notes from those interviews or surveys?

A. No.

Q. I mean, how was this reduced and how would you remember it if you didn't take notes?

A. We summarized it. Certainly for me, I remember, you know, what I did. And for the individual that made the rest of the calls, that's what she reported.

(Levitt Dep. 100:1-101:15, 102:1-12.) Levitt admitted that his opinion that other CHS practices did not accept Medicare and Medicaid patients was "sort of the fear" based on the calls to those four CHS practices alone. (Levitt Dep. 84:24-85:9.)

III. ARGUMENT AND CITATION OF AUTHORITY

A. Walsh's expert testimony regarding traffic issues relating to the proposed location of the CHS hospital site should be excluded because such testimony is not reliable under Rule 702, SCRE.

The testimony of Walsh regarding traffic issues related to the proposed location of the CHS hospital should be excluded under Rule 702 of the South Carolina Rules of Evidence because it is not reliable. Rule 702, SCRE, provides that if "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." In determining whether to admit expert testimony under Rule 702, SCRE, the Court must first make three inquiries: (1) whether "the subject matter is beyond the ordinary knowledge of the jury, thus requiring an expert to explain the matter to the jury;" (2) whether the expert has "acquired the requisite knowledge and skill to qualify as an expert in the particular subject matter;" and (3) whether the substance of the testimony is reliable. *Watson v. Ford Motor Co.*, 389 S.C. 434, 446, 699 S.E.2d 169, 175 (2010). Expert testimony is not admissible unless it satisfies all three requirements listed above. *Id.* The final requirement of reliability is the central feature of the inquiry. *State v. White*, 382 S.C. 265, 270, 676 S.E.2d 684, 686 (2009). Prior to admitting expert testimony, the trial court must fulfill the "affirmative and meaningful" gatekeeping duty of assessing the reliability of the expert testimony. *Id.*

Walsh's conclusory opinions about traffic concerns arising from the CHS proposed site should be excluded because they have no indicia of reliability. With regards to his first opinion that the site's entrances are too close to I-77, Walsh admittedly does not know where the entrances to the proposed location will be. He has never reviewed the site plan for the proposed CHS hospital and does not know where the entrances to the site will be, which necessarily precludes him from knowing whether the entrances are too close to I-77. These are fundamental facts that Walsh must know before he can reliably opine on any traffic issues related to the site. Moreover, Walsh did not conduct a traffic count study or traffic impact analysis in concluding that the CHS site's proximity to I-77 will create traffic safety and congestion issues. Rather, Walsh admitted that Sutton Road, where the CHS site will be located, "doesn't carry a significant amount of traffic," which is at odds with his testimony that the proposed site will cause traffic safety and congestion issues. In sum, there is no evidence indicating that Walsh's opinions regarding the proximity of the site to I-77 and any potential traffic safety and congestion issues arising therefrom are reliable, and therefore, they should not be admitted. *See Watson*, 389 S.C. at 452, 699 S.E.2d at 178 (ruling that trial court erred in admitting expert testimony where there was no evidence that it was reliable).

Similarly, Walsh's opinions regarding the proximity of the CHS site to the Love's Plaza truck stop and traffic issues arising from truck traffic are not reliable. He admittedly has been to the proposed site only twice for general site visits that each lasted only between fifteen and twenty minutes, approximately. While at the site on these two short visits, Walsh did not solely observe and evaluate truck traffic but also looked at general road conditions and the engineering aspects of the intersections. He did not take

photographs or notes, collect any data about truck traffic, or do anything that could quantify the amount of truck traffic. In fact, when asked to quantify the amount of traffic, Walsh offered no more precision than that it was "higher than average," without explaining what constitutes "average" truck traffic or how he determined this estimate. Instead, he offers only a lay – rather than an expert – opinion by claiming that "anybody could observe that it's a higher than normal truck traffic on a particular intersection or roadway." Without some data on which to base his opinions, Walsh's testimony is *per se* unreliable, speculative, and inadmissible. *See Elbert v. Bexley Planning Comm.*, 108 Ohio App. 3d 59, 75, 670 N.E.2d 245, 255 (1995) (declaring that expert's testimony on traffic impact was unreliable and inadmissible because expert did not collect local data on which to base his opinions) (attached).

It is clear that Walsh's opinions regarding the traffic issues relating to the proposed CHS site fail to meet the central reliability requirement under Rule 702, SCRE. The reliability standard should require, at minimum, that Walsh have a basic familiarity with the proposed site's entrances before he can conclude that they are too close to I-77. Likewise, Walsh should be required to base his opinions on actual, quantifiable data of the amount of truck traffic before he can reliably opine that a nearby truck stop will create issues of traffic safety and congestion. He fails on both fronts, and his opinions are consequently unreliable. Therefore, the Court should exclude any testimony from Walsh about traffic issues related to the CHS site.

B. The testimony of Drs. Singhi and Taylor relating to CHS's referral practices and acceptance of Medicaid patients should be excluded because it is based on inadmissible hearsay.

As explained above, Piedmont witnesses Drs. Singhi and Taylor are expected to testify regarding the referral practices of CHS physicians and CHS's policy of accepting Medicaid patients, respectively. Dr. Singhi's testimony is not based on personal knowledge but rather on what unidentified physicians, patients, and patients' families have allegedly told him. Dr. Taylor's testimony also is not based on first-hand knowledge of CHS's policy or practices but on the statements of unidentified patients.

Clearly, this testimony is inadmissible hearsay under Rules 801 and 802, SCRE. This testimony is offered for the truth of the matter asserted, which is that CHS maintains certain policies or practices regarding referrals and the acceptance of Medicaid patients. Such statements regarding a business's policies or practices are inadmissible hearsay. *See, e.g., Wright v. Bi-Lo, Inc.*, 314 S.C. 152, 159, 442 S.E.2d 186, 190-91 (Ct.App. 1985) (concluding that statements made by defendant's employee relating to his understanding of the defendant's policy was inadmissible hearsay); *Greensboro Prof. Fire Fighters Ass'n v. City of Greensboro*, 64 F.3d 962, 967 (4th Cir. 1995) (ruling that unattributed rumors regarding an employer's alleged practice of discriminating against union activity was inadmissible hearsay). Accordingly, Drs. Singhi's and Taylor's testimony regarding CHS's policies and practices regarding referrals and acceptance of Medicaid patients should be excluded from the contested case.[1]

[1] To the extent that Piedmont argues that the statements made by unidentified CHS physicians regarding CHS's alleged referral policy are not hearsay because they are an admission of party-opponents under Rule 801(d)(2), that argument fails because it is impossible to determine whether such unidentified physicians had authority to make such statements on behalf of CHS. *See Orta-Castro v. Merck, Sharp & Dohme Quimica P.R., Inc.*, 447 F.3d 105, 114 (1st Cir. 2006) (stating that alleged statement by unidentified human resources employee of defendant was not admissible as an admission of a party-opponent because there was no evidence in the record that the employee had authority to make the alleged statement).

C. The expert testimony of Sullivan and Levitt regarding CHS's referral practices and acceptance of Medicaid and Medicare patients should be excluded because it is based on unreliable hearsay evidence.

Piedmont's expert witnesses, Sullivan and Levitt, are expected to testify about their opinions regarding whether Piedmont's CON application or CHS's CON application most fully complies with the South Carolina CON Act. Sullivan's opinions include conclusions relating to the outmigration of patients from York County and CHS's referral practices. His opinions are based on hearsay reports from Piedmont doctors which are, in turn, based on hearsay from unidentified CHS physicians. Levitt's opinions include conclusory assertions that CHS physician practices do not accept Medicaid and Medicare patients based on an informal, unscientific survey that gathered responses from unidentified employees of only four of CHS's physician practices. Sullivan's and Levitt's opinions based on statements from unidentified individuals should be excluded because such statements are unreliable hearsay evidence.

Rule 703, SCRE, permits an expert giving an opinion to rely on facts and data that are not admitted into evidence or even admissible into evidence. It, however, "does not allow for an unqualified admission of hearsay evidence merely because an expert has used it in forming an opinion." *Wright v. Hiester Const. Co., Inc.*, 389 S.C. 504, 523, 698 S.E.2d 822, 833 (Ct.App. 2010). Rule 703 does not "make hearsay automatically admissible simply because it was relied upon by the expert." *State v. Kromah*, 737 S.E.2d 490 at *28 (2013) (attached); *see also Allegro, Inc. v. Scully*, 400 S.C. 33, 48, 733 S.E.2d 114, 122 (Ct.App. 2012) (admission of expert report which contained many instances of hearsay was in error).

Moreover, for an expert to base his opinion on inadmissible hearsay, the hearsay must be of "the type reasonably relied upon by other experts in the field." *State v. Franklin*, 318 S.C. 47, 57, 456 S.E.2d 357, 363 (1995). In assessing the reliability of the data and facts relied on by an expert,

> the court may not abdicate its independent responsibilities to decide if the bases meet minimum standards of reliability as a condition of admissibility. *See* Fed. R. Ev. 104(a). If the underlying data are so lacking in probative force and reliability that no reasonable expert could base an opinion on them, an opinion which rests entirely upon them must be excluded.

In re Paoli RR Yard PCB Litig., 35 F.3d 717, 748 (3rd Cir. 1995) (quoting *In re "Agent Orange" Prod. Liab. Litig.*, 611 F.Supp. 1223, 1245 (E.D.N.Y. 1985)).[2]

In this case, Sullivan's and Levitt's opinions, which are based on superficial information gathered from hearsay, should be excluded regardless of Rule 703. Sullivan admitted that the information he relied on regarding CHS's referral practices was "double hearsay" that he received during a discussion with only eleven Piedmont doctors. Importantly, Sullivan does not claim that he reviewed any written CHS policies or interviewed any CHS physicians or executives. Moreover, it does not appear that Sullivan ever attempted to verify the information that he uses to conclude that CHS's referral practices contributed to the outmigration of patients from York County. And even assuming that the information that he received from these second-hand reports is accurate, Sullivan cannot reasonably use this anecdotal information to quantify the effect of the alleged referral practices of CHS physicians and conclude that such practices have a causal relationship to the outmigration of patients. In sum, Sullivan's opinions

[2] Although these cases interpret Rule 703 of the Federal Rules of Evidence, South Carolina courts will utilize federal caselaw in interpreting Rule 703, SCRE. *See, e.g., State v. Slocumb*, 336 S.C. 619, 629, 521 S.E.2d 507, 512 (Ct.App. 1999) (applying federal caselaw to interpret Rules 703 and 705, SCRE).

regarding CHS's referral practices and any relationship between such practices and the outmigration of patients are speculative, unreliable, and based on hearsay. Therefore, they should be excluded from evidence. *See Jamison v. Morris*, 385 S.C. 215, 228, 684 S.E.2d 168, 175 (2009) (ruling that trial court erred in admitting an expert opinion based on unreliable evidence).

Like Sullivan's opinions on CHS's referral practices, Levitt's opinions regarding CHS's alleged practice of not accepting Medicaid and Medicare patients are based on superficial, unreliable hearsay. Levitt's opinions derive from an unscientific survey in which he and a Piedmont employee called only four CHS physician practices. The survey consisted of Levitt and the Piedmont employee calling the practices, deceptively pretending to be patients, and attempting to set up appointments. Levitt does not appear to have taken the names of the employees with whom they spoke or determined whether the individuals were knowledgeable or authorized to speak on any CHS practices or policies. Levitt and the other Piedmont employee did not keep notes of what they or the CHS employees said. Nor does it appear that they recorded the phone calls or did anything to verify that they actually made the calls. Nevertheless, from these mere four phone calls, Levitt concludes that CHS has a system-wide practice or policy of refusing Medicaid and Medicare patients. Yet when pressed during his deposition about this conclusion and whether other CHS practices also had a practice of denying Medicaid and Medicare patients, Levitt admitted "that's sort of the fear." (Levitt Dep. 84:24-85:9.)

Clearly, this opinion is speculative and unreliable. Notwithstanding the lack of evidence that Levitt is qualified to develop surveys on which to base his opinions, he cannot reasonably rely on undocumented statements of four unidentified employees to

conclude that CHS has a system-wide practice of not accepting Medicaid and Medicare patients. The unsubstantiated, uncorroborated hearsay statements on which Levitt relies are in no way reliable and cannot serve as the basis of an expert opinion under Rules 702 and 703, SCRE. Accordingly, the Court should exclude such hearsay statements and the opinions based on them.

D. CHS reserves the right to seek the disqualification of Levitt as an expert witness based on a conflict of interest arising from his previous relationship with Roper Hospital, which is owned and managed by CHS.

Courts have the inherent authority to disqualify experts where the expert has a prior confidential relationship with an adversary. *Koch Refining Co. v. Jennifer L. Boudreaux MV*, 85 F.3d 1178, 1181-82 (5th Cir. 1996). A confidential relationship justifying disqualification of an expert will exist where there is a "series of interactions, which have more likely than not coalesced to create a basic understanding of [the retaining party's] modus operandi, patterns of operations, decision-making process, and the like." *Marvin Lumber Co. v. Norton*, 113 F.R.D. 588, 591 (D.Minn. 1986) (attached). For example, in *Marvin Lumber Co.*, the court struck the testimony of the expert for the defendant based on the expert's prior work for the plaintiff that was "substantially related" to the pending litigation. *See also U.S. v. NHC Health Care Corp.*, 150 F.Supp.2d 1013, 1016 (W.D.Mo. 2001) (disqualifying defendant's expert witness based on her involvement in prior investigation for plaintiff).

In this case, Levitt's prior involvement in the CON case on behalf of Roper Hospital creates a potential conflict of interest that may warrant his disqualification as an expert. As explained above, CHS owns and manages Roper Hospital. Roper Hospital engaged Levitt to serve as an expert for its CON application for a new facility in

Berkeley County. Levitt has testified that he is comparing information related to the Roper-Berkeley CON application to CHS's pending Fort Mill CON application to discredit CHS's application. To the extent that Levitt is using confidential information obtained from his previous experience with Roper Hospital to testify against and prejudice CHS, he should be disqualified as an expert. CHS reserves the right to cross-examine Levitt regarding his prior relationship with Roper Hospital during the course of this hearing and to move to disqualify him as an expert at the appropriate time.

V. CONCLUSION

For the forgoing reasons, CHS requests that the Court exclude the evidence and testimony discussed above.

Respectfully submitted,

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April 1, 2013
Charleston, SC

Robert L. Walsh
Deposition Excerpts

STATE OF SOUTH CAROLINA

ADMINISTRATIVE LAW COURT

PRESBYTERIAN HOSPITAL-YORK, LLC AND AMISUB OF SOUTH CAROLINA, INC., D/B/A PIEDMONT MEDICAL CENTER D/B/A FORT MILL MEDICAL CENTER,

Petitioner(s),

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

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL AND THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY D/B/A CAROLINAS MEDICAL CENTER - FORT MILL,

Respondent(s).

D E P O S I T I O N

WITNESS: ROBERT L. WALSH, P.E.

DATE: Wednesday, January 30, 2013

TIME: 10:00 a.m.

LOCATION: Nelson, Mullins, Riley & Scarborough, LLP
1331 Main Street, 17th Floor
Columbia, South Carolina

TAKEN BY: Attorneys for the Petitioners

REPORTED BY: SHERI L. BYERS
Registered Professional Reporter

- -

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in a case involving the Laurel Glen or Larne Glen?

A. Larne, L-a-r-n-e, is the name of the development, Glen.

Q. Do you remember the case name?

A. I think it was the two companies involved, Adnah Hills, Incorporated, versus Barfield Grading or it may have been versus Alan Barfield.

Q. Is that the only case that you've served as an expert in?

A. I don't -- I provided some witnessing in another case between Adnah Hills, Incorporated, and one of the builders onsite. I don't recall if I was introduced as an expert witness in that case. I may have just provided testimony.

Q. Were you a fact witness?

A. I would have been a fact witness, yes.

Q. So that's the only case?

A. Those were two separate cases, yeah.

Q. Yeah, but those two are the only ones?

A. Yes.

Q. Okay. Earlier we spoke about your opinions with regards to the Carolinas site on Sutton Road. Can you restate what your opinion is regarding that site.

A. Well, first of all, the entrance at Love's Plaza by design requirements is too close to the

interstate, and there's a number of reasons for that from a safety perspective and the congestion management perspective.

Q. The existing road into Love's Plaza?

A. The existing road into Love's Plaza as well as the proposed entrance on the south side. Now, I haven't seen a site plan for the hospital, so I don't know where its proposed entrances really are. I know that that's been an issue that that particular entrance has been discussed time and again, so ...

Q. What have you reviewed with regards to the Carolina site on Sutton Road?

A. I'm sorry, restate the question, please.

Q. What have you reviewed with regards to the Carolinas site on Sutton Road?

A. Well, most recently just the documents that Nelson Mullins has provided.

Q. What documents were those?

A. Some of the information, these documents here that were shown to me earlier, and there's probably a few more I think that were all provided before this deposition.

Q. Have you been out to --

A. There's a letter from the DOT. There is a traffic impact study. Well, that's not relative to

MR. GASKINS: That's all I have.

MR. WESTBROOK: I've actually got a couple of questions just to follow up on some questions that both of these folks asked you, Mr. Walsh.

EXAMINATION

BY MR. WESTBROOK:

Q. With respect to your opinions as to the CHS site, I think I understood you to say that you have some concerns about the CHS site's -- let me just clarify. When I say "CHS site," I'm talking about the proposed site of CMC-Fort Mill there on Sutton Road across from Love's truck stop. So when I say "CHS site," that's what I'm talking about.

I think you expressed that you had some concerns about that site's proximity to the interstate; is that correct?

A. Yes.

Q. All right.

A. And specifically the access point across from Love's Plaza.

Q. All right. Well, do you also have any -- do you have any opinions, any concerns about the proximity of that site not only to the interstate but actually to the truck stop itself and the trucks coming in and out of the truck stop?

Q. Okay. What other than the access points do you have an opinion about?

A. I guess I don't have another opinion, any other opinions.

Q. Earlier with Ms. Kirk you reviewed the travel time studies and the maps. I call them maps. I don't know if that's the proper term.

A. Yeah.

Q. How was the data collected to draw these maps and determine the estimated travel times?

A. We placed a GPS unit in a car and had a driver with specific routes to travel between Piedmont Medical Center and the proposed site, the proposed Fort Mill Medical Center site. And this GPS unit will track and record the location of the vehicle and specific time increments. Like rapidly between, say, 15 to 20 seconds. So the data you've got there shows the location of the vehicle every 15 seconds on its trip from one place to another.

So what we did with that data is once we recorded that data on a trip, say, from Piedmont Medical Center, the existing Piedmont site using Herlong Avenue to each one of those identifies the route that was followed.

Q. How did you identify which routes would be

interstate, and there's a number of reasons for that from a safety perspective and the congestion management perspective.

Q. The existing road into Love's Plaza?

A. The existing road into Love's Plaza as well as the proposed entrance on the south side. Now, I haven't seen a site plan for the hospital, so I don't know where its proposed entrances really are. I know that that's been an issue that that particular entrance has been discussed time and again, so ...

Q. What have you reviewed with regards to the Carolina site on Sutton Road?

A. I'm sorry, restate the question, please.

Q. What have you reviewed with regards to the Carolinas site on Sutton Road?

A. Well, most recently just the documents that Nelson Mullins has provided.

Q. What documents were those?

A. Some of the information, these documents here that were shown to me earlier, and there's probably a few more I think that were all provided before this deposition.

Q. Have you been out to --

A. There's a letter from the DOT. There is a traffic impact study. Well, that's not relative to

this site, it is relative to the site on the other side of the interstate. And some of these court documents, I believe is what these are is court documents.

Q. Have you been to the proposed Carolinas site?

A. Yes.

Q. And when did you go there?

A. I've been there within the past few months to get some personal observations of the truck traffic and the entrance locations. I have also reviewed it through Internet sources like Google Earth.

Q. Do you remember how recent that Google Earth photo had been updated?

A. I think it was posted 2013.

Q. Did you take any photographs when you were onsite?

A. No.

Q. You said you reviewed a letter from the DOT; is that correct?

A. Yes.

Q. And do your opinions differ in any way from those provided by DOT?

A. I'd have to review the letter again and really give you a specific answer on that.

Q. Right now do you recall any disagreements you had?

MR. WESTBROOK: Object to the form. Go ahead and answer.

THE WITNESS: Okay. The letter from the DOT identified the entrance. And it was -- the letter was in regards to the Kanawha site, not to the hospital itself. So it was just -- the letter identifies discussions about three different access locations.

And as I said previously, the access point directly across from Love's Plaza was identified as a location that they would never signalize and that would need to be treated as a minor entrance into the Kanawha site, meaning the major entrances into the full package in that full development area would have to be further to the west.

BY MR. GASKINS:

Q. Is your opinion relating to the Carolinas site limited to the access points?

A. No. I would say no.

Q. Okay. Well, what other opinions do you have regarding the site?

A. I mean, the access is a big issue in my opinion. The Sutton Road itself and the first entrance there at Love's Plaza is too close to the interstate.

Q. But that would be access point, right?

A. That is access point.

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A. I'd have to review the letter again and really give you a specific answer on that.

Q. Right now do you recall any disagreements you had?

A. Yes. Because of the proximity of that access point and the fact that there's a lot of truck traffic coming in and out of Love's Plaza, that adds to the issue.

MR. WESTBROOK: Okay. Thank you. I don't have any other questions.

MS. KIRK: I don't have anything.

MR. GASKINS: I just have a couple more.

REEXAMINATION

BY MR. GASKINS:

Q. Regarding your concerns about the proximity to the truck stop, did you collect any data about the truck traffic in and out of Love's?

A. We did not record any traffic counts or collect any data of that sort. It's just strictly from visual observations.

Q. And how long were you on the site to make these visual observations?

A. I've been there on at least two occasions for 15 to 20 minutes.

Q. 15 to 25 minutes. And during those two times for 15 to 20 minutes, were you only monitoring the truck traffic?

A. No. I was observing not only the truck traffic but that was a predominant -- the predominant

traffic was the stream of trucks coming in and out of Love's. Sutton Road itself doesn't carry a significant amount of traffic at this time.

Q. Did you take any notes to record your observations about the truck traffic?

A. No. I was also looking at the pavement conditions, various aspects of the roadways itself and the intersections.

Q. So you were doing other things than just watching the trucks coming in out and out of Love's?

A. Well, yeah, it was a general site visit.

MR. WESTBROOK: Let me get my objection in, then you can answer.

Object to the form.

Now go ahead.

THE WITNESS: Okay. Yes. We evaluated -- or I evaluated not only the truck traffic but, you know, taking a look at the pavement and the intersection geometries and other engineering aspects of the intersections.

BY MR. GASKINS:

Q. And how did you evaluate the truck traffic? Earlier you said there was a lot of truck traffic. That's a pretty unscientific term. How do you quantify a lot?

A. Yes. Because of the proximity of that access point and the fact that there's a lot of truck traffic coming in and out of Love's Plaza, that adds to the issue.

MR. WESTBROOK: Okay. Thank you. I don't have any other questions.

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BY MR. GASKINS:

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MR. WESTBROOK: Object to the form.

THE WITNESS: Higher than average.

MR. WESTBROOK: Excuse me. Object to the form.

Go ahead.

THE WITNESS: I think anybody could observe that it's a higher than normal truck traffic on a particular intersection or roadway.

BY MR. GASKINS:

Q. So a truck stop has more truck traffic than a regular intersection?

A. Correct.

MR. GASKINS: Okay. That's all I have.

MS. KIRK: I don't have anything.

MR. WESTBROOK: Nothing further.

(The deposition concluded at 11:02 a.m.)

Sushil K. Singhi
Deposition Excerpts

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT
Docket No. 11-ALJ-07-0575-CC

AMISUB OF SOUTH CAROLINA, INC. d/b/a PIEDMONT MEDICAL CENTER d/b/a FORT MILL MEDICAL CENTER,

Petitioners,

vs.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL AND THE CHARLOTTE MECKLENBURG HOSPITAL AUTHORITY, d/b/a CAROLINAS MEDICAL CENTER - FORT MILL,

Respondents.

DEPOSITION OF: SUSHIL K. SINGHI, M.D.

DATE: March 15, 2013

TIME: 8:01 a.m.

LOCATION: Piedmont Medical Center
222 South Herlong Avenue
Rock Hill, South Carolina

TAKEN BY: Counsel for the Respondents

REPORTED BY: ANGELA D. ZUVER,
Court Reporter

understanding of that, what their contractual agreement is between their physician network of Piedmont and Piedmont Hospital.

Q. Do they refer patients to you, those primary care physicians who are in that network?

A. They do.

Q. And is there a cardiologist in that network?

A. No.

Q. Do they refer exclusively to you, as far as you know?

A. No. As I mentioned earlier, no. There are four groups here.

Q. When you said earlier that patients are asked or forced to go to Charlotte based hospitals what did you mean by forced to go?

A. Primary care physicians don't give any choices to the patient but one system.

Q. How do you know that?

A. It's been -- I've been told by physicians, primary care physicians, as well as the patient or the patient's family.

Q. And which primary care physicians have told you that?

A. That's also -- I will not mention it

understanding of that, what their contractual agreement is between their physician network of Piedmont and Piedmont Hospital.

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A. It's been -- I've been told by physicians, primary care physicians, as well as the patient or the patient's family.

Q. And which primary care physicians have told you that?

A. That's also -- I will not mention it

right now because that's my livelihood and I don't want to breach anything, my relationship with the primary care physicians, which I have for the last 20 years.

Q. But these are ones that you say --

A. They are owned by CHS. And you figure out how many practices they own.

Q. Well, I think you told me earlier that you're not getting any referrals from CHS. So how would that impact your referrals?

A. I'm talking about any new referrals, not getting back from them.

Q. So in the past you've not been getting any referrals, but you expect you will get referrals from CHS physicians in the future, Carolinas physicians in the future?

A. I don't know. I hope I get it one day.

Q. But these undisclosed physicians have told you that they are forced to send their patients?

A. Yes.

Q. And you are unwilling to tell us who those physicians are?

A. At this time, yes.

Q. How about patients -- which of your

patients have told you they have been forced to go to a Charlotte area hospital?

A. I don't want to disclose that.

Q. How many patients have told you that?

A. Again, the quantity, I cannot tell you that, but I have heard over and over from patients and families.

Q. Would it be your policy that a patient's right to choose would be an overriding interest?

A. Yes.

Q. So if one of your patients told you, I don't want to be treated at Piedmont Medical Center, I want to be treated at CMC-Pineville, what would you tell them?

A. Go to CMC-Pineville.

Q. And would you then --

A. And I'd find a physician whom I know and whom I can trust, a qualified physician. Yes, I would help them.

Q. Who would you refer that patient to?

A. It depends on what problem they have.

Q. Well, if they see you, you're seeing them for a cardiology problem?

A. Right. They also see me for pre-op

A. It is Charlotte. I don't know, again, the details, but it is annexed by the Charlotte city.

Q. On the next page sort of in the middle of that paragraph you say: I personally trained at the University of Pittsburgh and compare the treatment I offer my patients here in York County to that of Pittsburgh. The outcome is essentially the same.

In other words, do you believe that the quality of care offered at Piedmont Medical Center is the same as would be offered at the University of Pittsburgh?

A. Yes.

Q. The paragraph right below that on page two of Exhibit 4 states: There are several medical practices in York County that are owned by Charlotte, North Carolina hospitals that patients are directed to go to Charlotte for their medical needs. This has impacted negatively on our hospital. It has also hampered the continuity of patient care and has been very inconvenient for patients and their families.

How did you know that it had been inconvenient for the patients and their families?

A. Because of our firsthand experience from hearing from patients and patients' families. We get phone calls.

Q. And these are patients that are seeing you?

A. Yes.

Q. And what have they said?

A. They said, we've been asked to go to across the state line by our primary care physicians.

Q. For what type of care?

A. I'm in cardiac care so I know about the cardiac care.

Q. So if they're patients seeing you why are they -- in other words, are they being directed by their primary care physicians not to see you, but to see someone else?

A. Not necessarily that they mentioned that they don't see me, but they are referring to other hospitals in Charlotte.

Q. If your patient is talking to you, why would they be talking about going to North Carolina facilities? I'm not following that. Why would your patient be talking about going to a North Carolina facility?

R. Norman Taylor, M.D.
Deposition Excerpts

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,	:	CIVIL ACTION NO. 11-ALJ-07-0575-CC
Petitioners,	:	
vs.	:	
SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL AND THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY d/b/a CAROLINAS MEDICAL CENTER-FORT MILL,	:	
Respondents.	:	

- - -

Thursday, March 14, 2013

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ORAL DEPOSITION OF R. NORMAN TAYLOR, M.D., taken at Piedmont Medical Center, 222 South Herlong Avenue, Rock Hill, South Carolina, commencing at 3:00 p.m., before Tami I. Watters, a Federally Approved Registered Professional Reporter and Notary Public.

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EXAMINATION

- - -

BY MR. ANDREWS:

Q Dr. Taylor, just for a moment, let me refer you back to the notes that Mr. Levitt took that Mr. Muller asked you about, and turn to in Exhibit 4 the page -- bottom of the page 38875, if you would.

Now -- and if you'll look at that second series of notes -- are you with me? It says, "CMC OB/GYN won't take Medicaid patients."

A Right.

Q What's been your experience concerning that issue?

A Well, I mean, that was our experience is when patients went from private payers to Medicaid, they were dropped and they would come to us and look for care.

And, like I said, sometimes we could take them and we tried to accommodate them and sometimes we would send them to North Central Family Medical Clinic.

But we always did our share -- we always had generous spots for Medicaid patients because we

lose that status if we were unable to maintain an adequate volume to pay for a neonatologist.

Q Next bullet point states, "CMC OB/GYN won't take Medicaid patients."

Do you know what that was referring to?

A Well, we have always had patients that have returned to us -- and this -- and have returned to us and could not obtain care when their insurance changed, and that's been age old and -- it's just been age old.

So we have -- as a group, we felt it has been important to take our share of Medicaid patients, and we take a good share of them. And then we also care for Medicaid through a clinic that we back up on Saluda Street here locally.

But, anyway, that's been something that we've seen over the years, and that's been pretty consistent.

Q And I take it the bullet point below is -- it says, "Piedmont GYN/OB. They treated patients that were being dropped by CMC."

I guess what you mean --

A Well, they would change insurances and end up coming to us and say they can't get care from other OB/GYNs because they weren't taking

Daniel J. Sullivan
Deposition Excerpts

STATE OF SOUTH CAROLINA

ADMINISTRATIVE LAW COURT

PRESBYTERIAN HOSPITAL-YORK, LLC AND AMISUB OF SOUTH CAROLINA, INC., D/B/A PIEDMONT MEDICAL CENTER D/B/A FORT MILL MEDICAL CENTER,

Petitioner(s),

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

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL AND THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY D/B/A CAROLINAS MEDICAL CENTER - FORT MILL,

Respondent(s).

D E P O S I T I O N

WITNESS: DANIEL J. SULLIVAN

DATE: Friday, February 8, 2013

TIME: 10:00 a.m.

LOCATION: Nelson, Mullins, Riley & Scarborough, LLP
1331 Main Street, 17th Floor
Columbia, South Carolina

TAKEN BY: Attorneys for the Respondent

REPORTED BY: SHERI L. BYERS
Registered Professional Reporter

- -

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A. Again, I can't be in the minds of the people at Carolinas Health System. I mean, all I can say is what I observed happening. And what I observed happening was that they acquired a number of practices and it resulted in a significant out-migration of patients from the county.

Q. But that would be what is expected, I assume. I mean, if they have hospitals in North Carolina and they have physician practices in South Carolina immediately adjacent to where their hospitals are in North Carolina, you would expect that those referrals would go to their hospitals?

MR. MULLER: Object to the form.

THE WITNESS: I wouldn't necessarily expect that. I mean, I would expect that they would want to encourage patients to go there. But if it was in the patient's interest to stay in a local hospital either because of travel difficulties or insurance considerations or whatever, I would hope that the doctors would make the decision to send them to the most appropriate locations.

BY MR. MULLER:

Q. And do you have any information to indicate that that did not occur?

A. From discussions I had with some of the

doctors at Piedmont Medical Center, what they told me was that didn't occur, that the doctors who were acquired by CHS were pretty strongly directed to send those patients out of town.

Q. Can you just tell me who those doctors were that you spoke to.

A. Yeah. So I can test my memory -- when I was talking to them -- these are the letters of support that they wrote, so I just kind of circled their names --

Q. Okay.

A. -- when I was doing that, so I just -- this is sort of a cheat sheet for me.

Dr. Adlakha, A-d-l-a-k-h-a. He's a pulmonary medicine doctor. Dr. Michael Cowan, C-o-w-a-n, who's a neurosurgeon. Dr. Jeffrey Gilleland, G-i-l-l-e-l-a-n-d, who is a radiologist. Dr. Harry Hicklin, H-i-c-k-l-i-n, who's a cardiologist. Dr. Robert McClelland, M-c-C-l-e-l-l-a-n-d. And I don't recall -- oh, he's an obstetrical doctor. Dr. Vasant Patel, V-a-s-a-n-t, Patel, P-a-t-e-l, who's a cardiologist.

Dr. Joe Robinson, who is an OB/GYN. Dr. Pradeep, P-r-a-d-e-e-p, Singh, S-i-n-g-h, who's a cardiologist. Dr. -- I might not pronounce this

correctly -- but Taomina, T-a-o-m-i-n-a, who's a vascular surgeon. Dr. Norman Taylor, he's an OB/GYN. Dr. Robert Thomas, who I believe is a pathologist.

I think those are the doctors that I spoke with.

Q. And when you spoke to them, did you meet with them together in a room? Did you call them on the phone? How did you make that contact?

A. I went to Rock Hill. A couple of cases where doctors were in the same group, like two of the cardiologists were in the same group and two of the OB/GYNs were in the same group, I met with them together. The other guys, I met with individually. It wasn't just me. David Levitt was there and for a portion of the time Mr. Andrews was there.

Q. And who had arranged these meetings?

A. The hospital. Bill Masterton.

Q. So in other words, Mr. Masterton, who is the CEO of Piedmont Medical Center, called up these doctors and said they need to meet with you and David Levitt?

A. Right.

MR. WESTBROOK: Object to the form.

BY MR. MULLER:

Q. And Mr. Andrews?

MR. WESTBROOK: Object to the form.

THE WITNESS: I don't think he said, "You have to." I mean, he requested that they come in and interview with us.

BY MR. MULLER:

Q. And these doctors are attending physicians at Piedmont Medical Center?

A. I guess with the exception of the pathologist and the radiologist. I mean, the other ones would be attending physicians.

Q. Was the radiologist with Rock Hill Radiology?

A. I believe that's correct, yes.

Q. Is that -- I mean, is that correct? You mentioned Dr. Jeffrey Gilleland. Is he with Rock Hill Radiology?

A. Yeah, he is. I just confirmed that.

Q. On their Web site, they list their hospital affiliations as only Piedmont Medical Center. Are you aware of that?

A. I wasn't, but that doesn't surprise me. It's the only hospital in the county. They're located there, so ...

Q. Dr. Norman Taylor was the OB/GYN department chair at Piedmont Medical Center and served as chief of staff at Piedmont Medical Center.

A. Correct.

Q. And he lists himself as attending physician at Piedmont Medical Center, courtesy staff at Carolinas Medical Center Pineville?

A. I think that's sounds consistent with what he told me.

Q. Dr. Robinson served as chief of staff at Piedmont Medical Center.

A. Correct.

Q. And these individuals, for example, Dr. Taylor and Dr. Robinson, both have offices immediately adjacent to Piedmont Medical Center as well as offices at the same exit that Fort Mill Medical Center is going to be sited?

A. Again, that's consistent with my recollection of the conversation.

Q. And what were the Fort Mill -- I'm sorry, the cardiologists that you mentioned, were they with Carolina Cardiology Associates?

A. They were.

Q. And, again, the Carolina Cardiology Associates has an office on -- appears to be on the Piedmont Medical Center campus as well as an office on the same approximate location as the Fort Mill Medical Center that Piedmont is planning to build?

A. Again, that sounds correct.

Q. Where did you meet them, at their Piedmont-Medical-Center-located office?

A. No. They came to administration at the Piedmont Medical Center.

Q. Dr. Thomas has an office immediately adjacent to Piedmont Medical Center, correct?

A. That's correct. As a pathologist, I think he would need to.

Q. Dr. Hicklin is director of the cardiopulmonary rehabilitation department at Piedmont Medical Center?

A. I think you're correct, yes.

Q. And his office is relatively close to Piedmont Medical Center, 430 South Herlong Avenue?

A. Yeah. That would not be far.

Q. Were any of these physicians associated with the PMC physician network?

A. That, I did not ask them. I don't know.

Q. But I take it that the impression that you got from speaking with these physicians was that they felt that physicians with a Carolinas physician network were referring patients to their hospital -- their hospitals instead of referring them to Piedmont Medical Center?

A. Yeah. And probably one more level, as well.

And that is that, for example, the primary care physicians who used to refer to some of the specialists I talked to, the pulmonologists and the cardiologists and so forth, had stopped referring to local specialists and were sending them to either Carolinas-affiliated specialists in the county or outside the county. And so that sort of the referral stream from doctors who they had had long-standing relationships with had dried up pretty quickly after their practices were purchased.

Q. And what evidence did they have that these doctors were -- I think you used the words "strongly encouraging" patients not to go to these physicians?

A. Yes. I think it was from personal conversations they had with these doctors. And this is not a large community, and I think a lot of these guys are pretty friendly. In fact, one guy said he used to play golf regularly with one of the doctors who was a major referral source. And he said, "I just can't refer to you anymore, I'm sorry."

And so -- and what I understood is that the -- this is all recounted to me by the doctors, that the office managers in these practices were very carefully tracking referrals from physicians to other specialists and that if they were going outside of the

CHS network, then that was an issue that they would be contacted about.

Q. Now, how did he possibly know that?

A. Again, through conversations with these physicians.

Q. So, in other words, these physicians are recounting to you conversations they had with unidentified CHS network physicians?

A. Well, they identified them, but I don't recall their names. But they talked about specific doctors who they had personal relationships with and who they received significant referrals in the past. And when they asked them about it, this is what they recounted. I mean, I realize this is hearsay. I mean, I'm just telling you what I heard from the doctors.

Q. Well, it's really double hearsay, isn't it?

MR. WESTBROOK: Object to the form.

THE WITNESS: Yeah.

BY MR. MULLER:

Q. If somebody recounted to you what someone else told them.

A. That's true.

Q. Is there anything that to you is unexpected about employed physicians referring patients to their own hospital?

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BY MR. MULLER:

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Q. Is there anything that to you is unexpected about employed physicians referring patients to their own hospital?

A. You know, when there's -- you know, certainly, you know, like in an area like Atlanta, where you have hospitals like sometimes that are clustered together in certain areas, I wouldn't be surprised at all if, you know, referrals shifted, you know, dramatically, you know, overnight if a practice got acquired.

But when patients are having to drive some more distance through pretty congested roadways in the Charlotte area, you know, I think maybe in that situation you would expect maybe there would be some reliance on the local hospital and trying to minimize travel for the patients and their families. And also if there had been historical relationships with some of these other doctors that they would continue to honor some of these historical relationships.

But, I mean, I certainly would expect if you acquire a practice, that some referral patterns are going to change. But you would hope that the patients' interests would be the primary consideration and not the organization's interest.

Q. Do you have anything concrete that would tell you that patients' interests were not put first by these physicians?

MR. WESTBROOK: Object to the form.

THE WITNESS: Other than what these doctors recounted to me where there was no -- no real consideration of the patients' interests. It was all the determination by the CHS folks that these patients need to be sent out of the county.

BY MR. MULLER:

Q. But these doctors are not truly independent doctors, are they?

A. Who are you speaking of now?

Q. The doctors you were speaking to.

A. I think several of them are in private practice. They weren't employed by Piedmont.

Q. But their sole hospital affiliations for the most part are either with Piedmont Medical Center or they have something to gain by being close to Fort Mill Medical Center, correct?

A. I don't think that makes them not independent. I mean, my experience has been that medical staff members at many hospitals are not shy about disagreeing with hospital administration about various things. And so, I mean, the majority of the guys that I spoke with were not employed physicians and I think they were just generally concerned that the efforts of CHS and to a lesser extent Presbyterian was diminishing the level of patient activity going on in

David S. Levitt
Deposition Excerpts

STATE OF SOUTH CAROLINA

ADMINISTRATIVE LAW COURT

PRESBYTERIAN HOSPITAL-YORK, LLC AND AMISUB OF SOUTH CAROLINA, INC., D/B/A PIEDMONT MEDICAL CENTER D/B/A FORT MILL MEDICAL CENTER,

Petitioner(s),

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

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL AND THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY D/B/A CAROLINAS MEDICAL CENTER - FORT MILL,

Respondent(s).

D E P O S I T I O N

WITNESS: DAVID S. LEVITT

DATE: Monday, February 11, 2013

TIME: 10:00 a.m.

LOCATION: Nelson, Mullins, Riley & Scarborough, LLP
1331 Main Street, 17th Floor
Columbia, South Carolina

TAKEN BY: Attorneys for the Respondent

REPORTED BY: SHERI L. BYERS
Registered Professional Reporter

- -

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A. Yes. And I think we presented that at project review and other times as well.

Q. I recall sort of a box in your July 2011 letter where you compared Presbyterian and Carolinas applications to Trident, Berkeley, or Roper-Berkeley as examples where you believe that they were too ambitious in terms of showing a profit?

A. Those were the two most recent hospital approvals we compared them to, correct. And we said that this is what's reasonable, and this is what DHEC accepted. And the CHS -- or the CMC-Fort Mill was very different than that.

Q. If they had changed their pro formas -- well, let's address Carolinas specifically. If they had changed their pro formas to levels that you believe are more reasonable, would they have equally met this criteria with Piedmont?

A. Yes.

Q. So you thought that they inflated it somewhat, and by inflating it they best met the criteria. But if they hadn't inflated it, they would have equally met?

A. No. I don't think they best met it. That was my point. Yes, I guess in a roundabout way the answer is yes. I don't think they best met it because

access to medically underserved.

A. Number 3D.

Q. I'm sorry, 3D, you're right. No restrictions on admissions. What's your opinion on that?

A. I think that both facilities have admission policies that are nonrestrictive, but by practice the CHS facilities give priority. That was what was indicated in my physician interviews to CHS physicians. So it's hard for non-CHS physicians to get patients admitted.

Q. Were there any other restrictions on admissions? You know, there was some mention about that the CPN physician practices were not admitting new patients that weren't managed care patients. Do you have any reason to think that CMC-Fort Mill would do that?

A. Yes.

Q. Okay. Why do you say that?

A. Because the physicians that would practice at Fort Mill, CMC-Fort Mill, don't accept Medicaid, Medicare, self-pay patients.

Q. And what -- are those the practices that are referenced in your interview notes?

A. As well as the July 11 submission we submitted to DHEC. We had some information in there as

well about some research we had done about what the practice patterns were for those practices about admitting new patients. And then I personally called the CHS primary care physicians, and they told me they don't take Medicare or Medicaid patients.

Q. Do you recall who you -- what practices you called?

A. I called -- if we had a list. It's the one in Fort Mill and the one in Rock Hill owned by CHS. Not Shiland, the other one.

Q. It looks like the ones you identified in your July 11, 2011, comparative review analysis to DHEC --

A. Yes.

Q. -- are Shiland Family Physicians, Medical Associates of Fort Mill and Rock Hill, Palmetto Pediatrics and Rock Hill Pediatrics.

Those are the ones that you personally called and were told those things?

A. I called Medical Associates of Fort Mill and Medical Associates of Rock Hill.

Q. And who called Shiland and Palmetto Pediatrics and Rock Hill Pediatrics?

A. An individual at Piedmont.

Q. Okay. Any other -- I guess -- so in other words, in the scheme of things, the -- I'm not so sure

Q. Mr. Levitt, before we get into the adverse impact criteria, I just wanted to ask you a few follow-up questions from this morning.

In terms of the survey that you -- that was performed on the CHS physicians in York County, how did you go about doing that? I mean, how did you make that call?

A. The calls I made, I called and asked if they were accepting new patients, asked if they accepted new patients if they were covered under Medicare. I asked if they accepted new patients if they were covered under Medicaid.

Q. And did you identify who you were?

A. No. They never asked. And that was usually the first question, "I would like to make an appointment, and are you accepting new patients?"

"Yes. What's your insurance?"

Both practices that was the first question they asked me, what was my insurance.

Q. And when you say both practices, were those --

A. Carolinas Family Care in Fort Mill and Rock Hill were the two I called.

Q. Was it the pediatric?

A. No. I didn't call the pediatric.

Q. Would this have been Medical Associates of Fort Mill in Rock Hill?

A. Yes, that's who I called.

Q. So you had called and just said, "I want to schedule an appointment," and then they asked for your details. And when you gave your details --

A. We didn't even get that far. They asked what my insurance was, and I said, "Well, if it was Medicaid, could I make an appointment?"

And they said, "No, we're not taking any new Medicaid patients."

I said, "Well, if it was Medicare, could I make an appointment?"

"No. We're not taking any new medicare patients."

Q. And your letter of July 11, 2011, says, "No uninsured patients without advance payment of 70 percent of a new patient visit charge of 290 to $800."

Is that what they told you?

A. When we did the survey, that's what they told me.

"What if we don't have any insurance?"

They said, "Well, you can pay out of pocket, but you've got to make a down payment. And here's how much you've got to pay."

Q. Was that pretty much the same way that the other surveyors would ask questions of the practice?

A. Yes.

Q. Did you keep any notes from those interviews or surveys?

A. No.

Q. I mean, how was this reduced and how would you remember it if you didn't take notes?

A. We summarized it. Certainly for me, I remember, you know, what I did. And for the individual that made the rest of the calls, that's what she reported.

MR. MULLER: Would it help you if we marked this as an exhibit? I just want to want you about two more pages of this document.

(EXHIBIT 8, Comparative Review of the Competing CON Proposals to Build a Hospital in Fort Mill, was marked for identification.)

BY MR. MULLER:

Q. I was asking you about your July 11, 2011, Comparative Review of the Competing CON Proposals to Build a Hospital in Fort Mill. We were discussing specifically page 19. There are two figures that follow when you were referring to survey results, those were the survey results that you mentioned at the top

well about some research we had done about what the practice patterns were for those practices about admitting new patients. And then I personally called the CHS primary care physicians, and they told me they don't take Medicare or Medicaid patients.

Q. Do you recall who you -- what practices you called?

A. I called -- if we had a list. It's the one in Fort Mill and the one in Rock Hill owned by CHS. Not Shiland, the other one.

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A. An individual at Piedmont.

Q. Okay. Any other -- I guess -- so in other words, in the scheme of things, the -- I'm not so sure

there were any. But you believe there were other Carolinas Physician Network physician practices in addition to those four that would be the same thing?

A. Well, that's sort of the fear. So if a Medicaid patient isn't treated by a primary care physician, they can't then be referred to a specialist. So it has a downstream effect. And then they couldn't be admitted to a hospital because they're not in the quote, unquote CHS system.

Q. And does it always work that way, you go to primary care then you go to a specialist?

A. No.

Q. Does it sometimes happen that they go directly to a specialist?

A. Depending on their physician, they could go directly to a specialist.

Q. So is it your opinion that a Fort Mill -- I'm sorry, that a Carolinas Fort Mill hospital would provide very limited care to Medicare and Medicaid patients?

A. I'm not sure how they would get into the Carolinas system if their primary care physicians aren't taking them, so that was a concern of mine.

Q. And if Carolinas represented that they would take Medicare, Medicaid patients and they had that as a

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Unpublished Cases

The State, Respondent, v. Miama Kromah, Petitioner.

Opinion No. 27212

SUPREME COURT OF SOUTH CAROLINA

737 S.E.2d 490; 2013 S.C. LEXIS 9

September 20, 2012, Heard
January 23, 2013, Filed

NOTICE:

THIS DECISION IS NOT FINAL UNTIL TIME EXPIRES TO FILE REHEARING MOTION AND, IF FILED, DETERMINED.

PRIOR HISTORY: [*1]

Appellate Case No. 2009-140328. Appeal From Richland County. James W. Johnson, Jr., Circuit Court Judge.

State v. Kromah, 2009 S.C. App. Unpub. LEXIS 325 (S.C. Ct. App., June 15, 2009)

DISPOSITION: AFFIRMED IN RESULT.

COUNSEL: Chief Appellate Defender Robert M. Dudek, of South Carolina Commission on Indigent Defense, of Columbia, for Petitioner.

Attorney General Alan McCrory Wilson, Chief Deputy Attorney General John W. McIntosh, Assistant Deputy Attorney General Salley W. Elliott, and Assistant Attorney General William M. Blitch, Jr., all of Columbia; and Solicitor Daniel E. Johnson, of Columbia, for Respondent.

JUDGES: JUSTICE BEATTY TOAL, C.J., KITTREDGE and HEARN, JJ., concur. PLEICONES, J., concurring in result only.

OPINION

ON WRIT OF CERTIORARI TO THE COURT OF APPEALS

JUSTICE BEATTY: Miama Kromah ("Kromah") was convicted of (1) infliction of great bodily injury upon a child, and (2) unlawful neglect of a child. Kromah appealed, arguing the trial court abused its discretion in permitting two of the State's witnesses to testify about actions they took after hearsay conversations they had with the three-year-old victim ("Child"), who did not testify at trial. The Court of Appeals affirmed, finding the issue was not preserved for review. *State v. Kromah*, Op. No. 2009-UP-322 (S.C. Ct. App. filed June [*2] 15, 2009). This Court granted Kromah's petition for a writ of certiorari. We affirm in result.

I. FACTS

The victim in this case is Kromah's stepson, who was born on February 23, 2002 in Philadelphia. The Child initially lived with his biological mother. Child Protective Services eventually removed the Child from her care, and he lived with a foster family in Minnesota for most of his first three years.

Kromah married the Child's biological father, Musa Kromah, in March 2005. Three months later in June 2005, the Child, then three years old, came to Columbia to live with Kromah and her husband. In August 2005, just two months thereafter, the incident occurred for which Kromah was indicted for infliction of great bodily injury to, and unlawful neglect of, a child.

At trial, the evidence indicated Kromah brought the Child to the Lexington Medical Center, where he was examined in the triage area at around 2:23 a.m. on August 16, 2005. The Child was wearing a pull-up diaper and was crying. The Child had a cut on his scrotum, and his right testicle was hanging outside of the scrotum and was bloody. An emergency room nurse testified that

Kromah told her that the Child's scrotum had just "busted [*3] open or tore open," and that Kromah initially appeared very calm despite the severity of the wound.

Dr. Sean O'Meara testified that he examined the Child in the emergency room around 2:35 a.m. on August 16, 2005. In addition to the above injury, he also noticed dried blood on the Child's mouth. Kromah told him that she thought the Child's scrotum appeared enlarged when she was giving him a bath, so she had applied pressure to it using a towel and then noticed the Child starting bleeding on the right side. Dr. O'Meara stated that, due to the severity of the wound, he decided the Child needed surgery by a pediatric urologist, so he transferred the Child by ambulance to Palmetto Health Richland Hospital.

Dr. Erin Fields-Harris, a pediatric physician at Richland Hospital, who was qualified as an expert in pediatrics, examined the Child around 6:00 a.m. on August 16, 2005. She stated Kromah told her that, other than the pressure with the washcloth, there was no other trauma to the Child. However, the doctor noticed the genital injury consisted of a four to five centimeter, V-shaped laceration exposing the right testicle. In addition, she noticed bruising on the Child's face and an abrasion [*4] in the middle of his forehead. The Child also had lacerations on his upper and lower lip, and a red, swollen area along the abdomen near the inguinal crease where the torso meets the thigh, which she opined indicated a recent injury.

She stated when she asked the Child how the injury occurred, the Child "started to mouth something," but Kromah, who had been watching, interrupted the Child by coming over and asking him if he was okay and the Child never answered. She noticed this was the only time Kromah came over to the Child. Dr. Fields-Harris stated that, after observing the clean linear lines of the injury, she believed it was not consistent with Kromah's statements that she had only applied a washcloth to the area before the Child started bleeding. She told Kromah that there "appeared to be some traumatic injury to the patient" that was intentional and asked Kromah if she knew what caused it, but Kromah was not very responsive and just said "[t]hat she did not know."

Dr. Jennifer Amrol, a physician in the Children's Hospital at Palmetto Health Richland, testified that, in her expert opinion, the injury to the Child was the result of "non-accidental trauma or child abuse." She testified [*5] the injury was not accidental because the cut was "a very clean cut, [a] very straight line across the scrotum." She explained that if the Child was injured by accident, the wound would have had a ragged edge or tear.

Dr. Jeffery Thomas Ehreth, a pediatric urologist at Richland Hospital, testified that he performs about 850 surgeries a year and has extensive experience in cuts and lacerations. He was qualified as an expert in pediatric urology, and he is one of only two pediatric urologists in South Carolina.

Dr. Ehreth testified the Child had a four-centimeter laceration transversing the scrotum, and he performed the surgery to repair it the same day he examined the Child on August 16, 2005. The Child did have some fluid around the testicle, "a small hydrocele, but it was very small, certainly not pathological or a problem." Dr. Ehreth testified the Child's wound "looked like a scalpel incision," as it went through the skin and the underlying muscle area. He said there was no evidence of a stellate form and rough edges as would be present in an ordinary injury. Rather, Dr. Ehreth stated in his expert opinion that the wound had to be caused by a sharp instrument, such as a "scalpel, [*6] razor blade, steak knife, something very sharp." He noted the cut went across the grooves in the skin, so if it had been caused by pressure along a weak point in the skin, it would have occurred along the grooves, not across them. He opined that bleeding from the injury would be immediate and significant, and the pain would be severe.

Dr. Anne Abel, Medical Director of the Violent Intervention and Prevention Program in the Department of Pediatrics at the Medical University of South Carolina, testified that she was called in to consult on the case with Richland Hospital. Dr. Abel examined the Child around 7:30 p.m. on August 16th, after his surgery. She said his upper lip was pretty swollen and he had an injury inside his lip. She also noticed abrasions on his face and "a rather large bruise" about 4½ inches by 3½ inches on the lower right abdominal area, near his hip. The abdominal area was tender and swollen.

She did not remove his bandages after surgery, but she viewed pictures taken before the surgery and noticed the Child had a V-shaped wound with "very, very clean" edges that was several centimeters long. She stated the lip injury appeared to be caused, in her expert opinion, by [*7] blunt force trauma against the face, possibly a blow to the face with a hand or fist. She stated the injury to the mouth was not consistent with the Child biting his own lip. She opined that the abdominal area does not injure easily, so the bruising there was probably from a blow or "heavy pressure from a hand or a foot holding the belly down in a very forceful manner."

Dr. Abel concluded the Child's injuries were the result of physical abuse and not accidental. She found the clean, linear cut and the "V" shape of the wound were significant because they indicated the wound was caused by "physical trauma with a sharp linear object" such as "a sharp knife, a sharp object, a scalpel like a surgeon uses, a razor, a box cutter, [or] something very sharp."

She noted the laceration was "a grave bodily injury, which required surgical repair," as the cut went through all layers of the scrotal sack. Dr. Abel testified that, even if pressure had been applied to the area, the Child's scrotum would not "explode," and she had never heard of such a theory of injury. Moreover, even if this happened, or if the area were manually torn, it would have multiple openings with ragged edges, not a clean linear [*8] cut. She concluded the wounds were not consistent with the version of events that Kromah had reported to medical personnel.

An investigator with the Richland County Sheriff's Office, Roy Livingston, testified that Kromah had given a statement acknowledging that she was the only person at home with the Child when he was injured, but she denied cutting him.

Kromah reiterated at trial the version of events she had previously given at both hospitals and to law enforcement and denied that she had intentionally injured the Child. Kromah testified that she got off work from the Brian Center, where she worked as a nursing assistant, at 11 p.m. on August 15, 2005 and she picked up the Child from her sister's house and took him to her home on St. Andrews Road, about ten minutes away. The sister had been watching the Child for her. She noticed no blood on the Child at any time prior to taking him home and he slept on the way home.

As Kromah got ready to give him a bath, she noticed the Child's scrotum was swollen, and the Child made a face and said he "hurt." She placed him in the tub and then tried to put pressure on the area with a warm washcloth. When she removed the cloth, she then noticed blood [*9] in the bathtub. She placed a pull-up diaper on the Child, then replaced it with a second one due to continued bleeding and took him to Lexington Memorial Hospital.

Kromah denied that she had cut the Child and stated she had no explanation as to what caused his testicle to be hanging outside of the scrotum. She maintained he was biting his lip on his way to the hospital, so that's when the injury to his lip occurred, and she stated she did not notice the abdominal bruising, just the swelling. She insisted that the only thing she had done was to apply pressure with the washcloth to the area that was already swollen and she had not pressed down on the Child with a razor or other sharp object.

The Child did not testify. Although DSS had taken the Child into emergency protective custody after the injury, DSS returned the Child to the father, Kromah's husband, in January 2006. Shortly before the trial began in June 2006, Kromah's husband sent the Child to live with the Child's grandmother in Liberia, which is where Kromah and her husband were born. Kromah and her husband were still together at the time of trial.

A jury convicted Kromah of inflicting great bodily injury upon, and unlawful neglect [*10] of, a child. Kromah was sentenced to concurrent prison terms of eighteen years and ten years, respectively.

Thereafter, Kromah filed a motion for a new trial or for reconsideration of her sentences. A hearing was held on the motion on December 19, 2007. At the hearing, Kromah admitted that she had lied at trial when she said she did not know how the Child's injuries occurred. Kromah now maintained that she had caused the injury, but that it was an accident.

Kromah testified the Child did not want a bath and she was "agitated" because he was not cooperating, so she had "handled him roughly." Kromah stated she accidentally scratched him with her long acrylic fingernails when she was washing him, as the nails had sharp edges. She initially stated that she did not know what could have caused the bruising on his abdomen, but later acknowledged that she "probably" did apply sufficient force to cause the bruising on his stomach.

Kromah also presented the Child as a witness, who testified that Kromah hurt him when she was bathing him, but he did not see anything in her hand when the injury occurred and she did not hold him down. He was asked if he had bit his own lip because he hurt and because [*11] he was mad, to which he answered "yes." The trial court denied the motion for a new trial or a reduced sentence.

Kromah appealed, asserting the trial court erred in permitting two of the State's witnesses to testify about actions they took based on hearsay statements made by the Child, who was incompetent to testify at trial. The Court of Appeals affirmed, finding the issue unpreserved. *State v. Kromah, Op. No. 2009-UP-322, 2009 S.C. App. Unpub. LEXIS 325 (S.C. Ct. App. filed June 15, 2009)*. This Court granted Kromah's petition for a writ of certiorari. [1]

1 Other issues ruled upon by the Court of Appeals on which certiorari was denied are not before us.

II. STANDARD OF REVIEW

"The admission or exclusion of evidence is a matter addressed to the sound discretion of the trial court and its ruling will not be disturbed in the absence of a manifest abuse of discretion accompanied by probable prejudice." *State v. Douglas, 369 S.C. 424, 429, 632 S.E.2d 845, 847-48 (2006)*. "An abuse of discretion occurs when the conclusions of the trial court either lack evidentiary sup-

port or are controlled by an error of law." *Id. at 429-30, 632 S.E.2d at 848.*

III. LAW/ANALYSIS

On appeal, Kromah challenges the admission of testimony by two State's [*12] witnesses, Heather Smith, a forensic interviewer, and Roy Livingston, an investigator. The State contends the Court of Appeals properly found Kromah's issue is not preserved for appeal. It further contends the trial court did not err in admitting the testimony, in any event, and even if there was error, it was harmless beyond a reasonable doubt. We find the issue was preserved and address the merits of the appeal in the interest of judicial economy. We hold there was no error in the admission of Livingston's testimony, and that any error in the admission of Smith's testimony was harmless beyond a reasonable doubt.

A. Error Preservation

Kromah first contends the Court of Appeals erred in finding her issue was not preserved for review.

At the beginning of the trial, Kromah moved that the State's witnesses be prohibited from testifying about any statements made by the Child to them. Kromah asserted the Child was unavailable to testify because he had been removed from the country, and before the Child's hearsay statements could be introduced through other witnesses, the Child must have been deemed a competent witness. Kromah stated she believed the Child probably was not competent based on [*13] his responses during a videotaped interview with the Assessment and Resource Center ("ARC"). [2] During the ensuing colloquy, the trial court noted that, under Rule 601, SCRE, children are presumed to be competent unless it is shown otherwise. The trial court stated some of the proposed testimony was not hearsay and that it would reserve its ruling at that time as to potential hearsay issues.

> 2 The interview was with Heather Smith, a forensic interviewer and child therapist with ARC, and was taken on August 25, 2005. ARC is a non-profit child abuse evaluation and treatment center in Richland County administered under the auspices of the South Carolina Department of Mental Health in collaboration with the USC School of Medicine Department of Pediatrics and Palmetto Health Children's Hospital. (SCDMH website, http://www.state.sc.us/dmh/arc.index.htm)

Just prior to Smith taking the stand, the trial court viewed the one-hour videotape of the Child being interviewed by Smith. The trial court ultimately agreed with Kromah that the Child's statements to her could not be repeated at trial and advised the State, "You can't go into statements that were made." The court stated it would take up other [*14] objections as they came up, but Kromah asked if they could hear what Smith would say now. Smith then testified in camera that she had interviewed the Child for about an hour, that investigator Livingston was there for part of the interview, and that based on the interview as well as other information and data available, her finding was compelling for child abuse. The trial court stated it "will permit that." Kromah again objected, and the trial court overruled the objection and reiterated that Smith would be limited to what had been gone over in camera.

Smith, a forensic evaluator and child therapist with ARC who was qualified without objection as an expert forensic interviewer of children, then testified before the jury as follows:

> Q And once you -- and **you can't say what was said** or wasn't said during that evaluation, but once the evaluation was complete and you got sufficient information, were you able to **make an assessment as to whether or not this was founded for child abuse?**
>
> A Yes, I did.
>
> Q And what was your conclusion, based on your evaluation of the child?
>
> A Based on the interview that I conducted, as well as information provided by law enforcement and the child protective services [*15] worker, **I made a decision that the child had given compelling -- a compelling finding.**
>
> [Kromah]: Objection.
>
> The Court: Overruled.
>
> [Kromah]: Your Honor, may we approach? I apologize.
>
> The Court: All right. Come up.
>
> (Whereupon, a bench conference was held in the presence, but not within the hearing, of the jury.)
>
> The Court: **The objection is sustained as to the form of that question.**
>
> Please rephrase your question, solicitor.
>
> [State]: Thank you, sir.
>
> Q Ms. Smith, **your finding was compelling for child abuse or physical abuse**
>
> A For child physical abuse, yes.
>
> A **And without saying what was said during the interview or anything else,** did you pass that information along to law

enforcement officers including Investigator Livingston and other law enforcement agencies?

A Yes, yes, I did.

(Emphasis added.)

Livingston, an investigator in the Special Victims Unit of the Richland County Sheriff's Department, testified later in the trial. Livingston testified that he spoke extensively to Kromah and the Child's father, as well as to Kromah's sister, treating physicians, the responding officer, and a social worker. He stated that he had also spoken to the Child when he was in intensive care after his surgery:

> Q **And you [*16] can't say what [the Child] said, but what were you asking him about. Do not say what he said.**
>
> A I was asking what happened to him and who did it.
>
> Q Was the child -- you can't say what he said, but was he able to communicate with you?
>
> A Yes, he was.
>
> . . . .
>
> Q And he related -- was he able to relate information to you?
>
> A Yes, he did.
>
> Q And **based on your investigation at that point,** the next day did you arrest Miama Kromah?
>
> A Yes, I did.
>
> [Kromah]: Objection, Your Honor. That is an improper question based on that information. **We've already discussed this.** May we approach the bench?
>
> The Court: Yes, sir. Come up.
>
> (Whereupon a bench conference was held in the presence, but not within the hearing, of the jury.)
>
> The Court: All right. The objection is overruled. You may continue, Solicitor.
>
> Q Based on your investigation, what did you do the next day, Investigator Livingston?
>
> A I placed Ms. Kromah under arrest.

(Emphasis added.)

The Court of Appeals held that, "[w]ith regards to Heather Smith's testimony, the objection did not specifically pertain to her reliance on the victim's statements, but rather addressed the form of the State's question." *Kromah, slip op. at 1-2.* The court further stated, "Similarly, the [*17] objection lodged during Investigator Roy Livingston's direct-examination did not address any alleged hearsay statement." *Id. at 2.*

As to Smith's testimony, we find the objection is preserved based on Kromah's objection immediately prior to Smith's testimony. The objection during the testimony was to the form of the question, and the objection was sustained, so Kromah received the relief she requested in that particular regard. However, the trial court's statement prior to her testimony that he would allow her to testify as she did during the in camera exchange constituted a final ruling that preserved the hearsay issue for appeal since Smith's testimony immediately followed this ruling with no intervening testimony.

"Generally, a motion *in limine* is not a final determination; a contemporaneous objection must be made when the evidence is introduced." *State v. Wiles, 383 S.C. 151, 156, 679 S.E.2d 172, 175 (2009).* "There is an exception to this general rule when a ruling on the motion *in limine* is made 'immediately prior to the introduction of the evidence in question.' " *Id.* (quoting *State v. Forrester, 343 S.C. 637, 642, 541 S.E.2d 837, 840 (2001)).* "This exception is based on the fact [*18] that when the trial court's ruling is not preliminary, but instead is clearly a final ruling, there is no need to renew the objection." *Id. at 156-57, 679 S.E.2d at 175; see also State v. Mueller, 319 S.C. 266, 268-69, 460 S.E.2d 409, 410-11 (Ct. App. 1995)* (noting where there is no evidence between the motion and the testimony, there is no basis for the trial court to change its ruling, so the decision is a final one).

As to Livingston, we also find the objection is preserved. Although the full grounds for the exception were not articulated on the record at the time of the objection, as would have been advisable to avoid a question in this regard, it nevertheless appears from the transcript and the context of the proceedings that Kromah's reference to the parties' earlier discussion sufficiently apprised the trial court of the nature of the objection. The trial court immediately appeared to understand the objection as a renewal of the previous hearsay argument advanced against the State's witnesses. *See State v. Byers, 392 S.C. 438, 710 S.E.2d 55 (2011)* (holding defense counsel's challenge to the evidence was presented with sufficient

specificity to inform the circuit court of the [*19] point being urged as objectionable); Rule 103(a)(1), SCRE (stating for alleged errors in evidentiary rulings to be preserved, "a timely objection or motion to strike" must appear in the record "stating the specific ground of objection, *if the specific ground was not apparent from the context*" (emphasis added)).

B. Admissibility of Testimony of Two State's Witnesses

Having found the issue preserved, we find it appropriate, in the interest of judicial economy, to consider the merits of Kromah's appeal instead of delaying the proceedings with a remand to the Court of Appeals.

Kromah argues the trial court abused its discretion by permitting State's witnesses Smith and Livingston to testify regarding the actions they took as a result of hearsay statements made by the three-year-old Child, who would have been incompetent to testify. [3]

> 3 To the extent Kromah additionally argues on appeal to this Court that the disputed testimony unfairly impugned her character, this argument was not preserved for appeal as it was not raised to and ruled upon by the trial court.

Kromah asserts, "In this case, Smith was permitted to testify that following her conversation with the [C]hild, she turned the information [*20] over to law enforcement. Additionally, Livingston was permitted to testify that following his conversation with the [C]hild, he arrested petitioner the next day. Livingston's testimony was all the more damaging because he testified that he did not consider petitioner a suspect when he interviewed her the morning that he also interviewed the [C]hild."

Kromah essentially contends the trial court ruled the Child was not competent as a witness (based on the videotaped interview with the Child), so the Child's statements were inadmissible hearsay. Kromah then asserts the evidence offered by Smith and Livingston was unreliable and inadmissible because they relied upon their conversations with the Child in making their respective assessments (of child abuse and to arrest Kromah), citing *South Carolina Department of Social Services v. Doe, 292 S.C. 211, 219-20, 355 S.E.2d 543, 548 (Ct. App. 1987)* (holding, in a case rejecting the use of a child's out-of-court statements in a prosecution for alleged sexual abuse, that "[t]he admission of hearsay under an exception to the rule presupposes the declarant is possessed of the qualifications of a witness in regard to competency, personal knowledge, [*21] and the like," and that "the declarant's competency is a precondition to the admission of his hearsay statements on grounds of unavailability").

(1) Investigator Livingston

The trial court basically agreed with Kromah's initial objections at trial and ruled the State's witnesses could not repeat what the Child had actually said to them since the Child was not there to testify. In reviewing Livingston's testimony, we disagree with Kromah that the disputed portion of his testimony constituted inadmissible hearsay.

The South Carolina Rules of Evidence define hearsay as follows:

> "Hearsay" is a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted.

Rule 801(c), SCRE. "A 'statement' is (1) an oral or written assertion or (2) nonverbal conduct of a person, if it is intended by the person as an assertion." *Id.* Rule 801(a). The Hearsay Rule provides that "[h]earsay is not admissible except as provided by these rules or by other rules prescribed by the Supreme Court of this State or by statute." Rule 802, SCRE.

Livingston testified in detail about his investigative process and the numerous individuals [*22] he spoke to, including the Child, and that he made his decision to arrest Kromah based on *all* of this information. Livingston did not directly relate to the jury any statements made by the Child, and the defense had the opportunity to cross-examine Livingston extensively. Even as posed by Kromah in her issue on appeal, she challenges the testimony of the State's witnesses as to what *actions they took* in response to information they received from the Child. However, Livingston never revealed any of the Child's statements in the presence of the jury.

Moreover, even if Livingston's testimony were considered some form of *indirect* hearsay, we find the trial court did not abuse its discretion. Livingston's testimony referencing his interview of the Child, excerpted above, was only one part of the information he recited in his investigative process leading up to his conclusion that there was sufficient evidence to arrest Kromah, and we find his testimony in this regard was proper as he did not repeat what the Child said to him. *Cf. State v Weaver, 361 S.C. 73, 86-87, 602 S.E.2d 786, 792-93 (Ct. App. 2004)* (holding officer's testimony as to what his investigation revealed and his conclusion [*23] that all of the evidence led to the defendant was proper where he did

not repeat any statements actually made to him by individuals at the scene).

In addition, as mentioned at trial, Livingston's statement about the Child would appear viable as an excited utterance. The Child was interviewed while still under the influence of the traumatic events, as he was in intensive care after having had surgery for his injury when Livingston spoke to him. *Cf. State v. Sims, 348 S.C. 16, 558 S.E.2d 518 (2002)* (finding where a six-year-old suddenly stopped testifying that the trial court did not err in allowing a police officer to testify that the child had indicated who was in the apartment on the night his mother was fatally attacked and that it was the defendant; the testimony was admissible as an excited utterance under Rule 803(2), SCRE, even though some twelve hours had passed since the attack, as time is just one factor to consider, along with the declarant's demeanor and age, and the severity of the startling event, and even statements in response to an officer's questioning can be an excited utterance because the statements still have spontaneity, especially for a child, for whom stress [*24] can last longer than for an adult; the Court stated it is the totality of the circumstances that must be considered in this analysis). Similarly, under the totality of the circumstances, including the continuing stress of the incident, the Child's demeanor, and the traumatic nature of the event, we find the trial court did not abuse its discretion in allowing the disputed testimony here.

(2) Forensic Interviewer Smith[4]

> 4 The title of "forensic interviewer" is a misnomer. The use of the word forensic indicates that the interviewer deduces evidence suitable for use in court. It also implies that the evidence is deduced as the result of the application of some scientific methodology. The exact scientific methodology applied apparently defies identification. The RATAC style of interviewing is not scientific. It merely represents the objectives and topics of discussion between the interviewer and the child. Somehow RATAC is supposed to convert the interviewer into a human truth-detector whose opinions of the truth are valuable and suitable for the jury's consumption.

In contrast, we find Smith's testimony more problematical to the extent that she testified as to a "compelling finding" of physical [*25] child abuse.

Smith is a forensic interviewer of children. "[A] forensic interviewer is a person specially trained to talk to children when there is a suspicion of abuse or neglect." *In re K.K.C., 728 N.W.2d 225 (Iowa Ct. App. 2006)*. The job of the interviewer is not to provide therapy, but to collect facts. *State v. Borden, 986 So. 2d 158, 163 (La. Ct. App. 2008)*. It has been said that a forensic interviewer's purpose is to prepare for trial. *See State v. Blue, 2006 ND 134, 717 N.W.2d 558, 564 (N.D. 2006)* (observing "[t]he forensic interviewer's purpose was undoubtedly to prepare for trial" as "[f]orensic by definition means 'suitable to courts,'" (quoting *Merriam Webster's Collegiate Dictionary* 490 (11th ed. 2005)); *Black's Law Dictionary* 721 (9th ed. 2009) (stating "forensic" is derived from the Latin terms "forensis" (public) and "forum" (court) and defining "forensic" as "[u]sed in or suitable to courts of law or public debate"). Smith testified that she used the RATAC method of interviewing. This is an acronym for Rapport, Anatomy, Touch, Abuse Scenario, and Closure. RATAC is reportedly used nationwide in the forensic interviewing of children. *State v. Douglas, 380 S.C. 499, 500, 671 S.E.2d 606, 607 (2009)*.

Smith [*26] was qualified as an expert and, although an expert's testimony theoretically is to be given no more weight by a jury than any other witness, it is an inescapable fact that jurors can have a tendency to attach more significance to the testimony of experts. [5] The label of expert should be jealously guarded by the court and never loosely bandied about.

> 5 In this case, there was no objection made to Smith's qualification as an expert, but we have previously observed that such qualification may be unnecessary. *See, e.g., Douglas, 380 S.C. at 504, 671 S.E.2d at 609* (concluding it was unnecessary for the forensic interviewer to be qualified as an expert because no specialized knowledge was required there; the interviewer testified only as to her personal observations and experiences, and her interview with the victim; the Court found no error, however, noting the interviewer gave no opinion concerning the victim's veracity). In considering the ongoing issues developing from their use at trial, we state today that we can envision no circumstance where their qualification as an expert at trial would be appropriate. Forensic interviewers might be useful as a tool to aid law enforcement officers [*27] in their initial investigative process, but this does not make their work appropriate for use in the courtroom. The rules of evidence do not allow witnesses to vouch for or offer opinions on the credibility of others, and the work of a forensic interviewer, by its very nature, seeks to ascertain whether abuse occurred at all, i.e., whether the victim is telling the truth, and to identify the source of the abuse. Part of the RATAC method, which is not without its critics, involves evaluating whether the victim understands the importance of telling the truth and whether the victim has told the truth, as well as the forensic interviewer's judgment in deter-

> mining what actually transpired. For example, an interviewer's statement that there is a "compelling finding" of physical abuse relies not just on objective evidence such as the presence of injuries, but on the statements of the victim and the interviewer's subjective belief as to the victim's believability. However, an interviewer's expectations or bias, the suggestiveness of the interviewer's questions, and the interviewer's examination of possible alternative explanations for any concerns, are all factors that can influence the interviewer's [*28] conclusions in this regard. Such subjects, while undoubtedly important in the investigative process, are not appropriate in a court of law when they run afoul of evidentiary rules and a defendant's constitutional rights.

Rule 703 of the South Carolina Rules of Evidence allows an expert giving an opinion to rely on facts and data that are not admitted into evidence or even admissible into evidence if they are of a type reasonably relied upon by experts in the particular field. Rule 703, SCRE. The rule does not, however, make hearsay automatically admissible simply because it was relied upon by the expert. *See Allegro, Inc. v. Scully, 400 S.C. 33, 46-47, 733 S.E.2d 114, 122 (Ct. App. 2012)* ("However, Rule 703 does not allow the admission of hearsay evidence simply because an expert used it in forming his opinion; the rule only provides the expert can give an opinion based on facts or data that were not admitted into evidence.").

Further, even though experts are permitted to give an opinion, they may not offer an opinion regarding the credibility of others. It is undeniable that the primary purpose for calling a "forensic interviewer" as a witness is to lend credibility to the victim's [*29] allegations. When this witness is qualified as an expert the impermissible harm is compounded. Our courts have previously held that "[t]he assessment of witness credibility is within the exclusive province of the jury," and that witnesses generally are "not allowed to testify whether another witness is telling the truth." *State v. McKerley, 397 S.C. 461, 464, 725 S.E.2d 139, 141 (Ct. App. 2012)*; *see also* L.A. Bradshaw, Annotation, *Necessity and Admissibility of Expert Testimony as to Credibility of Witness, 20 A.L.R.3d 684* (1968 & Supp. 2012) (stating an expert witness should not vouch for the truthfulness of a witness). Specifically, it is improper for a witness to testify as to his or her opinion about the credibility of a child victim in a sexual abuse matter. *State v. Hill, 394 S.C. 280, 294, 715 S.E.2d 368, 376 (Ct. App. 2011)*; *cf. Smith v. State, 386 S.C. 562, 564-65, 689 S.E.2d 629, 631 (2010)* (observing the forensic interviewer interjected impermissible hearsay into the trial, which improperly bolstered the victim's testimony; the forensic interviewer testified that the victim told her that the defendant had sexually assaulted her and that she found the victim's statement "believable"). [*30] [6]

> 6 In *Seward v. State, 2003 WY 116, 76 P.3d 805, 814 (Wyo. 2003)*, the court found that a forensic interviewer's testimony about her use of "truthfulness criteria" and her assessment of the victim's credibility based on the content of the victim's interview responses was testimony that "directly vouched for the victim's credibility." The court stated, "It is evident that the purpose of [the interviewer's] testimony was twofold: establish the foundation for admitting her videotaped 'forensic interviews' with the victim and assess credibility of the victim's disclosure based on the content of those interviews." *Id.* The court noted that the interviewer herself had stated "the very purpose of a 'forensic interview' is to assess whether the victim's disclosure was 'credible or not'--a forensic interviewer is looking for 'elements that would support it either being a credible disclosure or a noncredible disclosure.'" *Id.* The court ultimately found that that State had not established that testimony of this nature assisted the jury in addressing an issue beyond the jurors' common experience. *Id. at 816.*

In *State v. Jennings, 394 S.C. 473, 716 S.E.2d 91 (2011)*, this Court held that the trial court erred in [*31] allowing the State to introduce portions of a forensic interviewer's written reports about interviews conducted with the three alleged minor victims. The Court stated, "In each report, the forensic interviewer stated that during the interviews, each child had 'provide[d] a compelling disclosure of abuse by [appellant].'" *Id. at 480, 716 S.E.2d at 94* (alterations in original). The Court found this was error as "[t]here is no other way to interpret the language used in the reports other than to mean the forensic interviewer believed the children were being truthful." *Id.* Similarly, we find Smith's testimony about a "compelling finding" to be inappropriate here. Smith should not have been allowed to testify about a compelling finding of child abuse as that was the equivalent of Smith stating the Child was telling the truth.

Because the admissibility of forensic interviews and the testimony based thereon at trial has been the subject of several recent appeals, we believe it would be helpful to set forth, by way of example, the kinds of statements that a forensic interviewer should avoid at trial: [7]

> o that the child was told to be truthful;
>
> o a direct opinion as to a child's veracity or tendency [*32] to tell the truth;

> o any statement that indirectly vouches for the child's believability, such as stating the interviewer has made a "compelling finding" of abuse;
>
> o any statement to indicate to a jury that the interviewer believes the child's allegations in the current matter; or
>
> o an opinion that the child's behavior indicated the child was telling the truth.

7 The General Assembly has enacted provisions allowing the admission of out-ofcourt statements by child sexual abuse victims under the age of twelve when certain conditions are met. *See S.C. Code Ann. § 17-23-175* (Supp. 2011); *State v. Bryant, 382 S.C. 505, 675 S.E.2d 816 (Ct. App. 2009)* (discussing the proper application of this provision).

A forensic interviewer, however, may properly testify regarding the following:

> o the time, date, and circumstances of the interview;
> o any personal observations regarding the child's behavior or demeanor; or
> o a statement as to events that occurred within the personal knowledge of the interviewer.

These lists are not intended to be exclusive, since the testimony will of necessity vary in each trial, but this may serve as a general guideline for the use of this and other similar testimony by forensic [*33] interviewers.

Although we find the admission of the challenged testimony by Smith was error, we conclude any error is properly deemed harmless beyond a reasonable doubt.

An appellate court generally will decline to set aside a conviction due to insubstantial errors not affecting the result. *State v. Black, 400 S.C. 10, 732 S.E.2d 880 (2012)*; *see also Arnold v. State, 309 S.C. 157, 420 S.E.2d 834 (1992)* (stating error is harmless beyond a reasonable doubt if it did not contribute to the verdict obtained); *State v. Watts, 321 S.C. 158, 165, 467 S.E.2d 272, 277 (Ct. App. 1996)* ("In applying the harmless error rule, the court must be able to declare the error had little, if any, likelihood of having changed the result of the trial and the court must be able to declare such belief beyond a reasonable doubt." (citing *Chapman v. California, 386 U.S. 18, 87 S. Ct. 824, 17 L. Ed. 2d 705 (1967)*)).

Smith testified in camera that the Child told her he had been hurt and that Kromah was the perpetrator. However, Smith's challenged testimony before the jury was that child abuse occurred in this case, the essential portion of which was outlined above, and it did not go so far as to indicate that Kromah was the perpetrator of the injuries. [*34] Rather, Smith restated what the overwhelming evidence had already indicated, that the injury was the result of physical abuse. *Cf. Jennings, 394 S.C. at 480, 716 S.E.2d at 94-95* (finding error in the admission of hearsay evidence and the forensic interviewer's report making a "compelling finding" of child abuse, interpreted to mean the interviewer found the children believable; the error was not harmless where "[t]here was no physical evidence presented in this case" and [t]he only evidence presented by the State was the children accounts of what occurred and other hearsay evidence of the children's accounts").

According to her own testimony, Kromah was alone with the Child in the bathroom when the bleeding incident occurred, and he had not been bleeding prior to this time. Numerous medical experts testified that the Child's genital wound could not have been caused by an accidental injury. They reached this conclusion based on the pattern of the wound and the circumstances of the Child's injury (spontaneous bleeding along with straight-edged lacerations in a V-shape that were consistent with the Child being cut by a razor, knife, box cutter, or other sharp instrument). Thus, Kromah's [*35] statements that the Child spontaneously started bleeding after she applied a warm washcloth while giving him a bath and that she had no idea how the Child's testicle came to be protruding from the Child's scrotum are inconsistent with the overwhelming expert medical evidence in the record that the wound resulted from physical abuse.

In addition, there was evidence of other injuries to the Child, such as an abrasion on the forehead, lip lacerations, and abdominal bruising, all of which were recently inflicted and indicative of physical abuse. Based on the entire record, including the physical evidence documented in this case, the challenged testimony could not reasonably have affected the result of the trial, so any error in its admission was harmless beyond a reasonable doubt.

IV. CONCLUSION

We find Kromah's issue on appeal is preserved and address it here in the interest of judicial economy. On the merits, Kromah has shown no abuse of discretion in the trial court's admission of Livingston's testimony, and any error in the admission of forensic interviewer Smith's

testimony was harmless beyond a reasonable doubt. Consequently, the decision of the Court of Appeals, which upheld Kromah's [*36] convictions and sentences, is affirmed in result.

AFFIRMED IN RESULT.

TOAL, C.J., KITTREDGE and HEARN, JJ., concur. PLEICONES, J., concurring in result only.

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MARVIN LUMBER & CEDAR COMPANY, Plaintiff, v. NORTON COMPANY, Defendant

Civ. 6-85-93

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MINNESOTA

113 F.R.D. 588; 1986 U.S. Dist. LEXIS 16045

December 23, 1986

PRIOR HISTORY: Lumber v. Norton Co., 1986 U.S. Dist. LEXIS 31166 (D. Minn., Nov. 14, 1986)

COUNSEL: [**1] Stephen Tourek and Stephen Snyder, St. Paul, Minnesota, for plaintiff.

Peter Sipkins, St. Paul, Minnesota, Paul Hempel and Raymond Hayward, Minneapolis, Minnesota, for defendant.

Vance Grannis, Jr., South St. Paul, Minnesota, for Twin Cities Testing.

JUDGES: Janice M. Symchych, United States Magistrate.

OPINION BY: SYMCHYCH

OPINION

[*589] ORDER

JANICE M. SYMCHYCH, United States Magistrate.

The above matter came on before the undersigned on November 26, 1986 and December 5, 1986 upon various pretrial motions. [*590] On November 26, Stephen Tourek, Esq. and Stephen Snyder, Esq., appeared on behalf of plaintiff; Peter Sipkins, Esq., and Raymond Hayward, Esq., appeared for defendant; and Vance Grannis, Jr., Esq., appeared on behalf of Twin Cities Testing. On December 5, Stephen Tourek, Esq. appeared for plaintiff, and Peter Sipkins, Esq. and Paul Hempel, Esq., appeared for defendant.

BACKGROUND

This is a multimillion dollar claim by a national manufacturer of insulated windows against a manufacturer of sealant utilized over a number of years by plaintiff in the construction of its windows. The claim is that the sealant was generically defective in its chemical formulation, and, [**2] among other things, allowed plaintiff's windows to leak, causing customer complaints, replacement obligations, and damage to plaintiff's commercial reputation. The litigation has presented unwieldy discovery challenges to the parties, and has generated a need for considerable court intervention in its pretrial phases. Presently before the court are the following:

> cross motions relating to defendant's employment of Twin Cities Testing as an expert in pretrial product inspections;
>
> defendant's motion to modify an October 15, 1985 order of United States Magistrate J. Earl Cudd regarding pretrial product inspections;
>
> defendant's motion to compel supplemental responses to its damages discovery; and
>
> defendant's motion to extend the pretrial schedule.

They will be taken up seriatim.

I. DISQUALIFICATION OF DEFENDANT'S RETAINED EXPERT

Plaintiff has moved to disqualify Twin Cities Testing (TCT), an independent scientific testing laboratory,

from its present role as a consulting expert of defendant, and from any role as defendant's expert witness at trial. It does so on grounds of conflict-of-interest, based upon TCT's relationship with plaintiff predating [**3] and continuing through the date of retention by defendant in this litigation. Plaintiff asserts that under the circumstances, TCT is simultaneously serving two masters, on substantially related matters. It further asserts that TCT is in possession of the confidences and secrets of plaintiff, on subject matter related to this litigation, and that the preservation of those confidences requires disqualification. The facts leading to this dispute are outlined in an order dated November 14, 1986, temporarily granting plaintiff's request for disqualification.

In essence, the parties concur that the court can and should determine issues regarding disqualification of expert witnesses, (as opposed to the better recognized role of the court in determining issues regarding disqualification of counsel). They further concur that if TCT was indeed engaged as a consulting engineer with plaintiff, on matters relevant to this litigation, at the time it was retained by defendant, that it should be disqualified. The court agrees with that proposition, and finds it supported in the case law. *Conforti v. Eisele, Inc. v. Div. of Building & Construction, 170 N.J.Sup. 64, 405 A.2d 487 (1979).* The [**4] parties, however, disagree on the question of whether TCT was so employed at the time. They have submitted affidavits and deposition transcripts in support of their views.

In essence, defendant characterizes the relationship as one in which TCT, upon intermittent agreements, would perform standardized, routine industry tests for plaintiff, and report its results. This is something which TCT does, as a large independent laboratory, for a wide variety of clients in a wide variety of industries. Defendant urges that TCT, during its relation with plaintiff, did not render opinions, provide advice, or consult as professional engineers. It denies that any expert-client relation existed. It emphasizes that TCT has not been retained by plaintiff for this litigation.

[*591] Plaintiff describes the relationship as one involving "professional advice," and more than the "simple reading of a speedometer" for a fee. Plaintiff states that beyond standardized testing, TCT has engaged in product development work for plaintiff, has performed in-house tests, more rigorous than the industry standards, and has had long-term access to sensitive product design information and plaintiff's manufacturing [**5] and research facilities. In addition, it points out that TCT has performed tests to determine water infiltration problems, which is a matter at the heart of this litigation. TCT previously served as plaintiff's litigation expert in an unrelated sealant case, and defendant has sought those materials in the discovery of this case.

As for TCT, it emphasizes the nature of the task assigned to it by defendant in this case, asserting that by its nature, it presents no conflict with plaintiff's interests. In doing so, it states that TCT is retained simply to attend plaintiff's window replacements, and to report as an eyewitness to defendant any installation problems present at the site, which could explain the reason for the window failure involved. TCT emphasizes that it has not divulged, and will not, any information or knowledge acquired by it during its relationship with plaintiff. Defendant has formally represented to the court that it has received no such information. TCT asks that, if disqualification is ordered, it not be based on a finding of an actual breach of confidentiality. Indeed, the record would not support such a finding.

Nonetheless, a disqualification order is [**6] warranted. To accept either defendant's or TCT's view of the relationship would amount to an artificially narrow view of its essence. Rather than the simple, unthinking performance of unrelated mechanistic tasks urged by defendant, the record supports a longstanding series of interactions, which have more likely than not coalesced to create a basic understanding of plaintiff's modus operandi, patterns of operation, decision-making process and the like. The rules governing disqualification are designed to protect against the potential breach of such confidences, even without any predicate showing of actual breach. That is the case with respect to expert witnesses, *Conforti,* 405 A.2d at 489-92, and *Miles v. Farrell, 549 F. Supp. 82, 84 (N.D.Ill.1982),* just as it is the well-accepted rule with respect to attorney disqualification. The threat or potential threat that confidences may be disclosed is enough. *Kearns v. Fred Lavery Porsche Audi Co., 745 F.2d 600 (Fed.Cir.1984), cert. denied, 469 U.S. 1192, 105 S. Ct. 967, 83 L. Ed. 2d 971 (1985); Arkansas v. Dean Foods Products, 605 F.2d 380 (8th Cir.1979) overruled on other grounds, In Re Multi-Piece Rim Products* [**7] *Liability Litigation, 612 F.2d 377 (8th Cir.1980), vacated and remanded, 449 U.S. 368, 101 S. Ct. 669, 66 L. Ed. 2d 571 (1981);* and *United States v. Shepard, 675 F.2d 977 (8th Cir.1982).* As the *Conforti* court observed, there is no sound basis for application of any different rule on the sole rationale that an expert, rather than an attorney, is the subject of the motion. *Id. 405 A.2d at 491.*

This result is particularly apropos here because the subject matter of the prior relationship clearly impinges upon this litigation. To distinguish the relationships upon the notion that the product inspections here are merely factual and mechanistic is disingenuous. Defendant surely will claim at trial that many of the defects in the subject windows are attributable to plaintiff's manufacturing flaws and installation errors. TCT's prior relationship with plaintiff includes exposure to infor-

mation about, and exchanges regarding the adequacy of plaintiff's window manufacturing. The test, regarding attorney disqualification, as articulated in this Circuit, is that the party seeking disqualification of opposing counsel must show that counsel to have an attorney-client relationship [**8] with an adverse party in the present suit, and that the matters involved in the pending suit are substantially related to the matters or cause of action in which the attorney previously represented him. *Fred Weber, Inc. v. Shell Oil Co., 566 F.2d 602, 608* [*592] *(8th Cir.1977), cert. denied, 436 U.S. 905, 98 S. Ct. 2235, 56 L. Ed. 2d 403 (1978), overruled on other grounds, In Re Multi-Piece Rim Products Liability Litigation, 612 F.2d 377 (8th Cir.1980), vacated and remanded, 449 U.S. 368, 101 S. Ct. 669, 66 L. Ed. 2d 571 (1981). See also, United States Fidelity and Guaranty Co. v. Louis A. Roser Co., 585 F.2d 932, 939 (8th Cir.1978).* A substantial relationship is present if the factual contexts of the two representations are similar or related. *Trone v. Smith, 621 F.2d 994, 998 (9th Cir.1980).* Under these well-established principles regarding attorney disqualification, the factual context in the instant case qualifies readily as "substantially related."

The court must then balance the interests and motivations of the attorneys and clients, and the public's interest in determining whether a motion for disqualification should be granted. *Arkansas v.* [**9] *Dean Foods Products Co., Inc., 605 F.2d 380, 383 (8th Cir.1979).* Any doubt is to be resolved in favor of disqualification. *Coffelt v. Shell, 577 F.2d 30, 32 (8th Cir.1978).*

It is thus clear, that the eyewitness observation of the window replacements (concededly on windows for which damages will be claimed) alone is likely to place TCT in an adversarial position against its past and present client. The very act of testifying on this subject on Norton's behalf would be adverse, and should not be permitted here. *Miles v. Farrell, 549 F. Supp. 82, 85 (N.D.Ill.1982).*

For the foregoing reasons, the motion to disqualify TCT will be granted. By virtue of that decision, defendant's motion to prohibit plaintiff's ex parte conversations with TCT is mooted. It should be observed, however, that the record does not support any finding that plaintiff's counsel improperly attempted to obtain information or discovery from TCT related to this case. Instead, the conversations in issue are best characterized as notice to and inquiries by an existing client regarding the "two masters" complaint of plaintiff. Just as defendant had a right to communicate with TCT regarding its retention, [**10] plaintiff had a right to do so as an ongoing client. The dispute is merely illustrative of the basis for disqualification. Therefore, application of *Durflinger v. Artiles, 727 F.2d 888 (10th Cir.1984),* and *Campbell Industries v. M/V Gemini, 619 F.2d 24 (9th Cir.1980),* as urged by defendant, should be and is rejected.

II. PRETRIAL PRODUCT TESTING

By way of an order dated October 15, 1985, United States Magistrate J. Earl Cudd granted defendant's motion for a Rule 26(c) protective order, to allow it to observe plaintiff's window replacements, and to test certain of the replaced windows for presentation of its defense at trial. The number of window replacements is voluminous, involving commercial and residential buildings alike, across the nation. Each window replaced will become part of plaintiff's claimed damages. Logistical problems with the application of the protective order, which were not foreseeable at the time of its issuance, have arisen. Defendant seeks, and will be granted, an amendment of the protective order as follows:

> 1. Plaintiff shall provide the name, address, and telephone number of the customer at each replacement site noticed pursuant [**11] to the order, at the time specified by the order, or such other time as agreed to by the parties;
>
> 2. To the extent known by plaintiff, its replacement site notice shall set forth the number of windows to be replaced at each location;
>
> 3. Defendant shall notify plaintiff within two weeks of any customer interview it conducts, identifying the customer interviewed;
>
> 4. Each party may conduct destructive testing of 1000 units, without providing prior notice of the fact or nature of the testing, except that with respect to distributor-replaced windows, defendant shall provide written notice of the intent to destructively test, and a reasonable opportunity for plaintiff to inspect such units prior to testing;
>
> [*593] 5. With respect to windows selected by defendant for destructive testing, plaintiff shall keep intact, retain, and not destroy any component parts related to that window unit, including substances affixed thereto;
>
> 6. Each party shall have free access, within the relevant Federal Rules of Civil Procedure, to all third party witnesses, in-

cluding customers, dealers, and distributors;

7. Plaintiff, notwithstanding its replacement site notice, may [**12] return to a site to complete replacements, if for some bona fide reason it cannot complete all replacements at a single time; in such a case, plaintiff shall provide defendant five days written notice of the need to return, the return date, and the reason therefore; and

8. Each party may seek further amendment of the protective order as may be necessary.

III. DAMAGES DISCOVERY

Defendant complains that plaintiff's damages claim is astronomically high, and that well after the mid-point in the discovery period, it lacks responses from plaintiff to its discovery requests on the subject. It urges the court to compel responses before the midnight hour, so that it can adequately prepare a defense to this significantly large and complex aspect of the case.

The damages portion of a trial may be as significant as the liability portion. It goes without saying that a defendant is entitled to discovery of its adversary's theory or measure of damages, its calculations under that theory, and expert opinions on the subject of damages. *Kodekey Electronics, Inc. v. Mechanex Corp., 486 F.2d 449, 458 n. 10 (10th Cir.1973)*; *Bogosian v. Gulf Oil Corp., 337 F. Supp. 1228, 1230 (E.D.Pa.1971)*; [**13] and *Technograph, Inc. v. Texas Instruments, Inc., 43 F.R.D. 416, 418 (S.D.N.Y.1967)*.

While it is clear that plaintiffs in civil actions often are unable to finally calculate their damages until discovery is received from the defendant, they are under some obligation to answer such discovery requests well prior to the discovery deadline. To have it otherwise would obviously and unfairly prejudice a defendant in its trial preparation. *Knapp v. Whitaker, 757 F.2d 827, 848-49 (7th Cir.1985)*; *Laclede v. Gas Co. v. G.W. Warnecke Corp., 604 F.2d 561, 565 (8th Cir.1979). See also, Phil Crowley Steel Corp. v. Macomber, Inc., 601 F.2d 342, 344-45 (8th Cir.1979)*. This is especially so, where, as here, plaintiff will rely upon expert opinion for presentation of its damages proof. Defendant is entitled to prepare contrary expert testimony within the discovery period. *Laclede*, 604 F.2d at 565.

In order to facilitate this result, this court issued an order on February 26, 1986, requiring plaintiff, in response to defendant's interrogatories 32 and 44, to produce bimonthly damages reports to defendant, with an obligation to keep defendant current on the state of plaintiff's [**14] damage calculations and the bases therefore. A review of the currently submitted report shows that for this stage of the discovery period, the report is quite inadequate, and at best, only hints at what plaintiff's total damage claim will be. Its greatest flaw is that it fails to set forth the basis for, or the sources of raw data to be relied upon by plaintiff. Plaintiff's counsel reassures the court that the forthcoming damages reports will be more detailed and full. It emphasizes to the court, however, that an absolutely final computation cannot be made at this time. That is understandable. With all of this in mind, the motion to compel more specific damages reports will be granted. The next damages report shall include an itemization of the component costs used by plaintiff in arriving at its $ 100 per replacement cost, as well as identification of and production of the raw documents in support of those component valuations.

Defendant also seeks to compel responses to Set I of its documents request, numbers 4 and 10, regarding plaintiff's lost [*594] profits. Plaintiff agrees to provide all financial data bearing on lost profits by January 1, 1987, including, but [**15] not limited to those enumerated in Exhibit C. Plaintiff, of course, is not obligated to produce documents it claims to be privileged.

IV. PRETRIAL SCHEDULE

Defendant seeks a three-month extension of the pretrial schedule. The primary reason for the extension is to allow for the taking of some 75 depositions, which defendant states would have to be taken at the rate of four per day in order to conclude by the present deadline of March 15, 1987. In addition, defendant states that the inadequate damages discovery produced by plaintiff to date has left it without sufficient time to conduct the "fact witness" aspect of damages discovery necessary before preparation of expert opinions on that subject.

Rule 16(b) of the Federal Rules of Civil Procedure requires a showing of good cause before a pretrial schedule may be expanded. This matter has been kept on a deliberately tight pretrial schedule, in order to keep counsel and the parties attentive to the need to work intensely and quickly on discovery, given the unwieldy nature of the fact investigation. The time thus far allotted has been well-utilized, and considerable work has been accomplished. It is apparent that the remaining [**16] time is insufficient to allow completion of discovery.

To alleviate the confusion asserted at hearing, it should be made clear that the pretrial schedule contemplates the conclusion of all fact discovery prior to the beginning of the period for expert discovery, without overlap of the two.

Therefore, based upon the briefs and arguments of counsel and all the files and proceedings herein,

IT IS HEREBY ORDERED that:

1. Plaintiff's motion to disqualify Twin Cities Testing as defendant's consulting and/or testifying expert is GRANTED;

2. Defendant's motion for a protective order regarding Twin Cities Testing is DENIED;

3. Defendant's motion to amend the pretrial order of October 15, 1985, is GRANTED as set forth;

4. Defendant's motion to compel more specific answers to Interrogatories 32 and 44, and Document Request Set 1, numbers 4 and 10 is GRANTED;

5. Defendant's motion for extension of the pretrial schedule is GRANTED, as follows:

a. All discovery shall terminate on August 1, 1987;

b. All nondispositive motions, specifically those which relate to discovery and the discovery period, shall be filed and heard prior to August 1, 1987;

c. All discovery on subjects [**17] other than expert opinions shall terminate and all nondispositive motions in that regard shall be filed and heard prior to May 15 1987;

d. All discovery regarding expert opinions shall terminate and all nondispositive motions in that regard shall be filed and heard prior to July 15, 1987;

e. All dispositive motions shall be filed and scheduled for hearing pursuant to Local Rule 4 prior to September 1, 1987;

f. This case shall be considered as ready for trial on November 1, 1987.

6. A *Rule 16* status conference will be held before the undersigned on April 8, 1987, at 1:30 p.m. The parties shall submit and serve matters for hearing pursuant to the local rules.

Steven M. Elbert, Anita C. Dawson, Gloria Harris, and William M. Goldberger, Appellants-Appellees, v. Bexley Board of Zoning Appeals and Dorothy Pritchard, Zoning Officer for the City of Bexley et al., Appellees-Appellees, (William D. Dargusch, Appellant). Steven M. Elbert, Anita C. Dawson, Gloria Harris, and William M. Goldberger, Appellants-Appellees, v. Bexley Planning Commission aka Bexley Environmental Review Board and Dorothy Pritchard, Zoning Officer for the City of Bexley et al., Appellees-Appellees, (William D. Dargusch, Appellant). Steven M. Elbert, Anita C. Dawson, Gloria Harris, and William M. Goldberger, Appellants-Appellees, v. Bexley Board of Zoning Appeals and Dorothy Pritchard, Zoning Officer for the City of Bexley et al., Appellees-Appellants. Steven M. Elbert, Anita C. Dawson, Gloria Harris, and William M. Goldberger, Appellants-Appellees, v. Bexley Planning Commission aka Bexley Environmental Review Board and Dorothy Pritchard, Zoning Officer for the City of Bexley et al., Appellees-Appellants. Steven M. Elbert, Anita C. Dawson and Gloria Harris, Appellants-Appellees, William M. Goldberger, Appellant-Appellant, v. Bexley Board of Zoning Appeals and Dorothy Pritchard, Zoning Officer Appellees-Appellees.

No. 95APE04-451 (REGULAR CALENDAR), No. 95APE04-452 (REGULAR CALENDAR), No. 95APE04-453 (REGULAR CALENDAR), No. 95APE04-454 (REGULAR CALENDAR), No. 95APE05-551 (REGULAR CALENDAR)

COURT OF APPEALS OF OHIO, TENTH APPELLATE DISTRICT, FRANKLIN COUNTY

108 Ohio App. 3d 59; 670 N.E.2d 245; 1995 Ohio App. LEXIS 4867

November 2, 1995, Rendered On

PRIOR HISTORY: [***1] APPEAL from the Franklin County Court of Common Pleas.

DISPOSITION: Judgment affirmed in part, reversed in part and cause remanded with instructions.

COUNSEL: Brunner & Brunner, Jennifer L. Brunner and Rick L. Brunner, for Anita Dawson, Steven M. Elbert and Gloria Harris.

William Goldberger, pro se.

Vorys, Sater, Seymour & Pease, William G. Porter, II, and Philip F. Downey, for City of Bexley Board of Zoning Appeals, City of Bexley Environmental Review Board and City of Bexley Zoning Officer, Dorothy Pritchard.

Chester, Willcox & Saxbe, and Stephen C. Fitch, for William G. Dargusch.

William F. Underwood, for amicus curiae City of Reynoldsburg.

Thomas L. Weber, for amicus curiae City of Gahanna.

Dennis J. Fennessey, for amicus curiae City of Whitehall.

Baker & Hostetler, and Michael E. Minister, for amicus curiae City of Worthington, State of Ohio.

Charles A. Schneider, for amicus curiae, City of Hilliard.

JUDGES: DESHLER, J. YOUNG and CLOSE, JJ., concur.

OPINION BY: DESHLER

OPINION

[*62] [**247] OPINION

DESHLER, J.

This case involves appeals by the city of Bexley Board of Zoning Appeals ("BZA"), the city of Bexley Environmental Review Board ("ERB"), [***2] Bexley Zoning Officer, Dorothy Pritchard and William D. Dargusch (collectively "appellants"), from a judgment of the Franklin County Court of Common Pleas, reversing a decision of the BZA granting a request for variances and reversing a decision of the ERB approving site plans and specifications for a proposed restaurant.

This action arose out of the efforts of Dargusch, a developer, to seek approval from the city of Bexley to build a McDonald's restaurant on property located at 2484 East Main Street, Bexley. The property is zoned as part of the city's "Community Commercial District." Currently, the property is the site of a vacant establishment, the Bexley Art Theater, a former adult movie theater and adult video outlet.

The site property is located on the north side of Main Street. The proposed plans provide for the building to be set off to the west side of the lot, with an outdoor cafe to be located at the south side of the building. The plans further provide for twenty-four off-street parking spaces for patrons.

As part of the application process, Dargusch sought a determination whether the proposed facility was a "permitted use" in the city's Community Commercial District. [***3] In application No. 829, the city zoning officer made a determination that the proposed McDonald's was an "eating place," thus qualifying as a permitted use pursuant to Bexley City Ordinance ("B.C.O.") 1252.03(j). The BZA subsequently voted to affirm the zoning officer's decision and interpretation that the proposed McDonald's constituted a permitted use.

[*63] On July 11, 1994, Dargusch filed an application with the Bexley Planning Commission for environmental approval of the site plans and for approval of a signage variance. On July 25, 1994, the planning commission, sitting as the ERB, held a meeting to consider the application, assigned as application No. 400. At the conclusion of the meeting, the ERB voted in favor of a motion for environmental approval of the site plan subject to the submittal of an ingress/egress plan acceptable with the city traffic engineer. The ERB also voted in favor of a motion to approve the signage application and variance, subject to certain conditions.

The ERB conducted a meeting on September 26, 1994 to take up further consideration of the issues pending in application No. 400. The ERB noted that the applicant, subsequent to the July 25, 1994 [***4] meeting, had submitted plans and documents addressing some of the concerns raised at that meeting, including a change to a single curb cut exit from the originally proposed combined driveway curb cut. A drawing was submitted, which was not presented at the July 25 meeting, in response to concerns regarding traffic flow on Main Street. Based upon a review of the drawings submitted, including the changes made since the prior meeting, the ERB determined that the requirements of B.C.O. 1222.03(b) had been met. Pursuant to B.C.O. 1222.04(a), the ERB granted approval of the proposed plans.

Dargusch further sought approval by the BZA of the following three variances: (1) a variance from B.C.O. 1256.06, which requires one off-street loading space to be provided for buildings under 5,000 square feet; (2) a variance from B.C.O. 1256.04, which prohibits parking spaces in front of the principal building, in order to allow one foot eight inches of one parking space to be located in front of the principal building; and, (3) a variance from B.C.O. 1260.07(e), which requires accessory uses to be at least three feet from all property lines, in order to permit parking spaces to be located on the real [***5] property line and parking spaces and trash enclosure to be located one foot from the side property line on the east. On September 21, 1994, the [**248] BZA met to consider the matter. Following the hearing, the BZA voted to approve the granting of the three requested variances.

On November 14, 1994, appellees, Steven M. Elbert, Anita C. Dawson, Gloria Harris and William Goldberger, filed notices of appeal with the Franklin County Court of Common Pleas from the following actions: the order of the BZA granting three variances to appellant Dargusch (Case No. 94CVH-11-8032, hereafter "case No. 8032"); the order of the BZA finding that the proposed restaurant was a permitted use in the Community Commercial District (case No. 94CVH-11-8033, hereafter "case No. 8033"); and, orders of the planning commission, sitting as the ERB, approving plans and specifications for the proposed restaurant (case No. 94CVH-11-8034, hereafter "case No. 8034").

[*64] By entry filed November 23, 1993, the trial court granted a motion by Dargusch to intervene pursuant to *Civ.R. 24(A)*. On December 12, 1994, appellees filed a motion to supplement the record in case Nos. 8032 and 8034. Specifically, [***6] appellees sought to present additional evidence regarding the issue of the impact of the proposed facility on traffic and pedestrian walkways in the site area. By judgment entry filed January 10, 1995, the trial court sustained appellees' motion.

On January 27, 1995, the trial court heard the testimony of two witnesses for appellees, Joseph Ridgeway and Leonard Kutney.

On April 7, 1995, the trial court rendered its decision in the matter. Specifically, in case No. 8033, the trial court affirmed the BZA's determination that the proposed facility was a permitted use. In case No. 8032, the trial court reversed the BZA's decisions to grant Dargusch's requests for variances, while in case No. 8034, the trial court affirmed in part and reversed in part the ERB's decision approving plans and specifications for the proposed McDonald's.

On appeal, the BZA, the ERB and Pritchard (collectively "the city") assert the following four assignments of error:

"Assignment of Error No. 1

"THE TRIAL COURT ERRED IN OVERRULING APPELLEES-APPELLANTS', THE CITY OF BEXLEY AND DARGUSCH, OBJECTIONS AND MOTIONS IN LIMINE TO EXCLUDE EVIDENCE REGARDING TRAFFIC REGULATION AND IN PERMITTING THE [***7] RECORDS IN CASE NOS. 8032 AND 8034 TO BE SUPPLEMENTED WITH TESTIMONY AND EVIDENCE OFFERED BY APPELLANTS-APPELLEES REGARDING TRAFFIC IN CONNECTION WITH THE TRIAL COURT'S REVIEW OF THE DECISION OF THE BEXLEY BOARD OF ZONING APPEALS TO GRANT AREA (NON-USE) VARIANCES TO APPELLEE-APPELLANT DARGUSCH AND THE DECISION OF THE BEXLEY ENVIRONMENTAL REVIEW BOARD APPROVING PLANS AND SPECIFICATIONS FOR THE PROPOSED RESTAURANT.

"Assignment of Error No. 2

"THE TRIAL COURT ERRED BY FAILING TO APPLY THE DEFERENTIAL STANDARD OF REVIEW TO THE DECISIONS OF THE BEXLEY BOARD OF ZONING APPEALS AND THE BEXLEY ENVIRONMENTAL REVIEW BOARD, BY BLATANTLY SUBSTITUTING ITS JUDGMENT FOR THE JUDGMENT OF BEXLEY'S ZONING OFFICIALS AND BY JUDICIALLY REWRITING BEXLEY'S ZONING ORDINANCES IN A MANNER CONTRARY TO LAW AND CONTRARY TO BEXLEY'S CONSISTENT INTERPRETATION AND ADMINISTRATION OF ITS ZONING CODE.

"Assignment of Error No. 3

"THE TRIAL COURT ERRED IN REVERSING THE BEXLEY BOARD OF ZONING APPEALS DECISION TO GRANT THE THREE AREA (NON-USE) VARIANCES REQUESTED BY APPELLANT DARGUSCH.

[*65]

"Assignment of Error No. 4

"THE TRIAL COURT ERRED [***8] IN REVERSING THE BEXLEY ENVIRONMENTAL REVIEW BOARD'S APPROVAL OF THE SITE PLANS AND SPECIFICATIONS FOR THE PROPOSED RESTAURANT."

Appellant Dargusch sets forth the following five assignments of error for review:

"Assignment of Error No. 1

"The trial court erred in (a) granting Appellees' motion to supplement the record in Case Nos. 8032 and 8034 with traffic evidence; and (b) overruling the City of Bexley's and Appellant William D. Dargusch's (Dargusch) motion in limine and objections to evidence regarding traffic in connection with the trial court's review of the decisions of the Bexley Board of Zoning Appeals (BZA) to grant variances to Appellant Dargusch and the Bexley Environmental Review Board (ERB) to approve plans and specifications submitted by Dargusch.

"Assignment of Error No. 2

[**249] "The trial court erred in (a) finding that the traffic testimony was reliable and credible; (b) finding that the variances approved by the Bexley BZA will increase traffic congestion; and (c) finding that the evidence of traffic congestion required reversal of the Bexley ERB's approval of Dargusch's plans and specifications.

[***9]

"Assignment of Error No. 3

"The trial court erred in reversing the decision of the Bexley BZA to grant two area variances to Dargusch.

"Assignment of Error No. 4

"The trial court erred in reversing the decision of the Bexley ERB to approve the plans and specifications submitted by Dargusch.

"Assignment of Error No. 5

"The trial court erred in interpreting and applying BCO Chapters 1222 and 1256 in such a was as to deprive Dargusch of due process guaranteed by the Ohio and U.S. Constitutions."

William Goldberger, an appellee in case Nos. 8032 and 8034, has filed a notice of appeal from the trial court's entry only as it relates to the disposition of Case No. 8033, in which the court affirmed the BZA's determination that the proposed restaurant was a permitted use. [1] Goldberger asserts the following assignment of error for review:

1 As noted above, William Goldberger has filed a notice of appeal only as to the trial court's decision in case No. 8033. In this court's discussion of case Nos. 8032 and 8034, Goldberger, along with Steven M. Elbert, Anita C. Dawson and Gloria Harris, will be referred to collectively as appellees.

[***10] [*66]

"The Court of Common Pleas erred in affirming the determination of the Bexley Board of Zoning Appeals that the proposed McDonald's restaurant at 2484 East Main Street in Bexley is a 'permitted use' in accord with the Bexley Codified Ordinances."

Initially, we note the standards of review by which a trial court and an appellate court are to consider appeals under *R.C. Chapter 2506.* In *Budd Co. v. Mercer (1984), 14 Ohio App. 3d 269, 471 N.E.2d 151,* the court discussed the applicable standards of review, holding that:

"It must *** be remembered that the appeal in the common pleas court was an appeal from an administrative agency and, as such, was governed by *R.C. Chapter 2506.* *** Specifically, the common pleas court is confined to the transcript compiled during the agency's proceedings (*R.C. 2506.03, 2506.02*), unless one of the conditions specified in the statute appears on the face of the transcript or by affidavit. *R.C. 2506.03(A)* and *(B).* *** When reviewing the decision of an administrative agency, the common pleas court, based on the entire record, may find that the agency's order, adjudication or decision is 'unconstitutional, illegal, arbitrary, [***11] capricious, unreasonable, or unsupported by the preponderance of substantial, reliable and probative evidence *** .' *R.C. 2506.04.* In undertaking this hybrid form of review, the common pleas court must give due deference to the administrative agency's resolution of evidentiary conflicts, *** and the court may not, especially in the areas of administrative expertise, blatantly substitute its judgment for that of the agency. ***

" ***

> "The key term in *R.C. 2506.04* is 'preponderance.' *** 'If a preponderance of reliable, probative and substantial evidence exists, the Court of Common Pleas must affirm the agency decision.' *** In determining whether the common pleas court properly applied the standard of review set forth in *R.C. 2506.04*, this court has a limited function. This court's determination is limited to the question of whether, as a matter of law, a preponderance of reliable, probative and substantial evidence exists to support the decision of the board. *** " *Id. at 273-274.* (Citations omitted.)

We will first address the single assignment of error of Goldberger. Under this assignment of error, Goldberger asserts that the trial court erred [***12] in affirming the BZA's determination that the proposed restaurant is a "permitted use" in the Community Commercial District of the city.

The issue of whether the proposed McDonald's restaurant is a permitted use is [**250] governed by the Bexley zoning ordinance. Pursuant to B.C.O. 1268.24, a permitted use is defined as "a use specifically allowed within a zoning district." B.C.O. 1252.03(j) provides that permitted uses in the Community Commercial [*67] District include "retail sales to include *** food" and "retail services to include *** eating places *** ."

In the present case, the trial court held that the BZA's determination that the proposed McDonald's restaurant is a permitted use was supported by a preponderance of reliable, probative and substantial evidence. We agree. The statutory language at issue is clear and unambiguous, and provides that an eating place is a permitted use in the Community Commercial District.

Notwithstanding the clear and unequivocal language of the ordinance, Goldberger contends that the proposed restaurant does not satisfy the "intent" language set forth in B.C.O. 1244.11. Goldberger further argues that the proposed restaurant falls under [***13] the definition of a "drive-in facility," thus constituting a specifically prohibited use in the Community Commercial District. Both of these contentions are without merit.

B.C.O. 1244.11 states:

> "The purpose of this [Community Commercial] District is to allow and encourage a strong local shopping center in the City. A broad range of commercial uses should be allowed, but especially those which attract leisurely comparison-type shopping rather than a convenient quick-stop service. Development standards should allow a maximum use of a limited space for both shopping and parking, while preserving and enhancing pedestrian walkways. Redevelopment should be encouraged to use the Planned Unit Commercial District, when appropriate."

In response to Goldberger's contention that the proposed McDonald's constitutes a "convenient quick-stop" service, the trial court held that the language of B.C.O. 1244.11 "is permissive and serves as a guide" to the BZA. The court further noted that the language of the ordinance does not specifically prohibit "convenient quick-stop services," nor does it define that term. We find that the trial court properly concluded that the "intent" clause [***14] relied upon by Goldberger, while serving as a guide, cannot be construed as a prohibition upon language defining permitted uses.

In so holding, the trial court followed well-established Ohio case law authority which provides that, "statutes or ordinances *** which impose restrictions upon the use of *** private property, will be strictly construed and their scope cannot be extended to include limitations not therein clearly proscribed." *State ex rel. Moore Oil Co., v. Dauben, Bldg. Inspr., (1919), 99 Ohio St. 406, 124 N.E. 232.* See, also, *State ex rel. Spiccia v. Abate (1965), 2 Ohio St. 2d 129, 130, 207 N.E.2d 234*, overruled on other grounds, *7 Ohio St. 2d 85, 218 N.E.2d 428*; *In re University Circle, Inc. (1978), 56 Ohio St. 2d 180, 184, 383 N.E.2d 139*; *Lykins v. Dayton Motorcycle Club (1972), 33 Ohio App. 2d 269,* [*68] *294 N.E.2d 227*; *Whiteco Metrocom, Inc. v. Columbus (1994), 94 Ohio App. 3d 185, 190-191, 640 N.E.2d 563* (statutes imposing restrictions on the use of private property must be strictly construed and all doubts resolved in favor of the free use of the property rather than in restricting such use). In the instant case, the language relied upon [***15] by Goldberger does not set forth a clearly proscribed limitation and we decline to find such a limitation by implication.

Goldberger further contends that the proposed restaurant is a "drive-in facility" as defined under B.C.O. 1268.10. We find no merit to this contention.

Pursuant to B.C.O. 1268.10, a "drive-in facility" is defined as "any place or premises used for sale or services to persons remaining in their automobiles, including those establishments where customers may serve

themselves and may consume the food or beverages in their automobiles." We note that it is undisputed that the proposed McDonald's does not include a drive-through window. Goldberger's argument, however, is premised upon his assertion that customers of the McDonald's may serve themselves and consume the food or beverages in their automobiles; [**251] thus, he contends, the McDonald's constitutes a drive-in facility.

During the BZA hearing conducted on October 23, 1994, city zoning officer Dorothy Pritchard testified that the BZA did not consider the proposed McDonald's to be a "drive-in facility" as that term is defined under the ordinance. Specifically, Pritchard stated:

> "Historically we [***16] have interpreted this to be places such as a car hop, a drive-in bank or any facilities of that type. We have not interpreted that to mean any restaurant where people may consume their food or beverages in their automobile. That could happen at any restaurant within the community commercial zoning district.
>
> "Certainly at Fourbakers or Grinders or Graeter's you take your ice cream to your car. We would also add car hops to what we would consider a drive-in facility where you are served in your automobile.
>
> " ***
>
> "That is not the intent of a restaurant to eat your food in your automobile or it is not the intent of that eating place, which is a permitted use, to eat the food in your automobile. The city of Bexley has no regulations that say you cannot eat food in your automobile, just as you can take your Fourbakers doughnuts and eat it in your automobile or your Grinders sandwich and eat it in your automobile.
>
> "I don't believe that is what the code is talking about when it says customary meaning. Drive-in has historically in our code been interpreted as a facility designed for an automobile to drive through and be served or receive [***17] service *** . (BZA meeting, Oct. 23, 1994, 34-36.)

[*69] Thus, according to the testimony of Pritchard, the BZA has historically interpreted the term "drive-in facility" to only include facilities in which services are provided to customers in their vehicles. By way of example, Pritchard noted that the proposed McDonald's contemplates services similar to other restaurants in the Community Commercial District, including Grinders, Fourbakers and Graeters, even though food at those establishments could be obtained in a quick manner and consumed off the premises or in the customer's car. Although not dispositive, we find the BZA's interpretation of the zoning ordinance to be reasonable and entitled to weight. Presumably, Goldberger's interpretation would mean that all of the above establishments would be in violation of the ordinance based upon the possibility that a patron might consume food in his or her vehicle. The trial court noted that the BZA's determination that the proposed restaurant is an "eating place," as opposed to a "drive-in facility," was in accordance with the BZA's "legal obligation to liberally construe restrictive zoning ordinances." We concur with the [***18] trial court on this point.

More significantly, the clear language of the ordinance defines a "drive-in facility" as a "place or premises used for sale or services to persons remaining in their automobiles *** ." The evidence in this case indicates that patrons must enter the restaurant to purchase their food and that indoor seating will be provided. Further, there will be no walk-up windows, no drive-through windows nor will there be car-hop service. Accordingly, Goldberger's assertion that the proposed restaurant falls under the zoning code's definition of a drive-in facility is not well-taken.

We note that case law further supports the BZA's interpretation. In *Spiccia, supra, 2 Ohio St. 2d at 130*, the Ohio Supreme Court held that a Dairy Queen type restaurant, in which "all services to the purchasers are to take place inside the building, and where it is contemplated that much of the food will be eaten at tables provided for that purpose," was properly held to be a "restaurant" as opposed to a "drive-in restaurant," despite the fact that "much of the food may be carried to the parked cars and there eaten or carried out and eaten entirely off the premises."

Finally, [***19] Goldberger appears to raise a constitutional challenge to the Bexley Zoning Code. The record indicates, however, that Goldberger never raised this issue before the trial court. The trial court's decision specifically noted that the constitutionality of the ordinances was not raised, holding that, "whether the zoning ordinances contain sufficient criteria, standards and clarity to

pass [**252] constitutional muster has not been posed as a question to this Court and therefore need not be considered or ruled upon." Having failed to raise the issue before the trial court, Goldberger has waived his right to raise it now. See, *e.g., Stores Realty Co. v. Cleveland (1975), 41 Ohio St. 2d 41, 322 N.E.2d 629*; [*70] *Danis Clarkco Landfill Co. v. Clark Cty. Solid Waste Mgt. Dist. (1995), 73 Ohio St. 3d 590, 653 N.E.2d 646.*

The single assignment of error of Goldberger is overruled.

The first four assignments of error of the city and the first four assignments of error of Dargusch are interrelated and will be considered together. These assignments of error involve the trial court's decisions in case Nos. 8032 and 8034, in which the trial court reversed decisions of the BZA [***20] and ERB granting Dargusch's request for variances and approving plans and specifications for the proposed restaurant.

As previously noted, in case No. 8032, the BZA rendered decisions granting Dargusch's requests for variances from the Bexley Zoning Code's requirement of one on-site loading space, pursuant to B.C.O. 1256.06, and from the requirement that no parking spaces be located in the front of the principal building pursuant to B.C.O. 1256.04(c). [2] The trial court, in reviewing the decisions of the BZA, held that "traffic impact evidence is relevant with respect to BCO Chapter 1256, Off-Street Parking and Loading Regulations, which is the chapter which governs the variances that were granted." The trial court concluded that the BZA erroneously failed to give proper consideration to traffic concerns, holding that, "given the current volume of vehicular and pedestrian traffic in suburban areas such as Bexley, Ohio, it is difficult to conceive how the Bexley City government could ignore the impact of these two factors and remain in compliance with its own code." The court concluded that it could not affirm the BZA's decisions to grant the requested variances because the transcript [***21] of the proceedings before the BZA did not contain reliable, probative and substantial evidence to support its decisions.

> 2 As noted under the facts, Dargusch originally sought three variances, including a variance from B.C.O. 1260.07(e), which requires accessory uses to be at least three feet from all property lines. The record indicates that the request for a variance from B.C.O. 1260.07(e) is now moot based upon revised plans approved by the ERB on February 27, 1995.

The trial court then considered the issue of the variances based upon additional evidence heard before the court regarding traffic impact. Specifically, the court considered the testimony of two witnesses testifying on behalf of appellees, Joseph Ridgeway, the Bexley City Traffic Engineer, and Leonard Kutney, a traffic engineer, regarding the potential effect of the proposed restaurant on traffic generation and traffic patterns. The trial court found that these two witnesses were qualified to testify on the impact of the proposed McDonald's [***22] restaurant on traffic and the court further concluded that the experts' testimony was reliable and credible. Upon consideration of the additional evidence regarding traffic impact, the trial court reversed the decisions of the BZA to grant the [*71] variances, holding in part that "credible evidence shows that the variances will increase traffic congestion." Similarly, in case No. 8034, the trial court reversed in part the ERB's decision to grant approval of the plans and specifications based upon the court's determination that the ERB failed to consider traffic and parking concerns.

Initially, appellants contend that the trial court erred in allowing appellees to present additional evidence regarding the issue of traffic impact. On December 12, 1994, appellees filed a motion to supplement the record in case Nos. 8032 and 8034. Specifically, appellees sought to supplement the record pursuant to *R.C. 2506.03* on the grounds that: (1) appellees, in proceedings before the BZA and ERB, were not permitted to present evidence as to public interest concerns regarding traffic to be generated by the proposed restaurant; (2) the testimony in the above proceedings was not given under oath; [***23] and, (3) the board and the ERB failed to file conclusions of fact in support of their final orders. Both the city and Dargusch filed briefs in opposition to appellees' motion to supplement the record.

[**253] By decision and judgment entry filed January 10, 1995, the trial court granted appellees' motion to supplement the record. The trial court conducted a hearing on January 27, 1995 to hear additional evidence by Ridgeway and Kutney testifying on behalf of appellees.

R.C. 2506.03 provides in pertinent part:

> "(A) The hearing of such appeal shall proceed as in the trial of a civil action, but the court shall be confined to the transcript as filed pursuant to *section 2506.02 of the Revised Code* unless it appears, on the face of that transcript or by affidavit filed by the appellant, that one of the following applies:
>
> " ***

"(2) The appellant was not permitted to appear and be heard in person, or by his attorney, in opposition to the final order, adjudication, or decision appealed from, and to do any of the following:

"(a) present his position, arguments, and contentions;

"(b) Offer and examine witnesses and present evidence [***24] in support;

"(c) Cross-examine witnesses purporting to refute his position, arguments, and contentions;

"(d) Offer evidence to refute evidence and testimony offered in opposition to his position, arguments, and contentions;

"(e) Proffer any such evidence into the record, if the admission of it is denied by the officer or body appealed from.

[*72]

"(3) The testimony adduced was not given under oath;

" ***

"(5) The officer or body failed to file with the transcript, conclusions of fact supporting the final order, adjudication, or decision appealed from; *** "

In the instant case, the trial court granted appellees' request to present additional evidence based upon the provisions of *R.C. 2506.03(2), (3)* and *(5)*.

While judicial review in a *R.C. Chapter 2506* administrative appeal is ordinarily confined to the transcript, additional evidence may be presented if a statutorily defined exception exists. *T.O.P. 1 Partners v. Stow (1991), 73 Ohio App. 3d 24, 26, 595 N.E.2d 1044.* In general, *R.C. 2506.03* "contains a liberal provision for the introduction of new or additional evidence to be heard by [***25] a reviewing court." *In re Annexation of Certain Territory (1992), 82 Ohio App. 3d 377, 381, 612 N.E.2d 477.*

The record supports the trial court's findings that the testimony adduced was not given under oath and that neither the BZA nor the ERB filed findings of fact. Thus, there was a statutory basis for the trial court to hear additional evidence pursuant to *R.C. 2506.03*. However, we agree with appellants' contention that the evidence ultimately heard and considered by the trial court was not reliable.

As previously noted, appellees presented supplemental evidence before the trial court through the testimony of Joseph Ridgeway and Leonard Kutney. Ridgeway, the traffic engineer for the city of Bexley, attended the July 25, 1994 meeting of the ERB, during which he gave his opinion that a maximum of 1,500 cars were expected to visit the proposed restaurant per day. At the hearing before the trial court on the motion to supplement the record, Ridgeway testified that, in order to arrive at that calculation, he relied upon a manual published by the Institute of Transportation Engineers, referred to as the ITE Trip Generation Manual ("ITE Manual").

On cross-examination, Ridgeway [***26] acknowledged that the opinion he provided at the July 25 meeting was based upon a "quick calculation." Ridgeway stated that his intent was to arrive at a maximum figure. He stated that the 1,500 figure was the "high end of the range," and that a "low end range" would be somewhere between 1,000 and 1,100 vehicles per day. Ridgeway further explained that a new facility has two types of traffic. The first type he referred to as "pass by traffic," meaning traffic already on the street which enters the facility. The second type of traffic he termed "new traffic," defined as "traffic that is attracted to the site which is not normally on that roadway at that location." (Tr. 56.) Regarding the new traffic to be generated by the restaurant, [**254] Ridgeway arrived at a high end figure of 900 vehicles per day. Ridgeway testified that the new traffic generated [*73] by the proposed restaurant would increase overall traffic between four and five percent.

Ridgeway noted that the ITE Manual was an "informational report," and that the data is based upon a compilation of studies. The ITE Manual provides that "no attempt was made to conduct original field studies for this report" and that [***27] "information concerning the generator or site were obtained either through personal interviews, actual measurements, telephone conversations, or mail-back questionnaires." (ITE Manual at I-3.) Ridgeway acknowledged that the ITE Manual contains "cautions" regarding the use of the data con-

tained within. The ITE Manual cautions that a user should collect local data for comparison when considering use of the data in the report. Ridgeway testified that he did not attempt to collect local data nor did he attempt to adjust his calculations based upon local factors as recommended by the ITE Manual.

Ridgeway indicated that the data base for the ITE Manual extends back to the early 1960's. He was aware that the ITE Manual urges that "users of this report should also exercise extreme caution when utilizing statistics that are developed from a small number of studies or when the data points are widely scattered." (ITE Manual, at I-2.) In the present case, Ridgeway relied upon a sample size of six studies. He further admitted that the data points he utilized to arrive at his calculation were widely scattered. Ridgeway was also questioned about his calculation of standard deviation which, according [***28] to the ITE Manual, "is a measure of how widely dispersed the data points are around the calculated average, the less dispersion (the lower the number), the better." (ITE Manual, at I-10.) Ridgeway admitted that while some of the charts had standard deviation numbers for restaurants as low as 1.10 and 4.31, he relied upon a standard deviation number of 147.

During cross-examination, Ridgeway admitted that he could not give an opinion based upon a reasonable degree of scientific certainty regarding the number of vehicles that will be generated by the site. Specifically, Ridgeway was asked the following on cross-examination:

> "Q. MR. RIDGEWAY, GIVEN THIS KIND OF DISCREPANCY ON THE DRIVE-THRU VERSUS THE NON-DRIVE-THRU, GIVEN THE SMALL STATISTICAL SAMPLE THAT IS SIX SAMPLES OVER A TWENTY-YEAR PERIOD -- WE DON'T KNOW IF THOSE INCLUDED A MCDONALD'S -GIVEN THE HIGH STANDARD DEVIATION RATE THAT YOU HAVE TESTIFIED TO NOW, DO YOU BELIEVE THAT THE STUDY THAT YOU USED, THE ONE THAT APPEARS ON 1287, IS SUFFICIENTLY RELIABLE FOR YOU TO EXPRESS AN OPINION TO A REASONABLE DEGREE OF SCIENTIFIC CERTAINTY AS TO THE NUMBER OF VEHICLES THAT ARE GOING TO BE GENERATED BY THIS SITE?
>
> "A. [***29] NO, I DO NOT.
>
> [*74]
>
> "Q. IF SOMEONE TOOK YOUR NUMBER AND DID NO FURTHER STUDY, JUST TOOK YOUR NUMBER THAT YOU GAVE THE PLANNING COMMISSION WITH NO FURTHER ADJUSTMENT OR MODIFICATION, WOULD YOU BELIEVE THAT THAT PERSON WOULD BE ABLE TO RENDER A PROFESSIONAL OPINION TO A REASONABLE DEGREE OF SCIENTIFIC CERTAINTY BASED UPON YOUR NUMBER WITHOUT FURTHER STUDY OR MODIFICATION?
>
> "MS. BRUNNER: OBJECTION.
>
> "THE COURT: OVERRULED.
>
> "A. NO, I WOULD NOT." (Tr. 81.)

Ridgeway further testified that "there is absolutely no scientific certainty in this manual. If you get into probabilities, some of the factors may be accurate and some of them might not." (Tr. 96.)

Ridgeway further acknowledged that he did not perform a traffic impact study. According to Ridgeway, a traffic impact study would have taken into consideration the amount of traffic a particular site would generate, including a "capacity analysis" to determine how much traffic the adjacent roadway network would handle and how much traffic the particular facility would add to the area. Ridgeway stated that, "if you are doing an impact study, there are really a lot of other things [***30] that need to be taken into consideration here that haven't been in my analysis." (Tr. 86.)

Appellees also presented the testimony of Leonard Kutney, a traffic engineer. Kutney's [**255] analysis of traffic impact was based upon the figure of 1,500 vehicles per day calculated by Ridgeway. Kutney acknowledged that he did not make any calculations of his own to determine the accuracy of the figure arrived at by Ridgeway.

In the present case, the trial court, in reversing the decisions of the BZA and ERB granting the requested variances and approving the plans and specifications, held in part that credible evidence had been admitted

which proves that traffic congestion will be increased as a result of the restaurant. Upon review, we find that the testimony of appellees' experts was not grounded upon reliable evidence and thus should not have served as a basis for reversing the decisions of the BZA and ERB.

Evid.R. 702 provides in part that a witness may testify as an expert if such testimony "is based on reliable scientific, technical, or other specialized information." In *State v. Benner (1988), 40 Ohio St. 3d 301, 313, 533 N.E.2d 701*, the Ohio Supreme Court held that, "in [***31] this jurisdiction, an expert opinion is competent only if it is held to a reasonable degree of scientific certainty."

By appellees' expert's own admission, the underlying data contained in the ITE Manual was so inherently unreliable that he could not provide an opinion, to a [*75] reasonable degree of certainty, regarding traffic volume to be generated by the proposed restaurant. Further, although Ridgeway testified on redirect that he believed there was "some" difference between a reasonable degree of scientific certainty and a reasonable degree of scientific probability, in terms of probability the most he could say was that "some of the factors may be accurate and some of them might not."

As noted above, the ITE Manual relied upon by Ridgeway as the basis for his estimate of traffic volume warned that local data should be collected for comparison when using the data. Ridgeway, however, did not collect local data. He further acknowledged that the sample size of the studies was small (a sample size of six over a twenty year period) and that the standard deviation in the data was extremely high (147). He also failed to conduct a traffic impact study to determine how much traffic [***32] this particular facility would add to the area. Appellees' other witness, Kutney, performed no separate calculation of his own; rather, he acknowledged that he accepted Ridgeway's "quick calculation" and used it as the basis of his estimates regarding traffic impact. Thus, the testimony by Kutney regarding traffic impact, premised upon data used by Ridgeway, was also lacking in reliability and highly speculative at best. In sum, the facts and data serving as the basis for the experts' traffic calculations, and further relied upon by the trial court in concluding that the proposed restaurant would increase traffic congestion, were inherently untrustworthy and thus of no probative value. Accordingly, the trial court erred in relying upon the supplemental evidence as grounds for reversing the decisions of the BZA and ERB.

Even assuming that credible evidence had been presented regarding potential traffic impact, the emphasis placed by the trial court on such evidence was, as a matter of law, erroneous. In case No. 8034, the sole basis for the trial court's decision reversing in part the plans and specifications for the proposed restaurant was the court's finding that the ERB failed to [***33] consider traffic impact evidence. Similarly, the trial court's decision reversing the BZA's grant of variances was predicated essentially upon the court's finding that traffic congestion would be increased as a result of the variances.

In *State ex rel. Killeen Realty Co. v. East Cleveland (1959), 169 Ohio St. 375, 386, 160 N.E.2d 1*, the Ohio Supreme Court held:

> " *** Traffic regulations must remain a byproduct of zoning activities, and the primary product must always be to insure the greatest enjoyment of one's land, taking into account the rights of others and the needs of the community. Thus, if the present proposal is otherwise lawful and proper, the public authorities must find some manner of dealing with the traffic hazards *** ."

[*76] The holding in *Killeen* has been applied by a number of Ohio appellate courts. See, *e.g.*, *Pure Oil Division v. Brook Park (1971), 26 Ohio App. 2d 153, 158, 269* [**256] *N.E.2d 853* (where commercial property is located in area burdened by heavy traffic, problems of additional traffic hazards must be secondary to the right of a property owner to have use of his property in a manner consistent with its location); [***34] *State ex rel. Stulbarg v. Leighton (1959), 113 Ohio App. 487, 490, 173 N.E.2d 715* (traffic regulations are a product of zoning and if land is located in zone where contemplated use is legal, public authorities must find some other method of dealing with traffic hazards than curtailing use of land); *Brockman v. Morr (1960), 112 Ohio App. 445, 447, 168 N.E.2d 892* (Ohio law well-settled that traffic regulations are mere by-products of zoning and public authorities may not adopt zoning changes to regulate traffic).

We make clear that we do not hold that traffic concerns could not have been considered as part of the review process. As will be discussed more fully *infra*, the record indicates that the ERB did consider evidence regarding potential traffic problems and their resolution. The trial court, however, failed to give due deference to the considerations of the ERB regarding these concerns and instead gave overriding importance to the supplemental evidence of traffic impact. Clearly, any development of the site at issue will result in increased traffic in

the area. However, evidence that a proposed facility will generate increased traffic is insufficient, standing alone, [***35] to justify the denial of an otherwise permitted use by a property owner. *Killeen, supra.*

Excluding the speculative evidence regarding traffic impact relied upon by the trial court, we now consider whether a preponderance of reliable, probative and substantial evidence exists to support the decisions of the BZA and the ERB in granting variances and approving plans and specifications for the proposed facility. We first address the decision of the BZA to grant the variances at issue.

B.C.O. 1264.14 empowers the BZA to grant variances under certain circumstances. 1264.14(b) provides:

> "The Board of Zoning Appeals shall have the power to authorize variances from the provisions of this Zoning Code. A variance is a modification of the provisions of this Zoning Code where such modification will not be contrary to the public interest. In authorizing a variance, the Board may attach conditions and require such guarantee or bond as it may deem necessary to assure compliance with the objectives of this Zoning Code. Variances may be granted only where the following requirements are met:
>
> "(1) Literal enforcement of this Zoning Code will result in an unnecessary [***36] hardship with respect to the property.
>
> [*77]
>
> "(2) The unnecessary hardship is caused by unique characteristics of the property which are not applicable to other properties in the same district, and the unique characteristics do not result from the actions of the applicant.
>
> "(3) The variance observes the intent of this Zoning Code, produces substantial justice and is not contrary to the public interest."

Pursuant to B.C.O. 1264.14, variances may be granted only upon a showing of "unnecessary hardship." In the instant case, however, the variances sought by the applicant are "area variances" as opposed to "use variances." In *Kisil v. Sandusky (1984), 12 Ohio St. 3d 30, 465 N.E.2d 848*, the Ohio Supreme Court held in the syllabus:

> "The standard for granting a variance which relates solely to area requirements should be a lesser standard than that applied to variances which relate to use. An application for an area variance need not establish unnecessary hardship; it is sufficient that the application show practical difficulties."

In adopting a lesser standard for granting an area variance as opposed to a use variance, the *Kisil* [***37] court relied in part upon the decision of the New York Court of Appeals in *Matter of Hoffman v. Harris (1966), 17 N.Y.2d 138, 144, 269 N.Y.S.2d 119, 216 N.E.2d 326*, in which that court noted "the reason for such distinctions between use and area variances as being, ' *** when the variance is one of area only, there is no change in the character of the zoned district and the neighborhood [**257] considerations are not as strong as in a use variance.'" *Kisil, supra, 12 Ohio St. 3d at 32-33.*

In *Duncan v. Middlefield (1986), 23 Ohio St. 3d 83, 86, 491 N.E.2d 692*, the court expounded on the "practical difficulties" standard, and set forth certain factors to be considered in determining whether a property owner seeking an area variance has met that standard, holding that:

> "While existing definitions of 'practical difficulties' are often nebulous, it can be safely said that a property owner encounters 'practical difficulties' whenever an area zoning requirement (*e.g.*, frontage, setback, height) unreasonably deprives him of a permitted use of his property. The key to this standard is whether the area zoning requirement, as applied to the property owner in question, [***38] is reasonable. The practical difficulties standard differs from the unnecessary

> hardship standard normally applied in use variance cases, because no single factor controls in a determination of practical difficulties. A property owner is not denied the opportunity to establish practical difficulties, for example, simply because he purchased the property with knowledge of the zoning restrictions. ***
>
> "The factors to be considered and weighted in determining whether a property owner seeking an area variance has encountered practical difficulties in the use of [*78] his property include, but are not limited to: (1) whether the property in question will yield a reasonable return or whether there can be any beneficial use of the property without the variance; (2) whether the variance is substantial; (3) whether the essential character of the neighborhood would be substantially altered or whether adjoining properties would suffer a substantial detriment as a result of the variance; (4) whether the variance would adversely affect the delivery of governmental services (*e.g.*, water, sewer, garbage); (5) whether the property owner purchased the property with knowledge [***39] of the zoning restriction; (6) whether the property owner's predicament feasibly can be obviated through some method other than a variance; (7) whether the spirit and intent behind the zoning requirement would be observed and substantial justice done by granting the variance. *** " (Citations omitted.)

The decision by the BZA to grant the variances was based upon evidence adduced at its September 21, 1994 meeting. At that meeting, the BZA heard from a number of individuals, including the developer and zoning officer Pritchard, regarding the variances sought. The BZA also saw plans, drawings and layouts of the proposed project.

As previously noted, one of the requested variances involves B.C.O. 1256.04, which prohibits parking spaces in front of the principal building. Regarding this variance request, zoning officer Pritchard stated that her research indicated that ten variances had been previously granted between 1972 and 1990 for parking in front of the principal building. In addition, a large number of parking lots in front of buildings exist as non-conforming uses. Pritchard also noted that, as to the proposed McDonald's, green space will buffer the front parking spaces from [***40] the sidewalk.

The other variance at issue involves B.C.O. 1256.06, which requires one off-street loading space for buildings under 5,000 square feet. Regarding the request to eliminate a loading space, Dargusch stated at the BZA meeting that deliveries should not pose a problem as they would be made every four to five days, with unloading time taking between twenty-five to thirty-five minutes. Dargusch indicated that delivery trucks would use the lot approximately one per cent of the time; thus, he preferred to seek additional parking spaces over a loading zone. Pritchard stated that this type of request had not been made with frequency because few new buildings had been constructed in Bexley since the adoption of the zoning code. Pritchard researched other similarly situated businesses built since 1972 which have loading space requirements. Pritchard stated that none of the thirteen businesses comply with the code, but that, except for one instance, there had been no complaints about the manner in which businesses were receiving their goods.

[*79] Upon review, the evidence in the record supports the BZA's determination granting the area variances. The variances sought are [***41] insubstantial, including one variance [**258] which seeks to extend one parking space twenty inches in front of the building. The evidence does not support a finding that the essential character of the neighborhood would be altered or that adjoining properties would suffer a detriment as a result of the extension of one parking space twenty inches. Further, the evidence indicates that the city has not mandated literal compliance with loading space requirements for other similarly situated businesses and that such policy has not resulted in a substantial detriment to adjoining property owners. There was no evidence to indicate that the delivery of governmental services would be affected by the variances.

We note that the trial court found that the variances were contrary to the intent of the zoning code based upon the court's finding that "the variances will increase traffic congestion." Assuming that traffic impact evidence was even relevant to the consideration of these area variances under the Bexley Zoning Code, we have previously concluded that the trial court's findings concerning potential increased traffic are not supported by credible evidence. The present site of the [***42] proposed restaurant is a vacant adult theater and adult video store with no off-street parking. As it presently stands, the building is an obsolete theater whose use, as intended, would require a number of variances, including a use variance and a variance from parking requirements. Zoning officer Pritchard noted that, due to the narrowness of lots on

Main Street, and the large number of non-conforming structures, few locations are able to provide the required number of off-street parking spaces. In the instant case, the evidence indicates that the requested variances would help maximize off-street parking and encourage local shopping. The evidence indicates that the variances are not contrary to the public interest nor in conflict with the spirit and intent of the zoning ordinance and that substantial justice would be done by granting the variances. Finally, while the trial court found that Dargusch contracted to purchase the property with knowledge of the zoning restrictions, we note that this is just one factor to be weighed and considered, and such factor is insufficient, standing alone, to preclude a property owner from obtaining a variance. *Duncan, supra, at 86* (a property [***43] owner is not denied the opportunity to establish practical difficulties simply because he purchased the property with knowledge of zoning restrictions).

In sum, the record indicates that the applicant demonstrated practical difficulties and that the BZA's decision to grant the requested variances was supported by a preponderance of reliable, probative and substantial evidence. Thus, the trial court erred in reversing the decision of the BZA.

[*80] We also find that the trial court erred in reversing in part the decision of the ERB regarding approval of the plans and specifications for the proposed restaurant based upon the court's finding that the ERB heard, but failed to consider, traffic evidence. While the trial court affirmed the decision of the ERB regarding the plans, drawings, lighting scheme, placement and appearance of an on-site trash enclosure, outdoor furniture and landscaping, the court further concluded that the ERB's decision approving the plans and specifications was not supported by a preponderance of reliable, probative and substantial evidence "in light of the above procedure utilized by the ERB with respect to the traffic/parking/pedestrian evidence *** [***44] ."

B.C.O. 1222.03(b) provides in pertinent part:

> "Regulations. No building, structure or space within the Bexley Environmental Review District shall be constructed, reconstructed, altered, moved, extended, razed, enlarged or changed in external appearance unless and until the plans and specifications for such building or structure and the landscaping plan for the premises on which it is or will be located have been approved by the Board. The Board, in reviewing such plans and specifications, shall examine the architectural design, the exterior surface treatment and color, the arrangement of buildings and structures on the premises, the use of signage, the means of integrating parking, the use of landscape materials and the impact of the proposed project on the surrounding properties to determine the effect the project will have upon the appearance and environment of the District. The Board shall endeavor [**259] to assure that the exterior appearance and environment of such buildings, structures and spaces will enhance the attractiveness and desirability of the District in keeping with its purpose and intent, encourage the orderly and harmonious development of the [***45] District in keeping with the character of the District, improve residential amenities in any adjoining residential neighborhood and enhance and protect the public and private investment in the value of all land and improvements within the District and adjoining districts. *** "

The trial court, in interpreting the ERB's role under B.C.O. 1222.03(b), held that "even though the ERB was responsible for examining 'the means of integrated parking,' and 'the effect the project will have upon the appearance and *environment* of the District,' the ERB heard, but would not consider, testimony on traffic/off-premise parking/pedestrian concerns." (Emphasis by trial court.) The trial court then held that the additional evidence admitted before the court regarding traffic impact precluded approval of the plans and specifications.

Initially, we note that the record of the proceedings before the ERB indicates that traffic concerns were addressed at both the July 25, 1994 and September 26, 1994 meetings of the ERB. As previously noted, at the July 25 meeting, environmental approval of the site plan was submitted subject to the applicant working out a traffic plan acceptable with the city [***46] traffic engineer. At the [*81] subsequent meeting on September 26, the ERB again considered the issue of traffic. The minutes of that meeting provide in part:

> "The ninth and final drawing, which was not submitted at the July 25, 1994 meeting, was drawn in response to concerns regarding traffic flow on Main Street. Mr. Helman asked if the City's Traffic Engineer had reviewed the drawing. Mrs. Pritchard stated that Mr. Ridgeway, the Traffic Engineer for Bexley, has reviewed and approved the current drawing with conditions. Mr.

Helman asked for the conditions. Mrs. Pritchard read Mr. Ridgeway's letter, a copy of which is attached and made part of the record. Chairman Swedlow asked Mr. Dargusch if he was aware of the conditions made by Mr. Ridgeway. Mr. Dargusch stated that he has responded in writing to the conditions and has further agreed to their acceptance. Chairman Swedlow asked who pays the costs involved. Mrs. Pritchard stated that the costs are to be borne by the developer. Mr. Helman asked off of which signal the Woodworkers driveway will operate. Mr. Dargusch stated that the Woodworkers shop will not be using the signals. The traffic from the Woodworkers Shop will [***47] merge into traffic. The lights will be optically shielded from the view of traffic exiting the Woodworkers lot onto Main Street. Mr. Dargusch stated that there were a total of four traffic plans submitted to the owner of the Woodworkers Shop to choose from and he wished to remain a separate entity on Main Street. Mr. Helman noted the time schedule on the no turn sign on the drawing and asked to be sure that the Safety Engineer has seen and approved of the times noted.

" ***

"Mr. Helman moved to adopt the following resolution:

"Based upon the Board's review of drawings 1 through 9 as submitted to the Board for their consideration at this meeting and any changes made to these drawings since their original consideration at the July 25, 1994 meeting, he moved that the Board find that the requirements of Bexley Code Section 1222.03(b) have been met and in accordance with Bexley Code Section 1222.04(a) that the Board reaffirms their approval of the plans and drawings as submitted. The conditions of the approval granted at the July 25, 1994 meeting remain as conditions of this approval and should the alley be made one way, the directional signs at the [***48] alley shall be removed. This approval is conditioned also on the acceptance of Bexley City Traffic Engineer, Joe Ridgeway's letter (attached) to the base approval, and that all required costs for said traffic improvements as recommended by our traffic engineer be borne by the applicant. *** " (Minutes ERB meeting, Sept. 26, 1994, 8-9.)

Thus, the record indicates that the ERB considered the issue of traffic and conditioned its approval upon the acceptance of a traffic plan proposed by the city traffic engineer. The record further indicates that the city traffic engineer made recommendations [**260] which the developer agreed in writing to implement. The trial [*82] court, however, failed to give deference to the ERB's interpretation of the city's zoning ordinance. Rather, the trial court held that B.C.O. 1222.03(b) outlines the factors the ERB shall consider with "a broad brush," and that "the ERB approached its task from a much narrower perspective." In giving the city zoning code an expansive interpretation, the trial court improperly substituted its judgment for that of the ERB and engrafted a "traffic volume" requirement to the zoning ordinance which is not part [***49] of the existing code. Further, the trial court's holding is tantamount to a finding that an increase in traffic alone is sufficient to justify precluding an otherwise valid use of property. As previously noted, however, such a ruling is not in accordance with law; nor was the supplemental traffic impact evidence reliable. Accordingly, the trial court erred in reversing in part the decision of the ERB granting approval of the plans and specifications for the site.

Based upon the foregoing, the first, second, third and fourth assignments of error of the city and the first, second, third and fourth assignments of error of Dargusch are sustained.

In light of our disposition of the previous assignments of error, Dargusch's fifth assignment of error, asserting an alleged violation of due process rights, is rendered moot.

Based upon the foregoing, the single assignment of error of Goldberger is overruled, the first, second, third and fourth assignments of error of the city are sustained, the first, second, third and fourth assignments of error of Dargusch are sustained and the fifth assignment of error of Dargusch is rendered moot. Accordingly, the judgment of the trial court is affirmed [***50] in part and reversed in part and this matter is remanded to the trial court with instructions to enter judgment affirming the

decisions of the BZA and ERB in case Nos. 8032 and 8034.

Judgment affirmed in part, reversed in part and cause remanded with instructions.

YOUNG and CLOSE, JJ., concur.

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, Petitioners, 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 **MOTION FOR RECONSIDERATION OF RESPONDENT THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY D/B/A CAROLINAS MEDICAL CENTER – FORT MILL**

Respondent The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center-Fort Mill ("CHS") submits this Motion for Reconsideration of the Court's "Final Order and Decision" of March 31, 2014 (the "Order") pursuant to Rule 59 of the South Carolina Rules of Civil Procedure ("SCRCP"), as incorporated by Administrative Law Court Rule 29(D).

As explained more fully below, the Court should reconsider its Order and find that CHS should be awarded the Certificate of Need ("CON") for the Fort Mill hospital. The Order as written has repeated the errors that were made by Joel Grice of the South Carolina Department of Health and Environmental Control ("DHEC") in his original decision in 2006 to award the CON to Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center d/b/a Fort Mill Medical Center ("Piedmont") and to exclude CHS. That decision was eventually reversed by Judge Matthews. The Order is equally erroneous – the entire basis of the Order is to protect Piedmont from the perceived adverse effects of competition from an out-of-state hospital and to reduce the number of South Carolinians who voluntarily seek healthcare from CHS at its North Carolina hospitals.

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In so doing, the Court has unconstitutionally engaged in economic protectionism that violates the dormant Commerce Clause of the United States Constitution and the basic tenets of the free market system.

Additionally, the Order contains numerous errors that have affected the ultimate decision: (1) the Court has relied on testimony that does not exist or which does not support the Court's ruling; (2) the Court has misunderstood and misapplied the current State Health Plan to inflate projected York County bed need; (3) the Court has failed to make complete findings on essential Project Review Criteria; (4) the Court has failed to weigh and balance any adverse effects of a new CHS hospital with the increased accessibility such a hospital would offer the majority of Northern York County residents who presently seek healthcare services from CHS; (5) the Court has erroneously admitted and relied upon the testimony of witnesses closely affiliated with Piedmont and who were not timely disclosed; and (6) the Court has erroneously applied a "traffic safety and congestion" standard on a comparative basis that does not exist in the Project Review Criteria .[1]

I. STANDARD OF REVIEW:

Administrative Law Court Rule 29(D) ("Motion for Reconsideration") provides in pertinent part that "[a]ny party may move for reconsideration of a final decision of an administrative law judge in a contested case to alter or amend the final decision, subject to the grounds for relief set forth in Rule 59, SCRCP,...." Under Rule 59, SCRCP, a motion for reconsideration serves the traditional role of asking the trial judge to reconsider any previously raised and decided issue encompassed in the judgment. *See* James F. Flanagan, *South Carolina Civil Procedure* (2d Ed. 1996), at 474 (citing *Arnold v. State*, 309 S.C. 157, 420 S.E.2d 834

[1] CHS reserves these and all other issues for appeal purposes should appeal be pursued.

(1992)). As aptly stated by the South Carolina Supreme Court in *Elam v. South Carolina Dept. of Transp.*, 361 S.C. 9, 602 S.E.2d 772 (2004):

> *First, it is proper to view a Rule 59(e) motion not only as a vehicle to request the trial court 'alter or amend the judgment,' but also as a vehicle to seek 'reconsideration' of issues and arguments. A motion under Rule 59(e) long has been viewed as 'motion for reconsideration' despite the absence of those words from the rule. Consequently, a party usually is allowed to ask the court to reconsider its decision even if it means rehashing all or part of an argument previously presented. There is nothing inherently unfair in allowing a party one final chance not only to call the court's attention to a possible misapprehension of an earlier argument, but also to revisit a previously raised argument. It is inherently unfair to disallow such an opportunity.*

Id. at 21-22, 602 S.E.2d at 778-79 (citations omitted); *accord Home Medical Systems v. S.C. Dept. of Revenue*, 382 S.C. 556, 677 S.E.2d 582 (2009).

II. ARGUMENT:

A. *The Court's Application of the CON Act and Project Review Criteria Violates the Dormant Commerce Clause of the United States Constitution.*

Although ALCs are without power to pass on the constitutional validity of a statute or regulation, the South Carolina Supreme Court has specifically held that ALCs are empowered to hear "as applied" challenges to statutes and regulations and may rule on whether a law as applied violates constitutional rights. *Travelscape, LLC v. S.C. Dep't of Revenue*, 391 S.C. 89, 108-109, 705 S.E.2d 28, 38-39 (2011) (involving the dormant Commerce Clause). Prior to the remand in this case, CHS and Presbyterian challenged DHEC's application of the Certificate of Need ("CON") Act and State Health Plan to effectively exclude out-of-state hospital systems from competing for the Fort Mill CON as a violation of the dormant Commerce Clause of the United States Constitution. The dormant Commerce Clause challenge was rendered moot by Judge Matthews' remand of the matter to DHEC and DHEC's subsequent approval of CHS's application for the CON. In approving CHS's application after remand, DHEC applied the CON

Act, State Health Plan, and Project Review Criteria in a manner that did not discriminate against out-of-state economic interests, specifically CHS and Presbyterian, or interfere with interstate commerce. Accordingly, the dormant Commerce Clause issues were not prominently placed before the Court during the contested case hearing. However, these issues were raised and preserved pursuant to the Court's Consent Order of April 4, 2013 and CHS's Counter-Proffer of Evidence and Legal Arguments on the Issue Concerning Interpretation of Bed-Need Provision in 2004-2005 South Carolina Health Plan, which was submitted to the Court shortly after the contested case hearing concluded.

The Court's Order returns the dormant Commerce Clause issue to prominence because it orders DHEC to award the CON to Piedmont to protect it from competition from an out-of-state hospital system and to reverse outmigration of patients from South Carolina to North Carolina, thereby interfering with and burdening interstate commerce in purpose and effect.

The dormant Commerce Clause doctrine serves as a "'negative' or 'dormant' constraint on the power of the States to enact legislation that interferes with or burdens interstate commerce." *Brown v. Hovatter*, 561 F.3d 357, 362 (4th Cir. 2009) (citing *Dennis v. Higgins*, 498 U.S. 439, 447 (1991)). Under the dormant Commerce Clause, state laws or regulations that discriminate against commerce are subject to strict scrutiny and must be invalidated "unless the state demonstrates both that the statute serves a legitimate local purpose, and that this purpose could not be served as well by available nondiscriminatory means." *Yamaha Motor Corp. v. Jim's Motorcycle, Inc.*, 401 F.3d 560, 567 (4th Cir. 2005). "[D]iscrimination simply means differential treatment of in-state and out-of-state economic interests that benefits the former and burdens the latter." *Oregon Waste Sys., Inc. v. Dep't of Envtl. Quality*, 511 U.S. 93, 99 (1994). "State laws that discriminate against interstate commerce in any of the three ways identified by

[the United States Supreme Court] – facially, in practical effect, or in purpose – are subject to 'a virtually *per se* rule of invalidity.'" *Wyoming v. Oklahoma*, 502 U.S. 437, 454-55 (1992).

The Court's Order applies the CON Act and the Project Review Criteria in a manner that discriminates against interstate commerce in both purpose and in practical effect. First, the discriminatory purpose of the Court's decision is expressly stated throughout the Order. The Court concludes that the CON should be awarded to Piedmont to protect it from perceived threats and consequences of competition from an out-of-state hospital system and to reduce the number of South Carolinians travelling to North Carolina for healthcare. Paragraph 43 of the Order states that awarding the CON to Piedmont "will best serve the public needs by reducing the outmigration of York County residents to North Carolina hospitals." While the Court may genuinely believe that outmigration is a problem that needs to be confronted, the United States Constitution does not permit a state to address such problems by "erecting a barrier against the movement of interstate trade." *See City of Philadelphia v. New Jersey*, 437 U.S. 617, 628 (1978); *see also Hazardous Waste Treatment Council v. South Carolina*, 945 F.2d 781 (4th Cir. 1991) (South Carolina's concerns over flow of out-of-state hazardous waste into the state did not justify compelling in-state waste disposal facilities to limit out-of-state waste).

Furthermore, the Order's Findings of Fact and Conclusions of Law are replete with findings of how awarding the CON to CHS will adversely affect Piedmont's profits, utilization, quality of service, types of services, payor mix, and staff. Thus, the Court's Order, by its stated purpose, intends to protect Piedmont from an out-of-state competitor, and such clear economic protectionism clearly violates the dormant Commerce Clause. *See Walgreen Co. v. Rullan*, 405 F.3d 50, 55 (1st Cir. 2005) ("[T]he Act discriminates against interstate commerce by permitting

the Secretary to block a new pharmacy from locating in its desired location simply because of the adverse competitive effects that the new pharmacy will have on existing pharmacies.")

In the Order, the Court relies extensively on testimony about the adverse impact that Piedmont would suffer as a result of a CHS hospital in Northern York County and its consequent effects on outmigration. There can be little doubt that the purpose of this decision is to discriminate against a North Carolina hospital and to stem the interstate commerce associated with South Carolina residents receiving healthcare in North Carolina. This reliance is most evident in the Court's adoption of the testimony of Joel Grice (*see* Order, Conclusions of Law ¶ 40.) Mr. Grice testified that he had previously been instructed by South Carolina lawmakers to interpret and apply the State Health Plan and CON Act for the benefit of South Carolina residents and economic interests without regard for out-of-state providers. (Trial Tr. 1086.) Consistent with that testimony, Mr. Grice testified that his support for Piedmont was based, in part, on his belief that "[i]t is more important to have more cardiac surgeons, neurosurgeons, infectious disease specialists, oncologists, et cetera, living and working in York County in South Carolina than to have those positions filled in Charlotte." (Trial Tr. 1093.) Similarly, the Court relied on the testimony of Piedmont's experts, who testified that Piedmont's plan to build a hospital in Northern York County is central to its plan to stem the outmigration of York County patients to North Carolina. (Trial Tr. 1199:23 – 1200:18.) In fact, the Court appears to have adopted *in toto* Piedmont's position that it should be awarded the CON for the primary purposes of stopping outmigration to North Carolina and protecting Piedmont from the effects of further competition. (*See* Order, Conclusions of Law ¶¶ 43-44.) Thus, the Court's stated purpose in awarding the CON to Piedmont for these reasons demonstrates that the Order applies the CON Act, the Project Review Criteria, and the State Health Plan in violation of the dormant

Commerce Clause. *See Waste Mgmt. Holdings, Inc. v. Gilmore*, 252 F.3d 316 (4th Cir. 2001) (finding Virginia state law had a discriminatory purpose based on officials' statements that law was intended to reduce effects of out-of-state waste being disposed of in Virginia).

Second, the Court applies the Project Review Criteria in a manner that has the practical effect of discriminating against out-of-state hospitals and favoring the existing hospital, Piedmont. Specifically, the Court applies several of the Project Review Criteria (2a, 2b, 2c, 2e, 16c, 22, 23a, 23b, 3h, 17) in a manner that concludes that awarding the CON to CHS will adversely affect Piedmont in a variety of ways, and the Court relies on these conclusions to award the CON to Piedmont. In so doing, the Court establishes a default preference for an existing facility with little regard for the needs and desires of the majority of Northern York County residents who have actively engaged in interstate commerce by voluntarily choosing CHS as their healthcare provider. Similarly, the Court failed to conduct any comparative analysis of how awarding the CON to Piedmont would affect the existing services offered by CHS in York County, indicating that it is only the perceived adverse impact on the existing in-state hospital, Piedmont, that matters to the Court.

Also, the Court implicitly favors the existing facility to the detriment of the out-of-state provider, CHS, by concluding that Piedmont's 100-bed facility will better meet future bed need for the area than CHS's 64-bed facility. This finding gives Piedmont an unfair advantage because it is the only hospital that can build a hospital with more than 64 beds, as it is the only hospital that can transfer beds from an existing facility in York County. In addition, the Court relies, in part, on the York County contract to award the CON to Piedmont despite the fact that Piedmont is the only hospital operating in York County and the only one who can enter into a contract for the operation of hospital services in York County. In making these preferences, the

Court employs an analytical framework that necessarily favors the existing facility and punishes out-of-state hospitals attempting to enter the York County market. Thus, the Court has applied the CON Act and the Project Review Criteria in a manner that has the practical effect of discriminating against out-of-state hospitals. *See Colon Health Centers of America, LLC v. Hazel*, 733 F.3d 535, 544 (4th Cir. 2013) (refusing to dismiss dormant Commerce Clause challenge to Virginia's CON program because the state health commissioner could apply CON criteria to protect existing providers or because program could be manipulated by in-state providers to exclude out-of-state entrants).

Even if the Court's application of the CON Act and the Project Review Criteria does not discriminate against interstate commerce in purpose or practical effect, it still violates the Constitution by placing an "undue burden" on interstate commerce. *See id.* at 545 (citing *Pike v. Bruce Church, Inc.*, 397 U.S. 137 (1970)). "Where [a] statute regulates even-handedly to effectuate local public interest, and its effects on interstate commerce are only incidental, it will be upheld unless the burden imposed on such commerce is clearly excessive in relation to the putative local benefits." *Pike*, 397 U.S. at 142. Here, the Court's decision burdens interstate commerce by restricting entry into the York County market by an out-of-state hospital and by making only conclusory findings of any local benefits that will result from awarding the CON to Piedmont. The Order demonstrates that the Court's decision is motivated by the private benefits that a for-profit hospital system will reap from diminished competition, rather than how Northern York County will benefit from an additional, $120 million hospital operated by a provider that has declining utilization at its existing hospital.[2] The Court further disregards the ample

[2] Piedmont's premise, which the Court has adopted, is that if Piedmont spends $120 million to build a new hospital, that new construction will enable Piedmont to acquire a portion of CHS's existing market share in Northern York County by seeking to divert CHS's South Carolina patients from "out-migrating" to CHS hospitals in North Carolina (Tr. Trans. 1199:23-1200:18).

evidence on the record of the competitive benefits that CHS will provide to its existing patient-base in York County if it is permitted to operate a hospital in Northern York County.

As a result of the Court's decision and application of the Project Review Criteria to favor the existing hospital, out-of-state providers will be discouraged from attempting to enter the South Carolina market. Accordingly, the Court has applied the CON Act, the Project Review Criteria, and the State Health Plan in an unconstitutional manner that excessively burdens interstate commerce in relation to the marginal local benefits that will be realized from Piedmont's award of the CON. *See Colon Health Centers of America*, 733 F.3d at 547 ("The bureaucratic red tape foisted upon businesses by the [certificate of need] program may well be so cumbersome that, as a functional matter, it imposes a major burden on interstate commerce and discourages out-of-state firms from offering important medical services in Virginia."); *Medigen of Kentucky v. Public Service Comm'n of West Virginia*, 985 F.2d 164 (4th Cir. 1993) (striking down regulatory scheme that operated to restrict market entry).

Based on the above, the Court should reconsider its Order and apply the CON Act and regulations and the Project Review Criteria in a manner that does not discriminate against out-of-state competition or interfere with the delivery of healthcare across state lines. If the State Health Plan is applied in such a fashion, CHS best meets the Project Review Criteria, and it should be awarded the CON.

B. *The Court's Application of the Project Review Criteria is Unsupported by the Evidence.*

In the Order, the Court sets forth its Findings of Fact related to the CON review criteria to be applied under S.C. Reg. 61-15, § 802. Following the criteria-by-criteria review by the Court, it then concludes:

> *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 aspects of Ms. Brandt's analysis, it was persuaded by the testimony of Mr. Grice and Ms. Fechtel, both of whom worked within the CON program for many years and possessed greater experience and institutional knowledge.***

(Order, Conclusions of Law ¶40.) (Emphasis added). Clearly, the Court's reference to "Ms. Brandt's analysis" is to the comparative analysis in the record, in which Beverly Brandt, acting on behalf of Respondent DHEC, applied the review criteria contained in S.C. Reg. 61-15, Section 802 to the competing applications of Piedmont and CHS.

The Court's reliance on the testimony of Mr. Grice and Ms. Fechtel is erroneous in several respects. First, Mary Fechtel, the prior reviewer, did not testify at the contested case hearing. More importantly, in Judge Matthews' Order of December 9, 2009, which the Court found dispositive, Judge Matthews found that neither Mr. Grice nor Ms. Fechtel conducted a comparative analysis of the applicants in the prior review. Instead, Judge Matthews found:

> *The Department's interpretation of the Plan vitiates the requirement that the Department review the CON applications, apply the Project Review Criteria and decide which competing applicant best complies with those criteria. In fact, DHEC witness Mary Fechtel, the project reviewer for each applicant, testified that once she made the finding that only [Piedmont] complied with the Plan, she did not address who best complied with the other Project Review Criteria. Ms. Fechtel specifically stated:*

> *Q. Okay. Now, now once you made the finding that only Fort Mill Medical Center complied with the state plan, you didn't go back and make the finding as to who best complied with each of the other project review criteria, did you?*
>
> *A. No, ma'am.*
>
> *Ms. Fechtel's testimony makes it clear that the Department never conducted a true comparative analysis and did not make its determination 'on the basis of which, 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 the CON Act. See S.C. Code Ann. § 44-7-210(C) (Rev. 2002) (emphasis added). Under the circumstances, I find that the Department committed an error of law and exceeded its statutory authority when it construed this ambiguous Plan so that only the existing hospital could comply with the Plan Bed Need.*
>
> *Further, I find that the error of law was so pervasive that it infected the entire decision making process. Ms. Fechtel testified that she was instructed to review the applications 'competitively' and Mr. Grice testified that the applications were reviewed competitively. Yet, each witness decided that only the [Piedmont] application could comply with the Plan; therefore, the Department did not make contemporaneous findings as to which applicant most fully complied with the purposes, goals and Project Review Criteria during the final decision making process.*

(Judge Matthews' Order of December 9, 2009 at pp. 24-25.) In fact, Mr. Grice only conducted a comparative review at the hearing as a paid expert for Piedmont. Although the Court describes him in the Order as a "a thirty year veteran" of DHEC, he was the architect of the previous DHEC decision that Judge Matthews concluded was plainly erroneous because it awarded the CON to Piedmont while unfairly excluding CHS.

Even if the Court intends to rely on the expert testimony of Mr. Grice, the Court's application of the Project Review Criteria does not match Mr. Grice's opinions. As illustrated by the chart below, the Court disagrees with Mr. Grice's opinions on many of the highest-ranked

review criteria, in which Mr. Grice found that CHS and Piedmont equally met the review criteria, while the Court concluded that Piedmont "best met" the same review criteria.

		Brandt	Grice	Court
Rank 2				
2a	Community Need Documentation	Both	Both	PMC
2b	Population projections	Both	Both	PMC
2c	Service to meet need	Both	Both	PMC
2d	Reduction, elimination or relocation of service	CHS	Both	PMC
2e	Current or projected utilization justified	CHS	Both	PMC
3a	Duplication and modernization	CHS	PMC	[redacted]
3b	Located to serve medically undeserved	Both	PMC	[redacted]
3c	Location allows for timely delivery of support services	Both	Both	Both
3d	No restriction on admissions	Both	Both	[redacted]
3e	Documentation of access means	Both	Both	Both
3f	Access to medically underserved	CHS	Both	[redacted]
3g	Provisions for access regardless of ability to pay	CHS	Both	[redacted]
22	Distribution	CHS	PMC	PMC

Rank 3				
6a	Charges	Both	Both	Both
6b	Projected Utilization/Expenses	CHS	Both	Both
7	Consistent with Similar Facilities	Both	Both	Both
9	Net Income	CHS	Both	Both
15	Financial Feasibility	CHS	Both	Both
16a	Cost Containment	CHS	Both	Both
16b	Lease Alternatives	-	Both	-
16c	Impact on Costs	CHS	Both	PMC
17	Efficiency	CHS	PMC	PMC

Rank 4				
13a	Record of the Applicant	Both	Both	Both
13b	Ability to Obtain Financing	CHS	Both	Both
13d	Record of Compliance	Both	Both	Both
4a	Acceptability	Both	Both	Both
4b	Opposition	Both	Both	Both
23a	Adverse Impact on Existing Facilities	CHS	PMC	[redacted]
23b	Adverse Impact on Staffing	Both	PMC	[redacted]

Unranked				
3h	Impact on providers' service to medically underserved	-	PMC	[redacted]

As the foregoing chart demonstrates, the Court's findings and conclusions do not match that of Mr. Grice. Ms. Fechtel did not testify, and Judge Matthews previously ruled that neither she nor Mr. Grice did a comparative analysis as reviewers for DHEC. As such, the Court erroneously relies on evidence that does not support the Court's findings and conclusions.

C. *The Court's Findings of Fact and Conclusions of Law are Incomplete.*

As noted in the chart set forth in the preceding section, in many instances the Court failed to conclude which applicant met certain Project Review Criteria. These omissions fall into three (3) different categories:

1. Under Rank 2, the Court fails to address review criterion 3(a) with a conclusion.

2. Also under Rank 2, the Court discusses the "charity care" review criteria – 3(b), 3(d), 3(f) and 3(g) – at length. (Order, Conclusions of Law ¶¶ 23-27.) While it is critical of CHS's charity care, the Court fails to conclude whether both applicants equally meet these review criteria or whether one meets them better. Significantly, Piedmont's experts concluded that CHS "equally met" Piedmont in most, if not all, of these categories. (*See* CHS Exhibit 14; Tr. Trans. at 1120-1122 (Grice), 2883-2885 (Sullivan)).

3. Under Rank 4 and the category of "unranked" review criteria, the Court correctly concludes that review criteria 23(a) and 23(b) are in the lowest ranking category, and that review criterion 3(h) is unranked. The Court engages in an extensive discussion of "adverse impact," but the only ensuing discussion of any of these review criteria is in Conclusion of Law

No. 34, which addresses only review criterion 23(b) but later recites to "Section 802.22" and concludes that "Piedmont best meets § 802.22" without addressing either 23(a), 23(b) or 3(h).

These deficiencies in the Order are substantial, as the Court failed to address completely the results of the Court's comparative review based on the evidence.

D. *The Court Did Not Properly Address the Weight of Adverse Impact or Conduct a Balancing Analysis.*

In assessing the ranking of the "adverse impact" criteria set forth in 23(a) and 23(b), the Court acknowledged in the Order that they are among the lowest-ranked criteria by DHEC, stating:

> *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. .....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.*

(Order, Conclusions of Law ¶ 29.)

Despite this conclusion, the Court elevates adverse impact over all other criteria in the Order. In fact, the adverse impact issue is discussed under several headings in the Order, including "Utilization" (Order, Findings of Fact ¶¶ 12-17), "Impact of Proposed Projects" (Order, Findings of Fact ¶¶ 18-35), and "Adverse Impact" (Order, Findings of Fact ¶¶ 36-46). The Court's discussion of adverse impact occupies almost half of the Findings of Fact and extends to the Court's discussion of review criteria 16(c) ("Cost Containment") and to 22 ("Distribution"), neither of which address the concept in the way the Court applies it. Instead, the Court focuses on Piedmont's loss of utilization since the case has been pending, and Piedmont's lack of success in competing with CHS even though it has the significant advantage

of owning the only hospital in York County. These factors are certainly evidence of the fact that Piedmont's $120 million hospital is not justified, but they do not represent a proper analysis of the "least important" adverse impact criteria set forth in review criteria 23(a) and (b), which are entitled "*Adverse Effects on Other Facilities*" and most clearly apply the concept of adverse impact.

S.C. Code Ann. § 44-7-180(B)(4) and the 2004-2005 State Health Plan both provide that the "*benefits of improved accessibility will be equally weighted with the adverse affects [sic] of duplication in evaluating Certificate of Need applications for those beds.*" While CHS disputes that "adverse affects of duplication" equates to "adverse impact" on existing facilities and services, it is indisputable that the improved accessibility offered by CHS's hospital should have been evaluated by the Court as part of its analysis. Piedmont's experts, Mr. Levitt and Mr. Sullivan, both agreed. Mr. Levitt testified that the language of S.C. Code Ann. § 44-7-180(B)(4) and the 2004-2005 State Health Plan warrants that accessibility should be "equally weighted" with adverse impact, and that there must be a balancing analysis. (Tr. Tran. 909:4-21). Mr. Sullivan testified concisely as follows:

> *Well, I think certainly this is pretty clear. I mean not – state health plan isn't always this clear in terms of what the priorities are. But in this case, I think it is pretty clear that accessibility should be given the same weight as adverse impact.*

(Trial Tr. 1215:15-20.)

Despite this acknowledgement by Piedmont's experts that accessibility should be given "equal weight," the Court has over-emphasized and placed far greater weight on adverse impact. The Order is devoid of any discussion of accessibility or the balancing analysis to be applied to these two factors, and it does not address at all the benefits of increased accessibility offered by CMC-Fort Mill. Instead, the Court ignores ample testimony and DHEC's own analysis that the

new CHS hospital would offer increased accessibility to York County patients, as CHS was servicing the majority of inpatients (52.9%) in Northern York County in comparison to the relatively fewer patients served by Piedmont in the same area. (Tr. Tran. 1399: 14 – 1401:5; Joint-A-CHS-001.0009-10, Figures 3-4.) The sole focus in the Order is the potential impact on Piedmont. As such, the Court's Order is deficient and flawed, and it must be corrected.

E. *The Court's Findings and Conclusions on York County Utilization Are Erroneous.*

The Court's findings on proposed utilization at the hospital and the need for a new, 100-bed hospital to Northern York County are critical to its decision. As evidenced by the chart above, these findings relate directly to the highest-ranked criteria and the Court's ultimate conclusion that the 64-bed hospital proposed by CHS – which is the maximum size that CHS is allowed to build under the 2004-2005 State Health Plan – is inadequate given the current demand for medical services in Northern York County. These findings and conclusions are not only inherently unfair to CHS – which is not permitted to propose a larger hospital – but they are also based on a complete misunderstanding of the testimony and the contents of the 2012-2013 State Health Plan.

In determining that Piedmont's proposed hospital best met the needs, the Court relied on the following finding:

> *DHEC also projected that the population of York County would increase from 229,600 in 2011 to 253,900 in 2018. Based on historical occupancy rates at Piedmont Medical Center, and the projected growth of the York County population, DHEC identified a need for sixteen (16) acute care hospital beds in addition to the 332 acute care beds identified in the 2004-05 South Carolina Health Plan. Thus, DHEC's current plan identifies a need for a total of three hundred forty-eight (348) acute care beds in York County.*

(Order, Findings of Fact ¶ 5.) The problem with this statement is that it is patently incorrect. The State Health Plan bases projected use on utilization at existing hospitals in each county –

which is why there are no numbers inserted for CMC-Fort Mill. The projected utilization is only for Piedmont Medical Center, and indicates that at its current utilization rates it requires only 16 more beds (284 beds total), not 64 beds, and certainly not 100 beds. There is no number calculated for CMC-Fort Mill because it has no utilization rates yet – the columns for "Patient Days," "Projected Average Daily Census," and "Bed Need" are left blank. Even if CMC-Fort Mill had utilization rates, that number would be calculated based on a multiplier using 65% of its capacity, not 100% of its capacity. The Court evidently reached this erroneous conclusion by adding the entire 64 beds allocated to the proposed Fort Mill hospital (which has no utilization yet) to the 284 total beds that Piedmont might need in 2018 given its current utilization and York County population growth if it were to operate at 70% of capacity.

This erroneous finding is later repeated in Finding of Fact No. 47. After the Court correctly states: "*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, not the utilization of residents of a county,*" the Court then erroneously states: "*In the 2012-13 Health Plan, DHEC projected York County would need three hundred forty-eight (348) acute care beds by 2018.*" (Emphasis added.) These two statements contradict one another. The Court's erroneous conclusion that the 2012-2013 State Health Plan reflects "over-capacity" at CMC-Fort Mill is clearly wrong, and that erroneous conclusion infects the Court's findings that CMC-Fort Mill will be "over-utilized."

As indicated by the chart below, the current State Health Plan does not reflect that Piedmont needs to build a 100-bed facility. In fact, its projected bed need has decreased from the 2004-2005 State Health Plan (which indicated a need for 64 beds) to the current 2012-2013 State Health Plan (which indicates a need for only 16 beds). This decrease is largely driven by

Piedmont's decreasing utilization and patient days, which has coincided with CHS's gain in market share. Rather than support Piedmont's application for a new 100-bed hospital, the current State Health Plan demonstrates that Piedmont will not be able to fill a 100-bed hospital because of its decreased utilization. Thus, the current State Health Plan is consistent with DHEC's determination that CHS is more deserving of a new hospital because CHS – and not Piedmont – will best increase accessibility to Northern York County.

2004-2005 STATE HEALTH PLAN

FY 2010 HOSPITAL NEED

Facility/County	AGE CAT	2003 POP	2010 POP	2003 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
York County									
Piedmont Medical Center	<18	44,300	45,910	2,937	8.34				
	18-64	110,210	125,480	36,863	115.08				
	+65	17,670	20,910	33,632	109.04				
	Total	172,090	192,300	73,432	232.46	0.70	332	268	64

2012-2013 STATE HEALTH PLAN

FY 2018 HOSPITAL NEED

Facility/County	AGE CAT	2011 POP	2018 POP	2011 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
Piedmont Medical Center	<18	57,900	59,600	1,408	4				
	18-64	145,100	159,800	30,390	92				
	+65	26,600	34,500	28,952	103				
	Total	229,600	253,900	60,750	199	0.70	284	268	16
Carolinas Medical Ctr-Fort Mill[3]	<18	57,900	59,600						
	18-64	145,100	159,800						
	+65	26,600	34,500						
	Total	229,600	253,900			.65		64	

[3] This entry bears the note "*CON Approved 9/9/11; Appealed*" (Piedmont Ex. 12 at p. 36.)

F. *The Court's Admission of and Reliance on Testimony of the "Independent" Physicians was Erroneous.*

Prior to the contested case hearing, CHS filed a Motion to Strike three (3) "independent" physician witnesses who were belatedly identified by Piedmont. At the hearing on the Motion to Strike, CHS's counsel explained:

> *We also believe that the witnesses were not timely named, two being named just three weeks before this hearing is to -- I mean, discovery is to end, one not until late January. These witnesses were named during the midst of ongoing depositions that were already scheduled during late January and throughout February, and they wait until just before the close of discovery to add these additional witnesses. This prejudices [CHS's] ability to respond, Your Honor.*

(Hearing of Feb. 27, 2013 at p. 8, lines 13-23.) Despite CHS's protests, the Court allowed these witnesses to testify.

At the contested case hearing, it became readily apparent that the witnesses were not "independent," and in some cases their testimony had expanded well beyond the scope of their relatively brief deposition testimony. Piedmont's first "independent" witness, Dr. Arun Adlakha, testified that he was currently on the Board of Governors of Piedmont, a fact he'd not disclosed during his deposition. (Trial Tr. 154:2–156:6.) Dr. Adlakha's testimony was substantially broader than his deposition testimony, which he claimed was because he "was not asked" the same questions at his deposition, despite touching upon many of the same subjects in his deposition. (Trial Tr. 152:6–154:1.) When pressed about a point on which he was asked, Dr. Adlakha responded by stating:

> *Q: Would it not have been logical at that point to tell me about your drop in referrals?*
>
> *A: At that time in a deposition the point was basically just a brief discussion, brief questioning and answering and not detailed like now.*

(Trial Tr. 172:12-17.)

The two other "independent" physicians offered by Piedmont as witnesses were not independent at all. Dr. Sunsil Singhi acknowledged that his partner was currently on the Board of Governors of Piedmont and that his practice was "currently talking" with Piedmont about becoming part of its system. (Trial Tr.782:1–14.) Dr. Norman Taylor conceded that he was formerly Chief of Staff at Piedmont, he was currently on the Credentials Committee for the medical staff, and his partner in his medical practice was on the Board of Governors of Piedmont. (Trial Tr. 302:1–24.) Like Dr. Adlakha, Dr. Taylor testified more broadly than in his deposition, at one point on direct claiming that a new CHS hospital would be "devastating" to Piedmont, while in his deposition he had only described it as having a "potential impact." (Trial Tr. 302:25–306:1.)

The belated identification of these witnesses by Piedmont, the fact that they were held out as "independent" witnesses when clearly they were affiliated with Piedmont, and their failure to fully disclose the scope of their intended testimony under oath in their depositions was prejudicial to CHS. Significantly, the Court relied on the testimony of these witnesses in the Order, on numerous occasions (Order, Findings of Fact ¶¶ 24-25, 36) describing them as "independent" physicians. To make matters worse, the Court also relied on hearsay evidence consisting of statements made by other, unnamed Piedmont staff members (Order, Findings of Fact ¶ 24), to which CHS had clearly objected throughout the contested case hearing as hearsay evidence. (*See* Trial Tr. 67:10–70:8; 582:15–584:24.) The Court's failure to exclude these witnesses and then to place unwarranted reliance on their testimony as "independent" physicians while also accepting hearsay testimony constitutes legal error that must be corrected.

G. *The Court Created a Project Review Criterion that Does Not Exist in S.C. Reg. 61-15.*

In Finding #8 of the Order, the Court reviewed the different categories of "ranked" Project Review Criteria and correctly noted that "the remaining criteria are grouped in the DHEC regulation in the general categories of Site Suitability and Special Consideration. § 801(1)." S.C. Reg. 61-15 § 801 states that the "criteria listed in Section 802 are to be used in reviewing all projects under the Certification of Need program. These criteria have been grouped under the following general categories:...Site Suitability (Section 802.26 through 802.30)...." (Emphasis added.) The "Site Suitability" standards are unranked Project Review Criteria that address zoning, utilities, site size, environmental hazards and square footage. None of them deal with traffic considerations, traffic safety or any other aspect of the proposed site as it relates to traffic.

Despite the absence of any Project Review Criteria dealing with traffic, in the Order the Court devotes an entire section to traffic at the "Proposed Hospital Sites." The Court made two (2) separate findings on traffic congestion at the CHS hospital site, stating:

> *83. The South Carolina Department of Transportation (DOT) requires that a distance of at least seven hundred fifty 750 feet separate a full access intersection and an interstate ramp. The purpose of the 750 foot requirement is to provide greater traffic safety and reduce traffic congestion. Although the DOT has authority to waive that requirement, no evidence has been presented that such a waiver has been granted for the CMC-FM site.*
>
> *84. The CMC-FM site is a part of a larger development site known as the "Kanawha Site." When the Kanawha Site is developed, the DOT intends to put traffic signals at the 1-77 ramps. DOT has no plans, however, to place traffic signals on the frontage road leading to CMC-FM's proposed site. Traffic signals at the interstate ramps are likely to result in greater congestion in the 300 feet between the southbound ramp and the frontage road. Mr. Walsh testified there is potential for traffic to back up along the road to the CMC-FM site. This congestion and safety concerns are heightened due to the heavy, slow-moving truck traffic accessing Love's Plaza.*

(Order, Findings of Fact ¶¶ 83, 84.)

These findings are based on the testimony of Rob Walsh, a traffic engineer offered by Piedmont. There are no conclusions drawn from these findings until Conclusion # 43, in which the Court concluded summarily that: "....CHS's proposed hospital site presents traffic and safety concerns. For all these reasons, FMMC will better serve public needs than CMC-FM."

These findings and conclusion are not properly part of the Court's review. Neither S.C. Reg. 61-15 nor the Project Review Criteria set forth in S.C. Reg. 61-15 require that the applicant conduct traffic studies or demonstrate to DHEC, on a comparative basis, that its site has less traffic congestion or easier access than a competing applicant. This standard is simply nonexistent. By adopting Piedmont's argument, the Order has created a Project Review Criterion that does not exist anywhere in S.C. Reg. 61-15. The Court is not permitted to apply standards or rules that are without support in the applicable statutes or regulations. *See Carter v. S.C. Dep't of Highways & Public Transp.*, 279 S.C. 332, 306 S.E.2d 614 (1983) (finding that hearing commissioner wrongfully denied application for outdoor advertising permit by employing a standard not mandated by statute or rule); *Byers v. S.C. Alcoholic Beverage Control Comm'n*, 281 S.C. 566, 316 S.E.2d 705 (Ct. App. 1984) (ruling that agency erred in denying alcohol permit based on factors not contained in the permitting statute). The Order should be corrected to delete this entire section of Findings and the sentence in the Court's Conclusion #43.

III. CONCLUSION:

For the foregoing reasons, Respondent The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center-Fort Mill respectfully requests that the Court grant its Motion for Reconsideration in its entirety. Additionally, Respondent requests that the Court grant a stay of the Order pursuant to Administrative Law Court Rule 29(E).

Respectfully submitted,

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April 9, 2014

Charleston, South Carolina

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.	Civil Action No. 11-ALJ-07-0575-CC **PETITIONER'S RESPONSE IN OPPOSITION TO MOTION FOR RECONSIDERATION**

A. CHS's Dormant Commerce Clause Arguments are Untimely and without Merit.

CHS argues that the Court's application of the CON Act, the CON regulations, the 2004-2005 State Health Plan, and the project review criteria in awarding the CON to Piedmont violates the dormant Commerce Clause of the United States Constitution.

1. The Dormant Commerce Clause Challenge is Untimely. In 2009, CHS and then-party Presbyterian Healthcare System, d/b/a Presbyterian Hospital – York, LLC argued that the DHEC Board's adoption of the 2004-2005 State Health Plan and application thereof by DHEC violated the Commerce Clause of the United States Constitution and was unconstitutional as applied to CHS. In particular, the Commerce Clause argument made by CHS and Presbyterian in 2009 centered around DHEC's interpretation that calculation of hospital bed need was to be made on a facility-by-facility basis under the State Health Plan. In its Motion for Reconsideration, CHS is attempting to take its narrow 2009 dormant Commerce Clause argument related to the issue of DHEC's interpretation of bed need calculation under

the State Health Plan and transform it into an expansive dormant Commerce Clause challenge against the entirety of the Court's Order and its application of the CON Act, the CON regulations, the State Health Plan, and the project review criteria.

By CHS's own admission, its 2009 dormant Commerce Clause challenge "was rendered moot by Judge Matthews' remand of the matter to DHEC and DHEC's subsequent approval of CHS's application for the CON." M. Recon. at 3. Now, CHS argues not that DHEC's interpretation and application of the State Health Plan violated the dormant Commerce Clause, but that the Court's Order in and of itself violates the dormant Commerce Clause as applied to CHS. It is of no consequence whether or not the 2009 dormant Commerce Clause argument is an issue that is considered raised and preserved before this Court, because CHS is not asking the Court to rule upon that issue in its Motion for Reconsideration. Rather, CHS has raised a completely new issue, asserting that the various legitimate bases for awarding the CON to Piedmont set forth in the Court's Order violate the dormant Commerce Clause as applied to CHS. A party cannot for the first time raise an issue by way of a Rule 59(e) motion which could have been raised at trial. *Patterson v. Reid*, 318 S.C. 183, 185, 456 S.E.2d 436, 437; *Hickman v. Hickman*, 301 S.C. 455, 392 S.E.2d 481 (Ct.App.1990). If CHS believed that Court's adoption of certain positions articulated by Piedmont with respect to adverse impact and outmigration would violate the dormant Commerce Clause when applied to CHS, it could have raised that issue at any time during trial. CHS failed to do so, and should be precluded from raising this issue for the first time in a post-trial motion, particularly when CHS was on notice that Piedmont asked this Court to approve its application, in part, on the very grounds that CHS now contends violate the dormant commerce clause.

2. **The Court's Decision Does Not Erect a Barrier Against Interstate Trade.**

Even if CHS had raised its dormant Commerce Clause challenge in a timely manner, which it did not, the Court's Order still does not erect a barrier against interstate trade. The Commerce Clause grants Congress the power to "regulate commerce . . . among the several States." U. S. Const. Article I, § 8, cl. 3. In addition, the clause implicitly "limits the power of the States to erect barriers against interstate trade." *Dennis v. Higgins*, 498 U.S. 439, 446 (1991). "Analysis of a dormant Commerce Clause challenge proceeds on two tiers, a discrimination tier and an undue burden tier." *Yamaha Motor Corp. v Jim's Motorcycle, Inc.*, 401 F.3d 560, 567 (4th Cir. 2005).

a. The Discrimination Tier. A state law that discriminates against interstate commerce "facially, in its practical effect, or in its purpose" will be struck down unless it "serves a legitimate local purpose" that "could not be served as well by available nondiscriminatory means." *Maine v. Taylor,* 477 U.S. 131, 138 (1986).

The purpose of the CON Act "is to promote cost containment, prevent unnecessary duplication of healthcare 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).

CHS does not challenge the facial purpose of the CON Act, but argues that the Court applied the Act and regulatory criteria with a discriminatory purpose of protecting Piedmont against out-of-state competition and reducing outmigration to North Carolina.

In fact, the Order makes it clear that the Court's purpose is to protect the healthcare system in York County. The Court found that the effects of outmigration from

York County "have 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." Order at 32. Approval of the CHS application would have "an adverse effect on the distribution of services by existing healthcare providers to the residents of York County." Order at 34-35. "[T]he ability of existing York County healthcare providers to serve residents of the county would be jeopardized by the operation of CMC-FM." Order at 36.[1] This would be equally true whether the outmigration were out-of-state or to another South Carolina county.

These considerations clearly support the public needs purpose of the CON Act. As summarized by the Court:

> This court concludes that the establishment of the FMMC will best serve the public needs by reducing the outmigration of York County residents to North Carolina hospitals and, in so doing, will strengthen the existing healthcare system in York County that consists largely of Piedmont Medical Center and independent physicians on the Piedmont medical staff. Approval of Piedmont's application will help stem outmigration, while approval of CHS's will escalate it, especially for specialty services. Furthermore, CHS's proposed hospital site presents traffic and safety concerns. For all these reasons, FMMC will better serve public needs than CMC-FM.

In addition, the Court's decision furthers the quality purpose of the CON Act:

> 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 two 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 of 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

[1] CHS contends that the Court adopted the testimony of Joel Grice, who, according to CHS, advocated for preferential treatment of South Carolina providers. CHS Motion at 6. However, in its Findings of Fact, the Court did not even cite Mr. Grice. In its Conclusions of Law, the Court cited Mr. Grice only with respect to the financial feasibility criterion. Order at 24, 26.

high quality services continue to be added and provided within York County.

CHS further argues that the practical effect of the Court's ruling is discriminatory, in that the Court's emphasis on adverse impact establishes "a default preference" for existing providers. CHS Motion at 7. As support, CHS argues that Piedmont had an "unfair advantage" over CHS because it proposed a 100-bed facility rather than a 64-bed facility. *Id.* Throughout the trial, however, CHS argued that 64 beds were all that were needed in Northern York County and that 100 beds would be excessive. CHS argues that the Piedmont had a further unfair advantage due to its contract with York County. According to CHS, because Piedmont is the only hospital operating in York County, it is the only one able to contract with the County. *Id.* At trial, however, CHS asserted that the York County Contract was of no consequence. Moreover, CHS conceded at trial that it had never attempted to contract with the County nor had it offered to enter into such a contract, in the event it was awarded the CON. Finally, even if these concerns had any merit, the "discrimination" is not directed against out-of-state providers, but rather would apply in the same manner to any out-of-county provider.

b. The Undue Burden Tier. Where a state law is non-discriminatory and its effects on interstate commerce only incidental, "it will be upheld unless the burden imposed on such commerce is clearly excessive in relation to the putative local benefits." *Pike v. Bruce Church, Inc.*, 397 U.S. 137, 142 (1970). As discussed above, the purpose of the CON Act and regulatory criteria, as applied by the Court, are the same as the nondiscriminatory statutory purposes of the CON Act. In particular, the Court wished to protect the healthcare system of York County, by "guid[ing] the establishment of health facilities and services which

will best serve public needs and ensur[ing] that high quality services are provided in health facilities in this State." *See* S.C. Code Ann. § 44-7-120 (2002).

Any effect on interstate commerce by this decision is purely incidental. The competing applicant in this case happened to be a North Carolina hospital system with a strategy of drawing patients out of York County to its facilities. The analysis would have been the same, however, if the competing applicant had been a South Carolina hospital system with a strategy of drawing patients out of York County to its South Carolina facilities. In both situations, the salient fact is not *where* the York County patients are going, but that they are leaving York County.

The burden imposed on interstate commerce by the Court's decision is hardly excessive. Patients from York County will still have the option of driving over the state line to North Carolina facilities. With a new hospital in Fort Mill, patients from Mecklenberg County will have a greater incentive to drive into South Carolina for services. Moreover, nothing in the Order constrains the ability of CHS to establish or maintain a wide range of health services in South Carolina. CHS currently owns or manages several South Carolina hospitals. It also has a controlling interest in a Rock Hill cancer center with Piedmont and employs 66 physicians in York County alone. Order at 9, ¶ 15.

In contrast to any limited effect on interstate commerce occasioned by the Court's ruling, the local benefits from this decision will be significant. As discussed by the Court, the establishment of Fort Mill Medical Center will reduce outmigration from York County - especially for specialty services, prevent the erosion of quality care at Piedmont, preserve Piedmont's ability to provide tertiary services, and protect the ability of independent York County physicians to provide specialty services, all of which will strengthen the

healthcare system in York County. These benefits far outweigh any incidental impact the decision will have on interstate commerce.

B. The Court's Application of Project Review Criteria is Supported by the Evidence.

The Court's Order sets forth in great detail the evidence upon which it relies in reaching its Findings of Fact and Conclusions of Law. Among the documentary evidence the Court references is the CPN employment agreement (p. 9), Piedmont and CHS utilization and market share data (pp. 10, 13-15), Piedmont projected occupancy rates and historical rates for South Carolina hospitals (p. 11), CHS emergency department admissions (p. 12), the CMC-Pineville CON application (p. 13), occupancy rates at various CHS facilities (p. 14), census data (p. 21), CHS internal financial data and PeopleSoft records (p. 22), CPN data regarding Medicaid and indigent care (p. 23), and projected costs and financial performance of other CON hospital projects (p. 25).

Moreover, the Court repeatedly acknowledges the weight it gives to the testimony of three independent physicians (Drs.Adlakha, Singhi, and Taylor) called by Piedmont, as well as to the testimony of Piedmont's experts - Mr. Levitt, Mr. Sullivan, and Mr. Walsh.

CHS contends that the Court's conclusions lack evidentiary support because it improperly pitted the testimony of DHEC's former CON Director, Beverly Brandt, against two former DHEC employees - Joel Grice, an expert witness for Piedmont, and Mary Fechtel, who did not testify. In fact, neither the Findings nor Conclusions pit Ms. Brandt against either Mr. Grice or Ms. Fechtel. The Order cites Ms. Brandt's testimony only twice in the Findings. First, the Court notes that Ms. Brandt relied heavily on a "maldistribution" analysis, relevant to bed need and need projections, which the Court rejected. Second, it notes Ms. Brandt accepted CHS's charity care projection without considering the historical experience of CMC-

Pineville or CMC-University or the demographics of York County. Order at 22 - 23.[2] The Order cites Mr. Grice's testimony only in reference to the criterion of financial feasibility. Order at 24, 26. The Findings of Fact and Conclusions of Law reference Ms. Fechtel only as the DHEC official who ranked the project review criteria in order of importance. Order at 7, 34 n.10.

The Court sets out its analysis of project review criteria in paragraphs 15-39 of the Conclusions of Law. Order at 31-37. In paragraph 40, the Court complements all the parties, noting that DHEC "conducted a thorough review process" and "properly reviewed and analyzed both applications." Order at 37. Apparently attempting to explain why it reached a different conclusion from Ms. Brandt, despite her "thorough review process," the Court states: "To the extent the court disagrees with aspects of Ms. Brandt's analysis, it was persuaded by the testimony of Mr. Grice and Ms. Fechtel, both of whom worked within the Department for many years and possessed greater experience and institutional knowledge." *Id.*

This sentence is misleading, since Ms. Fechtel did not testify and the Order otherwise references her only as the DHEC official responsible for ranking the project review criteria. The Court specifically relied on the testimony of Mr. Grice, as Piedmont's expert, on the issue of financial feasibility. In considering the weight to give Mr. Grice's testimony as an expert, it was certainly appropriate for the Court to consider, among other factors, his institutional knowledge and 30-year history with DHEC.

In any event, it is clear that an abundance of evidence unrelated to Ms. Brandt, Mr. Grice, or Ms. Fechtel supports the Court's application of the project review criteria to the facts of the case.

[2] While not citing Ms. Brandt's testimony, the Court also noted that in 2008 she approved the CON applications of two satellite hospitals at a projected cost of $2.3 million per bed. Order at 24.

C. **CHS's Contention That the Court's Findings of Fact and Conclusions of Law are Incomplete.**

CHS identifies three different categories in which it argues the Court failed to conclude which applicant best meets certain project review criteria. Piedmont will address each in turn.

1. **Criterion 3a.** CHS mistakenly asserts that the Court fails "to address criterion 3a with a conclusion." M. Recon. at 13. In paragraph 21 under Conclusions of Law, the Court states:

> 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.

Order at 33, ¶ 21.

2. **Charity Care Criteria.** CHS next objects to the Court's failure to conclude whether both applicants equally meet the project review criteria at section 3b, d, f, and g that address access of the medically underserved to services. Based on the Court's discussion of this subject, the conclusions the Court has reached concerning the criteria may be reasonably inferred, even if they have not been expressly stated, to include the following:

a. Criterion 3b. The parties equally meet Project Review Criterion 3b that requires the project to be located so that it may serve medically underserved areas. For this purpose, the locations of the proposed sites are not distinguishable. This criterion also provides that proposed services should not unnecessarily duplicate existing services or facilities. For the same reason, the Court found Piedmont to be in compliance with Project Review Criterion 3a above, the transfer of 36 beds to FMMC would not duplicate the existing services at Piedmont. *Id.*

b. Criterion 3d. Project Review Criterion 3d cautions applicants not to restrict admissions. As the Court noted, "CPN internal records support CPN practices in York County limit access for indigent, Medicaid, and even Medicare patients." Order at 33, ¶ 24. As the Court found, "the effect of these restrictions by CHS-owned physician practices has not only been to limit access of medically underserved individuals to primary medical care but would be to limit access of those same individuals to non-emergency admissions at CMC-FM, which would be heavily dependent on CHS-employed physicians." Order at 23, ¶ 66. In contrast, the Court found that Piedmont's payor mix reflects a heavier charity and Medicaid base of York County patients that its medical staff members carry than CHS physicians. Findings of Fact at 23, ¶ 68. For these reasons, the Court's Findings of Fact and Conclusions of Law support no conclusion other than the Court intended to conclude that Piedmont meets Project Review Criterion 3d and CHS does not.

c. Criterion 3f. Project Review Criterion 3f provides that applicants should address the extent to which all residents of the area, particularly low-income persons and other medically underserved groups, are likely to have access to the proposed services. While both CHS and Piedmont have "addressed" the availability of indigent care for lower income patients, the analysis of compliance with this criterion should not stop there. For the same reason that the Court found the limited access to CHS York County physicians would limit non-emergency access to CMC-FM, Piedmont would better meet Project Review Criterion 3f.

d. Criterion 3g. Project Review Criterion 3g requires applicants to ensure that patients will receive treatment regardless of ability to pay. This provision is different from criterion 3d and 3f in that it focuses on treatment to patients who would present for services rather than on those who are screened out through the practices of CHS-employed physicians.

the applicants equally meet this criterion in that both applicants proposed provisions to ensure patients who present for care would not be denied services due to an inability to pay.

3. **Criteria 23a, 23b, and Criterion 3h.** CHS objects to the absence of express conclusions of law related to three specific project review criteria – 23a, 23b, and 3h.

a. Criterion 23a. After reaching conclusions of law that CMC-FM would have an adverse impact on the costs of Piedmont (criterion 16c) and the services furnished by existing providers (criterion 22), the Court turns its discussion to the adverse effect CMC-FM would have on Piedmont's utilization and finances. Order at 35, ¶¶ 32 and 33. The Court states that it finds "Piedmont has demonstrated, by a preponderance of the evidence, that CHS would continue to take market share from Piedmont if CMC-FM were established." *Id.* at ¶ 32. The Court further finds under the application of the "more reasonable" lookback approach that the operation of CMC-FM would cause Piedmont to lose between 1,600 to 3,000 inpatients per year. When outpatient losses are considered, the reduction in patient revenue would result in annual lost income that would range from $12 to 22 million. *Id.* at ¶ 33. The Order is not susceptible to a conclusion other than the Court intended to find as a matter of law that CHS does not meet Project Review Criterion 23a while Piedmont, having no adverse impact on itself, does.

b. Project Review Criterion 23b. Paragraph 34 of the Order appears to include a clerical error. It begins with a summary of Criterion 23b. After the first sentence, however, the paragraph abruptly begins a discussion of Project Review Criterion 22. In doing so, paragraph 34 includes language that is an exact duplicate of the language in paragraph 31, beginning on the third line with the phrase "operation of CMC-FM would have . . . ." It appears that through a clerical error much of the language of paragraph 31 was unintentionally

transposed to paragraph 34. In any event, it is not possible from the Order to discern the Court's conclusion of law with regard to Project Review Criterion 23b.

c. Project Review Criterion 3h. Project Review Criterion 3h requires consideration of whether the proposed project will have a potential negative impact upon the ability of existing providers to serve medically underserved groups. While the Court did not reach a legal conclusion on this issue in the Order, it did make findings of fact that would support a legal conclusion that Piedmont meets this project review criterion and CHS does not. In particular, the Court found that "[h]ospitals must use the margins they achieve from managed care, or privately insured patients to subsidize the services they provide to uninsured and Medicaid patients." Order at 15, ¶ 34. The Court further found that from 2005 to 2011, Piedmont's payor mix declined substantially as CHS's York County market share grew. "During that period, Piedmont's managed care patients fell sixteen (16) percent, while Medicaid patients increased by the same amount and its charity care cases doubled." *Id.* at ¶ 35. In addition, the Court found that "[a]mong the greatest threats to Piedmont is that if CMC-FM were approved it would reduce the volume of services referred to independent 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." *Id.* at 16, ¶ 38.

These findings support the conclusion that CMC-FM would have a potential negative impact upon the ability of existing York County providers to serve medically underserved groups. Based on these findings, it would appear the Court intended to find that CHS did not meet Project Review Criterion 3h and that Piedmont did. Even if this criterion

should be given less weight than the other criteria DHEC chose to apply to these applications, this consideration should not be overlooked.

D. The Court Properly Addressed the Weight of Adverse Impact.

CHS also enters an objection over the extent to which the Order addresses adverse impact. CHS argues that the Court misinterprets Project Review Criteria 22 and 16c, inflates the significance of Criteria 23a and b, and fails to balance CMC-FM's adverse effects against the improvements in accessibility it would generate.

1. **Interpretation of Project Review Criteria 22 and 16c.** CHS's objection to the Order's treatment of adverse impact turns on its argument that the Court's consideration of adverse impact should be limited largely, if not entirely, to Project Review Criteria 23a and b. That position is not supported, however, by the project review regulations. In addition to the adverse impact provisions in 23a related to the efforts on utilization and 23b related to the effects on staffing, several other project review criteria require consideration of adverse impact. The Court made conclusions of law for two of those additional criteria. As the Order states, "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." Order at 34, ¶ 31. The Court found that the distribution of services rendered by existing healthcare providers to York County residents would be adversely affected by the operation of CMC-FM. The Court's analysis applies the plain meaning of the regulation. It is supported by substantial evidence in the form of the expert testimony of Mr. Levitt, Mr. Sullivan, and Mr. Grice.

Similarly, the Court applied the plain language of Project Review Criterion 16c to conclude that the effect on Piedmont of the loss of over a thousand patients and millions of

dollars a year would be to increase its cost per unit of service. For that reason, the Court rendered, as the regulation requires, a judgment as to whether the costs of existing providers would be effected by the proposed projects, holding that Piedmont best meets Project Review Criterion 16c.

2. **Balancing Adverse Effects Against Improved Accessibility.** CHS correctly points out that S.C. Code Ann. § 44-7-180(B)(4) and the 2004-2005 State Health Plan each provide that, in reviewing a CON application, the benefits of improved accessibility will be weighed against the adverse effects caused by the proposed duplication of services. The Order makes clear that extent of the adverse impact through its factual findings and legal conclusions. CHS incorrectly states, however, that the Court focused only on the adverse impact on Piedmont. This statement ignores the considerable findings the Court made related to the adverse effects on York County physician practices. *See* e.g., adverse effects on medical quality (Order at 15, ¶ 36), and on payor mix and volume of medical practices (Order at 16, ¶ 38 and at 38, ¶ 44).

With regard to consideration of any benefits that would be derived from the improved accessibility associated with the establishment of a new hospital in Fort Mill, the first step of the analysis is to compare the relative improvements in accessibility each applicant's project would produce. As the Court found, "expert witnesses presented by both parties agreed on one core issue: a need exists for a new hospital in Northern York County." Order at 32, ¶ 18. Thus, Piedmont and CHS would equally improve accessibility to the extent it is measured by new hospital services provided in the Fort Mill area. Otherwise, the findings in the Order demonstrate that FMMC would enhance accessibility to a greater degree than would CMC-FM.

a. Larger Facility Would Improve Accessibility. The Court found that as a result of the transfer of 36 beds from Piedmont to FMMC, hospital beds in York County would be more "equitably distributed" through the 100-bed FMMC facility than the 64-bed hospital CHS proposed to build. Order at 32, ¶ 18. In addition, the Court found that FMMC's capacity to expand to 250 beds in the future would enable it to "be better positioned to meet the needs of the rapidly growing Fort Mill area than CMC-FM." *Id.*

b. Restrictions on Admissions. One of the principal determinants of accessibility is Project Review Criterion 3d, which prohibits a facility from restricting admissions. The Court found that CHS-employed physicians limit access in their practices for indigent, Medicaid, and Medicare patients. Because CMC-FM would be heavily dependent on these physicians for non-emergency admissions, the Court found that access of these patient groups to CMC-FM for such are would be similarly limited. Order at 23, ¶ 66.

c. Access to Specialized Medical Services. The Court found that while either applicant would be capable of providing high quality healthcare at its proposed Fort Mill-area hospital, "one of the principal differences between the two applicants is that only the approval of FMMC would permit the expansion of specialized medical services in York County." Order at 38, ¶ 44. In contrast, the Court held that the approval of CMC-FM would have the effect of escalating the loss of specialized medical services in York County as a result of the diminution of patient volume and the degradation of the payor mix. *Id at 38,* ¶¶ 43 and 44. In this respect, approval of CMC-FM would harm, not improve access of York County residents to care.

Based on the Court's factual findings and legal conclusions related to accessibility, it is evident that the Court found that the approval of FMMC would improve accessibility for the

residents of York County more than would CMC-FM. Had CHS demonstrated that improvements in accessibility from the operation of CMC-FM were superior to those generated by FMMC, then it would be necessary to conduct a detailed assessment weighing the greater accessibility flowing from the CMC-FM facility against the adverse effects the operation of CMC-FM would pose for existing York County providers. That assessment, however, has a less significant role here because of the Court's determination that CMC-FM would improve accessibility only in the same manner as would FMMC, namely to establish a new hospital in the Fort Mill area. Otherwise, CMC-FM would not enhance, but would constrain access in the manner the Court has found. In contrast, FMMC would increase access in the very ways CMC-FM would constrict it.

With regard to adverse impact, the Court found a substantial likelihood that both Piedmont and independent York County physicians would be adversely affected by the operation of CMC-FM. The Court further found that by reducing outmigration from the Fort Mill area through the operation of FMMC, Piedmont would strengthen services to residents throughout York County. Order at 10-11, ¶ 18.

Based on the factual findings and legal conclusions in the Order, it is inescapable that the Court's judgment is that the benefits associated with the limited improvements in accessibility produced by CMC-FM, when balanced against the substantial likelihood of adverse effects to existing providers caused by its operation, militate against approval of CHS's application. In contrast, FMMC would improve access for York County residents consistent with the findings set forth in the Order without adversely impacting the delivery of healthcare services in York County. Thus, the application of the balancing test weighs heavily in Piedmont's favor.

E. **The Court's Findings and Conclusions on York County Utilization Are Supported by Substantial Evidence, and the Error CHS identifies in the Interpretation of the 2012-2013 Health Plan is Immaterial.**

CHS argues that an error in the Court's interpretation of the 2012-2013 Health Plan discredits and ultimately undermines the Court's holding that a greater need exists for a 100-bed facility in the Fort Mill area than for the 64-bed facility CHS proposes. Nothing in the Order, however, supports its argument. While a calculation error appears to have been made in interpreting the table identifying the number of York County beds in the 2012-2013 Health Plan, the sum of that calculation was not applied in the Court's analysis of bed need and did not affect the Findings of Fact or Conclusions of Law.

1. **Bed Need Under the 2012-2013 State Health Plan.** On two occasions, the Order states that the 2012-2013 Health Plan projected a need for 348 hospital beds in York County. Order at 6, ¶ 5; at 19, ¶ 47. Based on the computation set forth in paragraph 5 of the Findings of Fact, it appears that the Court calculated a projected total bed need of 348 in 2018 based on the sum of the number of "Exist Beds" for Piedmont (268), the number of "Exist Beds" for CMC-FM (64), and a number of beds "To Be Added" (16). The table, however, also includes a column for "Bed Need," which is derived from historic utilization at Piedmont coupled with the growth in York County population between 2011 and 2018. Existing beds are shown in the same table for CMC-FM because DHEC had approved its CON application. Because CMC-FM had not been constructed nor had it served patients, however, no "Bed Need" was identified for that facility. The actual bed need shown in the 2012-2013 Health Plan therefore does not include the 64 beds associated with CMC-FM. Thus the total hospital "Bed Need" shown in the plan for York County is 284, not 348.

2. **Bed Need Under the 2004-2005 State Health Plan.** The York County bed need identified in the 2004-2005 Health Plan was 332, not 284. After applying the 268 beds at Piedmont against the 332-bed need, a total of 64 beds could be added under the Plan to the York County hospital bed inventory. This bed need formed the basis for the CON applications submitted by Piedmont and CHS and reviewed by the Court.

CHS incorrectly asserts that the technical calculation error in the interpretation of the 2012-2013 Plan infected the Court's consideration of whether a 64-bed or 100-bed facility was needed. Nothing could be further from the truth. First, through its argument, CHS implies that Piedmont is adding 100 beds to the market, not 64 as CHS has proposed. As the Court is well aware, that is wrong. Piedmont is able to build a 100-bed facility because it has proposed to redeploy 36 beds from the Piedmont facility to meet the growing demands in the Fort Mill area. Both Piedmont and CHS are proposing to add 64 new beds to the York County hospital bed inventory as provided under the 2004-2005 Health Plan.

Second, the Court thoroughly examined the parties' market share assumptions and population projections through York County to form a basis for its finding that CMC-FM would be inadequate to meet the projected bed need. The Court found that the establishment of 100 beds at FMMC would better meet the need for a new hospital in the Fort Mill area. Order at 21, ¶ 57. Throughout the Court's bed need analysis, the Order makes no reference to the mistakenly calculated 348-bed need from the 2012-2013 Plan. Thus, the error played no role in the Court's conclusion that FMMC will best meet the needs of York County residents.

F. The Testimony of Piedmont Medical Staff Members.

This ground for reconsideration is based solely on the fact that the Court found persuasive the testimony of three physicians who are members of the Piedmont medical staff.

CHS complains that it has been prejudiced by the Court's reliance on the testimony in three ways.

1. **Naming of the Witnesses.** Piedmont named the three physician witnesses on February 6, 2013, over two months before the beginning of trial. Over CHS's objection, the Court permitted the witnesses and allowed CHS to name physician rebuttal witnesses. Piedmont deposed those witnesses before the hearing without prejudice. CHS has failed to demonstrate any basis for the prejudice it asserts.

2. **Characterizing Physicians as "Independent."** CHS complains that the Court mischaracterizes the relationship between Piedmont and the physician witnesses it called. The objection is spurious. It is clear from the Order that the Court uses the term "independent," as did Piedmont, to contrast the witnesses from physicians who were employed by or a hospital system or its affiliate. The physician witnesses were independent in the sense that they and their practices were entirely free to apply for privileges or resign their privileges from any hospital of their choice. They could admit patients to any hospital where they had privileges. They could refer patients to any colleague of their choosing without prior approval, oversight, reporting, or other encumbrances. They could align themselves contractually with CHS, Piedmont, or any other healthcare system in the future without notice should they elect to do so. Those options were available to independent physicians, not to those employed by CHS or other healthcare systems.

"Independent" physicians does not imply that the three physician witnesses were unaffiliated. Any physician that provides services to hospitalized patients must be credentialed and privileged by that hospital. The three physicians were members of the Piedmont medical staff. That they were current or former leaders of the Piedmont medical staff neither

disqualifies nor discredits them. One of CHS's physician witnesses, Dr. Alexander was the former chief of staff at Piedmont. One CHS-employed physician, C. Stephen Bale, M.D., was chairman of the Piedmont Board of Governors. Trans. at 988, ll. 8-15. This history demonstrates no inferences concerning bias can be made solely on the basis of the various positions held by Piedmont's physician witnesses or their partners.

3. **Testimony Beyond the Scope of Depositions.** CHS objects that the trial testimony of the physician witnesses was more expansive than their deposition testimony. Through cross-examination, CHS had every opportunity to attempt to impeach any witness whose trial testimony was inconsistent with prior sworn statements. On the few occasions where CHS trial counsel did attempt to impeach Dr. Adlakha or Dr. Taylor, those efforts were futile. It is the province of the Court to assess the credibility of witnesses. CHS presented nothing at trial or through this motion to disqualify these witnesses, to discredit them, or to otherwise demonstrate that the Court inappropriately exercised its discretion in relying on their testimony to support various factual findings.

G. **The Court Appropriately Considered Traffic and Safety Concerns Posed by CHS's Proposed Site.**

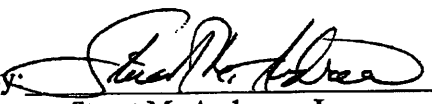
The Court found that CHS's proposed hospital site poses serious traffic congestion and safety concerns. Order at 27, ¶ 38. CHS argues that the Court improperly considered these findings on the grounds that traffic considerations are not encompassed among regulatory criteria. M. Recon. at 21-22.

In reviewing competing CON applications, the Court must consider more than regulatory criteria. In such circumstances, a CON must be awarded "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." Order at 29, *citing* S.C. Code Ann. § 307(2). One of the purposes of the CON Act is to "guide the establishment of health facilities and services which will best serve public needs." Order at 28, *citing* S.C. Code Ann. §44-7-120 (2002).

The Court appropriately considered the potential traffic congestion and safety concerns posed by CHS's proposed site because they relate to the "public needs" purpose of the CON Act. As the Court stated, "CHS's proposed hospital site presents traffic and safety concerns. For all these reasons, FMMC will better serve public needs than CMC-FM." Order at 38, ¶ 43.

NELSON MULLINS RILEY & SCARBOROUGH LLP

By: 

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Columbia, South Carolina

April 21, 2014

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT DIVISION
Docket No. 11-ALJ-07-0575-CC

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-Meckenburg Hospital Authority, d/b/a Carolinas Medical Center-Fort Mill, Respondent.	)

COPY

ADMINISTRATIVE HEARING

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The administrative hearing before the Honorable S. Phillip Lenski was taken at the Edgar A. Brown Building, 1205 Pendleton Street, Suite 224, Columbia, South Carolina was taken Monday, April 8, 2013, through Friday, April 12, 2013 before Alexandra A. Patrick, Andrea R. Taylor, and Sara L. Quattlebaum, Court Reporter and Notary Public in and for the State of South Carolina.

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DATES/TIMES:

MONDAY, APRIL 8, 2013
10:13 a.m. - 5:28 p.m.
TUESDAY, APRIL 9, 2013
10:03 a.m. - 5:46 p.m.
WEDNESDAY, APRIL 10, 2013
10:09 a.m. - 5:00 p.m.
THURSDAY, APRIL 11, 2013
10:00 a.m. - 3:54 p.m.
FRIDAY, APRIL 12, 2013
10:07 a.m. - 5:25 p.m.
MONDAY, APRIL 15, 2013
9:00 - 9:46
(No proceedings taken)
TUESDAY, APRIL 16, 2013
9:04 a.m. - 5:46 p.m.
MONDAY, APRIL 22, 2013
10:07 a.m. - 5:46 p.m.
TUESDAY, APRIL 23, 2013
10:02 a.m. - 6:04 p.m.
WEDNESDAY, APRIL 24, 2013
10:08 a.m. - 1:12 p.m.
THURSDAY, APRIL 25, 2013
10:05 a.m. - 2:43 p.m.
MONDAY, APRIL 29, 2013
10:09 a.m. - 6:26 p.m.
TUESDAY, APRIL 30, 2013
10:16 a.m. - 4:05 p.m.
THURSDAY, MAY 2, 2013
10:15 a.m. - 3:24 p.m.
MONDAY, MAY 6, 2013
10:12 a.m. - 5:01 p.m.
TUESDAY, MAY 7, 2013
9:09 a.m. - 10:08 a.m.

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EXHIBITS

(The Exhibit Index for this hearing is contained in a separate document.)

STIPULATIONS

It is stipulated and agreed that this hearing is being taken pursuant to the rules of the Administrative Law Judge Division and the South Carolina Rules of Civil Procedure.

MR. ANDREWS: Well, actually would go up to the current.

THE COURT: Okay. All right. I'm sorry, from 2005 forward.

MR. ANDREWS: Correct.

THE COURT: All right. Thank you, Mr. Andrews. Mr. Gaskins, is there anything more?

MR. GASKINS: No, Your Honor. Nothing on those.

THE COURT: All right.

MR. GASKINS: Your Honor, next we have moved to exclude expert testimony from Mr. Sullivan and Mr. Levitt. They're designated as experts in health planning and we'll offer their testimony regarding which applicant most fully complies with their Certificate of Need Act. Mr. Sullivan, among other things, is expected to testify about the out-migration of patients from York County and how that's related to CHS's referral practices. Mr. Andrews touched briefly on the issue of referral practices. And Mr. Sullivan, in his deposition testified that he doesn't have any personal knowledge of CHS's practices. He gained this information in a meeting with Mr. Levitt and some physicians affiliated with Piedmont. Ms. Robertson also

referred to Exhibit Number 65, which we have objections to. And those are handwritten notes of that meeting that contain a large number of hearsay statements from the physicians. What the physicians were telling Mr. Sullivan and Mr. Levitt was also hearsay based on what they had learned from physicians within the CHS network. Obviously, experts are allowed to rely on inadmissible evidence, but the evidence they rely on must be reliable. And in this case we don't think that it is. These individuals have not been identified, they are only a handful of physicians from a wide-ranging network. We don't think it's accurate, complete, or verifiable. But even if it was accurate and complete, Mr. Sullivan has no way of taking that small amount of anecdotal information and trying to establish a causal relationship between the referral practices and the out-migration of patients. So just this small amount of double-hearsay, unreliable evidence, I think, makes their opinions suspect and should be excluded. With regards to Mr. Levitt, he is going to testify regarding certain practices of CHS and their treatment of

Medicare and Medicaid patients. And Mr. Levitt's opinions are based on an informal survey in which he and a Piedmont employee called up four, only four CHS physician practices out of many. And I think deceptively pretended to be a patient in the set-up of an appointment. And according to Mr. Levitt, whoever he spoke with, who was not identified, said that practice was not taking Medicare or Medicaid patients at the time. Obviously -- from those four practices he says that there's a fear that this is a system-wide practice and there's just no evidence suggesting that as the case. These conclusions are unreliable. When asked about it in his deposition, he admitted he did not take notes. He doesn't appear to have recorded the phone conversations. We don't know who he spoke with or whether such individuals had authority or knowledge about the certain practices and policies. Also, we don't know the context in which these conversations were made. One of Piedmont's witnesses, Mr. Taylor, testified about his own practice accepting Medicare and Medicaid patients. And he says it varies and fluctuates

from month to month depending on a number of circumstances. So in this particular instance, they may have called at one time when this practice was not accepting Medicaid, but if they called a week later they might would have gotten a different result. So we believe that this evidence is unreliable, it's hearsay, and should be excluded. Before I turn it over for the second time, we also raise the issue about disqualification of Mr. Levitt, based on a potential conflict of interest. We are not going to address that at this time, but we just wanted to bring it to the attention of the Court and reserve our rights to make that motion at the appropriate time.

THE COURT: Thank you, Mr. Gaskins. Mr. Andrews, you going to do this one, too?

MR. ANDREWS: Yes, sir, Your Honor. Your Honor, again, this summary falls under the principle that this is a process in which experts engage in. It's a factual question of whether -- how common it is, and that goes to the weight, as does all of this, the extent of the survey, the formality of it. The point is they were gathering information which was not limited by

do openings, then we'll take our lunch break and then we'll come back in. All right. We'll recess for ten minutes.

(Off the Record)

THE COURT: Please be seated. We're back on the record. And I just wanted to briefly say, I have asked someone to take a look, I don't know if anybody's feeling this, it seems to be a little warmer than it needs to be in here. So I've asked that that be taken into account. Somebody's looking at that and hopefully we'll have the temperature a little bit more pleasant after lunch. Thank you. I am aware of the situation and just thought I would let you know. All right. Mr. Westbrook?

MR. WESTBROOK: Thank you, Your Honor.

OPENING STATEMENT - BY MR. WESTBROOK:

MR. WESTBROOK: If it please the Court, I'm Dan Westbrook; I represent Piedmont Medical Center. With me here today is my client, Mr. Bill Masterton, who's the CEO of Piedmont, sitting over here. My partner, of course, Stuart Andrews. My paralegal Leslie Sackett. And seated at the end over there is a gentleman who's going to provide our tech support

throughout this trial, Mr. Dan Bupp. I think that the first thing to understand is the geography. So I would like to ask Dan to put up Demonstrative 17 on the screen for us, please. This, of course, is York County, I-77 splits it in two. Rock Hill is just west of the interstate. And the further west you go from Rock Hill out northwest and south too, it tends to get more and more rural. It's a very rural area, pockets of this are very rural in places you don't, you know, find just Corner Pantry's and quickie marts, but real country stores, where old men like Mr. Andrews and myself sit around all day and play checkers and shoot the breeze. It's important not to lose sight, I think, of that part of the county. Because I think the entire county, including those rural parts of the county are at stake. But the focus, I think, of this trial is going to be on that northeastern portion of the county. Up there around Fort Mill and Tega Cay, near the North Carolina state line, that I'm going to call the Fort Mill area. Because that's really the prize the parties are going after, this area up here. It's become almost like an

extended suburb of Charlotte. It's the fastest growing part of the county and it's the most affluent part of the county. The old men who sit around up there aren't playing checkers, they're trading stocks on their iPhones. Piedmont Medical Center is in Rock Hill, of course. It's the only hospital in the county; it's been there for about 30 years. And Bill Masterton, the CEO, is going testify that for a hospital of its size located in what's mostly a rural county, Piedmont provides some really unusual, special kinds of services. Things like open heart surgery, vascular surgery, he's going to go through those with you. Bill's also going to testify that Piedmont over the last few years has won some very nice awards for the quality of their services, from organizations like the Joint Commission and the American Heart Association and Blue Cross and even DHEC. And he and other witnesses for Piedmont are going to testify that it's unusual for a hospital like Piedmont, its size and locale, to provide those kind of services and win those kind of awards. It's also unusual for a hospital like Piedmont, or for that

matter any hospital, to be party to the kind of contract that Piedmont is a party to. The contract with York County that has requirements of accountability and transparency that make Piedmont operate, at times, almost like a public hospital. But, of course, it's not a public hospital, it's a private hospital, it pays taxes. Dan, let's go to Demonstrative 147. This is a map, as you'll see, kind of a rough map of the Charlotte area. There are 21 hospitals identified on that map, 12 of them are in blue. Those are the hospitals owned or operated by the Charlotte-Mecklenburg Hospital Authority, or CHS, which is the dominant hospital system in this area. CHS, of course, is a big public hospital. The evidence will show it's actually one of the largest public hospital systems in the United States. That's huge revenues, huge profit margins, huge cash reserves. And yet, from 2007 to 2011, it filed about 10,000 lawsuits, collection actions against its patients, many of them uninsured resulting in about 5,000 property liens. CHS has a contract or had a contract with its county, Mecklenburg County, as well, under

which, among other things, a good bit of the charity care that CHS provided was reimbursed by the county. That ended last year when the county terminated the contract and there was an ensuing lawsuit that ended up getting dismissed. The closest CHS Hospital to York County is CMC-Pineville. It's the closest one to Piedmont, of course, too. CMC-Pineville has or CHS, rather, I guess, has spent $300 million or more in the last decade or so expanding, renovating Pineville, doubling its size, increasing the kinds of services it provides. So that now it provides really the same kind of high-end tertiary services that Piedmont provides, open heart surgery and things like that. CMC-Pineville has filed a number of CON applications in North Carolina during the past decade as part of its expansion. And in those CON applications filed in North Carolina, it specifically identifies, targets York County as part of its service area that it's seeking to serve. In other words, it relies, CMC-Pineville relies on York County patients to meet its patient volume projections in those North Carolina CON applications. Dan, let's go

to Demonstrative 158, please. Now, Piedmont's experts are going to testify in this trial that the single most important factor in determining where a patient goes for hospital services is the recommendation of his or her physician, not really a surprising conclusion. And it's important to note the growth of CHS employee positions in York County. In 2005, as this Demonstrative shows, CHS employed 35 physicians with offices in York County and in 2008 that number had grown to 46 and in 2012, the most recent figure we have is 66 as the chart shows, an 89 percent growth since 2005. Now, at the same time that CHS was building up Pineville and buying up physician practices in York County, it was also building office buildings, medical office buildings. Dan, let's go to those three Demonstratives, 161, I believe, 162 and 163. Building office buildings and urgent care centers in York County and a big new freestanding emergency room just across the state line in Steele Creek. Now, the result of all this activity by CHS during this last seven or eight years, the result on Piedmont has been a plummeting market share. I believe in the

DHEC decision letter, Ms. Brandt identified the market share for Piedmont and York County, back in 2003, as over 70 percent. By 2011, it was, I believe, it was 57 percent according to Ms. Brandt's numbers. Now, during this period of time, what we saw was a lot of patients in York County, particularly around the Fort Mill area out-migrating. That's the term that we're going to hear a lot of in the next few weeks. A lot of patients out-migrating for hospital services from York County over the state line to Pineville and Charlotte and the CHS facilities up there. Now, to be clear, not all patients were out-migrating, just the paying patients, the insured patients. During this period of time, population in York County, from 2005 to 2011 grew at a rate of about 22 percent, that's a pretty good growth rate. And the fastest growing part of that county, of course, as I said earlier, was up around the Fort Mill area. Now, during that time of that kind of growth, the insured admissions, the managed care commercial admissions, the patients who had insurance and could pay their bills, at Piedmont declined 23 percent,

population growing at 22, paying patients declining at 23. And during that same period of time, uninsured patients at Piedmont increased by 175 percent. Now, there's nothing wrong or illegal about what CHS has been doing in the last few years. There's nothing illegal about CHS going into York County, buying up physician practices, having those physicians steer patients to CHS facilities over the state line in North Carolina. It's a good, smart, aggressive business strategy. It's good for CHS. The question is, is it good for York County, South Carolina? Whether it's good or bad, Piedmont certainly has to come up with its own business strategy to counter it. Mr. Masterton is going to testify that in order to compete with CHS, Piedmont has to develop and implement its own business strategy and it's done that. It's developed it and it is trying to implement it. And it's not terribly shocking what the elements of that strategy are, there are three elements to it. He's going to discuss those in detail. I'll just give you the overview. First, Piedmont has to develop and expand its emergency department.

It has already taken steps to do that. And the reason for that, as he's going to tell you, is that the emergency department is the way in which a hospital acquires a lot of its patients. So it's important to have a good emergency department that people will come to and it's big enough to handle those. And as I've said, Piedmont is well on the way of doing that to its emergency department. The second element is to recruit more physicians. If physician recommendations are the most important factor in determining or influencing where a patient goes for hospital services, and that's certainly been proven by CHS over the last few years here, then Piedmont has to recruit its own physicians. And that element of the strategy is being implemented as well. Third, and most important, Piedmont needs to build a hospital in Fort Mill to stop the out-migration, to halt the out-migration that's been going on and to recapture some of that out-migration. Piedmont has to have its hospital in Fort Mill. Fort Mill will have its own emergency department, a second emergency department through which patients can come.

The presence of Fort Mill will be a tremendous enhancement to Piedmont's ability to recruit physicians. It's fine to say we're going to recruit physicians but if you have a new hospital in Fort Mill it's going to make that recruitment a lot less difficult. Now, Piedmont wants to build a 100-bed facility, a 100-bed hospital in Fort Mill. And to get to a 100 beds, Piedmont has to transfer 36 of its present beds in Rock Hill, up to Fort Mill. And as Mr. Masterton will tell you, that's not going to be a problem in doing that because right now on any given day on any average day at Piedmont Medical Center, he'll tell you there are about 100 unused beds at Piedmont. There are whole wings of the hospital that are shut down right now, they're closed off where beds are not being used. So transferring 36 beds to Fort Mill not only won't be a problem, it makes sense. Now, you're going to hear from CHS and, I guess, from DHEC because Ms. Brandt made this finding that somehow having a hospital in Fort Mill is going to harm Piedmont Medical Center, transferring those 36 beds and building a hospital in Fort Mill is going to

harm Piedmont. That's ignoring the fact of the facts. That these are not only going to be sister hospitals, they're going to actually divisions of the same legal entity. They're going to be parties to the same contract with York County. They're going to have shared administration. Mr. Masterton is going to be the CEO of both hospitals. They're going to form two hospital systems in York County. DHEC has made its decision in this case, well, actually I guess they've made two decisions. First, DHEC awarded the CON to Piedmont. And the DHEC officials made that decision, Joel Grice is going to be here later this week or maybe early next week to testify and tell you about that. And then, of course, after the remand DHEC awarded the CON to CHS and the person who made that decision, Beverly Brandt, is also going to be here to testify. But my point is the time for DHEC decision making is, of course, over. I don't want to say this, I don't want to say the ball is in your court, I just caught myself. It's now your decision, of course, it's the Court's decision. And it's going to be a new decision, a fresh decision,

a de novo decision. And in making that decision there are going to be a lot of criteria that, of course, you have to consider. And criteria, of course, are very important and you're going to hear a lot of testimony and a lot of arguments from both sides about who best complies with which criteria. For example, we strongly believe and we're going to have lots of testimony that we comply with each criteria, each sub-criteria, as well or better than they do. I'm sure they're going to have a different view on that. But the fact is, that both these applicants know how to build a good hospital. And with all the population growth in the Fort Mill area and all the affluence in the Fort Mill area, no matter which hospital gets built, it's going to be financially successful. And that is, of course, why these parties have been fighting, have been spending so much money and so much effort and energy over so many years to get this CON, because everybody knows it. Criteria are very important. It's also important to not loose sight of the forest for the trees, what this case is about, the criterium in this case is about is adverse

impact. The great distinguishing factor in this case between the applicants is adverse impact. All the other criteria even out, what does not even out is adverse impact. Dan, let's look at Demonstrative 148, please. Now, this little map here just shows the proximity of the relationship geographically between CMC-Pineville, Piedmont Medical Center and the proposed CMC-Fort Mill. With respect to adverse impact, what you're going to hear from CHS is the position that CMC-Fort Mill will not have any adverse impact on Piedmont Medical Center. Let me clarify that. Their position as they've stated so far, at least in the DHEC record and their expert depositions, is not that CMC-FM will have a moderate impact or only a minimal impact, it's that it will have no impact. The linchpin of their case, the linchpin of the DHEC decision awarding the CON to them is CMC-Fort Mill will not take a single new patient from Piedmont. Now, what our experts are going to testify at trial is that that is not a realistic projection. CHS says they're going to accomplish this, have a successful hospital without taking any new

patients from us by something that I'm going to just refer to for short as the big shift. By the big shift, what they say they're going to do is all those patients who've been out-migrating for the last seven, eight, nine years to CMC-Pineville, CMC-Main up in Charlotte and the other CHS facilities up around Charlotte, what they're going to do is shift all those patients back to CMC-Fort Mill. CMC-Fort Mill is not going to take any new patients they say, they're just going to do this big shift back to CMC-Fort Mill. Now, what our experts are going to testify is not only is that not practical, that as a matter of practicality they can't really do that, but also it's a matter of incentive. CHS has spent $300 million, at least, in the last several years building up CMC-Pineville which specifically targets York County and its service area. They're proposing to spend another $77 million to build CMC-Fort Mill. What our experts are going to testify is that a big, aggressive, rich, successful hospital system like CHS, doesn't spend hundreds of millions of dollars just for 64 beds and to maintain the status quo. What our

experts will tell you is that the real shift that's going to take place is not the shift that they're projecting, it's a continuation, an escalation of the shift that's been going on for the last seven, eight, nine years as patients out-migrate from York County to seek hospital services in North Carolina. CMC-FM will serve as what's known in the industry as a feeder hospital, feeding patients to the larger facilities like CMC-Pineville that provide more complex services and to the specialized physicians that are employed by CHS in North Carolina. What Piedmont will be left with, then, in the coming years are the uninsured patients, the Medicaid patients, and the patients that live in that big rural area in western York County. But when those folks come for services at PMC in the future at Piedmont, they're not going to find the same kind of high-end, high-quality tertiary services that Mr. Masterton will tell you that exist now. Because as in the coming years, if CMC-Fort Mill is built and the out-migration escalates, Piedmont faces the continued out-migration of the paying insured patients, as

their volumes decline and their revenues decline, they will be forced to cut staff, services and programs. And that's what the uninsured, the Medicaid, and the rural folks who come to Piedmont will be provided in terms of services in the future. Meanwhile, CHS will thrive across the border in North Carolina. I grew up in a rural area, not in western York County, but not unlike western York County. My mother was a high school English teacher. She was also a devout Baptist, and those two facts, according to Mr. Andrews, explains some of the darker side of my character. My mother loved the English romantic poets, she used to read those to me, particularly Byron, she loved Byron, particularly when he had a biblical theme. And I remember her reading to me one of her favorite poems, the Destruction of Sennacherib, it's based on an Old Testament story. It starts out, the Assyrian came down like the wolf on the fold, and his cohorts were gleaming in purple and gold. Now, CHS is a big, rich, powerful, aggressive hospital system right over the state line. And the fold that they are eyeing, the prize that they are eyeing

is the Fort Mill area. For years, CHS has been taking patients, paying patients out of the Fort Mill area over into North Carolina and providing them, steering them for hospital services. The presence of CMC-Fort Mill will only escalate that process. The only way to halt that out-migration and to give Piedmont the ability, the opportunity to provide high-quality services to all of York County is to allow it to build the Fort Mill Medical Center. Thank you.

THE COURT: Thank you, Mr. Westbrook. Mr. Muller?

MR. MULLER: Can I please switch the monitor over to this side?

THE COURT: Yes.

OPENING STATEMENT - BY MR. MULLER:

MR. MULLER: Great minds think alike. I guess Mr. Westbrook and I are focused, obviously, on maps to demonstrate to the Court visually what we're talking about. I want to go all the way back to the first application that was submitted by Piedmont. And this is a visual depiction of what is the primary service area for that application. And there was really no secondary service area; this was it. This was the zip

THE COURT: Yes.

MR. MULLER: And if it would help the Court, maybe we could present you with a list of what is still outstanding?

THE COURT: That would be good to make sure we're all on the same -- we don't have to do it right this second, but maybe by the end of the day or first thing tomorrow morning. If you would provide that for me.

MR. MULLER: Thank you.

THE COURT: Thank you very much.

MR. ANDREWS: Your Honor, Piedmont is ready to call its first witness.

THE COURT: Yes.

MR. ANDREWS: All right. Dr. Arun Adlakha.

ARUN ADLAKHA, being duly sworn, testifies as follow:

DR. ADLAKHA - DIRECT EXAMINATION BY MR. ANDREWS:

Q: Dr. Adlakha, please state your full name and your business address for the record?

A: It's Arun Adlakha. And it's 124 Glenwood Drive, Rock Hill, South Carolina.

Q: I might suggest that at some point, the court reporter may ask you to speak up loudly enough so that she can hear you audibly, okay?

A: Okay.

Q: If you'll work at projecting your voice for us and so the Court can hear you as well. Dr. Adlakha, are you currently on the medical staff of Piedmont Medical Center in Rock Hill?

A: Yes, I am.

Q: And what is your area of practice?

A: It's pulmonary, critical care and sleep disorders.

Q: Okay. Now, you've previously provided and we have provided to the other parties a copy of your resume and I believe you've handed us an updated, more recent version of that, is that correct?

A: Yes, sir.

Q: Your Honor, that's Exhibit 72, which has been agreed to be pre-admitted without objection as I understand it.

THE COURT: That's correct.

Q: All right. And, Your Honor, in fact, we just received from Dr. Adlakha this morning, a copy of his current CV and I provided a copy up here on the ledge for you and Kelly.

THE COURT: Thank you very much.

Q: Now, Dr. Adlakha, the resume that you have before you that we just handed to the Court, is

that current?
A: Yes, sir.
Q: And is it accurate?
A: It is accurate.
Q: Now, you've previously provided one that we made available to the parties and since that is the one that's been loaded into our systems electronically, we'll work off of the dated one, but I would like for you to identify the differences, the material differences, between your current resume or CV and the one that's been initially marked as Exhibit 72. So if you would tell us what the major differences are between your current curriculum vitae and the one that was originally identified?
A: The major difference is on page 19 on which I have done a lot more research projects in the last year and half or so. And so I've added them on to the resume. So that is the chief difference.
Q: And if we'll look at your current CV on page 18, the clinical result research projects, are you referring to those?
A: Yes, sir.
Q: And they carry on for a total of 42 as I

counted through page 23.

A: Yes, sir. I've done a significant amount in the last few years.

Q: Okay. All right. Are there any other principle differences between your current CV and the originally designated Exhibit?

A: No, sir. That's the only difference.

Q: Okay. All right. Now, Dr. Adlakha, provide the Court, if you would, with a little bit of background, about your training and education and experience. Let's begin with just identifying where you obtained your medical degree from?

A: I did my medical school in northwest India at a missionary medical school called CMC, which stands for Christian Medical College, and from there I finished my medical school. I did my residency in internal medicine there, so I was a board certified internist on the academic staff there. And then came on to America in 1987.

Q: All right. And to that point, did you obtain additional medical training?

A: Yes, sir.

Q: And where was that?

A: Initially, in Denver, Colorado where I did a research fellowship. And then started my residency in internal medicine again.
Q: And let me stop you there, just so we can track you on your CV, that would be page 4, is that correct? Top of page 4 and we can follow along?
A: Yes, sir, page 4. And I was at the University of Colorado Health Sciences Center. And from there then I moved on and started my first year of residency at Chattanooga. And then I followed with the rest of my training up at Mayo Graduate School of Medicine up in Rochester, Minnesota.
Q: And did you obtain a fellowship?
A: Yes, sir. I completed my internal medicine there. And then I obtained a fellowship in pulmonary intensive care and sleep disorders.
Q: Now, during your training and your graduate school development, have you had responsibilities for teaching medical students?
A: Yes, sir.
Q: Where have you had such responsibilities?
A: Nearly -- in any place I got an opportunity, starting from India and then in Denver, then at

Mayo Clinic, and then subsequently in Alabama at UAB.

Q: UAB would be?

A: University of Alabama-Birmingham.

Q: Okay.

A: So six, or more than six places I got an opportunity to do teaching of the residents.

Q: And are you currently a clinical instructor of medicine at MUSC?

A: I'm now the clinical assistant professor, I'm sorry if I didn't make that change, at the USC-Columbia.

Q: Okay. And let's look at the honors and recognitions that are identified on your resume as well, which began on page 5 of Exhibit 72. We don't need to go over all of these, but let's just draw the Court's attention to a few beginning at the bottom of page 5, your final professional MBBS. This indicates under paragraph (a), you were first in your class at Punjab University, is that right?

A: Yes, sir. First in the university, which consists of multiple medical schools.

Q: And indeed, what did that award consist of?

A: It was gold medal by one of the companies,

Pfizer was one of them.

Q: And let's look at the next page. And you obtained awards in multiple medical fields. First or second prize in several different disciplines, is that right?

A: Yes, sir.

Q: All right. And then once you began your post-graduate studies at Chattanooga, did you receive any awards there?

A: Yes, sir.

Q: And what were they?

A: Research awards. I had done some clinical research and for a presentation and publications there, that one year I was there.

Q: And for the two or three years you were at the Mayo Clinic in the medical school, did you receive any awards there?

A: Yes, sir. I got their outstanding resident award.

Q: Okay. Now, let's look at your experience that's reflected in your CV, beginning just with abstracts publishing. Your publications, would you describe these just in the very most general terms?

A: A lot of them are laboratory projects. And

then I got an opportunity to do a lot of clinical research. And so, once you do research, you submit them to various meetings and then you can get an opportunity to either publish them or present them at various scientific meetings.

Q: Okay. And your section under the publications, under the publications, you have 22 of those and the presentations, you have 39 of those, is that correct?

A: The manuscripts published are 42.

Q: In addition to the 39 presentations?

A: Yes, sir.

Q: And then finally, you have updated us concerning the clinical research projects of which there are over 40 as well?

A: Yes, sir. That is what I'm doing nowadays.

Q: And whatever spare time you have, and I can't imagine there's much, there's some miscellaneous achievements identified on page 18. You review manuscripts for these national journals?

A: Yes, sir.

Q: All right. Now, let's move to your experience, Dr. Adlakha. You've described where you've

been in various academic settings. Before you moved to Rock Hill and began your practice there, where did you practice?

A: I was in Charlotte.

Q: And what did you do there?

A: I was practicing in Charlotte for three years.

Q: And what responsibilities did you have in Charlotte?

A: I was a practicing pulmonologist, as well, as an intensivist in sleep disorders in Charlotte hospitals.

Q: Now, were you director of the lung disease clinic at Mercy Hospital?

A: Yes, sir. Of one of the types of lung diseases, called interstitial lung disease, so of that aspect I was, yes, sir.

Q: And did you have a position as director of Union Regional Medical Center?

A: Yes, sir. Because that's where subsequently most of my work was done. And so that's where I became the director.

Q: What were you director of?

A: Of the respiratory therapies department and the sleep department.

Q: And was Union affiliated with Carolinas Medical

Center at the time?
A: I left it in 2001. I'm not certain.
Q: Is Union now?
A: No.
Q: Okay. And did you also have a private pulmonology practice in Charlotte?
A: Yes, sir.
Q: And when did you move to Rock Hill?
A: In summer of 2001.
Q: And what's the name of your practice?
A: It's Carolina Pulmonary Physicians.
Q: Are you now with the same practice that you were when you moved to Rock Hill?
A: Yes, sir. For the last 12 years.
Q: And how many physicians are in your practice?
A: There are three of us.
Q: And are you a partner?
A: I'm a partner.
Q: All right. Describe for the judge, if you would, a bit about the kind of medicine that you and your partners practice?
A: We do outpatient and we do inpatient practice. Outpatients are mainly consults and referrals by other clinicians, other practices in town, pertaining to anything regarding lung diseases

or sleep disorders. And then the hospital practice is where we do our procedures. And then we see complex and sicker cases on the floor as well as in the ICU.

Q: And the ICU is what?

A: Intensive care unit. In the intensive care unit, and so that's how most of our practice is.

Q: Okay. And what hospital do your practice in?

A: The only one that I have been practicing in Rock Hill has been Piedmont Medical Center.

Q: How about your partners?

A: Only at Piedmont Medical Center.

Q: All right. Now, Dr. Adlakha, let me ask you to go back a few years, and actually I'm going to take you back to 2009. And describe for the Court, generally, how your group was doing at that time?

A: We were very busy, both outpatient and inpatient. Our volume was keeping us extremely busy, payor mix was very good. We had a full staff working, a total of nearly 15. So I would say we were doing extremely well. And at that point, because my interests were also in lung cancer in particular, so I wanted to then

expand the service of lung cancer. And I was anticipating new services in that department. And so that's where then I started to form the lung cancer center, having regular meetings and coming up with new techniques to try to help the patients and York County.

Q: Okay. And are you in a position with your practice to know and to understand its basic operating indicators?

A: Yes, sir. We meet on a monthly basis and we discuss business data.

Q: All right. Well, let's look at some of those indicators of that data. Let me ask you about how the volume of your firm was in 2009?

A: In 2009, I think we were really doing very well. I mean everything was to the max to a point that I was hoping of building a much more invasive department on top of what I was doing.

Q: What do you mean by an invasive department?

A: Invasive means to be able to give much more refined treatment to patients with lung cancers and patients with complicated airway diseases. Such as a piece of technology we have now, which I just started at that time, called navigation bronchoscopy. Where the system

navigates you and helps you to go to any part of the lung to be able to make a diagnosis, plus lasers and stents. And so I was wanting to build all those at the time, just because there was so much volume I had off lung cancer, as well as total number of patients.

Q: Okay. And let's look at another indicator of staffing. Now, you said you had three physicians, did you have any physician extenders?

A: We had one PA, including PA and the three MDs, total of 15.

Q: And let me ask you about payor mix, now, do you recognize that term?

A: Yes, sir.

Q: And what do you understand payor mix means?

A: Payor mix is mainly what percent can pay, what can't. And what kind of programs they are under.

Q: What kind of insurance programs?

A: Program insurance. If they are in the federal program for elderly, then that's the Medicare, which about 50 to 55 percent of our patients were at the time. State program for a certain poor, the Medicaid made up about 15 to 20

percent. And then we had about 30 percent or slightly more that was for the commercial or managed care or private insurance. And that's sort of where the majority of the profits came from.

Q: Now, how would it be that the majority of the profits came from that?

A: Because they essentially pay you a higher percent of what you bill, where as Medicaid was more of a loss, we never recovered our cost. We lost in Medicaid. In Medicare you had a small amount that you recovered above the cost.

Q: Okay. All right. Now, contrast and compare if you would, your experience in 2009 with your current experience today in your practice?

A: Since then we have had a decrease in our volume. We have had a decrease in our outpatient volume and inpatient complex cases, as well as procedures.

Q: And let's talk about the outpatient for a moment. Approximately how much is that now?

A: About 15 percent or so and the inpatient, if you look at the total bronchoscopies, about a drop of 25 to 30 percent.

Q: What are the bronchoscopies?

A: There's a regular flexible bronchoscopy, where you just take a visual examination of the airways. And then there are certain newer pieces of technology, such as navigation bronchoscopy which, with the help of the hospital, I had managed to acquire. And because of significant drops in the numbers, I could not maintain it and we had to give it away.

Q: I'll come back to that in a minute. But let me first kind of finish the overall picture by asking you about staffing. What does that look like?

A: We lost our PA. And then we lost two of our other personnel, so we are down to 12 now from 15.

Q: Out of your 15?

A: Yes.

Q: And how does your payor mix today compare to what it was in 2009?

A: The Medicare has gone up to about 60, 65 percent. Medicaid is about 15. And about 20 percent, around about that, is the commercial and the managed care.

Q: All right. So if commercial is 20 percent now,

it had dropped from 30 to 20, approximately, is that right?

A: At least by ten percent, maybe even more.

Q: What, about a third of it overall?

A: About a third.

Q: All right. And Medicare has increased?

A: Medicare has remained the same, or rather we have decreased slowly because it's very difficult to afford now, taking care of Medicaid. Because the margin that you made from the private insurances, you used it in seeing Medicaid patients. So now the percentage has come down on Medicaid.

Q: I'm sorry. I might not have been clear. I thought I said Medicare and I think you ---

A: No, Medicare has gone up.

Q: And Medicaid?

A: Medicaid has gone down.

Q: All right. And what's your relationship between the commercial and Medicaid?

A: And that's what I was saying that we use the profits off the commercial to be able to see Medicaid patients or whoever walks in, essentially. And that has become harder to do. Because if your own profits and revenues are

down and you're losing staff and seeing fewer volume of patients, then it affects everything along the way.

Q: Okay. Do you know what happened between 2009 and 2013 to produce the drop in the patient volume you testified about?

A: One of the main things that happened was significant shift in the referral pattern, in the consult pattern, outpatient particularly. And then slowly, we started seeing from there a drop in our hospital procedures.

Q: And how do you know there was a drop in the referrals?

A: Because we meet every month. And we look at our business data, total number of consults. Who's sending us the consults? Where are the consults coming from, new or old, referring physicians. So that's how we can track where the drop was.

Q: All right. And where was the drop?

A: The drop was mainly at the practices that had just been owned by CMC.

Q: All right. And do you know to what degree there was a fall off in the referrals?

A: At the height, I would say we were getting

about 90, 9500 patients a year. It came down to what 20, to less than 29.

Q: And did that happen over a period of one year or was it many years?

A: It happened fairly quickly. Because we just saw the drop or even saw the decrease of the regular phone calls we would get from them, just to discuss a patient or take a verbal consult on the phone. We saw a drop of all that.

Q: What kind of relationship did you have with the Carolinas physicians up to the point where you noticed the fall off in referrals?

A: Excellent. Very good friends with them. Our senior partner, Dr. Pier, which started the practice in 1983, had an extremely close relationship with them. And we were their primary resource for the pulmonary consults and sleep consults.

Q: And did you have any falling out of any sort with the Carolinas physicians?

A: Not at all, sir.

Q: Did you have any disputes over charges or quality of service?

A: Not at all, sir.

Q: All right. Did any of the administrators or physicians at CPN ever talk with you about changes in the referral patterns?

A: No, sir. It just that we noticed the rapid drop in the communications as well as the consults.

Q: And what effect does that loss in business have on your practice?

A: As I mentioned, it definitely decreased the outpatient and inpatient productivity. So it had effect on our volume, on the revenues, as well as staff. Also, the number of procedures that we used to do in the bronchoscopy has dropped nearly by 25 percent. And more importantly, I lost the navigation bronchoscopy which I had started to do and the volume was just picking up. I had to give that away. And also, it made it impossible to make a lung cancer unit where we could do additional procedures because now the volume wasn't there.

Q: And with regard to what you've identified, Dr. Adlakha, talk generally, if you would, about how the loss of these referrals and consults has affected your practices ability to serve your patients in York County?

A: One is, of course, as the volume goes down and as the complexity of the cases go down, it's difficult to maintain your skills. That's number one, difficulty to maintain additional skills that you have learned, such as navigation bronchoscopy. Difficult to maintain those instruments which are clearly expensive, such as navigation bronchoscopy was $150,000, which was for instrument. And we were the first ones in that area to have it. Nobody else, including Charlotte, had it.

Q: Let me ask you specifically about the navigational bronchoscopy. Explain for the judge, if you would, what that particular service was? But let's start with when you obtained it and how you obtained it?

A: Because the volume was so much and I was seeing so many lung cancer patients and we were discussing them on a regular basis in our meetings where oncologist radiation oncologist and surgeons were there. We felt the need for this new upcoming technology at the time because the only closest place that had it was USC-Columbia and MUSC-Charleston. So we thought to ourselves that we are seeing a very

large number of patients with lung cancers and lung nodules, which is soft shadows in the lung, that we can at least start with this procedure to be able to get to the correct diagnosis and give good service to our patients. And then from there on add on lasers and stents and other additional invasive therapy. Because at that time, we all felt, all of us in the lung cancer unit, that we could do it. So I approached ---

Q: Before you get there, who's in the lung cancer unit, your practice or the hospital's?

A: No, we would meet in the hospital. So the surgeon, myself, radiation oncologist, pathologist, and medical oncologist would once a month meet, which we still meet. But that time, of course, meeting was much more aggressive. Because we were wanting to really expand on the ability to serve a certain sector of patients to the best possibility as some of the academic institutions were doing. So that is what ---

Q: Excuse me for interrupting, and then you approached Mr. Miller?

A: I approached Mr. Miller that we would like to

obtain navigation bronchoscopy and so he ordered it. And then I went to MUSC-Charleston to learn the procedure and attend international course. And then we got the instrument and then we started to do the procedure, which around the time we initially thought, we were doing about six, seven, eight minimum.

Q: How frequently?

A: Six, seven, eight cases a month. And just rapidly as the consults start to drift down, the number of the procedures also significantly drifted down. So we were barely managing to do one or two a month. So it was very difficult to maintain your proficiency and justify keeping it for so long. We still hung onto it for about 15 months, before we transferred it.

Q: Who made the decision to at some point, to terminate the use of that navigational bronchoscopy?

A: It was myself.

Q: And why did you do that?

A: Because the volume just wasn't there at all. We were barely doing one or two a month, compared to eight to ten a month.

Q: Why would you not want to provide the services

to one or two people if it was needed?
A: Because you need a minimum amount of every procedure on a monthly basis, even it's a simple bronchoscopy, to be able to maintain the quality and proficiency of your procedures, so I think that's extremely important.
Q: Now, at the time was there a navigational bronchoscope in the Charlotte area?
A: No, sir.
Q: Well, was there one developed later to your knowledge?
A: Yes, sir. After I got it, it came in Charlotte.
Q: And how did that occur?
A: The word had spread that I was doing it and that, obviously, it was a very useful procedure for a certain type of patient. So after about a year or so, it came in Charlotte.
Q: And where in Charlotte?
A: At Carolinas Medical Center.
Q: Do you have any communications with the pulmonologist at Carolinas Medical Center in Charlotte?
A: Yes, sir. I know the gentleman and have met him in the meetings too. And once or twice he

had just expressed that maybe he would want to come and see a couple of patients being done. And that was a time when I was doing a lot of them every month.

Q: Okay. All right. Now, how did you feel about having to give up the use of this advanced technology?

A: It was definitely a hard and sad scenario, because (A), there was need for it, significant in that area. And (B), all of us who were meeting, four or five of us on a regular basis kind of wanted to expand our coverage into the best techniques and the best available treatments to our patients. And so, this was the first step to bring the best in and so, unfortunately, just closed the door, which I'm hoping we will still be able to open.

Q: Okay. Did the loss of this technology affect further and future training? How has that ---

A: Yes, sir. I used to go every year for invasive training, either at Duke or Cleveland Clinic or my alma mater, Mayo Clinic. But I haven't gone for a year and half or so now because I'm not sure where the future is going.

Q: What do you mean?

A: Means for us, as to the volume and the expertise and the proficiency and what we can or cannot do.
Q: And have you reviewed any data about the effect and the utilization of Piedmont's services in the cardiopulmonary department?
A: Yes, sir.
Q: Okay. Dan, let's pull what's been pre-marked as Exhibit 108, please, and has previously admitted. And if you'll pull up on the screen, is this a document you previously reviewed, Dr. Adlakha?
A: Yes, sir.
Q: All right. What do you understand it to be in general terms?
A: Basically, it's showing us as to specialty care over the last few years what percent of the patients, total number of patients of that particular speciality we have been seeing, Carolinas Healthcare System has been seeing and other systems have been seeing. And so you can see over the years, at least in pulmonary, which I saw that there was an ongoing decrease and drop in the number of complex cases that we were seeing, as well as procedures, and it was

doubling up at Carolinas.

Q: All right. And let's look at the first column it's the various degrees of speciality practices, is that right?

A: Yes, sir.

Q: And just to clarify what the components of the Exhibit are, and the second column is dated 2005, is that right?

A: Yes, sir.

Q: And the third one is dated what?

A: 2009. And then 2011.

Q: Okay. All right. And Dan, it's difficult to pull out, I think on that full screen, maybe we can do one year at a time. Let's look at 2005, the distribution of cases for pulmonary services at Piedmont.

A: Now, you can see 249 cases going from here. And then 25 to the others, and Piedmont seeing nearly 1400 out of a total of about 2000.

Q: Now, these are York County patients?

A: York County.

Q: That' right.

A: Yes, sir.

Q: All right. And let's turn to the next page, just to show in 2005, what that percentage was

of those cases and the distribution between Piedmont and Carolinas -- hospitals in the Charlotte area.

A: 2005, it was 13 percent and 73 percent was staying on at Piedmont. These are complex cases, cases that will require to be seen by specialists as well as require complex surgeries and procedures.

Q: All right. Let's move forward to the last column, Dan, if you would in 2011 and look at the same data. We can stay on that same page and look at the percentages and see how they've changed.

A: From 13 percent, CHS has gone up to 27, and from 73, 74 percent, we have come down to 60.

Q: Okay. And in general terms, how has that reduction in the number of procedures performed at the hospital and other consults at the hospital, affected the services performed there?

A: A physician's expertise, whether they're internal medicine or family practice or the specialist, is directly tied to the quantity and the quality of cases they see on a regular basis. So if you have volume, which is the

quantity, and if you have complex cases, or advanced cases, which are the quality of cases, then specialties as well as skills will grow. And that helps the local healthcare if you have those ranges of services available, the quality of services available, and the physicians are proficient in doing that, then it's a very good service that you give to the local community.

Q: All right. Thank you. Let's focus on the quality of services that you've experienced at Piedmont. Let's set the context by you explaining to the Court how many different hospitals you've practiced at?

A: Only one.

Q: That's all you practice at currently?

A: Piedmont is the only one.

Q: And over the course of your practice, how many different hospitals have you been an active medical staff member of?

A: Ten or 11, more than ten hospitals.

Q: And that includes how many in the Charlotte area?

A: In the Charlotte area, three.

Q: All right. Dr. Adlakha, how does the quality of the patient services at Piedmont compare to

those you've experienced at other hospitals where you've practiced?

A: It's extremely good. And I have not had any problems in the last 12 years, have never felt the need to go to another hospital, any other hospital. And I think one of the best examples would be is that I got my own spine surgery done at Piedmont. Even though I was suggested by many to go up north.

Q: Why did you decide to do it at Piedmont?

A: Because I was confident of the physicians and the surgeons there.

Q: All right. Now, with regard to this case in particular, have you provided letters of support related to this case?

A: Yes, sir.

Q: And let's pull up the one you provided to the Department in 2010, Exhibit 66, page 54, and that Exhibit, which has been pre-admitted. So do you recognize a copy of this letter, Dr. Adlakha?

A: Yes, sir. I do.

Q: And what is it?

A: It's the letter that I had written to South Carolina Department of Health and Environmental

Control requesting them to consider Piedmont Medical Center as the hospital to build another hospital at Fort Mill.

Q: Okay. Were you asked by the hospital administration if you would be willing to prepare a letter of support?

A: Yes, sir.

Q: Were you give a sample copies of other letters that had been submitted?

A: Yes, sir.

Q: Did someone draft this for you or did you draft this yourself?

A: No, sir. This was my own draft. I looked at all those letters and then formulated my paragraphs and my own thoughts in this letter.

Q: Okay. Dan, pull out the second full paragraph in that letter, if you would. And, Dr. Adlakha, read the first three sentences, if you would?

A: Since the day I joined Piedmont Medical Center, which was the summer of 2001, I was highly impressed by their patient care, hospital services, both diagnostic, as well as therapeutic, which is medical and surgical. The hospital provides excellent service to the

surrounding community, or the Tri-County. I think it's important to know that it's not just the York County, but it's three counties that we cover. They are dependant on us.

Q: What are they?

A: The Chester County, the Lancaster County. So it's a fairly large population.

Q: And in what sense are they dependant on you?

A: Say that again, sir?

Q: All the counties?

A: For managing all the complex cases and the procedures, wherever they needed expertise. They have maintained a very high standard of care and they've always been mindful of the needs of the patients and the physicians according to the change in times. And such as we got the navigation bronchoscopy in compliance with the change in disease understanding. So trying to keep pace with the growth as well as the future.

Q: All right. Now, the next sentence describes, does it not, your experience as you just testified to, related to the navigational bronchoscopy?

A: They got me, actually, two instruments. We

didn't mention about the other one, that is the endobronchial ultrasound-guided transbronchial needle aspiration, which we were also the first ones to get in this territory. And that is to be able to get to the enlarged lymph nodes in the middle of the chest, which are right next to the big blood vessels, the aorta, and pulmonary artery at the heart. So this is something we could never do before, but now with an ultrasound at the end of the bronchoscope, we are able to see everything outside and to be able to safely put our needle into these big lymph nodes right next to the big pulsating vessels. So they got that for me first and then they got for me the navigation bronchoscopy.

Q: When you say they got for me, who are you referring to?

A: The Piedmont Medical Center. So with their support we managed to get these two. The primary referrals of the EBUS-TBNA are the tumor doctors, the oncologists. Whereas the primary referrals for navigation bronchoscopy and nodules and all are internal medicine, family practice, the general practitioners. So

we still have the EBUS-TBNA even though the volume has dropped a little bit. But the navigation bronchoscopy suffered the most.

Q: All right. And what's your reference in the last sentence to Piedmont's ranking in pulmonary services in the state?

A: Yes, sir. We've been ranked number three, and this is obviously at that time. We now have been ranked number one in the pulmonary services.

Q: Okay. Now, if Piedmont were approved to build the Fort Mill Medical Center, how do you believe patient care, pulmonology services in York County would be affected?

A: I think it will help all of us. Us, as practitioners as well as Piedmont Medical Center. It obviously number one, it will be very good for the patients there, because they'll get a new service in the Fort Mill area. The out-migration will definitely decrease and with the quality of care, we can definitely do that.

Q: Why do you believe that to be true?

A: Because everything will be available at their doorstep. And we, the same physicians, will be

the same, equally well-trained are there, plus the volume will go up. One of the main things that will happen is that (A), you will be giving them a speciality care. The volume will go up. The payor mix will go up. And the range and the quality of the speciality services that you can get, right at the doorstep, will go up.

Q: Do you have any concerns about the effect of approving CMC-Fort Mill?

A: My feeling is that the volume will go down from where we are even more. Both outpatient, and particularly the inpatient. And mind you, it's the inpatients that bring the complex healthcare to the area. It's the inpatients that bring procedures to the area. So there will be a significant drop, not only in the total number of patients, but also the kind of patients and the payor mix.

Q: All right. But if the pulmonary services drops further, what effect do you believe it would have on the quality of care at Piedmont?

A: At Piedmont, the quality will definitely be affected because it's very difficult to maintain services and quality at the same level

if you don't have the proficiency or you don't have the volume to be able to keep that. If you're not able to grow with the county in the future. You are not able to do that if your payor mix is damaged. If your revenues are low, you can't do that. If the skills of the physicians slowly start to go down, or you're not able to provide skilled services, then it not only affects, not only the hospitals, but all of us and we all practice only at Piedmont.

Q: You said if the revenue falls and the payor mix changes, it would affect quality. What's the relationship?

A: As I said earlier, the quality of any hospital or any individual is dependant on the quantity that they see, as well as the quality of the cases that we see. So the more complex cases we see, the more harder cases you see, the more number of cases you see, the more proficient and efficient the system becomes and the people who are in the system become. And the more that they grow, then the more they give back to the community by giving them the best possible care, as close to the Mayo Clinic, where I think is the ultimate place.

Q: If Piedmont were approved to build a hospital in Fort Mill, would you obtain active privileges there?
A: Yes, sir.
Q: Why would you do that?
A: Because that would increase my volume. And we'll be able to keep the patients with all the complex nature and the procedures to us and be able to do more procedures, see more patients. And I'm hoping that one day I can reopen the chapter of invasive bronchoscopy and be able to provide that to our area.
Q: Now, if Piedmont were approved to build the Fort Mill Medical Center, do you believe that Piedmont patients that you currently serve at Piedmont would choose to use the Fort Mill hospital?
A: Yes, sir.
Q: Why do you think that?
A: Because patients do want to test new facilities. Ultimately, I think patients do want to stay in their own backyard. They want to come back to their own backyard. And if you provide quality service right in their backyard and provide it consistently, definitely they

will stay and they will come back.

Q: Now, if Carolinas were approved to build CMC-Fort Mill, what do you expect that the patients at Piedmont would want to do with regard to the new CMC-Fort Mill facility?

A: They will definitely want to try that because it's a new service, new availability. They will do that. They will go there.

Q: If Carolinas were to build a facility, what effect would it have on the volume and the complexity of the procedures at Piedmont?

A: It will definitely have an effect on all of us, not just Piedmont Hospital itself and everybody who is practicing at the Piedmont Hospital. Because patients, once they are inpatients, once they are sick, they need multiple more of complex services. They need surgeries. They need instrumentations. They need procedures. They are more vulnerable, so they definitely a large number of them, in addition to what's going on now, will go north. They will go to Charlotte. So I think we will lose, not only the quality cases we would lose, so the county, the Tri-County will not be able to keep all the advanced cases and complex cases in there but

also the quantity of total number of cases, the volume will go down.

Q: Now, if Carolinas were approved to establish the Fort Mill hospital, would you obtain privileges there?

A: If my patients go there, I will. And if I don't, my patients will be sent to Charlotte.

Q: What effect would that have, if you obtain privileges and your partners got privileges and your patients received services at CMC-Fort Mill, what effect would that have on Piedmont?

A: It will, I think affect the healthcare in the county. It'll stretch all of us, I think, with no added benefit. It will, I think, weaken the availability and the proficient, not just York County, but the whole Tri-County area. Because everybody will be then stretched in various directions and patients, as well as the physicians, as well as the procedures will be shifting and splitting to different places.

Q: And how would that stretching, shifting, and splitting affect the quality of care?

A: It will definitely affect the quality of care provided by us to the York County.

Q: Thank you. I have no further questions.

hospital.

Q: All right. Now, let me ask you to turn to page nine of your deposition. You say -- and I'm starting with line four, do you see it?

A: Yes.

Q: I asked the question are you employed by Tenet? What was your response?

A: No.

Q: I asked the question were you affiliated with Tenet? What is your response?

A: Meaning, I don't work for them, that I'm independent.

Q: You say, except I do my consults here, not otherwise, because we're an independent practice?

A: Yes.

Q: And then a little bit later on, on page 15.

A: Yes.

Q: Would you turn to that page? On 13, I asked you have you been a department head or held any kind of administrative leadership position at Piedmont Medical Center and your answer was no, right?

A: Yes, I have not been a department head or been a administrative head.

Q: Well, sir, you are on the governing board of the applicant in this case?
A: Yeah, but I'm not either a department head or I'm neither a resident or a vice president of the medical association.
Q: Well, you are on the governing board of the applicant who is challenging the CON in this case, right?
A: Yes. Yes.
Q: Okay. Let's put up Piedmont Exhibit 17(D). So when we received this Exhibit, which is Piedmont's Exhibit 17(D), there you are, on the board of governors ---
A: Right. I am.
Q: And the new CV that you provided to us, which is the new Exhibit 72, you've added from January 2012 to present, Piedmont Medical Center Executive Board Member.
A: Wait -- because I haven't updated my CV for a year and a half or two years.
Q: Why would you not disclose that to us at the time I was taking the deposition that you were on the governing board of the applicant?
A: Because you asked me, are you the head of any department or any medical society, which I'm

not.

Q: No, I said, do you have any leadership administrative position at any Piedmont Medical Center and you're on the governing board ---

A: And that's not a leadership, I'm just a member of the board.

Q: All right. I want to go back to your testimony about managed care and the concept of payor mix. And just for the Court's understanding, payor mix is the idea that you have certain payors of your services and different ratios and some of those are more profitable than others?

A: Yes.

Q: You have Medicare, which -- we're going to simplify this a little bit, but Medicare is benefits provided to people who are seniors, who are elderly. We have Medicaid, which is federal government benefits provided to the people who are indigent and are needy, is that correct?

A: Yes.

Q: You then have managed care, which is things like group health plans, for example, if someone has coverage through Aetna, that would

Q: I'm sorry, Dr. Adlakha.

A: That's okay. We all look the same.

MS. BIGGERS: I don't have any questions, Your Honor.

DR. ADLAKHA - RE-DIRECT EXAMINATION BY MR. ANDREWS:

Q: Dr. Adlakha?

A: Yes, sir.

Q: Let me ask you to open the transcript of your deposition.

A: Yes, sir.

Q: And let's track it and let me draw your attention to several different points in it. First, begin on page 28, if you would?

A: Yes, sir.

Q: Dan, if you could, if you have this, bring it up.

MR. MULLER: Your Honor, I'm trying to understand the basis for –

MR. ANDREWS: Sure, I'll explain it.

MR. MULLER: He's questioning this witness from his own deposition transcript for inconsistency in testimony.

MR. ANDREWS: I think you attempted to demonstrate there was inconsistency in testimony. And I'm going to identify, Your Honor, certain portions

of the transcript that show, in fact, that Dr. Adlakha does mention the effect on his practice. There is the issue raised and the deposition transcript was attempted to use to demonstrate that. I'm going to identify a number of areas in the transcript which reflect that Dr. Adlakha did talk about his practice.

MR. MULLER: And that's not uses of prior inconsistent statement, which presumably, you would have a declarant in the court, counter-designating portions of his testimony. If the Court would like to hear that, perhaps I could withdraw the objection, but it just seems out of sorts to be asking a witness, who he has in front of him questions from the deposition.

THE COURT: And I would agree normally that that would be the case, but my understanding of -- and at least, the portion of your cross-examination was that you were attempting to demonstrate that he not at any time in his deposition testified about the impact on his practice. And it's my understanding that Mr. Andrews is going to try show where he, in fact, did do that.

MR. MULLER: And I'll withdraw the objection. It

just seemed to odd to be doing it that way.

THE COURT: Yes, sir.

MR. MULLER: But if the Court would like to hear that, then fine.

THE COURT: Yes, sir. Thank you. I would like to. Go ahead Mr. Andrews.

MR. ANDREWS: Thank you, Your Honor.

Q: Mr. Singhi, I'll ask the -- excuse me, Dr. Adlakha. Let me draw your attention to the bottom of page 28 and the top of page 29. I'll ask the question on line 24 and 25, if you'll read the first four lines of your response on page 29, okay? All right. On page 28, the question is: I'm just trying to understand that, why would it make it worse? Your answer?

A: If I'm seeing the particular system, which means the healthcare system has a patient, then you've got to think of a patient's psychology, from a patient's perspective, that my doctors are in this system, in this hospital, my procedures are being taken by this hospital.

Q: Okay. That's all. And let me now draw your attention to the next page. On lines 16 and 17 on page 30, would you read your answer? Read your statement into the record. No, no.

Sorry, page 30, lines 16 and 17.

A: Yeah, but a lot of us physicians are going to lose those patients.

Q: And then finally, page 32, line 1 and 2. I will read and then if you give your answer from line 3 until line 9, okay? All right. The question: Wouldn't having them be treated in York County reverse out-migration?

A: I think, I guess, I think, what I have seen in the last few years is that out-migration has increased because I have seen that, less referrals coming from some physicians, less referrals coming, needing specialized procedures. So I can already see that happening in the last to five to seven years. And my worry is that it is going to get worse.

Q: Thank you, Your Honor, I have nothing further.

THE COURT: Thank you.

DR. ADLAKHA - RE-CROSS EXAMINATION BY MR. MULLER:

Q: Your Honor, I would like for him to read page 29, starting off at line 15. All right.

THE COURT: Dr. Adlakha, did you understand? It's page 29, Mr. Muller?

MR. MULLER: Yes, sir.

A: Fifteen, you want me to read that?

MR. MASTERTON - DIRECT EXAMINATION BY MR. WESTBROOK:

Q: Mr. Masterton, would you please state your full name for the record, please?

A: Sure, William Joseph Masterton.

Q: And Mr. Masterton, what do you do for a living?

A: I am the chief executive officer at Piedmont Medical Center.

Q: How long have you been CEO at Piedmont?

A: For nine months. I started in July of 2012.

Q: July of 2102. What did you do before that?

A: I was the CEO at Coastal Carolina Hospital in Hardeeville, Florida, which is right next to the Hilton Head area. And it's also a Tenet hospital like Piedmont Medical Center.

Q: Now, and I believe you said Hardeeville, Florida. You mean Hardeeville, South Carolina, right?

A: I do. Hardeeville, South Carolina, sorry.

Q: All right. Can you describe what your educational background is, please?

A: Sure. I received an undergraduate degree in accounting from the University of South Florida. And I proceeded immediately into the MBA program at the University of South Florida and graduated in 1993 with an MBA.

Q: All right. What did you do after getting your MBA?
A: Immediately after college I started with a public accounting firm, one of the Big Six, KPMG.
Q: And where you located when you worked with KPMG?
A: I was in the Jacksonville, Florida office. I worked in the Healthcare Life Sciences Division.
Q: All right. And were you a CPA then or are you a CPA now?
A: I became a certified public accountant while I was at KPMG.
Q: And you said what division or department you were in, what kind of work did you do for KPMG?
A: I did financial analysis for hospital clients across the country.
Q: All right. And when did you leave that job?
A: Well, I left the job -- I spent six years in total at KPMG. And after that I went to University Community Hospital in Tampa, Florida.
Q: All right. How about just running through, summarize for us your work history after you

left KPMG and the time you got to University? What did you do the next few years?

A: Sure. After KPMG, I went to University Community Hospital in Tampa, Florida as a controller. That was a stand-alone, large non-profit system in Tampa, Florida. At that time, when I was there, actually I had four hospitals in the system, but I was the controller. I was responsible for financial operations at two of the four hospitals.

Q: All right. And then when did you leave University?

A: After that, I went to IASIS Healthcare Corporation and that was an investor-owned hospital chain. And I went there for a chief financial officer job to one of the smaller hospitals in that 14 hospital chain, Memorial Hospital, Tampa.

Q: All right. And you said smaller, how big was Memorial?

A: It was 173-bed.

Q: Let me back up for a second. Would you spell IASIS for us, please?

A: Sure. I-A-S-I-S.

Q: Okay. Now, you were at Memorial Hospital, I

believe you said as a CFO, where did you go after that?

A: After that, I went to another hospital within their chain. I was promoted to a slightly bigger hospital, it was a 200-bed hospital, as chief financial officer, also located in Tampa, called Town & Country Hospital.

Q: All right. And then after that?

A: And then after that, they promoted me to another hospital as the Chief Financial Officer, called Palms of Pasadena, and that was one of their larger hospitals in the IASIS chain.

Q: All right. Now, you made a career move, I believe, around 2003, is that right?

A: I did, yes. I left IASIS and joined Tenet Healthcare Corporation.

Q: Okay. What kind of company is Tenet Healthcare Corporation?

A: Tenet Healthcare Corporation is a publically traded company. And they own or operate 49 hospitals in ten different states across the country. And they're headquartered in Dallas.

Q: All right. Tell us about the first job that you took at a Tenet hospital back in 2003?

A: I joined Atlanta Medical Center as a chief financial officer in 2003. Atlanta Medical Center was a very large teaching hospital in downtown Atlanta. It has physician residency, so it trained physicians in orthopaedic surgery, general surgery, family medicine, and internal medicine. It was a very busy trauma center, did about 2,000 traumas a year. And it was a Level Two trauma center then. And since I've left it's become a Level One trauma center. It's a very complex downtown hospital.

Q: And you were, did you say CFO at Atlanta Medical?

A: Yes, I was the chief financial officer when I started.

Q: All right. And then did that job change with Atlanta Medical at some point?

A: Yes, when I began getting involved in more and more operational issues. And then in 2006, I became the chief operating officer or COO.

Q: Okay. And when did you first start thinking seriously about coming a CEO?

A: Tenet had come out with a program called, The Tenet Executive Acceleration Program. And they identified some of their COOs with leadership

potential at some of their larger hospitals, and put them in a program with the Healthcare Advisory Board in Washington, D.C. And we went there for some training classes and then they also hired us a coach to help us make sure we were getting exposure to the right opportunities to be a CEO for one of the Tenet hospitals at some time in the future.

Q: All right. So did you complete that training program?

A: I did.

Q: Did an opportunity arise for you to be a CEO?

A: It did. The CEO job at Coastal Carolina Hospital in Hardeeville, South Carolina.

Q: All right. And I believe, maybe you said it, but if you have, I've forgotten it. When did you go to Coastal Carolina?

A: December of 2009.

Q: All right. And what kind of hospital is Coastal Carolina, what size is it?

A: It's a small hospital. It's a 41-bed hospital in Jasper County.

Q: And when you arrived at Coastal in 2009, what kind of track record did Coastal have?

A: Well, Coastal was a relatively new hospital in

terms of hospital ages, it was built in 2004. So generally, it was almost like a brand-new hospital. And Tenet was the third owner in five years when I arrived. And I was the third CEO in five years. So the track record was not very well. It was struggling on a number of performance indicators, plus financial and quality.

Q: All right. Well, when you took over there what did you do to try to address those quality and financial indicators?

A: The number one thing I tried to do initially was focus on quality and establish some clinical credibility in the community. And we did this through focusing on our evidence-based standards that we measure as being part of a Tenet hospital. And number two, by seeking out Joint Commission certification of our stroke program. Now the Joint Commission is the accrediting body for all hospitals and they actually have deemed status with CMS, or the government so that you can, if you're Joint Commission certified you can treat Medicare beneficiaries and receive payment for treating them. But in addition to overall

certification, you are able to apply to them and ask them to certify certain product lines that you're following high standards of having evidence-based medicine. So we did that at Coastal Carolina.

Q: You sought the certification and did you get it?

A: We did. The Joint Commission gave us a certified stroke program. And additionally, DHEC actually ended up giving us an award, a Distinguished Hospital of the Year for our stroke program. And only one hospital receives that and we were very honored to receive that at Coastal.

Q: Was that 2010 or 2011, do you remember?

A: 2011.

Q: 2011, okay. Well, in the next year, 2012, I believe, you said was the year you said you came to Piedmont, is that right? Was that a promotion?

A: It was a promotion, yes.

Q: All right. What were the circumstances that led to that promotion?

A: As I had mentioned when I started at Coastal Carolina Hospital, it was struggling on a few

measures and we had, by focusing on quality and development things had turned around there. And Tenet gives out an award called The Circle of Excellence to several hospitals every year. And Coastal had completed a turn-around in two years and we were inducted into Tenet's Circle of Excellence.

Q: Now, do you live in Rock Hill now?

A: I do live in Rock Hill, yes.

Q: Married?

A: I am married to my wife Kathy for almost 20 years now.

Q: And are you a member of any civic or professional organizations in Rock Hill?

A: I am. I'm on the York County Chamber of Commerce Board. I'm also a Rotarian in Rock Hill. And a parishioner of St. Anne Church.

Q: Okay. Mr. Masterton, let me ask you some questions that are focused on more specifically on Piedmont Medical Center. When you arrived at Piedmont nine months ago, can you tell us what your major first impressions were of that hospital?

A: My major first impression was that of being impressed. I was very surprised for a county

the size of York with roughly 240,000 people to have the breadth and depth of services that they offered. Things like open heart surgery, neurosurgery, and also the depth of the sub-specialities, the numbers that they had. I was very impressed with that. And as I studied a little bit more about the hospital, I knew that Piedmont was the only hospital in York County. And the second thing that sort of caught my attention was the extent of the out-migration.

Q: All right. Well, I'm going to ask you a number of questions about out-migration in a few minutes. Let's look at first impression as you identified that about the services. Let me start off by asking you though, what size hospital is Piedmont?

A: It's 288 licensed beds. And in my experience I would categorize that as a medium-size hospital.

Q: Okay. Dan, would pull up Demonstrative 13 for us please, and set it on the screen. All right. Ms. Masterton, you familiar with this chart up here, did you help prepare it?

A: Yes, I did.

Q: All right. Can you talk us through some of the

specialty services that are provided at Piedmont Medical Center?

A: Yes, this Demonstrative shows that some of the services that initially impressed me quite a bit when I was being considered for Piedmont Medical Center, mainly, open heart surgery. Also, in line with the cardiovascular services, they do interventional catheterization and so, that's something that's not done in all the Tri-Counties, their patients are transferred to Piedmont for interventional cath. We do vascular surgery and have two vascular surgeons on staff. Then also, advanced services, we have neonatologists on staff and are able to operate a NIC unit, which is up there as NICU, which is neonatal intensive care unit. And also, women's services, so we do approximately 2,000 deliveries a year. And then on the other end of the spectrum, possibly services that you wouldn't find in a medium-size hospital mainly because in a population you might not have enough cases to at least financially justify these services. We also offer pediatrics and inpatient behavioral health.

Q: Now, Mr. Masterton, in your experience as a CFO

and a COO, and controller and CEO of a number of hospitals that you've talked about, is this scope and level of services typical for a medium-size hospital?

A: In my experience this is atypical. This is more advanced than that. I mentioned earlier that I was CFO at Palms of Pasadena and that actually had a larger bed size than Piedmont yet didn't have this level of sophistication on the service lines.

Q: All right. I think you said earlier that Piedmont has 288 beds. What's your average daily census at Piedmont?

A: One hundred and eighty patients.

Q: And that 180, is that based on a period of time or is that today or do you know?

A: Well, the 180 is based on our 2013 budget, so that's an annual number.

Q: All right. Now, of those 288 beds, that's licensed beds you have at Piedmont, on an average day how many are unused?

A: On an average day there's approximately 100 beds unused.

Q: All right. And are all of your wings in your hospital open?

A: No. In fact, we have areas of the fourth floor that are actually closed.
Q: All right. Let's look at Demonstrative 15, Dan. Demonstrative 15, Mr. Masterton, does this accurately reflect the number of employees that you currently have?
A: Yes, 1538 employees.
Q: All right. And of those, talk about the nurses as a subset of those employees.
A: In a hospital your largest component of your work force is the registered nurses and we have 617 nurses. And additionally, I wanted to demonstrate on this slide that there are 141 nurses that live in Fort Mill, Tega Cay, or Mecklenburg County, which is about 23 percent of those 617 nurses.
Q: All right. As CEO, what is significant to you about having over 1500 employees?
A: Well, when I speak to employee groups one of things I mention is that being a hospital we do some pretty remarkable things because we help people in their time of need. We're there in the emergency room offering 24/7 availability to advanced care. But the other meaningful thing we do is offer meaningful work to 1538

employees right there in York County.
Q: All right. What type payroll do you have?
A: Our payroll is approximately $94 million in salary, wages and benefits on an annual basis.
Q: All right. How many physicians, let's go from employees to another category, physicians on your medical staff, how many of those do you have?
A: We have approximately 350 physicians on our medical staff, of whom 95 percent are board certified.
Q: All right. Now, how many of these 350 doctors are actually employees of Piedmont?
A: Approximately, ten percent employed.
Q: All right. And do the non-employed physicians, do the independent physicians on your medical staff, do they typically have privileges exclusively at Piedmont or do most of them have privileges at multiple places?
A: My experience is that most of them have privileges at more than one hospital.
Q: All right. Can you tell us about some of the kinds of specialty physicians that you have on the medical staff?
A: Sure. There's a few listed here:

neurosurgery, electrophysiology, and cardiothoracic surgery. Just to kind of give a flavor of the sub-specialities that are able to be located in Rock Hill, South Carolina. For example, we just actually added an electrophysiologist to our staff recently. And this is a procedure that is for irregular heartbeats. And before the recruitment of this electrophysiologist, one would have had to leave York County and go to Charlotte to receive this type of care.

Q: All right. And in your experience working in hospitals, is the degree of diversity which you have on your medical staff in speciality positions common or uncommon for a medium-size hospital?

A: Again, in my experience this is uncommon. It's more diverse.

Q: Dan, would you pull up Demonstrative number 1 for us please? And, Mr. Masterton, would you tell us what this chart or Demonstrative Exhibit shows for us?

A: This shows some of the quality awards that Piedmont Medical Center has received over the past couple of years. I mentioned earlier in

my testimony, Coastal Carolina won the Distinguished Hospital of the Year for cardiovascular disease and stroke in 2011. The Piedmont Medical Center has won that same award in 2013 and 2010.

Q: And who gives that award?

A: That's an award given by DHEC.

Q: And there's somebody else listed there in addition to DHEC, isn't it?

A: The American Heart Association.

Q: All right. And so did I understand you to say, then, that Tenet has won that award twice in the last four years?

A: No, Tenet would have won it three times if you include Coastal.

Q: Okay. And of those three times, one for Coastal and how many for Piedmont?

A: Two.

Q: All right. Now, what's the next entry on the chart?

A: The next one is 2012 Gold Plus Achievement Award for heart failure and stroke by the American Heart Association. And this is a demonstration for sustained performance of following evidence-based medicine related to

heart failure and stroke.

Q: All right.

A: And then the final one is an award given by the Joint Commission as a top performer on key quality measures. And what's important to me about that award is from the Joint Commission. Again, I've already mentioned how reputable they are, CMS has given them deemed status to certify hospitals to treat Medicare patients. But they gave out an award for compliance with evidence-based medicine in the areas of heart attack, heart failure, pneumonia and surgical care. And Piedmont Medical Center was one of only four hospitals in South Carolina to receive this award. And one of approximately 620 in the country to receive the award. And for some context for me why I thought it was so special is that there's about 5,000 key care hospitals in the country, so to be one of 620 to me it was quite an honor. So much so that we took out an ad in *The Herald* to showcase it.

Q: All right. Now, you have used the term evidence-based medicine a couple of times, can you explain what you mean by that?

A: Physicians are doing studies all the time and

these studies get published in journals and peer review and become evidence. So, for example, for surgical care, shown on the screen, they do studies to know or determine that if you give an antibiotic within the first hour of surgery, before one hour of surgery, and discontinue that antibiotic within 24 hours of surgery, you're much less likely to have a surgical infection. And another example if you're coming to the hospital with an AMI heart attack, if you get an aspirin upon arrival, and a beta-blocker on discharge, you're much more likely to have a positive outcome. So what we measure in quality is compliance with those standards. So how often did a patient come in and receive the aspirin on arrival or how often was the antibiotic started one hour before surgery.

Q: Let's take a look at Demonstrative Number 2 now, please. And this chart has the title, Piedmont Medical Center Certifications and Accreditations. What does this refer to?

A: This refers to not awards, rather, but where we have asked these agencies to certify our programs. So we asked the Joint Commission to

certify our stroke program. And we asked them to certify our heart failure program and we received that certification. For our cancer program, we asked the Commission on Cancer of the American College of Surgeons to certify our program and received that. And we did the same things with the chest pain center, listed below that. The nuclear and vascular services accreditation below that. And our cardiovascular and pulmonary rehab and cardiac rehab program below that.

Q: All right. And let's go now to Demonstrative Number 3 that says payor recognition for quality of care. What are payor recognitions?

A: Managed care companies or commercial insurers are also wanting to make sure that they deliver quality healthcare, that the healthcare they're reimbursing is done on a quality basis. And they allow providers of that care to apply to them and demonstrate that they meet their standards and, if so, they'll give you a distinction that they'll also make their beneficiaries aware of. And this is an example where Piedmont Medical Center is designated as Blue Distinction for cardiac care, Blue

Distinction for hip and knee replacement, and Cigna has recognized them as a center of excellence for heart attack, heart failure, COPD, stroke, pneumonia, and several services.

Q: All right. Thank you, Mr. Masterton. Is Piedmont a tax-exempt hospital?

A: No, sir. I mentioned earlier that Tenet is a publically traded company on the stock exchange and we pay taxes.

Q: Now, Piedmont Medical Center is actually a d/b/a, is that correct?

A: Yes.

Q: What does d/b/a mean?

A: It's doing business as Piedmont Medical Center, but the official legal entity is Amisub of South Carolina.

Q: All right. And if Fort Mill Medical Center is approved, that would be a d/b/a also, right?

A: Fort Mill Medical Center would be under the legal entity Amisub of South Carolina.

Q: And it would be doing business as Fort Mill Medical Center, right?

A: Yes.

Q: All right. So Amisub of South Carolina, the legal entity that is Piedmont Medical Center

and would be Fort Mill Medical Center, Amisub is a party to a contract with York County, isn't that right?

A: Yes.

Q: All right. Now, do you know how long this contract has been in effect?

A: Yes, since approximately 1980.

Q: And there have been a number of addendums since 1980, is that right?

A: Yes, I believe they're on the ninth addendum.

Q: Okay. Now, do you know when the contract expires?

A: Yes, it expires in 2045.

Q: Now, could you tell us generally how familiar you are, how familiar you've become in the nine months since you've been at Piedmont with the terms of the contract and its nine addendums?

A: I'm generally familiar with the terms of the contract. I've been there nine months, however, my predecessor, Charlie Miller, who's been there 14 years, is much more familiar than I am.

Q: All right. Let me ask you to -- or ask Dan to put up Demonstrative 16 on the screen for us, please. Is this a Demonstrative that you have

looked at before?
A: Yes, it is.
Q: All right. Does this summarize some of the areas of the general aspects of the contract that you're generally familiar with?
A: Yes, it does.
Q: All right. Would you walk through these for us?
A: Sure. One of the provisions is that our charges must be reasonable for there's a constraint on how much we're able to charge. There is also a requirement of transparency in the form of quarterly and annual reporting to York County Council.
Q: What kind of information is in those reports?
A: A lot of operational and financial information is reported.
Q: Okay. And once that's reported, is that public information?
A: It is.
Q: And, I'm sorry, I interrupted you, go on to the next bullet point.
A: It also requires that we be the EMS provider to the county and it's noted there that Piedmont Medical Center doesn't receive any fees from

the county for providing that service. And then lastly, there's a number of services that we're required to include, these are just a snapshot of them, behavioral health and an urgent care center in western York.

Q: All right. Now, as Piedmont's CEO, what's the significance to you of this contract?

A: Two things in my mind. Number one is that there is some accountability. We have constraints on what we're able to do. And then number two is transparency. Some information that would typically be private is actually made public through this process.

Q: All right. Where in the town of Rock Hill is Piedmont located?

A: It's about a mile from Winthrop University, near the business district.

Q: And do you know what approximately Rock Hill's population is?

A: Rock Hill's population is approximately 67,000 people.

Q: In the nine months you've been living in Rock Hill, have you had a chance to drive around York County?

A: I have.

Q: Let's look at Demonstrative 17, it's another map. As Mr. Muller said, we're going to be looking at a number of maps, I think, throughout the next couple of weeks. Let's use this to get oriented a little bit. This, of course, is York County. And I would like to ask you about some of the areas, towns, and other areas that we're going to be talking about today and throughout the next couple of weeks. Where does I-77 run in relation to York County?

A: It's the main north/south thoroughfare and it's on the eastern side of York County.

Q: And where is Rock Hill in relation to the interstate?

A: It's west of I-77.

Q: All right. Obviously, we're going to be talking about Fort Mill a good bit. Where is the town of Fort Mill located?

A: Fort Mill is east of I-77 and northeast of Rock Hill.

Q: Okay. We also will be talking some about the town of Tega Cay. Where is that located?

A: Tega Cay is west of Fort Mill and north of Rock Hill, also west of I-77.

Q: Okay. We see the state line there, boundary line in yellow. What about the town of Pineville, North Carolina?
A: Well, Pineville is in North Carolina and it's just across the border and it's northeast of Fort Mill.
Q: I'm sorry. And what is the big city in the area?
A: Charlotte.
Q: All right. And where would you describe Charlotte's area?
A: That's due north on I-77.
Q: Okay. Have you personally driven from Rock Hill to these other towns, one time or another?
A: I have.
Q: And let me ask you just to give us roughly, approximately, how long did it take you to drive from Rock Hill to Fort Mill?
A: Less than 20 minutes.
Q: Okay. How about Rock Hill to Pineville?
A: About 25 minutes.
Q: All right. Finally Rock Hill to Charlotte?
A: Approximately, 35 minutes.
Q: Okay. Now, as CEO of Piedmont, who would you consider to be Piedmont's principle competitor?

A: Carolinas Health System.
Q: All right. And is that the same as Charlotte-Mecklenburg Hospital Authority?
A: Yes, it is.
Q: And I'm just going to call it CHS, short, okay?
A: Okay.
Q: Now, CHS, what is CHS?
A: According to the Charlotte Observer, Carolinas Health System is the second largest public hospital system in the country. And for me to even understand how big that is, I found out that, I think, the largest public hospital system in the country is the Veteran's Administration.
Q: Let's look at Demonstrative 147, Dan. All right. Mr. Masterton, what does this map show?
A: All right. This map shows the acute care hospitals in Charlotte and surrounding areas.
Q: All right. How many hospitals are listed on that map, do you know?
A: I do know. There are 21 listed on there.
Q: All right. And how many are owned or managed by CHS?
A: Twelve.
Q: What is the closest CHS hospital to Piedmont?

A: CMC-Pineville.
Q: All right. And now, you have awareness and knowledge about CMCs expansion for the past few years?
A: Yes. The hospital has expanded a great deal. I believe bed size has almost doubled if you go back to before 2002 to the present day, and they've undergone a lot of expansion.
Q: All right. Let me shift your attention to downtown Charlotte. What's listed on the map there simply as CMC, which I'm going to represent to you stands for Carolinas Medical Center. I'm going to refer to that as CMC-Main. What kind of hospital is CMC-Main?
A: It's a very large research hospital. It's over 800 beds and offers the most advanced care.
Q: All right. More advanced than Piedmont?
A: Yes, in fact, patients which we don't have the capability to take care, we transfer to CMC-Main.
Q: All right. And now let's go to Demonstrative 161, please? You recognize this photograph?
A: I do.
Q: What is it?
A: That is or looks to be CMC-Steele Creek.

Q: All right. Now, is CMC-Steele Creek a hospital?
A: It is not.
Q: What is it?
A: It's a free-standing emergency department.
Q: All right. What do you mean by free-standing emergency department?
A: Well, just like the name implies, it's an emergency department. But instead of being connected to a hospital, it's free-standing. So it's available 24/7 for people to come to and also accepts ambulances at the facility.
Q: All right. Let's go back to our map, Demonstrative 43, just to kind of get oriented as to where Steele Creek is. Does that look right to you, Mr. Masterton?
A: Yes, that looks right.
Q: You've been to Steele Creek before?
A: I've driven by it.
Q: All right. You've driven from Rock Hill to Steele Creek?
A: I have.
Q: And how long did it take you to drive there?
A: Approximately 25 minutes.
Q: Now, would you explain why, even though it's

not a hospital, you consider CMC-Steele Creek to be a competitor with Piedmont?

A: Right. In my experience, they're two ways that patients access inpatient hospital services. It's either through their physician or through the emergency room. And if -- Piedmont's own ambulances take patients to CMC-Steele Creek and so the reason I believe it's a competitor is that if a patient goes to CMC-Steele Creek and needs inpatient services, it's transferred to CMC-Main or CMC-Pineville.

Q: All right. Now, you testified earlier about the County contract requiring Piedmont to provide EMS services. And I believe you testified that the County doesn't pay you for those services, is that right?

A: That is right.

Q: How much of the County do you have to cover through those services?

A: A 100 percent of the County.

Q: How many days a week do you have to provide that coverage?

A: Seven days.

Q: All right. And how many hours a day?

A: Twenty-four hours a day.

Q: All right. And patients that you pick up with Piedmont ambulances, do you bring them all to Piedmont?
A: No.
Q: Where do you take them?
A: Well, to the closest facility or where ever the patient requests.
Q: All right. Would that CMC-Steele Creek?
A: Yes.
Q: Would it include CMC-Pineville?
A: Yes.
Q: Now, early on in this testimony, I asked you about your first impressions when you came to Piedmont and you gave me two of them. And we discussed one of those, the services that Piedmont provides. But we haven't talked much about the others, so let's get to the other one. I think, your second impression you said was, you identified, was your concern over out-migration, is that right?
A: Yes.
Q: What do you mean by out-migration, first of all?
A: Out-migration to me means a patient that is in a hospital service area that leaves that

service area to get hospital services elsewhere.

Q: All right. Now, have you seen data or are you familiar through hospital data or any other data, what York County's population growth has done in the last few years?

A: I have.

Q: All right. And I tell you what, I'm going to hold off on that for just a minute, because I just realized I skipped a question. First of all, the question I skipped is this, what has happened to Piedmont's market share since say 2005, 2006, that time frame?

A: It has declined from approximately 64 percent to around 54 percent right now.

Q: Okay. And that's the market share in York County?

A: Yes.

Q: Okay. Let's look at Demonstrative 199, that will get me to my population question. Is this a Demonstrative that you're familiar with?

A: I am.

Q: Okay. And it says up at the top, total admission to population comparison 2005 to 2011, right?

A: Yes.
Q: And just identify for us first, overall, on my left there's a column that has some numbers. What does that represent?
A: Those represent inpatient admissions at Piedmont Medical Center.
Q: All right. Inpatient admissions at Piedmont Medical Center. What does the column over on the right indicate?
A: That is total population in York County.
Q: All right. And finally, let's go up to the top of the page, where it says source, ORS, is that the South Carolina Office of Research and Statistics?
A: Yes.
Q: All right. Now, first of all, what does the orange line represent on that graph?
A: The orange line represents the population growth since 2005.
Q: All right.
A: And indicates that the population has grown over those six years 22 percent.
Q: Okay. What is that purple? What does the purple, it looks purple to me, line represent?
A: The purple line indicates that our total

admissions have decreased eight percent over that same time period.

Q: All right. Now, it looks like from 2009, it looks like they decreased steadily to 2009 and then there's been a little rebound since 2009, is that correct?

A: That is correct.

Q: All right. Let's go to another Demonstrative and sort of break down that rebound a little bit in the total admissions that make up that rebound. Let's go to Demonstrative 159, okay? All right. This looks like a similar chart, but I'm going to need your help again, kind of telling us what everything refers to. Again, the source, it looks like, is ORS, Office of Research and Statistics, the title says, Managed/Commercial and Self Pay/Charity Admission Comparison 2005 to 2011. First of all, what is managed/commercial, what does that mean? That is the payor source for the admission. So, for example, on the axis on the left hand where it says, managed/commercial and there's number of admissions going down the side, those are patients who had managed care or commercial insurance like Blue Cross, for

example.

Q: All right. So those are all insured patients, is that right?

A: Yes.

Q: Okay. What is self pay/charity mean?

A: Those are patients without a payor source. And the differentiation between self pay and charity is that charity meets certain levels or falls below certain levels of income and assets to qualify for charity. A self-pay person doesn't have insurance either and may not be able to pay, but they don't quality on income or assets they own to qualify as charity.

Q: All right. Now, as a hospital, based on your experience at Piedmont and the other hospitals you've worked at, charity implies that the hospital would not get paid for any services provided, is that correct?

A: Yes, that's correct.

Q: What about self pay? How much does the hospital end up being paid by the category of patients classified as self pay?

A: It's very minuscule. It usually ends up in bad debt.

Q: All right. And so, self pay/charity,

cumulatively represent uninsured patients that come to the hospital, is that right?

A: Yes, that's right.

Q: And the column there on my right, what does that represent?

A: That is the self pay/charity admissions to Piedmont Medical Center.

Q: Okay. What does the blue line represent on the chart?

A: The blue line is managed care/commercial admissions changed since from 2005 to 2011.

Q: And what does that show?

A: It shows that it decreased 23 percent.

Q: Okay. And what does the green line represent?

A: The green line is self pay/charity admissions at Piedmont Medical Center and it shows that over that same time frame it grew 175 percent.

Q: All right. Now, what's happening -- so you're getting plenty of uninsured patients, the insured patients are out-migrating, is that what they're doing?

A: That's what I believe they're doing.

Q: All right. Where are they going?

MR. MULLER: Your Honor, if I may, I need to make a verbal objection to this. Apparently, these

are some Demonstrative Exhibits that he's presented to the witness. I'm not so sure if I'm even going to have a chance to cross examine him on these Demonstrative slides. If we could just pull that up again, I would like to tell you what I'm talking about. I mean, we have a bar chart here where the numbers don't even correspond with one another. You have 700 admissions on the right side and 1500 admissions on the left. This chart has no scientific basis at all. It appears to be completely random. They don't correlate with anything. As I read it, there's 5000 admissions here at the top and 1300 admissions on the other side and it makes it look as if the lines are the same and clearly they're not. I just want to raise that objection to the chart because I'm not so sure if I'm going to have a chance to cross.

THE COURT: Mr. Westbrook, this is a Demonstrative?

MR. WESTBROOK: It is a Demonstrative. And I'll simply point out -- and I'll be happy to ask Mr. Masterton to point out. But I would just say that I think, as he had explained, the column on the left, the one that goes up to

5000 represents the insured patients, the column on the right the uninsured patients. The charts -- the lines on the chart are accurate, each one of them. One of them, the self pay and charity increased by 175 percent and the other one decreased by 23 percent. And those numbers bear that out. The source of this is material, you know, produced by the State that we produced to CHS. So, I think the lines of the charts are accurate. We could have made two charts, but we put them on one. But the testimony that I elicited from Mr. Masterton about the 175 percent increase in the one category and the 23 percent decrease in the other category was perfectly accurate. And the lines, in and of themselves, are accurate too.

MR. MULLER: What I'm saying, Your Honor, if you had what is here on the right-hand side, the aqua-colored line, it would be way above on the right-hand side of these numbers, because it's 1500 where it says 1300. In other words, this whole -

THE COURT: Five-thousand versus 1300.

MR. MULLER: Yeah, I mean -- right. I just think this thing to be to scale, this whole aqua line

would have to be shifted all the way up here.

THE COURT: Certainly, I can see that. And I understand your –

MR. MULLER: And my objection simply, it is a little bit of a misrepresentation of the chart in front of me, Your Honor. Because it's interfaced two charts that have entirely different numbers. You see on one side it's 700 and the other side is 1500, its juxtaposition doesn't make a lot of sense. And I just want to preserve that objection.

THE COURT: I see and as far as the Court's concerned, I'm looking at the fact that all I'm seeing from this is that this is a Demonstrative Exhibit in an attempt to somehow show a 175 percent increase in the number of charity admissions, while at the same time showing a corresponding 23 percent decline in the number of managed care admissions over the same period of time. The numbers obviously -- it does seem somewhat confusing, that's really all that I'm getting out of this, looking at it. But, your objection, you're welcome to discuss that with the witness when you cross-examine him on the Exhibit.

MR. WESTBROOK: Thank you, Your Honor.

Q: Mr. Masterton, what has been from 2005 to 2011, based on the data that you've looked at, what percentage of managed care/commercial admissions, well, what has been the decrease in percentage of managed care and commercial admissions at Piedmont Medical Center from 2005 to 2011?

A: Twenty-three percent.

Q: What has been the increase, in terms of percentage, of self pay and charity admissions during that same period of time?

A: One hundred seventy-five percent.

Q: And do you recall from the previous chart during that same period of time, what has the population in York County done?

A: Yes, it's increased 22 percent.

Q: Thank you. Now, for the patients who are out-migrating, where are they going? Where are they out-migrating to?

A: In the market share data I've seen, it suggested they're going to CHS or Charlotte.

Q: All right. Charlotte?

A: Well, Charlotte, primarily CHS hospitals.

Q: All right. Would that include CMC-Pineville?

A: Yes.
Q: All right. And CMC-Main?
A: Yes.
Q: All right. Another CHS facility. Now, what kind of balance in your experience, what kind of balance does a hospital need to maintain between insured patients and uninsured patients. Can you explain that for us?
A: Sure. There's a term hospitals use called, cross-subsidized. And what they mean is they need to utilize any profits or any earnings that they make on managed care lines of business to enable them to offer free care to people without insurance that need those same services.
Q: Okay. In your experience, Ms. Masterton, what is the most important factors influencing where patients go for hospital services?
A: In my experience, physician preference helps to decide where a patient goes for service.
Q: Let's look at Demonstrative 158, please. Mr. Masterton, this bar graph says at the top CHS Employed Physicians in York County and it gives a source down at the bottom for this data. Do you see that?

A: I do.
Q: Have you looked at this before?
A: Yes.
Q: All right. Based on this chart, how many CHS employed physicians were in York County in 2005?
A: Thirty-five.
Q: How many were in 2008?
A: Forty-six.
Q: And how many in 2012?
A: Sixty-six.
Q: All right. What percentage does that represent?
A: Eighty-nine percent.
Q: All right. I'm sorry, go ahead.
A: Eighty-nine percent growth.
Q: Okay. Now, how does the data on this chart relate to the concept of out-migration to North Carolina?
A: To the extent that patients are seeing any of these 66 employed physicians, there's a likelihood that they would receive care at a CHS facility to the extent those physicians refer them.
Q: All right. Now, you have lost, it sounds like,

a good bit of market share over the last several years, right?

A: Yes.

Q: Do you have a strategic plan to recapture these out-migrating patients?

A: Yes, we do.

Q: All right. Why don't you tell us what that is?

A: Well, our plan to recapture the out-migration is number one, and most important, is to build a facility in Fort Mill, an acute care hospital, our plan for a 100 beds. And we -- I think this is really important. It is one of the fastest growing areas of York County. It's one of the most affluent when you compare it to the rest of York County, having a higher average household income. And then lastly, there is higher penetration of managed care patients in the area this would serve. The other elements of our plan to recapture out-migration is the recruitment of physicians. And we plan to recruit physicians in 2013. And then lastly, the expansion of our emergency room.

Q: Okay. I'm going to ask you about those elements. Let me get back to the hospital for

a second. Why would you transfer 36 of Piedmont's beds to make a 100-bed hospital in Fort Mill?

A: A couple of reasons. Number one, when you're building a hospital it's more efficient to build it to the size you need it in the beginning when you can leverage your overhead cost. Number two, is that we have excess beds at Piedmont Medical Center. And then number three, some of the patients, it would be closer for them to receive inpatient care at Fort Mill Medical Center than Piedmont. So some of our patients would actually not be at Piedmont, but at Fort Mill Medical Center.

Q: Because you currently serve patients from the Fort Mill area, is that what you mean?

A: That's what I mean.

Q: All right. Now, you mentioned a second element as being recruiting physicians, is that right?

A: Yes.

Q: Why is recruiting physicians a strategy to halt out-migration and recapture market shares?

A: Well, to the extent that there's a community need for physicians. Recruitment of physicians will allow us to meet the need in the community

and if the patients accept the recommendation of their physician to receive care in the market, they'll be able to go there, to that hospital.

Q: How many physicians does Piedmont employ today?

A: Piedmont currently employs 32 physicians, approximately.

Q: How many do you plan to recruit in the near future?

A: In 2013, we plan to recruit 14 physicians.

Q: All right. Now, how will having a hospital in Fort Mill, how would that affect your ability to recruit physicians?

A: It would enhance our ability to recruit physicians. Physicians want -- when they're evaluating opportunities to where they could be recruited, things that are important to them are they going to be able to have a large enough patient base to be able to practice their craft. And then number two, be able to provide a living for their family.

Q: Now, you also, I think the third element that you mentioned is expansion of the emergency department, is that right?

A: Yes.

Q: What have you done to implement that?
A: Well, we filed a Certificate of Need and have actually begun mechanical drawings for an expansion that will roughly double the size from 21,000 square feet to 42,000 square feet of emergency room. The project cost approximately $20 million. And right now, Piedmont, why it's so important for us is we get about 69 percent of our inpatients in the hospital, access the hospital through the emergency room.
Q: All right. You mentioned that you had filed a CON application, has that application been ruled on by DHEC?
A: Yes, we received it.
Q: You were approved?
A: Yes.
Q: Okay. And when do you project completing that expansion?
A: Next year in the fall or the end of 2014, beginning of the fall or in the summer.
Q: Now, you said you're spending $20 million on this project, is that right?
A: That's right.
Q: How do you justify spending $20 million on a ER

project like this and it's doubling your ER size, at a time when you're worried about the hospital's volume and out-migration?

A: Well, that's precisely why we invested in the hospital to try to stop the out-migration. And as I mentioned, 69 percent of our inpatients access the hospital through the ER, so an a attractive ER with capacity will help us fight this out-migration.

Q: Now, if Fort Mill Medical Center is built, who would be the CEO?

A: I would be the CEO.

Q: All right. Now, who would be the CEO at Piedmont?

A: I would.

Q: So the two hospitals would share in those jobs?

A: Yes.

Q: Are there any other shared functions that you would envision for the hospitals, the two hospitals?

A: We would do any services that make sense. I came from a hospital within Tenet, Coastal Carolina, where we shared with Hilton Head Hospital on the Island. We shared a human resource person and a business development

person. So we would operate as a system and share as many of those services as we could. But in addition to simply overhead savings from, you know, sharing an administrative person, we would also make sure that we don't compete with ourselves. We could be strategic about investing in service in Fort Mill and then having it available to York County, but not having to replicate it unnecessarily every time at Piedmont.

Q: All right. You had any concerns that Fort Mill Medical Center would adversely impact Piedmont?

A: No concerns. The whole reason we're doing this is because we believe it will help Piedmont Medical Center.

Q: Now, speaking of adverse impact, you're aware that CHS takes the position that CMC-Fort Mill would not adversely impact Piedmont but simply shift patients currently going from its North Carolina facilities to South Carolina. Is that right, you're familiar with that concept?

A: I've heard that argument. I'm not sure how I'd be able to justify building a new hospital without one new patient.

Q: All right. What about the concept of the

shift? Do you have concerns about when that shift is going to take place, the shift from the patients going to North Carolina back to CMC-Fort Mill?

A: Yes, I have concerns. I think the opposite will happen. I think there will be additional out-migration.

Q: All right. Why is that?

A: Well, this is a 64-bed hospital and their advanced services would still be offered in the Charlotte area. So this, in my opinion, would just be another way to have patients out-migrate to sub-specialists outside the market.

Q: All right. Let's take a look at Demonstrative 162, Dan. What is this, Mr. Masterton? Do you recognize this building?

A: This is a medical -- Carolinas Healthcare Urgent Care on Gold Hill Road.

Q: All right. And let's go to Demonstrative 163, please? And what is this?

A: This is CMC-Rock Hill, which is also a medical office building on the corner of I-77 and Celanese Road.

Q: All right. Now, what effect do these medical office buildings, or what concerns do you have

about these construction projects in relation to CMC-Fort Mill and out-migration?

A: My concern, I guess, really would start almost at the border. You have CMC-Steele Creek, a free-standing ER on Gold Hill Road. And then at the hospital, Piedmont Medical Center is Exit 82, another medical office building. Now, all the kind of major exits on the north/south border are covered by Carolinas Health System.

Q: All right. What concerns do you have on how CMC-Fort Mill, if it's approved would affect independent physicians on your medical staff?

A: My concern is that they would have to join staff at Piedmont Medical Center -- or they would join staff at the new CMC-Fort Mill Medical Center and put pressure on their availability at Piedmont Medical Center.

Q: All right. Now, you're familiar with Dr. Taylor, are you not?

A: I am.

Q: He's going to be a witness testifying at some point during this trial?

A: Yes.

Q: What group is he with?

A: He's with Rock Hill GYN and OB.
Q: All right. Do they refer patients to Piedmont?
A: They do.
Q: Characterize it?
A: They provide about 75 or three-quarters of all the deliveries we do at Piedmont Medical Center. That group's responsible for them.
Q: All right. And are there other groups that refer a lot of patients to Piedmont, in addition to Dr. Taylor's? Not another OB/GYN, I'm just talking about other kinds of physicians.
A: There are. There are a lot of independent physicians at Piedmont.
Q: All right. If a group like Dr. Taylor's group would go to affiliate with CMC-Fort Mill, what would the impact be on Piedmont?
A: It would be devastating. When you have a single group responsible for that significant portion of a product line and they affiliate there. They already have offices in Fort Mill because a portion of their practice comes from the Fort Mill area. So if there's a competing hospital up there, the patients they have from Fort Mill are going to want to be seen in the

hospital in their area. And so they would have to join staff there for their own practice's sake.

Q: Okay. If CMC-Fort Mill is built, do you have any concerns over the effect it would have on your nursing staff?

A: I do. When nurses leave Piedmont Medical Center, we conduct exit interviews. And one that we hear is that why a nurse left us that they got a job another hospital that was closer to home. So that reinforces to me that if they can earn the same wage and doing the same job closer to home, they would do that. And since 23 percent of our nurses are from that area, that's a concern to me.

Q: How much does it cost to recruit and train a replacement nurse?

A: Our vice president of human resources has told me that it cost $60,000 to retrain a nurse. It's not just the recruitment, but they have to be oriented to the new hospital. They can't just walk in the hospital on day one and start doing the job.

Q: All right. Now, if CMC-Fort Mill is built and if your concerns are realized, what steps would

you, as CEO, consider taking?

A: Well, if the volume is not going to be able to grow and out-migration is going to continue to go there, the revenue will not be there. So I would be forced to look at cutting expenses to maintain the same kind of margins to reinvest in capital. And since half of your expenses are related to salaries, a lot of the cuts will be in the area of jobs. And then potentially, to the extent we're not constrained by the contract, we would have to cut services or at least reduce them in many instances.

Q: What kind of services or programs would you have to consider cutting?

A: Well, one, for example, some of the programs that I've already talked about that helped us establish our clinical credibility like the stroke program, wound care, programs like that.

Q: All right. What effect would this have on the York County public?

A: Well, for western York or the more rural parts of York, it would reduce access to services for them. Because as we cut services correspondingly they wouldn't be able to access them. And then also for people without

insurance, they're going to have less access to services as well.

Q: All right. The people that are going to be coming to Piedmont, whoever comes to Piedmont, what effect would cuts in these kind of services and programs have on them?

A: It would be a negative impact on them.

Q: No further questions. Thank you.

A: Thank you.

THE COURT: Thank you, Mr. Masterton. Mr. Muller.

MR. MASTERTON - CROSS EXAMINATION BY MR. MULLER:

Q: Mr. Masterton, good afternoon. I wanted to start with your emergency department, Mr. Masterton.

A: Okay.

Q: Now, as I understand it, this application would have been filed before you arrived, but shortly before you arrived.

A: I think it's dated in November of 2011 and I arrived in July of 2012.

Q: Well, I'm referring you to a page in this application. These were some responses to questions that Mr. Levitt, your healthcare expert was providing to DHEC. And he provided this chart and I'm puzzled, because when you

Honor.

THE COURT: Yes, sir.

MR. MASTERTON - RE-DIRECT EXAMINATION BY MR. WESTBROOK:

Q: Dan, would you put up Demonstrative 199, please, on the screen? Mr. Masterton, this is the Demonstrative that we examined on direct and I think Mr. Muller asked you a couple of questions about the numbers on this Demonstrative, if these are the numbers from the ED application. And I just wanted to ask you this. These total admission numbers that are represented by the purple line on this, do you know if this based on all admissions to the hospital or is it based just on admissions from York County to the hospital, do you know?

A: I don't know the answer to that.

Q: All right. I think we've already established that you're not very familiar with the ED application. Let me ask you this specifically. The numbers in that emergency department application, it showed total admissions that were higher than these numbers. I believe that was the point of Mr. Muller's questioning. Do you know whether those numbers were total

numbers or limited to York County, do you know?
A: I don't know what's in the application.
Q: Okay. Mr. Muller asked you a couple of questions about Beaufort County and Charleston County and the Tenet facilities there. And again -- well, let's start with Beaufort County, because you were CEO at Coastal for a while. In the Beaufort County area, is there a hospital system, a dominant hospital system that dominates hospital services in that area to the same extent that CHS does here?
A: Not to my knowledge, no.
Q: Do you know, and I know you haven't worked in this area, so if you don't know that's fine. Do you know whether in the Charleston area there's a single dominant hospital system like CHS here?
A: I don't know.
MR. WESTBROOK: Your Honor, if I can just ask your indulgence just for a moment while I try to decipher Mr. Andrews handwriting.
THE COURT: Yes, sir.
Q: If the Savannah hospitals -- I mean, let's go back to your time at Coastal, and following up on Mr. Muller's questions, if the Savannah

hospitals had established a hospital in the Bluffton area -- which is pretty close to Hardeeville, isn't that right?

A: Yes.

Q: Or anywhere in that area in Beaufort County, what effect would that have had on Coastal and Hilton Head?

MR. MULLER: Your Honor, I'm going to object to this. It's being total speculative. He's asking now for expert opinion testimony about what impact a hospital applicant would have on a non-existent hospital application. It's pure speculation.

MR. WESTBROOK: Well, I would say he opened the door. And in fact, I'll rephrase the question. I'll start off saying don't speculate, but based on your experience as a CEO for several years at Coastal, do you have an opinion about that? I'm just saying Mr. Muller opened the door by asking him questions about that area and the hospitals systems there.

THE COURT: I'm going to allow it in the sense that you did -- on cross examination the door was opened in that area. Only if he knows it, not if he's speculating.

Q: So let me caution you Mr. Masterton, and, you know, I'm not asking you to speculate at all. I don't want you to speculate, if you have an opinion about this, based on your experience from 2009 to 2012 as CEO at Coastal Carolina, if one of the Savannah hospitals, one of the large Savannah hospitals had established a hospital in Beaufort, relatively close, in the same way that CMC-Fort Mill will be close to Piedmont Medical Center to your facility, what kind of impact would it have had?

A: The impact would have been on Hilton Head Hospital. And that's the reason Tenet acquired Coastal Carolina Hospital to the south, so they could control the east/west corridor, which is State Road 278, the only way to access the Island and 170 -- that's the way to get to Savannah, so the concept was get Coastal so you can control the patients east/west between Hilton Head and Coastal.

Q: I think you had said that Coastal had several ownership changes in its short history when you came there, is that right?

A: Yes. Tenet was the third owner.

Q: All right. In what, five years?

A: Yes. It was built in 2004.
Q: All right. And so did I understand you to say that Tenet acquired Coastal in part to prevent one of the Savannah hospitals from acquiring it?
A: No, it was ---
Q: Or establishing another hospital there? I'm sorry.
A: It was a strategic decision to try to stop out-migration out of that area, control the east/west corridor.
Q: And did it do that? Did it accomplish that goal?
A: In my opinion, yes.
Q: No further questions, thank you.
THE COURT: Thank you. Mr. Muller do you have follow-up or re-cross?
MR. MULLER: No, sir.
MR. BIGGERS: Nothing, Your Honor.
THE COURT: All right.
MR. WESTBROOK: Your Honor, I'm sorry it's only five thirty.
THE COURT: It's been a hot day today so, we finished with Mr. Masterton? Sir, you may be excused thank you very much. And so tomorrow

we'll start at ten, then. And hopefully, we'll have this climate situation a little bit better under control. We're recessed. All right.

(There being nothing further, Day One recessed at 5:28 p.m.)

DAY TWO - TUESDAY, APRIL 9, 2013

THE COURT: Good morning, everyone. Is there anything we need to take up before we go with the next witness or are we ready to go?

MR. ANDREWS: I'm ready to go, Your Honor.

THE COURT: All right.

MR. ANDREWS: At this point we would like to Dr. Norman Taylor.

THE COURT: Come up and be sworn in, sir.

ROY NORMAN TAYLOR, M.D., being duly sworn, testifies as follows:

DR. TAYLOR - DIRECT EXAMINATION BY MR. ANDREWS:

Q: Good morning, Dr. Taylor.

A: Good morning.

Q: I think you're voice carries well enough and projects well, but you might need to lean forward to the mic every now and then if you're having any trouble. Please, state your full name and business address for the record?

A: Roy Norman Taylor. We're at 1721 Ebenezer Road

in Rock Hill, South Carolina. We have a second office in Fort Mill.

Q: Dr. Taylor, you're currently a physician on the medical staff of Piedmont Medical Center?

A: Correct.

Q: What's your area of practice?

A: I am an obstetrician and gynecologist.

Q: And we have provided the other parties with a copy of your resume. We'll bring it up on the screen so you can introduce your history and experience and training to Judge Lenski this morning. Is this your current CV?

A: Yes, it is. The only correction I did notice, it said I had courtesy privileges at CMC-Pineville and Charlotte and my office let them lapse and I'm about to get them back. I think I have to get my picture taken and that's only -- but it was a lapse for about six months.

Q: Okay. All right. And where did you get your medical degree?

A: I trained and got my medical degree at the Medical University of South Carolina.

Q: And when was that?

A: I graduated in 1981.

Q: Okay. And where was your residency?

A: From then I was on an Army scholarship. I was married after my first year, so instead of being broke, was on an Army scholarship. So I did my residency at Fitzsimmons Army Medical Center, which is in Aurora, Colorado. That was a four-year residency. And then that was followed by an order to pay off Army time, I was a staff hospital OB/GYN at Lyster Army Hospital, that was in Fort Rucker, Alabama.

Q: Okay. And where have you been licensed to practice?

A: Well, I was licensed in Colorado when we were there. I was licensed in Alabama when we were there. Currently, North and South Carolina.

Q: And before working in Rock Hill, where did you practice?

A: Well, I was at Lyster Army Hospital for the prior four years and that was in Fort Rucker, which we lived in Enterprise, Alabama.

Q: Okay. And since moving to Rock Hill, what hospitals have you been affiliated with?

A: We've been affiliated with Piedmont Medical Center in Rock Hill and Carolinas, formerly Mercy South, but Carolinas Medical Center-Pineville. Although I have had activity at

CMC-Main, it's been many years.
Q: Okay. And have you held leadership positions in the hospitals you've worked in?
A: Yes. In the hospital in Rock Hill, I've been department chairman. I've been chief of staff of the hospital. And you work your way up with that, so you're treasurer and vice chair. And so you work your way up, as far as that. I've been president of the York County Medical Society. I'm currently a state representative for the South Atlantic OB/GYN Society, which is a invitation society in our speciality. And currently also, at Rock Hill, I'm the chairman of the Credentials Committee.
Q: At Piedmont?
A: Correct.
Q: All right. Okay. Let's discuss a little bit about your practice currently. What's the name of the group you're affiliated with?
A: Rock Hill GYN/OB Associates.
Q: And when did you join it?
A: I joined in 1988.
Q: And was it an established practice when you joined it?
A: It is. It's the oldest practice. Our practice

is 60 years old. Jimmy Simpson founded our practice in 1952. He was the first obstetrician in York County. So we go back a long way of taking care of a lot of people. He was joined by Frank Strait in the mid-fifties and then from there I have continued to practice. When I joined in '88, Dr. Simpson retired and has since deceased. Dr. Strait worked for several years in GYN. And then Joe Robinson, who is my contemporary, he was there already. And then everybody since then has been people that we've added.

Q: How many physicians were part of the group when you joined it?

A: We had four when I joined.

Q: How many do you have now?

A: We have seven now and a nurse practitioner.

Q: And what's your position in the practice today?

A: I've been the president for eight years, I think.

Q: And what range of services do you and does your group provide to your patients?

A: Well, we are a mature practice, once our practice matures beyond a certain point, you end up doing about half obstetrics and about

half GYN. So we offer sort of the full range of services that an OB/GYN practice would offer. And that would be infertility, it would be delivery, high-risk OB, gynecology, urogynecology, so just kind of a full-range. We've got a lot of talented physicians, so we're really fortunate, they're well-trained and so we do a large scope of procedures.

Q: And for the outpatient work you do, where do you do it?

A: Well, our offices, we have an office in Rock Hill, as I mentioned. And then an office we've had, probably ten years in Fort Mill, right across from Baxter, which is in Fort Mill. We've had that about ten to 12 years. So probably the split is 70/30 Rock Hill to Fort Mill.

Q: Okay. And for the services you've performed at hospitals, where do you and your partners provide those services?

A: Currently, we do the majority of our work at Piedmont Medical Center. We've got two of our physicians who are Da Vinci robot certified and they've done a fair amount of work at CMC-Pineville. Now, we were at CMC-Pineville until

2007. We did obstetrics and gynecology there.

Q: All right. Now, let me ask you to go back a few years to 2009. Describe your group's practice, if you would, at that time?

A: Well, in 2009, we were busy, both with obstetrics and gynecology. We had an additional nurse practitioner at that time to handle, mainly, the obstetrical side. We had more obstetrical patients than we could handle by ourselves, so we employed a nurse practitioner at that time. And we were doing probably, as a group, about an 123 deliveries a month. So obstetrically, we were doing that, gynecologically, I would have to look. We were busy, so it was a busy time.

Q: Okay. And in your position as president, do you keep up with the operational business indicators of your practice?

A: Yeah. One of my tasks is sort of long-range planning or strategic planning. So we, on a monthly basis meet with our office manager to review statistics. And it's just like any business, I mean, you look at trends. You look at tendencies, so we do that on a monthly basis.

Q: Okay. And were you doing that back in 2008?
A: Yeah, we've done that since I've been there.
Q: All right. Describe, if you would, in general terms how the volume was going looking at your basic lines at work and your measurements?
A: Well, I mean, we were satisfied. One of the things all practices in this state that are private, we were independent, we've never been owned. One of the things that you have to very careful about is your payor mix. Quite frankly, it's very difficult for a large practice to be successful if you have too much indigent or even Medicaid or Medicare business.
Q: Why is that?
A: Well, because of the pay. The reimbursement is such that in order to run a practice, our tensions right now are malpractice, as an independent, labor, our cost for employees. The number of employees that we have to employ in order to get paid has gone up inordinately a lot, because it takes so many people to file insurance and re-file and appeal, that the whole medical practice set up has gotten so much more complicated. So we look -- and back then one of the issues we have is we always

look and say how much indigent care do we do. But we have to balance that, because we've always, we live in Rock Hill, we're South Carolinians, and we've always had a very strong desire to do our share of Medicaid and indigent work. And I've been very proud of our practice because we have really stepped up in that arena. So part of what back in 2009, to answer your question is, we looked at payor mix. We looked at volumes. We looked at our capability to take care of that. And then we've got to look, do we need to expand? Do we need to cut back? So just basic business things that you look at.

Q: What was your payor mix in 2009?

A: Well, our payor mix, obstetrically was probably 70 percent private insurance and 25 to 30 percent Medicaid. At the time in 2009, Medicaid, in this state, probably ran 35 percent. And if you looked at all the obstetrical patients in our state, it was probably around 35 percent. And we tried to mirror that, now again, back then we could change month-to-month, if we had more private, you could say this month or the next couple of

months we can vary. But we tried to keep it around 30 Medicaid patients in our private practice per month.

Q: Okay. All right. Then compare, if you would, your practice back at that period with what it is today from those business indicators?

A: Well, you know, there's been somewhat of a sea change in medicine over the last three or four years. Certainly, the economy has had a lot to do with it, but there's some unique factors, I think, in our county that have influenced the situation as well. And, I think we'll talk a little bit about the dynamics of that. But right now in our state, about 50 percent of women that are pregnant are now on Medicaid, that's a huge difference, so it's 50/50. We have seen an erosion or a siphoning of patients especially in the northern part of the county. And we know this because we're in Fort Mill, so we certainly know this. We've had a siphoning of our paying patients north. They receive care in North Carolina, so we have sort of seen a steady erosion so that now our payor mix is probably, we do mirror the Medicaid rate here, it's probably more 50/50 for us in terms of the

payor mix.

Q: All right. Now, Dan, if you pull up Carolinas Exhibit 27. Have you gotten an opportunity to review the document that Carolinas provided as a designated Exhibit that's showing up on the screen right now, Dr. Taylor?

A: Yes, I have.

Q: All right. And let's, Dan, if you highlight the Piedmont OB/GYN practice, do you see that? And what is this comprised of, Dr. Taylor, are you familiar with it?

A: Piedmont OB/GYN is the second, well, they're probably the largest now. But when we first started in Rock Hill, they had an office in Rock Hill and so they're a large OB/GYN group in Rock Hill. They have an office in, I think now it's Ballentine, they used to be back by the hospital at CMC-PIneville and I think, even Steele Creek, I'm not sure. But they're a large OB group in York County.

Q: Okay. What I would like for you to do is -- ask you a few questions concerning the payor mix that's reflected in this document for purposes of comparing it against yours. When you talk about private insurance, would that

include both commercial and managed care?
A: Correct.
Q: All right. And if you then do the rough arithmetic on that you're looking at, what would that total be for those two fields of private coverage?
A: In terms of?
Q: Just adding those together.
A: What, the number of deliveries?
Q: Yes, no, no. Just the percentage of the payor mix that would constitute private insurance?
A: Well, for theirs, their commercial is 18 percent and managed care is 65, so that's what, 83 percent.
Q: Eighty-three percent. And what is yours currently?
A: Ours is 50/50, as far as commercial and managed care and then Medicaid.
Q: Okay. And then the Medicaid percent of Piedmont is reflected in Exhibit 27 is what?
A: For Piedmont, their Medicaid is 11.3 according to this.
Q: And again, compare yours currently?
A: Well, it's 40 percent difference, so it's a large difference.

Q: And yours, as you said, 50 percent?
A: Correct, that's 40 percent difference.
Q: Okay. All right. Now, with regard to the difference, how has that affected or has it at all affected your practice by this change in the payor mix that you've experienced in the last three years?
A: Well, we've seen with that, we've seen a decrease in our total obstetrical numbers, so we're down from 2009. And I'll explain it a little bit, because I think there are several factors. We're down about 28 percent, I think, in terms of just absolute numbers. So we've had a decline in numbers. We've also had a decline in our ratio. Now, I think some of that, quite frankly, is the economy's taken such a hit. But also, York County is a growing county. And I know we see it in Fort Mill, so we certainly have a steady stream of new patients that move in. So I'm not sure; I think part of what we're seeing is an out-migration north to Charlotte that has influenced our numbers and certainly, our payor mix. Because I think, as they take payors, you're left with more Medicaid and different

payors. So what's left is different and we're seeing that in our office.

Q: All right. Now, when you say your total numbers are down around 28 to 30 percent, would that be deliveries?

A: Correct.

Q: All right. What's your experience been in your new patients?

A: Well, with new, and again, this is compared probably to 2008. We're down probably 20 percent for new patients and also we have returned E and M, those are patients that we've seen in the past, probably 20 percent over that time frame.

Q: And what are the implications of those reductions for your practice?

A: Well, I mentioned we had a nurse practitioner and actually at one time, we had two additional nurse practitioners. One left that we did not replace initially. But the one that most recently left, one of our partners really had a lot of free spaces and it made no sense for us to replace her, so just in a business model, we have not replaced her. Just in order to keep the volume, can keep everybody busy that

we currently have.

Q: Okay. Let's talk for a few minutes about the services that you provide your patients at Piedmont. Describe what you do there and what your partners do there as well?

A: Well, Piedmont has a women's center that has four ORs down on the first floor, so we do our GYN surgery there. We do our C-sections there. We also do our deliveries on their labor and delivery floor, as well, there. So really everything that we do, we're able to do at the women's center. So that's in our complicated surgery, our lesser surgery, hysterectomies, so the whole gambit. Our two partners I mentioned, they do Da Vinci surgery up in CMC-Pineville. So they'll go up there and do the surgeries.

Q: Okay. You've been practicing at Piedmont for a long time?

A: Yes.

Q: All right. Have you seen any changes in the facility and services during that period?

A: Well, it's been a sea change, because I've been there a long time. I was involved with our development of the Women's Tower, so I was

intimately involved. And we made tours different places, so we've been able to do that. And as our surgeries have become better for patients, we do what is called minimally invasive surgery, where ladies with hysterectomies can get out in a day. And that's an evolution that's taken place. And the hospital's been good with our equipment and things that we've needed. So we've certainly kept up and we'll real proud of our statistics with that. So as things have gone along, and really, we feel even better because, I think, Tenet even lately has been more agreeable to help us as far our endeavors, in terms of equipment and staffing and stuff. So we've been pleased.

Q: Okay. Now, when was the Women's Tower opened?

A: I think it was 2004.

Q: Okay. Were you involved with the development of the plans?

A: Yes. There was a group that was involved. We went to probably seven or eight facilities around the state, North and South Carolina and looked at their women's centers because that was sort of a new concept. And it was based on

the fact that women drive healthcare. So if women have a good experience, they're more likely to bring their family there. And it made sense, because really, women are able to shop for obstetrical care. It's the one thing that they're going to look and kick the tire and decide, unlike an appendectomy where you have to go, you know, whatever you get, you get. So we were able to look at a lot of different facilities and really gather a lot of information to try to kind of piece that together to make a facility for us that was state of the art and was appealing for the population.

Q: Were there issues raised among the medical staff during this process about the kinds of rooms that would be provided in the tower?

A: Well, the great debate, CMC-Pineville and Mercy South before then, they had a strong obstetrical service and that was probably one of their best services. One of the concepts that they had was called, LDRP, that means labor, delivery and postpartum was in the same room. And as a concept, that was a fairly nice concept. And we went into it thinking that

perhaps, even on a competition basis but just, more importantly, of our patients, if that was something that they felt was a better concept that, that would be the concept that we may adopt. What we found is, we looked and gathered information from other entities, is we heard several things. One is, as that concept gets bigger and you have more rooms that are LDRP rooms, they spread out and you can really can be very far away from a nurses station, if there's an emergency. So in order to handle an emergency, if you've got a hall that's far down there, it really becomes cumbersome. We even saw one place had to have two nurses stations to divide it, because they were so far away. So there were some issues there, especially as a hospital's volume got larger. So it was apparent ---

Q: Why was that? Why would the volume of a hospital affect?

A: Well, because obviously, if you're keeping moms postpartum in the same room, then that room's not available for a laboring patient. And one of our frustrations at CMC-Pineville, while we were there doing our deliveries, was if they

ran out of rooms, you had to put the postpartum on a med-surg room, which is a little shoe box and they all are, not just up there. Well, they didn't like that. And that did happen with some regularity, you had two or more patients and there was nowhere to move them. So as a concept, we wanted to have a concept that would allow us to grow and not rope us in with, perhaps a set-up that was not maybe the best set-up. And so we chose a little different set-up and it's more of a traditional -- we have a triage area, where they're seen and then a labor area. Our big push with them were the room sizes, because typically, you'll have one room will be very nice and a lot of times that's the labor room. And you go to the postpartum room and it's not so nice compared to the labor room. And the labor room has to have more oxygen and equipment. So one of the real stipulations is that we did not see a degradation of room size or amenities as you went from one to the other. And they did that. We have very large rooms and so we've been pleased with that.

Q: When you're referring to they?

A: Tenet and Piedmont.
Q: Who is the medical staff you're talking with about this decision?
A: Well, Charlie Miller was the CEO at the time. And they had a staff, David Anderson was one of the heads that was involved with that, so we had a committee. And so it was when we would go look at other hospitals, we would go with not necessarily Charlie every time, but usually nursing staff and it was a multi-speciality group. Because everybody had their own needs and wants. So when you develop it, you want to make sure everybody gets their little niche in the say that they think they can operate more efficiently.
Q: So if I understand your testimony correctly, there was a medical staff, combined with the nursing staff, a committee that developed a recommendation for administration?
A: Correct.
Q: That right?
A: That's right.
Q: And the recommendation was to do what?
A: Well, after we had looked, and this was probably an eight month process, so we looked

at a lot of hospitals. So our recommendation, because of our desire for anticipated growth and what we felt like it would be a better concept, even nursing-wise I think it's probably as good or better a concept. We elected to have the labor area separate from the postpartum. And then we go up one floor and we have a postpartum floor, with the nursery on the postpartum floor. And then we have our breast feeding facilities and breast feeding rooms and all that. And our special care nursery is up there as well.

Q: Okay. And since the establishment of the Women's Tower, have you or your partners or members of the OB/GYN department communicated with the administration about your various needs?

A: Yes. You know, there's a healthy tension between independent groups and hospitals, and it's a good thing, because you can sort of use it as leverage. So we do let them know when we feel like we need things that we will make the experience better for our patients and ourselves.

Q: Do they always meet your needs?

A: Well, not always, because some of it is more for us and not so much for our patients, but that's the tension that exists.

Q: What have they offered, with respect to addressing the needs and interest and desires of the members of your department?

A: Well, we were frustrated right after the development of the Women's Tower, there were frustrations. We felt like that we needed to have anesthesia available for epidurals, which was a new concept. Because we were having new patients and when somebody has to wait for an epidural, mama's not very happy with that. And so that was a big issue, that we worked with them and finally resolved that. We have anesthesia 24/7. Actually, I'm old enough, we used to put in our own epidurals, but that's a thing of the past. And then we had issues, as far as nursing, mainly involving, and this is where as physicians we like to make it good for us, maybe not so good for the hospital. Our nursing issues had to be with our ability to schedule inductions. In other words, if we called and said Ms. X needs to be delivered next Thursday, you know, I want to put her on

for induction. Well, you hate to say, well, we don't have the staff for that. And we understand if they say, you know, we have three inductions already, obviously you've got to be patient with that. But you want to make sure that the hospital's available when families want that to occur. And they've worked very hard with that, that is a big issue. So a lot of the issues are procedural with nursing. You want the best care you can get. That's really, both places, provide good care. And we wouldn't go to a place that didn't have good care. So a lot of this is sort of patient-centered things. And, quite frankly, physician-centered things.

Q: When you're saying both places, you mean, Piedmont and CMC-Pineville?

A: Right. Piedmont and CMC-Pineville, when we went there.

Q: Let's talk about your experiences when you practiced at Pineville. You had privileges there?

A: We did. We delivered, I would say around 20 patients a month for the time that we were there. We left Pineville in 2007. I think we

wrote a letter in January and maybe did a few more deliveries and that was sort of our last. So we were there a good while and we did the LDRP concept. And again, quality-wise, and I think this is probably, if I can make any point, quality was at both places. They had good quality. And it's interesting as physicians, both places had issues for physicians. And I know with Dr. Revel, the other group, the issues overlap. I mean, our issues in Pineville were when somebody would get moved to med-surg room, they didn't like that because they were out of space. We had a terrible time with inductions and that was always hard. It wasn't so much to put them on, but they would call we can't do Ms. X on Thursday because we don't have the staffing. So the problem is somebody takes time off or the husband takes time off. So when you have an induction scheduled that gets called off, patients don't like that. So we would find ourselves bringing those patients from CMC-Pineville back down to Rock Hill. It rarely went the other way, we were lucky that way. It always went that way. And we didn't know

whether we were the independent practice or we didn't know that was because we were the low man on the totem pole or what. But anyway, that was an issue. And the nursing dynamics are different. You know, they have the concept because they had LDRPs, their nurses were one-on-one with a labor patient. So they would have a nurse assigned to a labor patient. But then the problem, and the nurses would complain to us about this, as our nurses in Rock Hill complained about their issues, was they would also have postpartum patients assigned too. So they were one-on-one with the labor, but they may have two postpartum patients. And they always felt guilty that they couldn't give the postpartum patient the time that they deserved because they were tied up with a labor patient. And a labor patient requires a lot more time and effort, especially if they have an epidural or something like that. So, you know, quality was good, but differences that you see in every hospital.

Q: Okay. With regard to the Da Vinci robotics equipment, you said that a couple of your partners rely on it at Pineville?

A: Correct.
Q: Is there anything comparable or available at Piedmont?
A: Well, three or four years ago, Charlie Miller did come to us and said we could have a Da Vinci. And he looked at the two specialities that are using Da Vinci robots are urology and probably gynecology. As we looked at it at the time, we were able to do everything the Da Vinci robot could do. And this is a great debate right now. In the last week I've read articles about Da Vinci robots. And the question with Da Vinci is, they cost about a million and a half dollars. And for a hospital they're great, because you make a lot of money off a Da Vinci. They're much more expensive and the studies are very unclear as to whether there's an advantage, in terms of discharges, return to work, pain scores, if you're able to do something laparoscopically without the Da Vinci. There's even a sort of an undercurrent, a recent article we read had to do with complications that tend to be more severe with a Da Vinci. That may be nothing more than a learning curve and as we get better, obviously,

we get better and there complications are less. So Da Vinci, by no means in my mind, is going to be -- especially with the Affordable Care Act, there maybe a lot of Da Vincis that are in the closet. But we were offered that and our hesitation was exactly what I just expressed. What will it allow us to do. Now, what's changed a little bit is there's been sort of this clamor by patients and we are a patient-driven practice. You have to kind of say if the perception is, boy, a Da Vinci's a lot better and you're able to have that available, you may decide to do it. So we have looked into the Da Vinci robot. It was never a problem getting one. We're looking at one now and our two partners, as they get better, they may be able to do more complicated cases. And so they are willing to do that. And the robot issue, that's not an issue for us here, but that's the Da Vinci story. And they've been willing to get that. We were hesitant at first and I think we'll probably look into getting one soon.

Q: Okay. Is there anything underway related to the development of the Center of Excellence at

Piedmont?

A: Well, one of the things and this is where we're very proud of our group is, we've been very talented. One of the things with hysterectomies is, nationally about 40 percent of hysterectomies are still done through an abdominal incision and people have to stay in the hospital two or three days with that and recovery is slower. So what's evolved over the last ten years is, either how can we do less invasive surgeries so women can get out of the hospital quicker and get to return to work quicker. And so nationally, you've seen really a change. And we do so much more surgery laparoscopically through the laparoscope or even vaginally, that we would never have attempted before and those ladies go home the next day. They're at work sometimes as quick as two weeks, so it's been really a sea change. And we keep that data for us, for our group. And I was proud of our group. Because while the national average for an abdominal hysterectomy is about 40 percent, our average last year as a group was eight percent, meaning that only eight percent of women had abdominal

hysterectomies, the rest had either vaginal or laparoscopic. And you're seeing that everywhere, so that's been the trend. And so we said, how can we use our talent and yet be recognized as hey, we do this pretty well and our complication rates are low. So we're in the process, I think we're about half way through of becoming, it's called the Center of Excellence for Minimally Invasive Surgery. In other words, you can hang on your shingle that, hey, we're sort of ahead of the curve, in terms of this type surgery, because we know it has advantages for females.

Q: Is the service that would performed through that Center of Excellence volume-sensitive?

A: Like anything else in medicine, the more you do, the better you get. So it very much -- anything is volume-sensitive.

Q: And in general terms, is the quality of services that delivered by Piedmont and delivered by your group sensitive to fluctuations in volume over time?

A: Yes.

Q: In what way?

A: Well, again, it's back to when you don't have

the volume and as a credentials chairman, what we look at when we re-credential physicians is we look at the volumes. And this is becoming more and more of an issue nationally is, what do you do when a physician has a complicated procedure that they do and they don't do many of them because of volume. At what level should you say, you know, you probably shouldn't do that anymore. It used to never be an issue, it's becoming more and more of an issue, so we wrestle with that establishing numbers. So to your point, there are credentialing issues, there's recruitment issues, because if you do a procedure and somebody gets them and you don't do them anymore, you know. So that's a big area that you have to be careful. It's very volume-sensitive.

Q: All right. Well, let's talk about a few of those areas and your responsibility as chair of the Credentials Committee at Piedmont. What areas of practice have you observed that are particularly volume-sensitive in the sense that quality is tied to that?

A: Well, I'm going to be selfish because the area

that bothers us the most right now is the ability to maintain our neonatal program, which is very volume-sensitive. Right now, in York County and I think this is so much the crux of, I think, why we're here. We're able to take care of babies that are ten weeks early. We're a level II-E nursery, that's established by the state. And we have two neonatologists, so when a lady presents to our hospital and she's 30 weeks or above, we're able to keep her there, manage her labor, and keep the baby there and take care of the baby. So that's a very volume-sensitive area. And our concern is with numbers, will we lose the ability, will York County lose the ability to take care of those premature infants. Because what will happen if we don't have that service, they're either going to have to go to Charlotte, or probably the Medicaids will have to go to Columbia. And that's a major step backwards for us. So other things we look at, I mean, just your point, credentials we've got some complicated pulmonary procedure that somebody wanted to do, one of our pulmonologists and there weren't just enough numbers to do that. The

radiologists have some procedures, we have the expertise, the problem is you have to have the volume in order to say we can do this in a manner that we're comfortable, that we're confident.

Q: All right. Let's move to your role over a period of time relating to these applications that are now pending before the Court. Were you involved in any way, Dr. Taylor, during the first series of DHEC's review of the Fort Mill applications?

A: Yes, in 2002, it was sort of one of our frustrating stages and as the county had the opportunity ---

Q: Would that have been 2005?

A: Excuse me, oh, 2005, yes. And when they were discussing the Fort Mill Hospital the first time and that long ago -- we really -- because of the frustration, and again, it wasn't a quality thing, but it was us being able to get what we wanted to get in a timely manner. And it reflected inductions. It reflected, you know, equipment a little bit. It reflected just the things that we felt like we needed with the Women's Center because it was such a

nice facility. And we were frustrated even at the time, we were even frustrated about cost a little bit with Piedmont and Rock Hill. That was a concern, as a physician you would hear that. And our leverage as an independent group would be to say, okay, let's get some competition in, you know, let's go get another hospital. And as we surveyed the potential candidates, we looked at Presbyterian because CMC-Pineville was already there. So it made no sense really, for them to put a hospital in Fort Mill economically. We looked at Presbyterian, who did not have a presence there. And we looked at the hospital at Piedmont. And we, and I came to the conclusion that maybe Presbyterian would be a good fit. We thought it would introduce some competition and so at the time, back in 2005, I wrote letters. I think I wrote several in support of a hospital at Presbyterian, which didn't go over very well at Piedmont. But anyway, we felt that was the right thing to do. And at the time, I really did think it was the right thing to do.

Q: All right. And as you're here today, is your

opinion the same or has it changed?

A: Well, what's happened and this is where medicine, you're talking about 2005, so we're now seven years down the road, which is unfortunate for a lot of reasons. But nevertheless, what we've seen since then, medicine is totally changed. Since 2005, what have we seen? We've seen more and more practices, especially primary care, are owned by hospitals. And that seems to be the trend, you will probably see very little private practice, which is unfortunate, because of the tension between private practice and hospitals. That's such positive thing, you're going to see less of that. And we saw that in York County between Presbyterian buying primary care, CMC buying primary care, pediatric groups. And what happens with that, you say, well, you know, okay, well, they're owned by, you know, a bigger hospital, and especially with CMC or Presby in another state. What happens suddenly, and I think this is what we've seen with our numbers is, if I'm a physician and I go to Shiland Medical, which is a CMC for my primary care. I'm dear friends with my

physician that I've known for years. But what happens is, over time if I've got a new patient and I'm owned by anybody, Presbyterian, CMC, in order for me to profit and be successful, I want my team to be successful. You know, as a solo practitioner I want to perform good surgery and give good care so that my practice can be successful. It's a business model. And as they see patients, although they're certainly not told -- I would get my patients back in a heart beat. So if they see a patient of mine -- and I don't mind referring, because I know professional integrity and ethics require them to send them back. But if I have a patient that is new to York County that has no preconceived ideas or preconceived physicians, you're naturally -- and it's not a bad thing, you're going to send them to the team members because it helps the team. And what we've seen since 2005 -- and I can demonstrate it with our practice numbers, we've seen it and we've seen it in Fort Mill because we have an office there. We've seen a close creep or siphoning, if you will, of patients that go to other facilities at CMC-Pineville or

CMC-Main. And this has been sort of an ongoing creep that has continued. Now, the problem for us is twofold. Number one, is it affects our volume and our ability to make a living. Number two, the creep is pretty much been limited to payors.

Q: What do you mean by payors?

A: These are people with insurance, either commercial or managed care. So as that happens, not only you lose volume, we have a deterioration in our payor mix. And that's not a very good model. So if you look at the health of York County in terms of our ability in the county, it's been more difficult as this phenomenon has taken place.

Q: Why is that not a very good model?

A: Well, again, I think potentially if you lose services that you have, and again, I'm being totally selfish, because I'm an obstetrician/gynecologist, I'm very concerned about our ability to keep neonatal patients. That is a huge plus. We have to ship very few patients elsewhere. You just don't have many less than 30 weeks that need care. And so we've been able to help the state with Medicaid

patients. Our private payors staying at home, they live there.

Q: What about, do you serve patients from other counties there?

A: Well, the other thing, and the analogy that we see a little bit, and this is a mentality that we all have and it's interesting, but it happens in several layers. Obviously, if I live in a little town and there's a big city across the state line from me, the perception is always bigger is better. And they've got big buildings and they're nice and they're beautiful and it's nice. And they have expertise because they're big and it's better. Well, in Rock Hill, the mentality for us is we take care of people in York County, Chester County, Lancaster County and the eastern part of York County. Chester County has not had an obstetrician in about 15 years. They have nobody in Chester County to deliver babies. Those people look at York County as their Charlotte, they come. Chester County is an extremely poor county. So Piedmont, to their credit, and one of the problems they've had like everybody has, is ER issues. Because they

get a lot of people in Chester will say I'm going to Piedmont ER, because it's better than Chester ER, because it's bigger or Lancaster or western York County. So we have gotten, the bigger is better mentality works, at a lot of levels. It works at our level to Charlotte. It works at Chester and Lancaster, they think Piedmont is great compared to Chester. And then obstetrically, there's nobody. And we have always taken care of probably the majority of those obstetrical patients, some will go to Columbia and some can go to Union and a few can go to Lancaster. But because we're the biggest, a little bit closer sometimes depending on the county, they come to us. So there's such dynamics, and I think for the state -- because the game has changed now. And this is why I really feel strongly that the game has changed. As states are required to take care of indigent patients, this may be by law federally as we go into the Affordable Care Act. States cannot have siphoning of their payors at the expense of the non-payors and we see that in York County. If we lose the service, it'll affect me because of my ability

to recruit or perhaps, you know, be profitable. It'll affect other specialities. It's a big deal for us right now. I mean, this is so different than even five years ago. It's totally different. And I fear that we lose all of our payors north or a lot of them and be stuck with the non-payors. And that's not a tenable model; it does not work.

Q: How would that model affect your ability to recruit physicians who would take your place over the ten years?

A: Well, I mean, as an independent it would force us to do something. I mean, we would have to get under somebody's umbrella. We could not continue as an independent and that's happening. It may be that it is inevitable anyway. I mean, we have talked to CMC years ago when they did the upgrade to CMC-Pineville. I talked to their hospital administrator. We've talked to Presbyterian on two occasions. We've talked to Greenville Memorial on several occasions. And we have talked to Tenet on several occasions. As the president, we have to sort of keep our finger in a lot of pies because we don't know whether my model of a

private practice, how much longer that's going to be successful. And we have to be nimble enough to say, okay, well, let's look at what's there because if we have to make that decision that we can't make a living anymore and that will come someday, we've got to go somewhere.

Q: Given the changes you've seen in the nature of the referrals and, as you put it, the payors, the patients with insurance being sent in larger numbers to North Carolina facilities, why do you believe the approval of Piedmont's application to build a hospital in Fort Mill could change that?

A: Well, again, I think this is the crux. And this is why, you know, at the time in 2005, I mean, I was fine but it totally has changed. If we cannot as a state do anything that is going to cost us medical care dollars, and again, I'm going to go back to the neonatal numbers. If you know anything about medicine, when do people spend the most money? They spend the most money with neonatal care, hundreds of thousands of dollars to take care of a preemie and end of care. So if you're saying in York County, we're going to award a

hospital that potentially will take all these healthcare dollars out of our state because that service will not be there anymore, and we're going to have to send them to Columbia in an ambulance. And you're going to have an erosion of your payor mix, we're also going to send people, we're going to let people that pay go north to go to CMC-Fort Mill, which that's not north, so the issue now is really the hospital there. But any complicated care, anything that's going to cost a lot of healthcare dollars will go north. And that's right, because that's their business, they should do that. But for our state it has huge implications. Because if a CON is suppose to do what's right for the community in which the CON is being issued, it's just become untenable in my mind. I know for us personally, we have the data to support that.

Q: All right. Let me ask about -- with regard to your privileges. If Piedmont were approved to build a hospital in Fort Mill, would you get privileges at the new facility?

A: Sure. Absolutely.

Q: Why?

A: Well, we have an office there. We have patients there. And our hope would be, I mean, regardless of who gets the hospital, there's kind of the new restaurant mentality. You know, people are going to say, well, I'm going to try it a couple of times and if I like it, I'm going to keep going back. I mean, it's no different than anything else and we're all human. So I think a lot of people in Fort Mill that maybe even went north and have established relationships, I'm sure if they had a good experience, whether Piedmont had it or CMC had it, you would capture people. Because there's some pride when your local community has a hospital and you want to support it. So, I mean, I think either hospital, if they provided quality care, which I think both would, and provide it in a way that was pleasing to the people of Fort Mill, I think both would be highly successful.

Q: All right. Well, if Carolinas approved to build that hospital, would you try to get privileges there?

A: I mean, yes, yes. We're independent. We have patients that would want to go there. And

because it's new, we would probably have patients from Piedmont that would want to go there.

Q: If the Carolinas hospital were built or if Piedmont build that Fort Mill hospital, you believe that either case that patients who have been receiving services at Piedmont would want to go there?

A: Well, I think any new hospital -- it's like the new restaurant, I mean, you know, we certainly need them in Rock Hill because we go to Charlotte. So, we go to the new restaurants. And we want to support the restaurants that stay open more than Friday, Saturday and Sunday, so sure they would.

Q: Okay. Now, if CMC-Fort Mill were build, what effect do you think it would have on Piedmont if patients were moved there?

A: Well, I mean, like I mentioned day one, it would probably be very little impact. But, I think with our patients I know we would have a tendency for them to say, well, I want to try the new hospital, it's new. And I'm convinced because of history, eventually there would some erosion, again, with difficult cases being

moved north. They just have to do that, that's why they want to be there, that's life. They all want to be there, it's a wonderful community. But it would potentially have effects for us. But for Piedmont, who really needs volume for some of these services, it would be devastating. You would have a bigger hospital that theoretically should have better services that may not be able to maintain those services, and again, because of volume.

Q: All right. If Carolinas were approved -- you said earlier that you had conversations with all of the systems in York County and many in Mecklenburg County, how do you believe the approval of Carolinas to build a hospital in Fort Mill would affect the ability of independent members of the Piedmont medical staff to sustain their practices at the time?

A: Well, I mean, again, it's the same scenario. I think the impact may be in levels. I mean, you know, my concern coming here today is that if CMC gets the hospital in Fort Mill and I want to get in with them, I may be burning my bridge here today. So they may say, we don't need you. We've got so many physicians up in

Charlotte, you guys fend for yourself. I mean, there is real risk about doing all this. And the only reason I do it is I'm old and I'm trying to do what's right for the county. But it will impact all of the specialties, so I think you'll see a degradation of the quality of the physician because young physicians want to be able to do specialty things that they've been trained that maybe different than when I came through and they like that. So specialty will be difficult to recruit and you may see even a decrease in the number of physicians in the county.

Q: All right. Now, if your group were to become employed by the Carolinas Physician Network, what effect would that have on your ability to continue to see patients at Piedmont?

A: Well, I mean, you know, they would come in and this is the way it works. And listen, I would be a team member. They will say listen, you don't have to do anything different and they have to. I mean, we know that from our friends and stuff. They will say, you don't have to do anything different. But over time, the mentality is that human nature is such that you

want to be a good team member because of meetings that you have and you meet comrades up in Charlotte or gastroenterologists or specialists that you know, you will refer to them. And it's good for you, because it helps the organization. I mean, it goes without saying that would happen anywhere. So I mean, I think over time, sure, you may say, well, I'm not going to change my practice. And that's what we see a lot of times. You kind of see it. But we've had the expertise of ten years now of hospital-owned practices and it's inevitable. And it's not their problem, it's just the nature of being in an organization and you want it to be successful, just like I want my practice to be successful. And so you'll refer to the team members.

Q: Dr. Taylor, what percentage of Piedmont's OB/GYN services does your practice currently provide that are based at the hospital?

A: Ninety-five percent probably.

Q: And what effect would it have on Piedmont if your practice became employed by Carolinas and your work over time moved away?

A: Well, if we moved today, they would have to

close the Women's Tower. And they would lose the neonatal service and I don't know what they would do. I mean, they would have to recruit new physicians but that doesn't happen very quickly.

Q: And given the uncertainty of your future, why have you chosen to make yourself available here today and to provide the testimony you have?

A: I just think the State -- we have been at this for a long time. And for physicians we are all frustrated. And I know both sides are very frustrated. This has been way too long. The dynamics have changed so much over this time frame. This is not the same as it was in 2005 and in five years it will not be the same as it is now. As a resident of York County that is not going to practice -- I do not want to practice necessarily in Charlotte, this happens at every border of every state in every state in the country. We have to decide going forward as it gets more complicated, how do we take care of our people in our counties. And what we're seeing now is we lose payors. We're getting more from even Chester and Lancaster. We've got a payor mix issue. If we lose

services, we have a service issue and this could all be decided by a court that sets this chain in motion. And I think it's a huge decision. And it's going to be -- I'm worried because we've flipped-flopped by and forth and it's been issue as a physician. I shake my head and think, wow, this is terrible. But it's a big decision, it's a huge decision. And it'll affect me and it'll affect a lot of physicians. But the thing that I worry about is how it's going to affect the Medicaid patients and the uninsured patient in York, Chester, Lancaster and the eastern part of York County. It will be a huge impact. They will have to come to Columbia to get a lot of their care; that's a travesty.

Q: Thank you for being here, Dr. Taylor. Please answer any questions that Mr. Gaskins may have.

MR. GASKINS: Your Honor, can we take a short break?

THE COURT: That'll be fine. Ten minutes.

(Off the Record)

THE COURT: All right, we're back on the record.

DR. TAYLOR - CROSS EXAMINATION BY MR. GASKINS:

Q: Good morning, Dr. Taylor.

A: Morning.

Q: Dr. Taylor, I believe you testified earlier that you formerly served as the department chair for the OB/GYN Department at Piedmont, is that correct?
A: Yes.
Q: And you also formerly served as chief of staff?
A: Correct.
Q: And you worked your way up the ladder and served as treasurer in another leadership role?
A: Worked my way up the ladder, correct.
Q: And you're currently on the Credentials Committee?
A: I'm the chairman of the Credentials Committee.
Q: You're chairman of the Credentials Committee. And you're partners with Joe Robinson, is that correct?
A: Correct.
Q: And he was formerly chief of staff at Piedmont?
A: Correct.
Q: And was he also on the Board of Governors?
A: He was.
Q: So you've got a long affiliation with Piedmont Medical Center?
A: Correct.
Q: Now, Dr. Taylor, you were asked about what

access to two hospitals and that would be a good thing. I think, again, you know where I'll go with this. But the ultimate impact for the county and the accessibility of upper level healthcare services in York County would change, would, again, deteriorate, whatever you want to use term-wise.

Q: That's all I have at this time.

THE COURT: Thank you, Mr. Gaskins.

MS. BIGGERS: I don't have any questions, Your Honor.

THE COURT: All right. Thank you. Mr. Andrews?

MR. ANDREWS: Your Honor, just to anticipate potential objection, since there was quite a bit of examination about the degree to which Dr. Taylor may have qualified his opinions. There are several things that I would like to draw out from his deposition, if I may concerning his opinions that he expressed there.

THE COURT: All right.

DR. TAYLOR - RE-DIRECT EXAMINATION BY MR. ANDREWS:

Q: In that regard, Dr. Taylor, do you have your deposition transcript in front of you?

A: Yes.

Q: Let me draw your attention first to page 11, in response to a question that Mr. Muller asked you concerning the Carolinas having a hospital in York County and draw your attention to page 11, line four. Read lines four through ten, if you would.

A: Well, in the borderline areas, which means cities right against the state line where you have states that are up against each other, as far as big cities above or below a state line, I think if you lose a population that can potentially infuse healthcare dollars in a state, then that's going to really have an adverse impact on hiring of nurses and infrastructure and ---

Q: And with regard to that, did you express any doubt or uncertainty concerning the likelihood of that adverse impact?

A: Well, again, payors pay better than Medicaid and non-payors. Those healthcare dollars are used to employ physicians, they buy equipment, nursing care. And when you lose them over a state line, you never get them back, so those are dollars lost that the state desperately needs. In this case, I think, to take care of

indigents and more people that are obviously going to be placed on Medicaid going forward.

Q: All right. Page 14, turn to that if you would, lines five through eight and read your statement there in response to the question?

A: So you're going to bleed out the better paying patients and the state's going to be stuck with the lessor paying patients and I think that's detrimental.

Q: Okay. And now turn to page 17, if you would, lines six through 11?

A: I mean, it's just going to have major, major impacts. And every state, that is, that has a border with another town, I think they've got to figure out what's going to work the best for them to be able to capture as many of the healthcare dollars as you can.

Q: Now, you've been focused in your testimony today as you were here in your deposition, on the effect of the lost healthcare dollars to York County to medical practices who are independent and to Piedmont. Why has that been the focus of your attention?

A: Well, again, you know, I feel strongly -- I've done this a long time. I've done this for 30

years. And we've certainly seen the direction that medicine is taking. And as a resident of York County and a resident of Rock Hill, South Carolina, I certainly want the best for the county and for the people of the county in terms of access to care. But also high level care and being able to capture the dollars, so that we may provide that within our county and in our state. And I think that it's, again, we've had such a change over these years that we've been trying to figure out who gets this hospital. And now, I think it's become clear what needs to happen.

Q: What's the relationship -- just so we can be clear about this, is this about dollars or this about quality of care?

A: Well, I think there's two levels. I mean, I'll admit, I'm selfish. I'm the president of Rock Hill GYN/OB. I run a business. I've got to figure out what, can we continue to have the practice as we have it now. It may not, so I've got to decide that. And this is kind of the decision that medicine has in general. So on one level I'm very selfish and that's part of the reason I'm here is, we've seen this

erosion over the border and it's a big healthcare system. They've got lots of people and we're not part of that ship. On another level, we come from being very committed in our community to take care of people that cannot afford normal medical care. Because we live there, it's been sort of our mantra, and it's now coming at quite a price for us. On a second level, I'm not going to do anything in Fort Mill to think that we're going to put something up there that's going to further deteriorate that. It certainly will hasten our demise. And we'll be okay, we will figure it out. I mean, I'm not doom and gloom. We'll do what we need to do to be viable. But in terms of what's good for the people of the county, it's important to me. I've children there, my wife's delivered and my daughter's delivered, so it's very important to me what this state decides. And it's a state decision, what they decide.

Q: All right. Now, Mr. Gaskins asked you about the payor mix and comparing that, based on Exhibit 27, with what you saw from Piedmont. That is Piedmont OB/GYN, not Piedmont Hospital.

What is your total practices, excuse me, let me finish so the record will be clear. What's your total Medicaid percentage of revenue currently?

A: Our last -- it's about 30 percent to this point. His point is that it's a 50/50 GYN to OB and your point is well-taken. That number doesn't necessarily reflect, you've got GYN patients, we don't have to see a lot of Medicaid GYN, because they have resources with primary care physicians that do pap smears. You know, we're really totally dependent on OB, we're the only game that's in town, any OB group. So you really get diluted with Medicaid. There's not that need to have a physician to see you for a GYN problem. And hence to his point, your total practice won't reflect that number. Your OB will, because you're the only game in town for OB services.

Q: All right.

A: So the total would be for us at this time is 30, 31 percent.

Q: And that compared, do you remember the total percentage?

A: Well, it was probably about ten points less and I would not ---

Q: We'll bring it up just so the record's clear. Exhibit 27, the line for Piedmont OB/GYN for Medicaid, just identify it if you would? Take a look at that, Dr. Taylor, and tell me what it says?

A: 11.3.

Q: And so it's about a third of your practice, is that correct?

A: Correct.

Q: All right. Now, with regard to the questions into your letters with regard to competition. Since you wrote the letter that's been identified in 2005 concerning competition, what lessons have you learned about whether competition exists and has existed in York County?

A: Well, this is where it's changed. The government and what you've seen in healthcare, good, bad, or indifferent has been the move towards hospitals that buy physicians and create these large organizations. Now initially, when we did it years ago there was an organization called a PHO, that stands for physician hospital organization. And it was a means by which physicians and hospitals would

get together to try to get better insurance rates from the insurance companies. And they worked for a while, but because of that tension that I talked about, they usually fell apart, because either somebody was scared they were getting less or more. And so initially, the fault with these big organizations was, you know, we're going to buy the physicians and we'll have leverage with insureds because we represent the whole game in town. Blue Cross Blue Shield is a huge organization in our state. And we know big organizations can mandate better rates. I know CMC had a thing with what, Aetna, I think, or Cigna, one of them. They had a situation where they dropped them for a while, for about six months in order to get higher rates. So initially, the whole theory behind bigger organizations was, you know, we're able to negotiate more powerfully with healthcare, with insurers I mean, excuse me. But now, what's happened is the government sort of wants these big monolithic organizations so they can write one check and say we'll pay you this and we don't have to worry about the details. And so that's the

trend. Now, the problem with that, again, involves, you know, how do you do this over a state line. I mean, that's where I feel like states, why North Carolina and Georgia and it's going to be happening in South Carolina probably soon, will not let Medicaid go across the state line. Why do they do that, they need those dollars. It makes no sense to send state payor money over the border, you lose that. That's why I'm saying since 2005, the whole picture has changed in healthcare so much. And I don't pretend to know where it's going but we're trying to figure it out as a private practice.

Q: Well, let me ask you whether competition exists in York County?

A: Yes, it does exist. I mean, it exists for us, because there are other OB groups and it's a good thing. I like competition, it makes me better. The problem with big groups is sometimes you don't have competition. So the big monolithic things and that's where, you know, we talked about nurses and this tension between private practice and nurses. You know, a big group tomorrow could say, you know, we're

cutting a nurse. And if I'm an employee of the big group, I may say, I don't like it. They're going to say tough, we own you. And that's not necessarily a good thing. So it has changed and I don't know the direction, but I know we've got to be so careful when we're so close to the border what it can do to our people.

Q: What effect do you believe of the approval of Carolinas Fort Mill would have on competition in York County? Would it increase it? Would it decrease it?

A: Well, you know, I mean, you know, we're saying they own a lot of groups. They have a lot of specialists in their organization, so it would definitely for them in going forward, you would think there would be less competition as more people have to get under umbrellas. In other words, is we say we've got to get in with them or somebody because I can't compete. Well, so I'm in with them, so I'm not competing with them anymore. And that happens everywhere, it's not unique to CMC but it's just the nature of what's going on right now in healthcare.

Q: Thank you. I have no further questions, Your Honor.

MS. BIGGERS: Nothing, Your Honor.

THE COURT: All right. Thank you.

MR. ANDREWS: Nothing further, Your Honor.

THE COURT: All right. Nothing further. Dr. Taylor, sir, you may be excused.

MR. WESTBROOK: The next witness would be mine. The next witness we're going to call is Mr. Walsh, he's here. I would ask that maybe we consider a lunch break now, though.

THE COURT: That would acceptable.

(Off the Record)

THE COURT: Please be seated. All right. Back on the record. Mr. Westbrook, you have the next witness, is that right?

MR. WESTBROOK: I do, Your Honor, thank you. Piedmont would call for our next witness, Rob Walsh.

THE COURT: All right.

ROBERT WALSH, being duly sworn, testifies as follows:

MR. WALSH - DIRECT EXAMINATION BY MR. WESTBROOK:

Q: Mr. Walsh, would you state your full name for the record, please?

A: Robert Luke Walsh.

Q: And what do you do for a living Mr. Walsh?

A: I'm a transportation engineer.

Q: What is a transportation engineer?
A: A transportation engineer is an individual who's been educated and trained and works in and around the highway environment, highway systems to evaluate research and design improvements in the transportation system.
Q: Okay. Where do you live, Mr. Walsh?
A: I live in Rock Hill.
Q: All right. And let's take a look at Piedmont's Exhibit 7, I believe this has already been admitted. Mr. Walsh, can you identify this as your current resume?
A: It is.
Q: Would you use that as reference if you need it, but if you don't that's fine. Just tell us about your educational background, please?
A: Yes, I attended the West Virginia Institute of Technology, received a bachelor of science degree in civil engineering in 1986.
Q: All right. How about your professional background, can you run through that?
A: I'm a registered professional engineer in the state of South Carolina and in North Carolina.
Q: All right. Now, you said, you used the term registered and I see it on your resume there.

It uses the term registration. Are you also licensed? Is there a difference licensing and registration of engineers?

A: Really, no difference. I'm licensed and registered in the state. It's basically the same thing.

Q: Okay. Now, when did you get first licensed or registered?

A: Well, the registration process begins upon graduation if you have a bachelor of science degree, bachelor of science in civil engineering is required as a minimum. There is a internship exam that you can take in your senior year of college or shortly thereafter to begin your internship upon successful passing of that exam. There's a four-year internship, where upon you have to work under the direction of a registered engineer. Upon successful completion of those four years, you're eligible to take the professional engineer's exam, which I took in 1990; I successfully passed that exam in 1990 to gain my registration at that point.

Q: Was that in South Carolina?

A: In South Carolina.

Q: Okay. Have you maintained your license in

South Carolina ever since?
A: Yes.
Q: What the licensing organization, what's the entity that actually issues the licensing?
A: It's the South Carolina Board of Engineers.
Q: All right. And did you say you were also licensed in, was it West Virginia?
A: North Carolina.
Q: North Carolina, I'm sorry. And so would there be a North Carolina board similar to the South Carolina board?
A: Yes. There's a separate board. Most states don't have a reexamination process, it's reciprocity. You can apply to the State of North Carolina and obtain licensure with a short ethics exam.
Q: Now, is there any kind of national organization that oversees any of this?
A: There's a National Society of Professional Engineers, that is the national organization.
Q: Now, you told us what you had to do to get your license. What do you have to do to maintain it?
A: As a registered engineer, South Carolina requires 12 hours per year of continuing

education.
Q: And have you maintained that throughout since 1990?
A: Yes, I have.
Q: You a member of any professional associations?
A: I'm a member of the Institute of Traffic Engineers and have been a member since around 1990.
Q: All right. Now, what company in Rock Hill do you work with?
A: I work with Campco Engineering in Rock Hill.
Q: All right. Can you spell Campco for us?
A: C-A-M-P-C-O.
Q: Campco. Now, so Campco is located in Rock Hill, is that correct?
A: Yes, it is.
Q: What's your position with Campco?
A: I'm the vice president.
Q: And do you also have an ownership interest?
A: I do. I own 50 percent of the company.
Q: Now, how long has Campco been around?
A: Campco was established in Rock Hill in 1973 by a fellow name by Len Campol. And Len retired about ten years ago.
Q: All right. How long have you been with Campco?

A: I've been with the firm since 1988.
Q: What kind of work, just describe the kind of work that Campco does?
A: Campco Engineering, about 70 percent of our work is transportation and traffic engineering.
Q: And what's the other 30 percent?
A: We do some utility design work, municipal-type work for city and county. We also do a small amount of development work, land development-type work, schools, warehouses, and so forth.
Q: All right. Now, geographically where is Campco's work focused?
A: Primarily in the York County area. Most of our work is pretty local. We do some work for South Carolina Department of Transportation that takes us into various parts of the state. Historically, we've had work in North Carolina also, which requires a North Carolina registration.
Q: Mr. Walsh, has your work, personally, focused on any particular kinds of projects?
A: Yes, my work, personally, has been heavily involved in traffic and transportation work.
Q: All right. Can you describe what some of the major projects you've worked on over the last

several years?

A: Sure. Most recently, our most recent contract with South Carolina DOT has been some intersection safety improvement projects. We studied, developed, recommended improvements to the DOT and designed intersection improvements, three of those. There were four intersections over the past two years that we've worked on. Three were redesigned as roundabout intersections for safety improvements. One was an intersection widening and signalization project.

Q: All right. You mentioned you've done some work with the South Carolina Department of Transportation. When you have worked with the Department of Transportation or I'm going to refer to it as DOT, if that's okay with you?

A: That's fine.

Q: When you've worked with the DOT in the past, what's been the nature of that relationship? Has it been contractual or some other kind of relationship?

A: Yes, we're a consulting engineering firm, so we compete for contract work with the DOT to provide engineering services for studies and

design work around the state.

Q: All right. Do you submit bids, is that what you mean?

A: We don't submit a bid, a dollar-amount bid. The process is a qualification-based selection process where we supply a set of resumes of our staff as well as resumes of the firm, previous experience in similar projects and that sort of thing, which the DOT takes the firm that is most qualified for the particular project and matches the consultant with the project as far as the most qualified firm. Upon selection, then there's a negotiation process to scope the work and develop budgets and engineering cost estimates to conduct the work.

Q: Now, how many over the years, how many contracts have you had with the Department of Transportation?

A: I don't have that number in my head, but I can say that we have, since my employ, I think we've always had an open contract with the state. We've probably had a successful contract start up with the DOT every, within every two-year period or so.

Q: Okay. All right. Good. At this point, Your

Honor, I move to have Mr. Walsh qualified as an expert in the field of transportation engineering.

THE COURT: Any objection?

MR. GASKINS: No.

THE COURT: All right. Mr. Walsh is qualified and I recognize him an expert in the field of traffic engineering and transportation.

MR. WESTBROOK: Actually, I just said transportation engineering.

THE COURT: Transportation engineering. Here we go, transportation engineering.

Q: And that actually leads me to my next question. Mr. Walsh, can you explain what the difference, if there is any, between transportation engineering and traffic engineering?

A: Well, transportation engineering is a little more generalized term. Traffic engineering is specifically revolving around traffic analysis, traffic impact studies and so forth. Where transportation engineering is more design work. It's a little more -- transportation engineering actually would include trains, automobiles, airports. There's some firms that do airport designs. We strictly work within

the highway environment.
Q: Would traffic engineering be a subcategory, a subset of transportation engineering?
A: It would.
Q: Okay. Thank you. Now, Mr. Walsh, you conducted some drive time studies or travel time studies related to this case, is that right?
A: That's correct.
Q: All right. Why don't we take a look at Demonstrative 42. And Mr. Walsh, is this a chart or a little map that you've prepared?
A: It is.
Q: Does it help explain, would it help explain some of your testimony?
A: It certainly will.
Q: All right. It looks that's York County and we've now focused on a part of York County. Tell us the significance of those three zip codes up there? The significance of those zip codes with respect what you did related to travel time studies?
A: These zip codes are areas which we were asked to concentrate on within York County and the Rock Hill area. You see down here on the lower

right, the bottom line is the York County line, this is 29704, the solid line represents the county line. The dashed line above such shows the boundary of 29074 and 29730, which is the next one up, 29730 is actually bisected by I-77 here. So both sides, left and right, encompass all of 29730.

Q: All right.

A: And 29732 surrounds the existing Piedmont Medical Center Hospital.

Q: Okay. The first one that you talked about, 29704 down south, does that zip code end at the York County line?

A: No, it doesn't; 29704 extends into Chester County, but our emphasis, our study limits were within York County.

Q: Okay. All right. They're two other landmarks it looks like on that map, PMC, and FFMC, what are those?

A: PMC is the existing hospital site located here.

Q: Piedmont Medical Center?

A: Piedmont Medical Center. And the FFMC is the proposed Fort Mill Medical Center site.

Q: All right. Now, that we've gotten those zip codes out of the way, let's take a look at

Exhibit 111, and I believe this has been admitted into evidence without objection. Mr. Walsh, did you prepare this?

A: Yes.

Q: All right. And does this reflect the results of your findings related to the travel time studies?

A: It does.

Q: Now, on the right, my right, my right on the screen there's a time, what is that?

A: Over here in the border, it shows seven to nine a.m. Travel time studies involved three different time periods of the day to evaluate how traffic changes during the day. We do travel time studies in the morning between the hours of seven and nine a.m. and midday, off-peak periods, off travel peak periods. And the midday period of eleven to one. And in the evenings during the period evening peaks, four to six p.m.

Q: Okay. And I believe Exhibit 111 includes all three of those times, does it not?

A: It does.

Q: All right. Were there any material differences in your conclusions between those three sets of

times?
A: No significant differences.
Q: All right. Then we're going to focus just for the sake of efficiency on one of those. And we'll just use the early morning, if that's okay with you?
A: Sure.
Q: All right. Now, with respect to the travel time studies, first of all, why don't you tell us, give us an overview. What was your purpose in doing these? What were you trying to find out?
A: Well, the question we were trying to answer was that in the geographic areas between the three zip codes that we previously identified, what areas were closer to one hospital than the other.
Q: All right. When you say closer, do you mean as the crow flies, or what?
A: Not by distance, by travel time in an automobile.
Q: All right. Were there any other zip codes other than those three zip codes that you were looking at?
A: No.

Q: All right. What's the significance, first of all, why don't you show us on the map, because there's a lot of lines up there, where I-77 is?
A: Okay.
Q: Can you do that with your finger?
A: I'll try to trace I-77.
Q: All right. Good. I think we got that. All right. And all those other little lines in the colored parts and in the white parts, are those roads or what?
A: They are other roadways in the transportation system and streams as well.
Q: Okay. Now, what's the significance of I-77 with respect to how you went about doing this travel time study?
A: Well, I-77 and natural geography of the area were essential in developing the methodologies that we used. If we look at this area, you can see I-77. But the other issue here is in evaluating travel times between the two hospital sites we have a natural geographic barrier in here. You see up here, I'm going to trace this area. This is Lake Wylie coming through and the Catawba River that's down, it's just before you get to I-77. The Catawba River

comes down here and then runs along the county line.

Q: Okay. And where you made that mark about the Catawba River, is the Catawba River actually the northern boundary of 29730?

A: And 29732.

Q: Okay. Both of them are. Go ahead, I interrupted.

A: Okay. So with this natural barrier, it's a limited number of ways that you can get across that bridge that's across the river. You can go by 77, which we've already shown at this point. Directly parallel to it, and probably covered up by the finger point I've already made, is US 21. If we head to the west we have Lake Wylie. There's no other way to get across the waterway until we get all the way up here. At Lake Wylie, SC 49 comes across at the state line there, and actually runs into North Carolina before you can get back to South Carolina. Heading in the other direction, SC 5, down here is the next bridge crossing to cross that natural barrier. So from a travel time perspective, inside any of these zip codes to get from Piedmont Medical Center to the

proposed Fort Mill Medical Center site, these two other crossings are way out of the way. There's no way that you could get there quicker than by using 77 or 21. So we've narrowed it down to two bottleneck points, those two bridges.

Q: Let me interrupt just a second. I mean, you've mentioned no way to get from Piedmont Medical Center to Fort Mill Medical Center other than those two ways. But was the purpose of your study, I think you've already explained it one time, just remind me the purpose was to find out the quickest way to do what?

A: The quickest way to get -- if you're located in any of this area that is shown by the different colors, the question was if you're located anywhere, let's just pick a point down here. From that point, the question we're trying to answer is what would be the closest hospital to get to. What would be the easiest or the fastest site to get to?

Q: Okay. All right. Go ahead, you were talking about -- you looked like you had two options there.

A: So yeah, what I'm talking about is kind of

developing the methodologies or how we figured that out. Okay. So we have these two crossings and the way that we identify it, again, looking at US 21 and making some trips there. US 21 is a lower speed limit facility and has traffic signals on it. And just by making a few dry runs, it was easy to determine that Interstate 77 at 60 miles an hour is a much faster route to head north and south than US 21.

Q: All right.

A: So we've narrowed down now that the way to get between these two sites, again Piedmont Medical Center and a proposed Fort Mill site, the quickest way to get there is by using I-77.

Q: Okay. And again, with respect to any of the colored areas, not just from Piedmont to Fort Mill Medical Center, but from any of the colored areas on that map, is your point that the quickest way to get to Fort Mill Medical Center would be I-77?

A: That's correct.

Q: All right. Go ahead, I'm sorry.

A: So every traveler going between those two sites, and I think it'll become a little

clearer in a few minutes as to why we're talking about the travel distance between the two sites relative to the rest of the geographic areas.

Q: Okay.

A: There's correlation there. By finding that I-77 is the route that everyone would use between the two sites helps us get to the answer that we're looking for.

Q: Okay.

A: Okay. Now, when we find that we know that by reviewing transportation maps and knowing the area that there's a limited number of ways to get to I-77. There's south of the river there or six interchanges between south Rock Hill and the Catawba River.

Q: Okay.

A: Okay. So what we did is we identified the six different routes of travel between the two sites. And ran our travel time studies between the two sites, utilizing the six interchanges on I-77. Okay. And finding the easiest route to get to each interchange, traveling up 77 to the SC 160 exit and following SC 160 to the Fort Mill Medical

Center site.
Q: Okay. All right. I noticed some circles, what do those circles represent?
A: The circles are the next important issue. You see these six circles, each one of these circles identifies the midpoint along a route between the two hospital sites. The travel time studies that we ran to each interchange, once we recorded the data, brought it in-house and evaluated it, we used those travel times and data to identify the midpoint on each route between the two sites.
Q: Midpoint in time?
A: Midpoint in travel time in an automobile.
Q: Right.
A: So if you look at a particular circle, for instance, this circle right here or any of the circles, that identifies the midpoint on the route. If you're anywhere to the right of that circle, that places you closer to the Fort Mill Medical Center site and further away from the existing Piedmont Medical Center. So if you're right of that circle, to the right if as you're looking at the map ---
Q: When you say to the right, you mean to the

east?

A: To the east. To the east on the map or to the right as you look at the map, to the east. That will place you a shorter trip to the Fort Mill Medical Center site. And a longer vehicle trip to Piedmont Medical Center.

Q: All right.

A: One of the significant things we found in this is, if you look at all these circles, they're all to the left or west of Interstate 77. So anybody that's located east or right of the circles is in a geographic area that's closer to the Fort Mill Medical Center site than it is to the Piedmont Medical Center site.

Q: All right.

A: So any place in these zip codes east of the interstate, they're going to get to Interstate 77 before they get to the midpoint of that travel time, which means they're closer to the Fort Mill Medical Center site.

Q: What's the relationship of the six circles that you said were the midpoints, right?

A: That's right.

Q: What's the relationship of those six midpoints to the interchanges on I-77?

A: As I said, they're all west of the interchange points.
Q: But is there a correlation, would there be six different routes between travel?
A: Yes. We use six different routes. One using each one of the six interchanges south of the Catawba River.
Q: How many trips did you make all together?
A: We made two trips per route, per time frame. So we had three time frames, the morning, the midday, and the evening. Two trips per route and we had six routes, so that's 12 trips per time frame, by three times, so that's 36 total trips.
Q: All right. And who made these trips?
A: Employees of my firm.
Q: All right. And how did you measure or record the times?
A: The travel time work is conducted by placing a GPS technology unit inside the vehicle. And the driver follows the route from one hospital to the next. The GPS device will record the time and the position of the vehicle every 15 to 30 seconds. So we get a data file when it's done of the vehicle's position every 15 to 30

seconds during that 20 to 30 minute trip.
Q: All right.
A: So that data is then brought into the office and downloaded, entered into spread sheets and then the evaluation work is done from there to identify that midpoint.
Q: Now, Mr. Walsh, you've prepared a Demonstrative that is based on this Exhibit, is that right?
A: Correct.
Q: Are we ready to move to that Demonstrative now?
A: Yes, I believe so.
Q: Okay. Dan, let's go over to Demonstrative 38, please? Mr. Walsh, did you prepare this?
A: Yes.
Q: All right. And what's the relationship between this and the more detailed map?
A: It's basically the same map, but a lot of the smaller roadways and the streams have been eliminated to give you a clearer image of the results of the study.
Q: All right. And are the zip codes the same zip codes that we talked about before?
A: Yes, they are.
Q: Are they identified on there?
A: Yes.

Q: All right. And let's see we have the interstate on there, correct?
A: That's correct. See the interstate again here.
Q: All right. And the circles that represent the midpoints are they in the same places they were on the other map?
A: The same circles that you saw on the other map.
COURT REPORTER: Please let's try not to talk over each other.
Q: So, I'm sorry. Would you repeat your answer to that Mr. Walsh?
A: Yes, these are the same circles that were shown on the other map.
Q: All right. Now, tell me what the colors represent. And before you do, are these the same three colors, or supposed to be the same three colors that were in Exhibit 111?
A: Yes.
Q: All right. What does the pink represent?
A: Okay. This pink area shown here shows the geographic areas that represent a trip to the proposed Fort Mill Medical Center site would be a shorter trip than a trip from anywhere in this area, again, to the existing Piedmont Medical Center.

Q: All right. And what about the middle color which I'm going to call orange. I'm not sure if that's exactly orange, but ...

A: The orange area that starts at the circles and heads west or to the left is the area where the difference in travel time between the two hospitals sites is somewhere between no difference, represented by the circles and then the left boundary at the blue line. The boundary between orange and blue will be a ten minute longer trip to the Fort Mill Medical Center site or ten minute shorter trip to the Piedmont Medical Center site. In other words, if you started anywhere on this boundary between orange and blue and two vehicles started at the same time, one drove to Piedmont Medical Center and the other drove to the proposed Fort Mill Medical Center site, the vehicle going to Piedmont Medical Center would get there ten minutes before the other vehicle got to the Fort Mill Medical Center site.

Q: All right. And finally, what's the blue represent?

A: The blue represents a similar area only it's the time difference. It would be anywhere

between ten minutes and 20 minutes longer trip to the Fort Mill Medical Center site.

Q: Okay. All right. Anything else you need to add that we haven't covered about this travel time study, about what you did or your conclusions?

A: I think that summarizes our study.

Q: All right. And with respect to your opinion, do the drive times that you just described, does that summarize your opinion with effective travel times between the two sites of these zip codes?

A: Yes. What is shows is that there's a significant amount of -- you can see most of this pink area is inside the zip code of 29732.

Q: Excuse me, 29732?

A: 29730. I'm sorry.

Q: Okay.

A: 29730. So there's a large area, a pink area, where this area in 29730 if your sole decision on which hospital you were going to go to was based on travel time, you would go to the new Fort Mill Medical Center site because of the fact that it's a shorter trip there. The entire area of 29704 within York County would

also use, have a shorter trip length to Fort Mill Medical Center.

Q: And can you take off the purple lines for a minute. Okay. Good. Go ahead.

A: Okay. And there's a small area up here in 29732 that also has a shorter trip length to the proposed Fort Mill Medical Center site.

Q: Okay. Thank you. Now, while we're talking about the Fort Mill Medical Center site, where is the Fort Mill Medical Center site located, not just on that map, but what are the highways?

A: It's located at the intersection of SC Highway 160, that is shown on this map and US Highway 21, which is not shown on this map.

Q: All right. Let's go to a Demonstrative that does show that. Demonstrative 40, Dan. All right. Is this a Demonstrative that you prepared?

A: It is.

Q: Okay. And you mentioned a moment ago and this Demonstrative refers to South Carolina Highway 160. And does that go roughly east-west?

A: Yes. This is a simplified sketch, showing, this is SC 160, as you can see by the label up

on the right. And this is US 21, heading roughly north-south with the Fort Mill Medical Center site generally located over here in this, what I would call the northwest quadrant of the intersection.

Q: All right. Now, have you personally been to this site?

A: I have.

Q: And in your life, how many times have you been there?

A: I couldn't say how many. I've been in Rock Hill since 1988. I used to ride my bicycle up there and buy peaches at the peach stand and sit by the road and eat them up before I went back home. Over the years, I've, you know, it's pretty close by to where I live, so I've traveled this area quite often.

Q: All right. Now, aside from that, since you were retained to work on this case, how many times have you specifically been to this site for purposes related to your testimony today?

A: For the purposes of this evaluation, I personally visited this site a half a dozen times. A couple of times in the morning, twice during the midday, and twice during the

evenings to get a good feel for how the traffic moves in this area. And each one of those visits was 30 minutes minimum.

Q: All right. Let's talk about these two highways. Can you just describe for us, how would you characterize US 21?

A: US 21 is two-lane highway. It's one travel lane in each direction, double yellow line in the middle.

Q: Does it run roughly north-south?

A: It runs roughly north-south, yes.

Q: Okay. And State 160, South Carolina 160, how would you characterize that?

A: It's what we would call a multi-lane facility, two lanes in each direction for traffic moving. There's a grass median separating the opposing directions of traffic. That grass area opens up at intersections to provide left-turn lanes for safe moving of left-turning traffic.

Q: Okay. So is it a four-lane highway?

A: It's four-lane highway.

Q: All right. Now, in describing these two highways and your findings and conclusions related to this issue, would it help you if we took a visit on the Google Earth?

A: Yes, it would.
Q: All right. Dan, let's go to Google Earth, please? Let's start with an aerial view of this site. And Dan, if you could focus in on it a little bit. And why don't you orient us, Mr. Walsh?
A: Okay. This again, is an aerial photograph showing South Carolina Highway 160.
Q: That's the four-lane, right?
A: That's the four-lane.
Q: Okay.
A: And then this road is US 21 heading, again, approximately north-south.
Q: All right. Let's start, why don't you take your, you know, there you go. Before we go any further, just show us again, now, where is the proposed hospital site roughly?
A: The hospital site is in this area here.
Q: Okay. All right. Good. All right. Dan, let's start at the intersection and just head north aways on US 21, just from the aerial photo. And Mr. Walsh, any comments that you would like to make, feel free to. Why don't you take that circle off, because it's going to be misleading, I think.

A: So you can see US 21 is an undeveloped facility, both sides of the road as you head north are completely forested, no intersections, maybe a small driveway that we're just passing there. And it's hard to see what that is, but basically, undeveloped section of highway.

Q: All right. What's the first intersection that you come to?

A: We're coming to it now on the screen, this Coltharp Road.

Q: How do you spell Coltharp, please?

A: C-O-L-T-H-A-R-P.

Q: All right. Is there a traffic signal at that intersection?

A: There is not a traffic signal at that location.

Q: Okay. And about how far if you know, is it from Coltharp Road intersection down to the intersection what it's SC 160?

A: It's a little less than two miles, about 1.7 miles.

Q: All right. Okay. Dan, let's head back south the way we were coming and go back down to the intersection and then take a little trip on South Carolina 160, we're heading, it looks

like, is this northwest that we're going?

A: Right. Northwest.

Q: Okay. Now, you've already pointed out to us roughly where the proposed hospital site is, what's this area to the left across Highway 160 from the hospital site?

A: Well, this big white building is a grocery store with some other typical-type developments within the, you know, grocery store complex. There is a bank over here somewhere, it might be this one. Residential development back in here and some business commercial, business offices over here on Monroe. This side is, as you can see, this side of SC 160 is pretty well developed.

Q: All right. It looks like after the grocery store, what's that street to the left there?

A: This street right here is Peach Lane.

Q: I'm sorry, which street?

A: This one.

Q: Okay. And what's the next one after that?

A: Okay. It's listed on the map. I believe it's Springcrest. All right. And this is Monroe, which is the next signal on 160 west of the US 21 intersection.

Q: All right. Let's head on, continue heading west or northwest on State 160. Why don't you take your purple lines off and what are we coming to now?

A: Okay. Now, we see Interstate 77, the SC 160 exits and interchange with Interstate 77.

Q: All right. Do you know what the distance is, approximately, from the interstate to the proposed hospital site intersection?

A: It's approximately three-quarters of a mile.

Q: All right. Okay. Let's go back down to US 21, Dan. And Mr. Walsh, can we move to the street view, the Google Earth street view and you help us with describing US 21. And what I would like for you to do, Dan, is why don't you start about a quarter mile north from the hospital site and pull down there. I don't think we need to go all the way to Coltharp. And let's turn around and head south, like we're driving towards the intersection with South Carolina 160. As we do that, Mr. Walsh, why don't you describe any points that you consider to be relevant?

A: Okay. As I said before, you can see US 21 is the two-lane highway. There's a double yellow