THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
John D. McLeod, Administrative Law Judge

Case No. 09-ALJ-07-0332-CC

Trident Medical Center, LLC, d/b/a
Berkeley Medical Center, ... Appellant/Respondent,

v.

South Carolina Department of Health and
Environmental Control and Roper St. Francis
Hospital-Berkeley d/b/a Roper St. Francis Hospital,

Of Whom South Carolina Department of Health and
Environmental Control is the ..... Respondent, and

Roper St. Francis is the ..... Respondent/Appellant.

Case No. 09-ALJ-07-0333-CC

Trident Medical Center, LLC, d/b/a
Berkeley Regional Medical Center, ... Appellant/Respondent,

v.

South Carolina Department of Health and
Environmental Control, and Roper St. Francis
Hospital-Berkeley, Inc. d/b/a Roper St. Francis
Hospital-Berkeley,

Of Whom South Carolina Department of Health and
Environmental Control is the ..... Respondent, and

Roper St. Francis is the ..... Respondent/Appellant.

INITIAL BRIEF OF APPELLANT/RESPONDENT

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Case No. 09-ALJ-07-0336-CC

CareAlliance Health Services and Roper St. Francis Hospital-Berkeley, ...Respondents/Appellants,

v.

South Carolina Department of Health and Environmental Control and Trident Medical Center, LLC .....Respondents,

Of whom Trident Medical Center, LLC is the.....Appellant.

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STATEMENT OF THE CASE

On August 13, 2008, the Appellant/Respondent Trident Medical Center, LLC d/b/a Berkeley Medical Center ("Trident") filed a Certificate of Need ("CON") application with the Department of Health and Environmental Control ("Department") pursuant to the *2004-2005 South Carolina Health Plan* (*"2004-2005 Plan"*). In its application, Trident proposed to construct a new 50-bed acute care hospital to be known as "Berkeley Medical Center" in Moncks Corner, Berkeley County, South Carolina ("Moncks Corner Hospital"). (Jt. Ex. 1, pp. 0001-0008).

On December 10, 2008, the Respondent/Appellant Roper St. Francis Hospital-Berkeley, Inc. d/b/a Roper St. Francis Hospital-Berkeley ("Roper") filed a CON application under the *2008-2009 South Carolina Health Plan* (*"2008-2009 Plan"*) requesting approval for the construction of a new 50-bed hospital to be known as "Roper St. Francis Hospital–Berkeley" at Carnes Crossroads in Berkeley County, South Carolina ("Carnes Crossroads Hospital"). (Jt. Ex. 2, pp. 00001-00005). Both of the proposed

hospitals will be located within the Charleston-Berkeley-Dorchester health planning area (the "Tri-county Service Area"). (Tr., p. 639, line 17-p.640, line 6).

The Department conducted a combined project review hearing on the proposed Berkeley County hospitals on May 21, 2009. (Tr., p. 784, line 21 – p. 785, line 2). On June 26, 2009, the Department approved both applications, finding that Trident and Roper were not competing applicants and finding that each application met the standards and criteria of the respective Health Plan under which it was filed. (Jt. Ex. 1, p. 0884-0899; Jt. Ex. 2, p. 1269-1281).

On July 6, 2009, Trident filed requests for final review conferences before the Board of Health and Environmental Control ("Board"), asking the Board to reverse on legal grounds the Department staff's decision to approve Roper's application, or in the alternative, asking the Board to overturn the staff's determination and find that the applications are competing and that Trident is the better applicant. (Trident's Petition, Case No. 09-ALJ-07-333-CC, Exhibits E and F). On July 10, 2009, Roper filed its own request for a final review conference with the Board. In its request, Roper supported the decision of the Department to approve both applications but argued that, if the Board determined that the applications were competing, the Board should reverse the decision to approve Trident's proposed project and declare Roper to be the applicant that most fully met the goals of the CON program. (Trident's Petition, Case No. 09-ALJ-07-333-CC, Ex. H).

In July, 2009, the Board declined to conduct final review conferences on both Trident's and Roper's requests. (Trident's Petition, Case No. 09-ALJ-07-333-CC, Exhibits B, G and I). On August 7, 2009, Trident and Roper filed three separate written requests for contested case review before the Administrative Law Court ("ALC" or

"court"). Trident filed two requests. One sought review and reversal of the Department's decision that Trident's and Roper's applications were not competing under the law. The other sought reversal on legal grounds of the Department's decision to approve Roper's Carnes Crossroads Hospital. (Trident Petitions for Administrative Review, August 7, 2009). Roper filed a request in which it urged affirmation of the Department's decision to approve both applications, but alleged the superiority of its own application in the event the court decided that the applications were competing. (CareAlliance and Roper's Request for Contested Case Hearing, August 7, 2009).

On January 7, 2010, the ALC ordered that the proceedings be consolidated for trial and discovery purposes and that all parties be allowed to intervene as needed to achieve commonality of litigants in the three cases. (January 7, 2010 Order of Consolidation and Intervention). The court conducted a hearing on the consolidated matters beginning January 30, 2012.

Prior to receiving testimony at trial, the court announced its rulings on certain prehearing motions made by the parties. Among its rulings, the court denied Trident's motion for summary judgment, finding that further inquiry into the facts was needed on the issue of whether the Department committed legal error in applying the bed transfer standard of the *2008-2009 Plan* to Roper's application to establish a new hospital. The court also granted Roper's motion for partial summary judgment, holding that, if the court determined that Trident's and Roper's applications were competing, the case would be remanded to the Department as only the Department could choose which was the better applicant. (Tr., p. 7, line 22 – p. 8, line 1; February 10, 2012 Order, pp. 3-4).

At the close of its case, Trident renewed its motion for summary judgment on the issue of inapplicability of the bed transfer standard to Roper's proposed project. The

court again denied the motion in favor of continuing to hear further evidence. (Tr., p. 1817, line 9 - p. 1854, line 15). The hearing on the merits of the consolidated cases concluded on February 16, 2012.

On September 26, 2012, the ALC issued its Final Order and Decision ("Order") affirming the Department's decision to approve both Trident's and Roper's CON applications. (September 26, 2012 Order). In the Order, the court deferred to, and adopted, the Department's interpretation of the bed transfer standard of the *2008-2009 Plan* as allowing Roper to create a new hospital facility through the transfer of beds. The court also found that the need for hospital facilities and services in the area would not be exceeded if both hospitals were approved, and that, therefore, Trident and Roper were not competing applicants. The court held that both applicants met the standards and criteria of the state health plan and CON regulations under which they were filed and that both applications should be approved.

On October 5, 2012, Trident timely filed its Motion to Alter or Amend (Reconsider), which was argued before the court on October 31, 2012, and denied on November 1, 2012. (Motion to Alter or Amend (Reconsider) dated October 5, 2012; November 1, 2012 Order). Trident timely filed its appeal of the decisions of the ALC on November 28, 2012. Roper timely filed its cross-appeal on December 3, 2012.

STATEMENT OF FACTS

Trident entered the Tri-county Service Area in 1972, when its parent company responded to a request from Dorchester and Berkeley Counties to build a new hospital to replace two older, smaller county-owned facilities. Trident Medical Center in North Charleston opened in 1975, and the existing county hospitals closed with the understanding that Trident would assume the mission of providing care to the residents of

Berkeley and Dorchester Counties. (Tr., p. 77, lines 1-9; p. 82, lines 7-15; Jt. Ex. 10, pp. 002, 004, and 0010-0011; Tr., p. 313, line 14 - p. 315, line 8).

With the Department's guidance, Trident Medical Center chose to locate centrally in the Tri-county Service Area, in North Charleston, about one mile from the Berkeley County line and several miles from the Dorchester County line. (Jt. Ex. 10; Pet. Ex. 112; Tr., p. 314, line 10 – p. 315, line 2). Since its initial investment of over $9 million, Trident has invested in excess of $90 million to add services, modernize the facility, and take the acute care bed count up to the current 296 beds. (Tr., p. 80, lines 9-18; p. 86, line 16-p. 87, line 17; and Jt. Ex. 10, p. 004).

In addition to Trident Medical Center, Trident also owns and operates a freestanding emergency department[1] and outpatient center in Moncks Corner in Berkeley County and a 94-bed acute care hospital known as "Summerville Medical Center" in Dorchester County.[2] (Tr., p. 86, line 18-p. 87, line 17; Tr., p. 316, line 22–p. 317, line 1). All of Trident's current facilities operate under a single license issued to Trident. (Tr., p. 320, lines 14-20). In its CON application for the Moncks Corner Hospital, Trident proposes to operate that facility under the current license as well. (Jt. Ex. 1, p. 0016).

Roper is owned jointly by the Medical Society of South Carolina, Bon Secours Health System, based in Baltimore, Maryland, and Carolinas Health System, based in Charlotte, North Carolina. (Tr., p. 2154, line 22–p. 2156, line 3). Roper operates three hospitals, all located in Charleston County: the Roper Hospital, located in downtown

[1] The Department allows a licensed hospital to establish a free-standing emergency department located off its hospital campus provided it meets certain requirements. *See, e.g., 2004-2005 Plan* (Jt. Ex. 3, pp. 0096-0097).

[2] In 2010, Summerville Medical Center filed a CON application to add 30 acute care beds, which was approved by the Department. In a separate proceeding before the ALC, Roper has formally opposed this decision. (Rardin, Tr., p. 87, lines 15-17; Bowling, Tr., p. 2553, line 22–p. 2554, line 12; Jt. Ex. 9).

Charleston ("Roper Downtown"), Roper St. Francis Mt. Pleasant Hospital, and Bon Secours St. Francis Hospital. (Tr., p. 2157, line 12-p. 2158, line 4). Like Trident, Roper operates a freestanding emergency department and outpatient center in Moncks Corner. (Depo. Myers, p. 20, line 18–p. 22, line 22).

On August 13, 2008, Trident filed a CON application under Chapter II, Section G.1(A)(4)(d) of the *2004-2005 State Health Plan* in which it proposed to develop a 50-bed community hospital in Moncks Corner. (Jt. Ex. 1, pp. 0009 and 0884; Jt. Ex. 3, p. 17). Under the *2004-2005 Plan,* the need for additional hospital beds is calculated on a hospital specific basis. The overall bed need for a particular health planning area is derived by totaling the specific bed need for each of the hospitals in the area. (Tr., p. 1054, lines 20-24). Under the *2004-2005 Plan*, a hospital with a positive bed need could add up to 50 beds to its inventory in order to provide for a cost-effective addition. (Jt. Ex. 3, Chapter II, Section G.1(A)(4)(d), *2004-2005 Plan*). Thus, in its CON application, Trident sought to use Trident's facility-specific need for 17 additional beds to establish a 50-bed community hospital in Moncks Corner, Berkeley County, at an estimated project cost of $115 million.[3]

Trident proposed to locate its Moncks Corner Hospital on a 21-acre site adjoining the site of Trident's existing freestanding emergency department and outpatient center. Trident intends to convert the existing facility to a medical office building upon the opening of the new hospital. (Jt. Ex. 1, p. 0008; Tr., p. 139, line 22 – p. 40, line 3). If built in that location, Trident's Moncks Corner Hospital will reduce the drive time to a

[3] The *2004-2005 Plan* showed a 42 bed need for Trident Medical Center and a 20 bed need for Summerville Medical Center. (Jt. Ex. 3, p. 0027). However, because of a prior conversion of nursing home beds to hospital beds, Trident Medical Center actually had a bed need of 17 when its application was filed. (Jt. Ex. 1, p. 009).

hospital to 30 minutes[4] or less for most residents residing above and around Lake Moultrie in Northern Berkeley County. (Pet. Ex. 169, pp. 001-004). Quantified, approximately 30,000 residents of Berkeley County will be brought within 30 minutes drive of a hospital by the establishment of the proposed Moncks Corner Hospital. (Tr., p. 1431, lines 15-23, p. 1435, lines 18-23; Pet. Ex. 46)

On December 10, 2008, and specifically in response to Trident's application, Roper filed a CON application under the *2008-2009 Plan* to transfer 50 licensed hospital beds from Roper Downtown in order to create a new 50-bed community hospital at Carnes Crossroads in Goose Creek. (Jt. Ex. 2, p. 0005 - 0007; Tr., p. 642, line 24 – p. 643, line 8; p. 2652, lines 12-17). Roper proposed to locate the new Carnes Crossroads Hospital on a site just 11.8 miles from Trident's proposed Moncks Corner Hospital, 7.9 miles from Trident Medical Center, and 10.3 miles from Summerville Medical Center. (Jt. Ex. 2, p. 0004; Pet. Ex. 169, p. 004). At the undeveloped Carnes Crossroads site, there is no existing hospital or any other medical facility to receive the transfer of the beds from Roper Downtown. (Tr., p. 695, lines 12-16). Therefore, in order to accomplish the transfer of hospital beds, Roper proposes to construct an entirely new receiving hospital facility and to create all new ancillary services, such as operating rooms, mammography, ultrasound, nuclear medicine, and other imaging equipment and services, emergency department services, laboratory equipment and services, and outpatient functions to support the transferred beds, at a total project cost of approximately $113 million. (Jt. Ex. 2, p. 0009, 0317-0318).

[4] Both the *2004-2005* and the *2008-2009 Plans* contain the statement that "[g]eneral Hospital beds are located within approximately thirty (30) minutes travel time for the majority of residents of the State . . ." (Jt. Ex. 3, p. 0019; Jt. Ex. 4, p. 0019) Although witnesses for the parties disagreed whether the statement regarding 30 minutes travel time should be characterized as a standard, a goal, or a comment on the current state of affairs, the consensus was that a 30 minute time travel measure for hospital services is reasonable for health planning purposes. (Tr., p. 1088, lines 6-23; Tr., p. 1332, lines 10-22; Tr., p. 3302, lines 7- 9). *See, also,* S.C.Code Ann. §44-7-180(B)(Supp. 2012).

Given the proximity of Roper's proposed Carnes Crossroads Hospital to Trident's existing hospitals, virtually all of the population residing in the area to be served by Roper is already within 30 minutes drive time of a hospital. (Tr., p. 90, lines 15-23; p. 1432, line 16–p. 1434, line7; Pet. Ex. 46, p. 009). Quantified, only 940 additional people will be placed within 30 minutes drive of a hospital as a result of the construction of Roper's proposed Carnes Crossroads Hospital. (Tr., p. 1431, lines 15-23, p. 1435, lines 18-23; Pet. Ex. 46).

At the time Roper filed to create a new hospital at Carnes Crossroads, Roper had no need for beds under the *2008-2009 Plan*, and, in fact, had an excess of 23 beds in its system.[5] In total, there was a 48 bed surplus in the Tri-county Service Area when Roper applied.[6] (Jt. Ex. 4, p. 0027). Because of the lack of need for any new hospital beds by Roper or in the Tri-County Service Area as a whole, Roper could not utilize either of the two undisputed methods set forth in the *2008-2009 Plan* that would have allowed Roper to locate hospital beds away from its Roper Downtown campus.[7]

Because of existing Department practice, however, the bed transfer standard provided for in the *2008-2009 Plan* at Chapter II, Section G.1(A)(4)(j) (the "Bed Transfer Standard") was available to Roper as the only mechanism under which Roper could seek to put hospital beds at Carnes Crossroads. (Tr., p. 1069, line 24–p. 1070, line 12). Roper

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[5] Roper had an excess of six beds under the *2008-2009 Plan* at Roper Downtown/Roper St. Francis Mt. Pleasant Hospitals and an excess of 17 beds at its West Ashley Bon Secours St. Francis Hospital. (Tr., p. 642, lines 10-22; p. 644, line 20–p. 645, line 1; Jt. Ex. 4, p. 0027).

[6] Of the seven hospitals in the Tri-County Service Area, only Trident had facility-specific need for beds under the *2008-2009 State Health Plan*, with the plan showing 56 beds needed at Trident Medical Center and 24 beds needed at Summerville Medical Center. (Jt. Ex. 4, pp. 0018-0019).

[7] Under the *2008-2009 Plan*, an individual hospital with a facility-specific bed need can seek approval to add the needed beds at its existing facility or to place them at another site if the hospital already has a physical presence there. (Jt. Ex. 4, p. 0015, § G.1(A)(4)(d)). The *2008-2009 Plan* also allows a provider to use the need for additional hospital beds in the planning area as a whole and to locate those beds anywhere in the area, if approved by the Department. (Jt. Ex. 4, p. 0015, § G.1(A)(4)(e)).

was allowed to use the Bed Transfer Standard in this manner because the Department had an unwritten policy of interpreting the Bed Transfer Standard to allow a hospital to transfer hospital beds even when no receiving facility existed to receive them.[8] (Tr., p. 694, lines 2-7).

Although the Administrative Law Court conceded that the plain language of the Bed Transfer Standard limits its application to cases in which both the transferring and receiving hospitals exist, the court in its Order deferred to the Department's contrary interpretation and approved Roper's application as consistent with the *2008-2009 Plan.* (Order, p. 3). As its first two issues on appeal, Trident contends that this conclusion of the court is affected by error of law and is arbitrary and capricious.

[8] In a written May 8, 2009 Decision on Remand, the Board affirmed the Department staff's use of the bed transfer standard contained in the *2004-2005 State Health Plan* to allow creation of a new satellite hospital in the case before it. (Jt. Ex. 16, pp. 001-0008). The Administrative Law Court affirmed the Board's Decision on Remand in that case. (Tr., p. 703, line 24-p. 704, line 9).

ARGUMENT

I. THE ADMINISTRATIVE LAW COURT ERRED IN DETERMINING THAT THE BED TRANSFER STANDARD OF THE STATE HEALTH PLAN CAN BE USED TO CREATE A NEW HOSPITAL WHEN THE PLAIN LANGUAGE OF THE STANDARD ALLOWS A TRANSFER OF BEDS ONLY BETWEEN HOSPITALS THAT ARE ALREADY IN EXISTENCE.

This case is governed by the Certificate of Need program for health care facilities and services. The framework of the CON program is established by the State Certification of Need and Health Facility Licensure Act (the "Act")(S.C.Code Ann. §§ 44-7-110, *et seq.* (2002 & Supp. 2012)), the regulations set forth at 3 S.C.Code Ann.Regs. 61-15 (Supp. 2012), and the State Health Plan.

The purpose of the CON program is to "promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State." S.C.Code Ann. § 44-7-120 (2002). The primary means by which the goals of the Act are carried out is the requirement that a provider apply for, and receive, a CON from the Department prior to establishing a new health facility, adding beds, making large capital expenditures or acquiring medical equipment when the total project cost exceeds a certain threshold.[9] S.C.Code Ann. §§ 44-7-120 (2002) and 44-7-160 (Supp. 2012).

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[9] David L. Dunlap, the Chief Executive Officer of Roper St. Francis Healthcare, testified that the CON program restricts competition to some degree in order to ensure the financial health of facilities and their ability to provide services to all patients, regardless of profitability. As explained by Mr. Dunlap:

> I think in the absence of ...[CON]..., we see, as was my experience in Oklahoma, the entrepreneurs coming in and stripping out the more profitable services and leaving hospitals, like ours, as the provider of last resort. In effect, hospitals are a collection of a number of departments and entities, some of which lose money and some of which make money. And at the end of the day, we've got to have a margin to be able to allow us to continue to sustain our work. And if you allow people to come in unregulated – entrepreneurs to come in unregulated and pull out those profitable services, it leaves the hospital with those unprofitable services and makes it difficult for us to survive.

(Depo. Dunlap Tr., p. 80, line 4–p. 81, line 13).

In determining whether to grant or deny an application for a CON, the Department must evaluate the proposed project under the project review criteria found in the CON regulations and under the applicable policies and standards of the State Health Plan in effect at the time the application is filed. S.C.Code Ann. § 44-7-210 (Supp. 2012). Project review criteria fit generally into five categories: (1) criteria related to the need for the proposed project, (2) criteria related to the economic considerations of the project, (3) criteria related to the project's impact on the resources of the health care system, (4) criteria related to the suitability of the site of the project, and (5) criteria related to other special considerations. 3 S.C. Code Ann.Regs. 61-15, §§ 801, 802 (Supp. 2012).

The State Health Plan is a health planning guide, developed by the Department and the State Health Planning Committee, and approved by the Board. By law, the State Health Plan must be promulgated at least every two years through a process which requires public notice, public hearings, and a public comment period for both the original plan and for any subsequent amendments. S.C.Code Ann. § 44-7-180(C) (Supp. 2012). The Act further requires that the Plan contain an inventory of existing health care facilities, beds, and services in South Carolina, provide projections of the need for additional facilities, beds, and services, and establish the standards to be followed by the Department and addressed by providers in applying for new or additional facilities, beds, and services. S.C.Code Ann. § 44-7-180(B) (Supp. 2012).

Finally, the CON Act provides that "The department may not issue a Certificate of Need unless an application complies with the State Health Plan, Project Review Criteria, and other regulations." S.C.Code Ann. § 44-7-210(C)(Supp. 2012). The Department's CON regulations also mandate that, "The proposal shall not be approved unless it is in compliance with the State Health Plan." 3 S.C.Code Ann.Regs. 61-15, §

802 (Supp. 2012). *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)("Section 44-7-210(C) and the governing regulations are clear in establishing Plan standards and project review criteria as separate and distinct requirements that must be met as part of the CON application process.").

Roper filed its application for the Carnes Crossroads Hospital under the *2008-2009 Plan*. Therefore, the standards, findings, and policies set forth in the *2008-2009 Plan* are applicable to the review of Roper's application. 3 S.C.Code Ann.Regs. 61-15, § 504 (Supp. 2012).

During the course of the proceedings, Trident raised as a threshold issue that, as a matter of law, Roper's proposed Carnes Crossroads Hospital fails to comply with the *2008-2009 Plan* and, therefore, cannot be approved. Trident contends that the Department's policy of allowing the Bed Transfer Standard to be used for the establishment of a new hospital contradicts the plain language of the Standard, which presupposes the existence of both a transferring and a receiving hospital in order for a bed transfer to occur. Because the plain language of the Bed Transfer Standard indicates that it applies only when both the hospital transferring the beds and the hospital receiving the beds are in existence, Trident argues that Roper's attempt to create a new hospital by transferring beds pursuant to the Bed Transfer Standard does not comply with the *2008-2009 Plan* and must be denied.[10]

The Bed Transfer Standard, which is found in the general hospital bed need methodology of the *2008-2009 Plan*, provides:

[10] The Department acknowledges that the Bed Transfer Standard is the only provision of the *2008-2009 Plan* under which Roper could apply because of the lack of facility-specific or service area need. (Tr., p. 684, lines 9-18; Tr. p. 1068, line 22–p. 1070, line 12).

Changes in the delivery system due to health care reform have resulted in the ***consolidation*** of ***facilities*** and the establishment of provider networks. These consolidations and agreements may lead to situations where ***affiliated hospitals*** may wish to transfer beds ***between themselves*** in order to serve ***their patients*** in a more efficient manner. A proposal to ***transfer or exchange*** hospital beds requires a Certificate of Need and must comply with the following criteria:

1. A transfer or exchange of beds may be approved only if there is no overall increase in the number of beds;

2. Such transfers may cross county lines; however, the ***applicants*** must document with patient origin data the ***historical utilization of the receiving facility*** by residents of the county giving up beds;

3. Should the response to Criterion 2 fail to show a ***historical precedence of residents of the county transferring the beds utilizing the receiving facility***, the ***applicants*** must document why it is in the best interest of these residents to transfer the beds to ***a facility with no historical affinity*** for them;

4. The ***applicants*** must explain the impact of transferring the beds on the health care delivery system of the county from which the beds are to be taken; any negative impacts must be detailed along with the perceived benefits of such an ***agreement***;

5. The ***facility receiving the beds*** must demonstrate the need for the ***additional*** capacity based on ***both historical and projected utilization patterns***;

6. The ***facility giving up the beds*** may not use the loss of these beds as justification for a subsequent request for the approval of additional beds;

7. A written contract or agreement ***between*** the governing ***bodies*** of the affected ***facilities*** approving the transfer or exchange of beds must be included in the Certificate of Need application;

8. Each facility giving up beds must acknowledge in writing that this ***exchange*** is permanent; any further transfers would be subject to this same process.

(Jt. Ex. 4, pp. 0017-0018)(emphasis added).

When read as a whole, as required under the rules of construction, both the preamble, which sets forth the purpose of the Bed Transfer Standard, and the criteria,

which set forth the conditions for the transfer of beds, indicate that the facility receiving the beds must be in existence at the time of transfer. *See, 2008-2009 State Health Plan*, Chapter I(I), p. I-4 ("The criteria and standards set forth in the Plan speak for themselves, and each section of the Plan must be read as a whole."). *See, also, Dreher v. S.C. Dep't of Health & Envtl. Control*, 399 S.C. 259, 265, 730 S.E.2d 922, 925 (Ct.App. 2012)("The true guide to statutory construction is not the phraseology of an isolated section or provision, but the language of the statute as a whole considered in light of its manifest purpose.") (*quoting, Floyd v. Nationwide Mut. Ins. Co.*, 367 S.C. 253, 260 626 S.E.2d 6,10 (2005)).[11]

According to its preamble, the Bed Transfer Standard was promulgated to address and assist providers in their response to health care reforms that resulted in the "***consolidation of facilities***" and "***the establishment of provider networks***" where "***affiliated hospitals***"[12] might wish to exchange or transfer beds "***between themselves***" in order to serve "***their patients***" more efficiently. The plain and ordinary meaning of this language contemplates two existing, related hospitals, each with existing beds and patients, who, because of the changing health care environment, may need to swap

[11] Although the State Health Plan is not itself a statute or a regulation, it is incorporated into the CON Act and regulations, which make compliance with the Plan a regulatory prerequisite to CON approval. S.C.Code Ann. § 44-7-210(B)(Supp. 2012); 3 S.C.Code Ann.Regs. 61-15, § 801(3). Thus, it is appropriate to apply the rules of construction to the Plan. *See, Murphy v. S.C. Dep't of Health & Envtl. Control*, 396 S.C. 633, 639, 723 S.E.2d 191, 195 (2012)("Regulations are interpreted using the same rules of construction as statutes."); *MRI at Belfair, LLC v. S.C. Dep't of Health & Envtl. Control*, 379 S.C. 1, 7 n.4, 664 S.E.2d 471, 474 n.4 (2008)("The issue whether the Plan standards satisfy the statutory requirements is a legal conclusion based on statutory interpretation principles.").

[12] "Affiliated hospitals" is defined in Chapter II(B) of the *2008-2009 Plan* as "two or more health care facilities, whether inpatient or outpatient, owned, leased, sponsored, or who have a formal legal relationship with a central organization and whose relationship has been established for reasons other than for transferring beds, equipment or services." (Emphasis added). Chapter II(B), which provides for the transfer of equipment and services, is the first of two references to "affiliated hospitals in the *Plan*. The second occurs in Chapter II(G), which is at issue in this case and concerns the transfer of beds. By its terms, the single definition of "affiliated hospitals" contemplates both beds and equipment and services and should be applied to both types of transfers. *See, Winters v. Fiddie*, 394 S.C. 629, 642-643, 716 S.E.2d 316, 323 (Ct.App. 2011)(holding that it is "not unreasonable" to resort to the definition of a term found in a different chapter of the same Title of the law).

resources. Hospitals cannot consolidate, they cannot be part of provider networks, they cannot transfer or exchange beds between themselves, and they cannot enter into agreements with one another when one hospital exists and the other does not.

In the mandatory criteria of the Bed Transfer Standard, the concept of two existing hospital facilities continues. The Standard refers to the plural "applicants", "bodies", and "facilities" and contains numerous references to the "facility giving up the beds" as contrasted with "the facility receiving the beds." To work around these plain English references to two facilities, both of which must be in existence, the Department deems a single hospital, *i.e.*, the one transferring the beds, to be both the facility transferring the beds and the facility receiving the beds. (Tr., p. 696, lines 5-8). The Department then contorts the plain requirements of the Standard to allow the single hospital applicant to comply.

For example, the Bed Transfer Standard requires, in subsection 2, that the "***applicants*** must document with patient origin data the ***historical utilization of the receiving facility*** by residents of the county giving up beds" and in subsection 5, that "[t]he ***facility receiving the beds must*** demonstrate the need for the ***additional*** capacity based on both ***historical*** and projected ***utilization patterns.***" Under its policy of using this section for the creation of new hospitals, the Department allows the only actual existing hospital, *i.e.*, the facility transferring the beds, to submit utilization data for itself in satisfaction of the requirement that the facility receiving the beds demonstrate the need for additional capacity. (Tr., p. 699, lines 11-25, p. 705, line 13-p. 706, line 16; Tr., p. 1076, line 22–1077, line 4). This practice clearly contradicts the plain meaning of the Bed Transfer Standard, and the Department admits that it does.

At trial, two Department witnesses testified. Both were questioned about the plain English meaning of the criteria of the Bed Transfer Standard. Beverly Brandt, Chief of the Department's Bureau of Health Facilities and Services Development, testified:

> Q. ...[L]et's try to apply this language as it's written in plain English between Roper Downtown and the greenfield or cow pasture. Okay. We can agree and you testified in your deposition that there's nothing at Carnes Crossroads right now but grass and trees, agreed?
>
> A. Yes.
>
> * * *
>
> Q. Okay. Would you agree with me that there is not affiliated hospitals, plural, in this case of Roper? If you look at J, these consolidations and agreements may lead to situations where affiliated hospitals . . .but there's no affiliation between Roper and an existing hospital at Carnes Crossroads, agreed?
>
> A. There's no bricks and mortar facility at Carnes Crossroads, but our interpretation is that this bed transfer policy is appropriate and the receiving facility is the applicant.
>
> Q. Okay. You can restate that policy every time and I'm fine with that. I'm just asking about the English. And I'm accepting for purposes of your testimony your statement of what your department's position is. But is hospitals a singular or plural noun?
>
> A. In this case it does have an S, so it is plural.
>
> Q. Plural in the English language, is it one or more than one?
>
> A. In the English language, it's more than one.
>
> Q. More than one.
>
> A. But as we apply the bed transfer provision appropriately and according to-
>
> Q. I'm willing to accept that there's DHEC language and there's the English language. My questions are just about the English language.
>
> * * *

Q. Okay. Let's go back, not DHEC language, English language, receiving facility, that contemplates there's something there. Wouldn't you agree with me that facility means there's something there?

A. Yes.

* * *

Q. "The facility receiving the beds must demonstrate the need for the additional capacity based on both historical and projected utilization patterns." Again, we can agree because there's no physical facility existing at Carnes Crossroads, Carnes Crossroads cannot demonstrate historical and projected utilization patterns, correct?

A. Correct, but the applicant can and did.

* * *

A. Roper did in its application.

Q. Correct. But we've agreed in plain English there's no receiving facility, correct?

A. In plain English.

Q. Right. And if in plain English there's no receiving facility, it can't have historical utilization patterns? It's never delivered a baby, it's never taken an ER visit, it's never performed a surgery, correct?

A. Correct.

Q. And I'm only going to get historical utilization as a healthcare facility if I deliver services, perform surgeries, take care of inpatients, so this can't be done by a facility that does not yet exist, in the plain English language, correct?

A. In the plain English language.

(Tr., p. 695, line 9-p. 706, line 16). The only other Department employee to testify, Les Shelton, who is responsible for overseeing development of the State Health Plan, similarly admitted that the Department's policy of interpreting and applying the Bed Transfer Standard to cases with no existing receiving facility in order to establish a new

hospital contradicts the plain English meaning of the words used in the Standard.[13] (Tr., p. 1070, line 31-p.1086, p.20).

In construing the Bed Transfer Standard, the Court is guided first by the plain language of the section. As stated by the South Carolina Supreme Court:

> When the language of a statute is plain, unambiguous, and conveys a clear and definite meaning, the application of standard rules of statutory interpretation is unwarranted. *Paschal v. State Election Comm'n,* 317 S.C. 434, 454, S.E.2d 890 (1995); *Miller v. Doe,* 312 S.C. 444, 441 S.E.2d 319 (1994). The statutory terms, therefore, must be applied according to their literal meaning. *Paschal,* 317 S.C. at 436, 454 S.E.2d at 892; *Holley v. Mount Vernon Mills, Inc.,* 312 S.C. 320, 440 S.E.2d 373 (1994). In such circumstances, this Court simply lacks the authority to look for or impose another meaning and may not resort to subtle or forced construction in an attempt to limit or expand a statute's scope. *Paschal,* 317 S.C. at 437, 454 S.E.2d at 892; *Berkebile v. Outen,* 311 S.C. 50, 426 S.E.2d 760 (1993).

Tilley v. Pacesetter Corp., 355 S.C. 361, 373, 585 S.E.2d 292, 298 (2003), *quoting, State v. Benjamin,* 341 S.C. 160, 163, 533 S.E.2d 606, 607 (Ct.App. 2000).

The plain and ordinary English language of the Bed Transfer Standard clearly and definitely contemplates the involvement of two, existing hospital facilities, each with its own beds and its own patients. The Standard plainly requires that the receiving hospital be able to show historic utilization in order to validate the additional capacity being created by the transfer of beds from its affiliated hospital. In the face of such plain language, neither the ALC nor the Department can justify application of the Bed Transfer

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[13] For example, Mr. Shelton testified:

> A. The Department has used the historical utilization from . . . [the existing] facility to show the utilization for what's proposed to be the receiving facility.
> Q. You would agree with me that there's not currently a hospital facility at the Carnes Crossroads property, correct?
> * * *
> A. No, there isn't an existing hospital at that site.
> Q. Therefore, there is no historical utilization of that site, is there?
> A. You can't have utilization from a facility until it's operational.

(Tr., p. 1076, lines 13-25).

Standard to transfers involving only one existing hospital. In other words, the Bed Transfer Standard, by its plain and ordinary terms, does not allow for the creation of a new hospital through the transfer of beds.

Further, the purpose of the Bed Transfer Standard, which is set forth plainly and unambiguously in the preamble of the Standard, addresses the need for affiliated hospitals to exchange or transfer beds between themselves in response to consolidations and the formation of provider networks brought about by health care reform. This straightforward statement of purpose cannot be construed and contorted to justify the construction of a brand new $113 million hospital that duplicates existing hospital services in the complete absence of need in the *Plan* and that improves timely access to hospital services for only 940 people.[14] This is especially true given the stated goals of the CON program to "promote cost containment" and "prevent unnecessary duplication of health care facilities and services." S.C.Code Ann. § 44-7-120 (2002). *See, Sloan v. S.C. Bd. of Physical Therapy Exam'rs*, 370 S.C. 452, 468, 636 S.E.2d 598, 606 (2006)("A statute as a whole must receive practical, reasonable and fair interpretation consonant with the purpose, design, and policy of lawmakers.").

[14] At trial, Roper argued that access to hospital services would be improved for those Berkeley County residents that utilized Roper Downtown. Trident argued that the improvement in convenience for persons who choose to patronize a distant provider over a closer one does not translate into improving "access" to hospital services under the *Plan*. (Tr., p. 1280, line 8–p. 1281, line 2; p. 1402, line 9-p.1403, line 8). The law requires the Department to establish an objective time travel standard for those services in the Plan. As noted, the Plan in this case indicates 30 minutes as a reasonable goal. (Jt. Ex. 4, p. II-11).

II. THE ADMINISTRATIVE LAW JUDGE ERRED IN DEFERRING TO THE DEPARTMENT'S INTERPRETATION OF THE BED TRANSFER STANDARD BECAUSE SUCH INTERPRETATION CONTRADICTS THE PLAIN LANGUAGE OF THE PLAN.

As noted above in Argument I, the Department concedes that its interpretation of the Bed Transfer Standard is not in accord with the plain meaning of the words of the Standard. Remarkably, the ALC in its Order also recognizes and acknowledges that "[i]t cannot be denied that, on its face, Section II(G)(1)(A)(4)(j) of the 2008-2009 State Health Plan (the bed transfer provision) appears to anticipate the existence of an existing facility." Despite this finding, the ALC nevertheless deferred to the Department's interpretation that the Bed Transfer Standard could be applied to create a new hospital. Such holding is illogical, arbitrary, capricious, and contrary to established case law. *See Wade v. Berkeley County*, 348 S.C. 224, 229, 559 S.E.2d 586, 588 (2002) ("The first question of statutory interpretation is whether the statute's meaning is clear on its face...If a statute's language is plain and unambiguous, and conveys a clear and definite meaning, there is no occasion for employing rules of statutory interpretation and the court has no right to look for or impose another meaning.") (Emphasis added).

The Department and Roper assert that the ALC is required to give deference to the Department's interpretation regarding the transfer of beds and to the Board's affirmation of that interpretation because the Department is the agency charged with administration of the CON program. This argument is contrary to the law.

The courts recognize that an agency specifically is not entitled to the usual deference accorded in the construction of its laws and regulations when such construction contravenes the plain and unambiguous language of those laws and regulations. *See, Savannah Riverkeeper v. S.C. Dep't of Health & Envtl. Control,* 400 S.C. 196, 207, 733 S.E.2d 903, 908 (2012)("An agency's interpretation of a statute or regulation that is

erroneous or controlled by error of law presents a compelling reason not to defer to the agency's interpretation."); *Media Gen. Commc'ns, Inc. v. S.C. Dep't of Revenue*, 388 S.C. 138, 149–50, 694 S.E.2d 525, 530–31 (2010) ("An agency's long-standing interpretation of a statute is usually entitled to be given deference and should not be overruled by a reviewing court in the absence of cogent reasons, but the interpretation will not be sustained if it contradicts a statute's plain language."). *Cf.*, *MRI at Belfair, LLC v. S.C. Dep't of Health & Envtl. Control*, 394 S.C. 567, 576 716 S.E.2d 111, 115 (Ct.App. 2011)("Because DHEC's interpretation in this instance was not contrary to the plain language of section 44-7-230(A) or section 802 of Regulation 61-15, we find the ALC properly deferred to DHEC . . ."). Both the Department and the ALC acknowledge that the Department's interpretation and application of the Bed Transfer Standard to create new hospitals contravenes the plain meaning of the Standard. Therefore, as a matter of law, deference to the Department's interpretation in this case is improper.

The Department and Roper also point to the Department's prior history of applying the Bed Transfer Standard to the creation of new hospitals as justification for deference in this case. Again, this position is contrary to the established law. In *Monroe v. Livingston*, 251 S.C. 214, 217, 161 S.E.2d 243, 244 (1968), the South Carolina Supreme Court refused to adopt an agency's repeated mistaken application of the law, holding that, "It is argued that the defendant Tax Commission has construed [the law] over a long period of time as inapplicable . . . and that its interpretation should be given controlling effect in this case. Such administrative construction however affords no basis for the perpetuation of a patently erroneous application of the statute." *Accord Richland County Sch. Dist. Two v. South Carolina Dep't of Educ.*, 335 S.C. 491, 517 S.E.2d 444 (Ct.App. 1999)(declining to defer to the agency's past interpretation of a proviso

concerning teacher's salaries because the plain meaning of the proviso provided a compelling reason to reject such interpretation).

In its Order, the ALC rejects *Monroe* and attempts to distinguish it by searching for "a tipping point after which the rule on deference to agency interpretation no longer applies." (Order, pp. 25-26) The holding of *Monroe* is that an agency's construction of a law is not entitled to deference if it is contrary to the plain meaning of the law, no matter how long or how consistently the agency has followed its construction. Any discussion of a "tipping point" after which, presumably, an agency's erroneous construction would be accepted is arbitrary, capricious and affected by error of law.

Finally, the ALC in its Order finds that deference is warranted because the Department is the "final arbiter" of the State Health Plan. The court concludes that the Department is the "final arbiter" because the CON Act does not require the submission of the Plan to the Legislature for final approval and, therefore, legislative intent must be what the Department says it is. (Order, pp. 25-26) From this erroneous conclusion regarding the Department's status, the court draws the further erroneous conclusion that the ALC must therefore defer to the Department's interpretation whether or not, as the court admits, that interpretation is inconsistent with the plain words that the Department chose to use in the Plan.

Under the ALC's erroneous premise, the Department could change its interpretation at will, and the ALC would be forced to defer to the new interpretation because the Department is the "final arbiter" of the intent of the Plan. This holding is offensive to the laws governing the authority of the Department with regard to development of the Plan and to the laws governing oversight by the ALC and the courts. *See, Triska v. Dep't of Health & Envtl. Control*, 292 S.C. 190, 194, 355 S.E.2d 531, 533

(1987)("DHEC is a state administrative agency and can only exercise those powers which have been conferred upon it by the South Carolina General Assembly . . . DHEC must follow its own regulations and the provisions of the Administrative Procedures Act . . . in carrying out the legitimate purposes of the agency. . . . Any action taken by DHEC outside of its statutory and regulatory authority is null and void." [Citations omitted]).

Although the CON Act does not require that the State Health Plan be submitted to the General Assembly for review and approval, the General Assembly in the Act does impose a strict and detailed structure for the promulgation, amendment and content of the Plan. The CON Act, at S.C.Code Ann. § 44-7-180(C), establishes a health planning process pursuant to which the State Health Planning Committee drafts the Plan, gives public notice of the contents of the draft Plan, and receives public comments on the draft Plan in writing and at mandatory regional public hearings. Under the Freedom of Information Act, all of the votes to recommend and approve the Plan by the State Health Planning Committee and the Board are taken after public notice and in open session. S.C.Code Ann. §§ 30-4-60 and 30-4-80 (2007). Any amendments to the Plan must go through the same public notice and comment process. S.C.Code Ann. § 44-7-180(C)(Supp. 2012).

In addition to specifying the process, the General Assembly also mandates that the contents of the Plan include "at a minimum": (1) an inventory of existing health care facilities, beds, specified health services, and equipment; (2) projections of need for additional health care facilities, beds, health services, and equipment; (3) standards for distribution of health care facilities, beds, specified health services, and equipment including scope of services to be provided, utilization, and occupancy rates, travel time, regionalization, other factors relating to proper placement of services, and proper

planning of health care facilities; and (4) a general statement as to the project review criteria considered most important in evaluating certificate of need applications for each type of facility, service, and equipment, including a finding as to whether the benefits of improved accessibility to each such type of facility, service, and equipment may outweigh the adverse affects caused by the duplication of any existing facility, service, or equipment. S.C.Code Ann. § 44-7-180(B)(Supp. 2012). The Act further requires that "The State Health Plan must address and include projections and standards for specified health services and equipment which have a potential to substantially impact health care cost and accessibility." S.C.Code Ann. § 44-7-180(B)(Supp. 2012). Thus, the law requires that the Plan contain specific, detailed standards for the establishment of new hospital facilities.

Far from giving the Department the sole and unbridled discretion to interpret the Plan at will, the Act imposes a strict statutory structure, requiring both public notice and public comment, which is designed to result in the consistency of health planning in the State.[15] The very purpose of the State Health Plan is to create a blueprint for health planning upon which both the regulators and the regulated providers can rely. *Spartanburg Reg'l Medical Center v. Oncology and Hemotology Associates of South Carolina, LLC*, 387 S.C. 79, 83, 690 S.E.2d 783,785 (2010)("The purpose of the Health Plan is to outline the need for medical facilities and services in the State. The Health Plan is used as one of the criteria for reviewing projects under the CON program."). Allowing the Department to create nebulous standards for the establishment of new hospitals by

[15] Prior to the change in the law that prohibits approval of an application unless it complies with the State Health Plan, the Board was not bound by the standards set forth in the Plan and could approve applications that were not consistent with the Plan. (Tr., p. 1034, lines 5-13).

"interpreting" portions of the Plan contrary to their plain meaning violates both the statutory process and the purpose of the State Health Plan.[16]

In this case, Trident is the only hospital with a need for hospital beds in the Tri-county Service Area. Yet, through the device of "interpreting" the Bed Transfer Standard, the Department allows Roper, which has no bed need, to construct a $113 million new hospital within several miles of Trident's existing hospitals. It is the intent of the CON Act that all providers, including Trident, be allowed to rely on the plain meaning of the State Health Plan in making decisions regarding the development and allocation of health care resources.[17] Giving the Department the authority to ignore the plain meaning of its own Plan, as the ALC's decision in this case does, undermines this intent.

Finally, the approach of deferring to the Department as the "final arbiter" of the plain meaning of the Plan provisions is an unwarranted and overbroad construction of the Department's role as the sole administrator of the CON program. Such an approach would permit no effective legal oversight, which is contrary to the law and to the role of the ALC and the courts in the process. *See* S.C. Code Ann. § 44-1-60(G); S.C. Code Ann. §1-23-600(Supp. 2012); *S.C. Dep't of Revenue v. Blue Moon of Newberry, Inc.*, 397 S.C. 256, 260, 725 S.E.2d 480, 483 (2012) ("The construction of a regulation is a question of law to be determined by the court."). *See, also*, *MRI at Belfair, LLC v. S.C. Dep't of Health & Envtl. Control*, 379 S.C. 1, 7 n. 4, 664 S.E.2d 471, 474 n. 4 (2008) ("The issue

[16] The issue before the Court is not whether the Board or the Department has the authority to formally adopt a policy which allows the establishment of a new hospital through the transfer of beds. Trident contends that the Department, having adopted the Bed Transfer Standard through the formal public notice and comment process mandated for amendments to the State Health Plan, must follow the same process with regard to any further amendments or expansion of the Standard. *See* S.C. Code Ann. § 44-7-180(C) (Supp. 2012).

[17] Trident management testified before the ALC that the Moncks Corner Hospital will not be built if the Carnes Crossroads Hospital is allowed to proceed. (Tr., p. 163, lines 13-24; Tr., p. 359, line 20–p. 360, line 2).

whether the Plan standards satisfy the statutory requirements is a legal conclusion based on statutory interpretation principles.").

As a matter of law the Bed Transfer Standard in the *2008-2009 State Health Plan* cannot be used to create a new hospital because it does not allow for the transfer of beds to a facility that does not exist. As a matter of law the Department cannot approve a CON application that is not in compliance with the *State Health Plan.* Because Roper proposed to establish its new Carnes Crossroads Hospital through the use of the Bed Transfer Standard, which does not permit this action, and because the Department granted Roper's application solely under the "authority" of the Bed Transfer Standard, as a matter of law, the Order of the ALC must be reversed and Roper's application must be denied.

III. THE ADMINISTRATIVE LAW COURT ERRED IN DETERMINING THAT TRIDENT AND ROPER ARE NOT COMPETING APPLICANTS BECAUSE THE NEED FOR FACILITIES AND SERVICES WOULD NOT BE EXCEEDED BY APPROVAL OF BOTH APPLICATIONS BECAUSE, AS A MATTER OF LAW, SUCH DETERMINATION IS INCONSISTENT WITH THE STATE HEALTH PLAN.

As an alternative ground for reversing the decision of the ALC, Trident contends that, even if the Bed Transfer Standard applies, the Department and the ALC committed errors of law in holding that Trident and Roper were not competing applicants under the CON Act. Under the law of the case, this matter must therefore be remanded back to the Department for evaluation and determination of which applicant should be awarded a Certificate of Need to construct a new 50-bed hospital in the Tri-county Service Area.[18]

In certain circumstances, the Department is required to evaluate one or more applications pending before it and to choose which one to approve. Under the law, "'competing applicants' means two or more persons or health care facilities . . . who apply for Certificates of Need to provide similar services or facilities in the same service area within a time frame as established by departmental regulations and whose applications, if approved, would exceed the need for services or facilities." S.C.Code Ann. § 44-7-130(5)(2002) Similarly, the Department's regulations provide:

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

[18] The ALC granted Roper's motion for partial summary judgment holding that only the Department can determine which is the better applicant in the case of competing applications. (February 10, 2012 Order, pp. 3-4). Trident has not appealed this conclusion. Therefore, the ALC's finding on this issue is law of the case. *See, Transportation Ins. Co. v. S.C. Second Injury Fund*, 389 S.C. 422, 431, 699 S.E.2d 687, 691 (2010)("An unappealed ruling is the law of the case and requires affirmance.").

> considered to be competing. Any applications received by the Department later than the fifteenth day following publication of the Notice of Affected Persons in the State Register for the first application(s) will not be considered to be competing with the(se) application(s).

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

The parties agree that the applications propose to provide similar services and facilities in the same service area and that they were filed within the appropriate time frame for competing applications. (Tr., p. 638, line 6–p. 639, line 22; Tr., p. 917, line 25–p. 918, line 5; p. 1399, lines 16-22; Tr., p. 2547, line 22–p. 2248; Tr., p. 3362, line 22–p. 3363, line 1; p. 3396, line 23–p. 3397, line 20). Trident disputes, however, the Department's and the ALC's determination that the approval of both proposed hospitals would not exceed the need for hospital facilities and services in the area.

In reaching the conclusion regarding whether the need for hospital beds and services would be exceeded by the approval of both Trident and Roper's projects, both the Department and the ALC determined that, because Roper proposed to transfer existing licensed beds, the need for those services would not be exceeded. (Jt. Ex. 1, p. 0884-0899; Jt. Ex. 2, p. 1269-1281; Order, pp. 8-9, 19-20). The Department viewed Roper's application to construct a brand new $113 million hospital over 25 miles from Roper Downtown as a simple "repositioning" of a portion of Roper Downtown's licensed bed complement, for which no further analysis of need was required.[19] The ALC affirmed this approach by the Department. (Order, p.p. 19-20).

[19] Specifically, the Department determined in its June 26, 2009 decision letter that ". . .the applications are not competing because the beds used for the Roper St. Francis Hospital-Berkeley project are a permanent bed transfer, not a bed increase; therefore, the bed need will not be exceeded. The proposed project is basically a re-positioning of currently licensed acute care beds from an area of limited growth to an area of strong growth and will have no impact on the Tri-County's bed count or bed need." (Jt. Ex. 4, p. 001262).

Again, the ALC and the Department ignore the plain language of the Bed Transfer Standard. As discussed earlier in Argument I, the Bed Transfer Standard of the *2008-2009 Plan* provides, in part:

> A proposal to transfer or exchange hospital beds requires a Certificate of Need and must comply with the following criteria:
>
> 1. A transfer or exchange of beds may be approved only if there is no overall increase in the number of beds;
>
> * * *
>
> 5. The facility receiving the beds ***must demonstrate the need for the additional capacity*** based on both historical and projected utilization patterns . . . ;

2008-2009 Plan at Chapter II, Section G.1(A)(4)(j).

When read as a whole, the Bed Transfer Standard by its terms applies only when no beds are added, *i.e.*, only when the transfer or exchange of beds does not result in an increase of beds in the overall service area inventory. Despite the Bed Transfer Standard's limitation to cases in which beds are simply being "repositioned", the Standard nevertheless requires that the receiving facility demonstrate the need for the additional capacity being created through the bed transfer. Thus, the ALC's and the Department's conclusions that Roper did not have to demonstrate need because it was not proposing to add beds contravenes the plain language of the Bed Transfer Standard.

Furthermore, had the need for Roper's proposed new hospital been appropriately considered by the Department, Trident contends that, as a matter of law, the Department was required to conclude that the need for hospital beds in the service area would be exceeded by the approval of both Trident and Roper's applications. When Roper applied to construct a new $113 million hospital at Carnes Crossroads, the *2008-2009 Plan* showed that Roper's inventory of beds exceeded Roper's need for hospital beds by six.

The 2008-2009 Plan also showed a 48 bed surplus in the Tri-county Service Area. (Jt. Ex. 4, p. II-19).

Trident proposed using its facility specific need for 17 new beds by Trident Medical Center to justify establishment of the Moncks Corner Hospital. With the filing of Trident's application to establish the 50-bed Moncks Corner Hospital and Summerville Medical Center's application to add 30 beds to its facility, all of the stated, facility-specific need for beds under the *2008-2009 Plan* was applied for by the facilities that actually had a bed need.[20] (Tr., p. 3680, lines 13-23).

At the time it applied, Roper did not have a positive, or even a neutral, bed need. Roper had an excess of beds. Thus, before the approval of the Carnes Crossroads project, Roper had an excess need for hospital beds and, after Carnes Crossroads Hospital was approved, Roper had an excess need for hospital beds. Similarly, before approval of the Carnes Crossroads Hospital, the Tri-county Service Area had an excess need for beds and after approval of Carnes Crossroads Hospital, the Tri-county Service Area had an excess need for beds. Both the ALC and the Department accepted this static bed count as a sufficient showing that the need for hospital services would not be exceeded by the approval of two new 50-bed hospitals in Berkeley County. (Tr., p. 646, lines 18-23)

Under the competing applications law, however, the test is not whether the bed count for the facility or for the service area remains unchanged or unaffected. Under the competing applications law, the test is whether the approval of both projects would *exceed* the need for the services or facilities. Because the *2008-2009 Plan* reflects that there is an aggregate excess of beds in the Tri-County Service Area and that each of Roper's existing hospitals has an excess of beds, as a matter of law, the Department and

[20] As acknowledged by the Department, Roper could not have successfully applied to use any of Trident's facility specific need. (Tr., p. 1068, lines 9-17).

the ALC were required to conclude that Roper's proposed hospital ***by itself or in conjunction with Trident's proposed hospital*** exceeds the need for hospital beds in the service area.[21] To draw any other conclusion is inconsistent with the *2008-2009 State Health Plan.*

Thus, even if the Bed Transfer Standard is determined to apply to Roper's proposed hospital, the ALC's finding that Roper and Trident were not competing applicants is an error of law that requires remand to the Department for determination of which 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." S.C.Code Ann. § 44-7-210(B)(Supp. 2012).

[21] In its January 28, 2011 Order, the ALC denied Trident's motion for summary judgment on this issue, holding, erroneously, that whether need was exceeded requires further inquiry into the facts. In this order, the court cited *Spartanburg Reg'l Medical Center v. Oncology and Hemotology Associates of South Carolina, LLC*, 387 S.C. 79, 690 S.E.2d 783 (2010) in support of its ruling. In *Spartanburg*, which also concerned the issue of competing applications, the South Carolina Supreme Court upheld the ALC's determination that need would not be exceeded by the approval of both applications, finding substantial evidence to support the ALC's conclusion. *Spartanburg*, however, concerned radiation therapy services, the need for which was calculated and projected by the applicants under a mathematical formula set forth in the Plan. (387 S.C. 79 at 86-87, 690 S.E.2d 783, at 787). In the case of hospital beds, the Department performs the calculation of need and states it empirically in the Plan. (Tr., p. 1054, line 9–p. 1063, line 12). Thus, whether there is a need for beds or an excess of beds in a specific facility or in the service area is established in the Plan itself without resort to any calculations or facts outside the Plan.

CONCLUSION

For the reasons stated herein, Trident respectfully requests that the Court hold that the Bed Transfer Standard, set forth in the *2008-2009 State Health Plan*, Chapter II, Section G.1.(A)(4)(j), is not applicable to the establishment of a new hospital and that the Order of the ALC granting Roper's Certificate of Need Application for the Carnes Crossroads Hospital must be reversed. In the alternative, Trident requests that the Court hold that Trident and Roper are competing applicants under the law, reverse the Order of the ALC to the contrary, and remand this case to the Department for a determination of which applicant best meets the goals and standards of the CON program.

Respectfully submitted,

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