STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper St. Francis Berkeley Hospital and Roper Mount Pleasant Hospital, Petitioners, vs. South Carolina Department of Health and Environmental Control and Medical University Hospital Authority, d/b/a MUHA Community Hospital, Respondents.	Docket No.: 18-ALJ-07-0358-CC **AMENDED FINAL ORDER**
Walterboro Community Hospital, Inc., d/b/a Colleton Medical Center, Petitioner, vs. South Carolina Department of Health and Environmental Control and Medical University Hospital Authority, d/b/a MUHA Community Hospital, Respondents.	Docket No.: 18-ALJ-07-0360-CC
Trident Medical Center, LLC, d/b/a Trident Medical Center and Summerville Medical Center, Petitioners, vs. South Carolina Department of Health and Environmental Control and Medical University Hospital Authority, d/b/a MUHA Community Hospital, Respondents.	Docket No.: 18-ALJ-07-0366-CC

Appearances:

For Petitioner Roper:	Jennifer J. Hollingsworth, Esq., Cheryl Shoun, Esq., and Shannon Lipham, Esq.
For Petitioners Trident and CMC:	William R. Thomas, Esq., and David B. Summer, Jr., Esq.
For Respondent MUHA:	M. Elizabeth Crum, Esq., Celeste T. Jones, Esq., and Pamela A. Baker, Esq.
For Respondent DHEC:	Vito Wicevic, Esq., and Rupinderjit S. Grewal, Esq.

STATEMENT OF THE CASE

The above-captioned matters come before the South Carolina Administrative Law Court (ALC or Court) pursuant to Requests for Contested Cases filed by Trident Medical Center, LLC, d/b/a Trident Medical Center (TMC) and Summerville Medical Center (SMC) (collectively, Trident), Walterboro Community Hospital, Inc., d/b/a Colleton Medical Center (CMC), and CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper St. Francis Berkeley Hospital, and Roper Mount Pleasant Hospital (collectively, Roper, and together with Trident and CMC, Petitioners). Petitioners challenge the decision of the South Carolina Department of Health and Environmental Control (Department or DHEC) to issue a Certificate of Need (CON) to the Medical University Hospital Authority (MUHA or Respondent) for a 128-bed general acute hospital to be located in Berkeley County at a cost of $325,000,000 (Project or MUHA Berkeley). The parties moved to consolidate the contested cases and the Court granted the motion in an Order dated December 4, 2018. After various pre-hearing motions,[1] the Court conducted a hearing on the merits from November 6, 2019 through November 21, 2019. On July 8, 2020, a Final Order was issued. On July 20, 2020, Petitioners filed Motions for Reconsideration (Motions). On July 30, 2020, the Court rescinded its Final Order to better consider and respond to the parties' lengthy Motions and

[1] On March 26, 2019, MUHA filed a Motion for Summary Judgment, which this Court denied by Order dated April 15, 2019. Thereafter, MUHA filed a Motion in Limine and a Motion to Make More Definite with regard to Roper, which this Court denied in part and granted in part. MUHA also filed a Motion in Limine with regard to Trident and CMC, which this Court also denied. MUHA next filed a Motion to Lift Stay, which this Court denied by Order dated June 6, 2019. MUHA filed a Motion for Reconsideration of the Court's June 6, 2019 Order. After a hearing, the Court issued an Amended Order Denying MUHA's Motion to Lift the Stay.

responses. This Amended Final Order is now issued and incorporates the Court's response, if any was deemed necessary, to the issues Petitioners raised in their Motions.[2]

After an exhaustive and thorough review of the testimony and filings in this case, I find MUHA's CON application satisfies the State Health Plan, the Project Review Criteria (PRC),[3] the section 501 findings, and the purposes of the Certificate of Need and Health Facility Licensure Act. Therefore, I conclude that MUHA should be granted a CON for the Project.

FINDINGS OF FACT

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

The Parties

DHEC is the State agency charged with implementing South Carolina's CON program, which includes publishing the South Carolina Health Plan (SHP), promulgating regulations, reviewing and approving CON applications, issuing CONs, and monitoring the implementation of CON projects. *See, e.g.*, S.C. Code Ann. § 44-7-140 (2018); S.C. Code Ann. § 44-7-150 (2018). On July 23, 2018, DHEC approved MUHA's CON Application for development of the Project.

The Medical University Hospital Authority is an agency of the State of South Carolina. S.C. Code § 59-123-60(E) (2020). MUHA owns and operates the Medical Center of the Medical University of South Carolina (MUSC), an academic medical center, which consists of University Hospital, the Ashley River Tower Hospital (ART), the Shawn Jenkins Children's Hospital and Women's Pavilion (Shawn Jenkins),[4] and the Institute of Psychiatry, all of which are located on the peninsula in downtown Charleston. The mission of MUHA and MUSC[5] is, in part, to preserve

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[3] The PRC, consisting of thirty-three general criteria (and accompanying sub-criteria), are set forth in Regulation 61-15 § 802 of the South Carolina Code of Regulations (2012 & Supp. 2019). Each criterion will henceforth be referred to using PRC in place of the regulatory citation followed by the subsection. For example, Regulation 61-15 § 802(2)(b) will be cited as PRC 2(b).

[4] At the time of the hearing in November 2019, Shawn Jenkins was expected to open in early 2020.

[5] Although MUHA and MUSC are distinct entities, because of their inter-related nature, the Court will primarily refer to MUHA in this order even if it is technically referring to MUSC's operations.

and optimize human life in South Carolina through learning, discovery, healing, education, research, and the provision of clinical care.

As an academic medical center, MUSC provides general hospital services but also provides tertiary and quaternary services, which are specialized services delivered to high acuity[6] patients. No other hospital providers in Charleston, Berkeley, or Dorchester counties offer quaternary services.[7] Pursuant to the 2017-2018 SHP, MUSC has 656 existing beds and an institutional need for 147 more beds. In addition to the downtown medical complex, MUHA owns and operates a pediatric imaging center and a pediatric ambulatory surgery center in North Charleston, an ambulatory surgery center in Mount Pleasant, and the MUSC Musculoskeletal Institute in Charleston.

After the Department issued its decision approving MUHA's 128-bed Project, MUHA acquired an additional 715 acute care hospital beds as result of its $137 million purchase of Springs Hospital in Lancaster County, Carolinas Hospital System in Florence County, Chester Regional in Chester County, and Marion Regional Medical Center in Marion County (collectively, CHS hospitals).

In addition to the Project currently under review by this Court, MUHA has a pending CON application to add twenty-nine additional acute care beds to its downtown Charleston facilities and an approved, but appealed, CON for a freestanding emergency department (FSED) to be located in Summerville, two miles from the Project.[8] In its CON application, MUHA asserts this FSED will be relocated to the proposed hospital "in order to co-locate services and reduce duplication of Emergency Services within the same zip code."

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[6] Acuity generally refers to complexity of services provided by a hospital or, stated differently, how sick the patients are – the sicker the patient, the higher the acuity.

[7] TMC and Roper Hospital in downtown Charleston offer tertiary services.

[8] Pursuant to Rule 201 of the South Carolina Rules of Evidence, the Court takes judicial notice of the Court's own docket in which the MUHA FSED CON is now under appeal. *See Trident Med. Ctr, LLC, d/b/a Trident Med. Ctr. & Summerville Med. Ctr. v. S.C. Dep't of Health & Envtl. Control and Med. Univ. Hosp. Auth., d/b/a MUSC Health Emergency Servs.*, 17-ALJ-07-0441-CC; *CareAlliance Health Servs., d/b/a Roper St. Francis Healthcare, Roper Hosp., Inc., Bon Secours-St. Francis Xavier Hosp., Inc., Roper Mount Pleasant Hosp. and Roper St. Francis Berkeley Hosp.*, 17-ALJ-07-0444-CC. On May 28, 2020, the Court issued its decisions in these cases denying MUHA's request for a CON for the proposed FSED. On June 8, 2020, MUHA filed a Motion to Alter or Amend the May 28, 2020 Order, which was denied on July 6, 2020 Thereafter, MUHA filed a Notice of Appeal at the South Carolina Court of Appeals, where the matter is currently pending.

Roper St. Francis (Roper) is a 501(c)(3) non-profit healthcare system consisting of four acute care hospitals: Roper Hospital is a 266-bed hospital located in downtown Charleston;[9] Bon Secours St. Francis is a 204-bed community hospital located in West Ashley; Roper St. Francis Mount Pleasant Hospital is a 85-bed community hospital located north of Mount Pleasant; and Roper St. Francis – Berkeley Hospital (Roper Berkeley) is a 50-bed community hospital located in southern Berkeley County. Roper Berkeley was under construction when MUHA filed this CON application. Roper Berkeley has since opened and began providing inpatient hospital services on October 4, 2019. The Project is approximately four miles from Roper Berkeley.

Trident Health System (Trident) is a subsidiary of Hospital Corporation of America (HCA), a for-profit operator of health care facilities. Trident owns and operates two acute care hospitals: Trident Medical Center (TMC), located in North Charleston, and Summerville Medical Center (SMC), located in Dorchester County. TMC is a 296-bed tertiary hospital that had an institutional need for thirty-one additional beds in the 2017-2018 SHP. Trident was recently approved to add another six beds at TMC. SMC is a 124-bed community hospital that had a surplus of 8 beds in the 2017-2018 SHP. TMC and SMC recently consolidated their women's and children's services at SMC. MUHA's Project is approximately 10.7 miles from TMC and 11.2 miles from SMC.

Trident also obtained a CON to build a fifty-bed hospital in Moncks Corner called Berkeley Medical Center (BMC). The fifty beds associated with BMC were not included in the 2017-2018 SHP in error. However, because of wetlands issues, BMC is still in the pre-construction phase.

Colleton Medical Center (CMC) is a 116-bed for-profit community hospital located in Walterboro, South Carolina. Like Trident, CMC is a subsidiary of HCA. CMC is the only hospital in Colleton County. The 2017-2018 SHP shows a thirty-one-bed surplus in the Colleton County service area.

Application at Issue

Procedural Background

MUHA submitted its CON application for the Project on December 27, 2017. Thereafter, by publication in the March 23, 2018 State Register, DHEC notified the public and affected

[9] According to the 2017-2018 Plan, Roper Hospital had a total of 316 existing general acute beds; however, fifty of the 316 existing beds were transferred for the construction of Roper Berkeley pursuant to CON-SC-16-01.

persons that MUHA's CON Application was "deemed complete, and the review cycle began."[10] In the deemed complete letter, the Department prioritized four PRC that it deemed most important to its review, to include: (1) Compliance with the Need Outlined in the South Carolina Health Plan; (2) Community Need Documentation; (3) Distribution (Accessibility); and (4) Ability to Complete the Project. On March 22, 2018, Roper notified DHEC by letter of its status as an "affected person" and specifically stated its opposition to MUHA's CON application. On April 19, 2018, and July

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[10] The notification in the State Register provided that a "proposed decision will be made no earlier than 30 days, but no later than 120 days, from March 23, 2018." One-hundred and twenty days from March 23, 2018 was July 23, 2018. The letter notifying the parties of the application's deemed-complete status was dated May 21, 2018, but it was not actually sent to the parties until July 11, 2018, a couple weeks before DHEC's decision was due on July 23rd. Margaret Murdock, the Department employee in charge of reviewing the application, acknowledged the deemed-complete letter was not mailed when it was ready. As a result, DHEC extended the time to respond to the deemed-complete letter to July 18, 2018, only a few days before the Department was required to make a decision.

Pursuant to regulation 61-15, DHEC is required to first notify the applicant that the application is complete and invoice the applicant with the CON application fee; in particular, DHEC is required to collect the application fee before publishing notice that the review cycle has begun in the State Register. S.C. Code Ann. Regs. 61-15 § 303(1), § 305(1) (Supp. 2019). This notification to the applicant also includes notice of the relative importance of the PRC to be used in review of the application. *See id.* § 304(1). Thus, the applicant should be in receipt of the relative importance of the PRC prior to publication in the State Register, which initiates the review time frame and decision deadline. *See id.* § 305(2). In this matter, DHEC published MUHA's CON application as "deemed complete" in the March 23, 2018 State Register when the notification to the applicant and the applicant's application fee had not yet been received in violation of regulation 61-15 §§ 304-305.

Despite the procedural irregularities in this case, I find neither Roper nor Trident were prejudiced. At the agency level, MUHA had to show its proposed hospital met all statutory and regulatory requirements for a CON, and the Department determined MUHA met the requirements. To the extent the review period was shortened to such to an extent that Petitioners could not properly mount an offense against the proposed hospital, they have received due process before this Court. Specifically, an adjudicatory hearing held before the Administrative Law Court satisfies the requirements of due process in cases involving agency decisions. In *Ross v. Medical University of South Carolina*, 328 S.C. 51, 68, 492 S.E.2d 62, 71 (1997), the South Carolina Supreme Court held:

> Article I, § 22 requires an administrative agency provide notice and an opportunity to be heard, but does not require notice and an opportunity to be heard at each level of the administrative process. It mandates notice and opportunity to be heard at some point before the agency makes its final decision.

In other words, even if a party does not receive review at the agency level, an adjudicatory hearing held before the Administrative Law Court satisfies the requirements of due process unless a fundamental right is at stake which could only be addressed by the party having an earlier opportunity to be heard before the agency and which right can only be protected by imposing an additional procedure at the Department level. Furthermore, "[a]n adequate de novo review renders harmless a procedural due process violation based on the insufficiency of the lower administrative body." *Unisys Corp. v. South Carolina Budget and Control Bd. Div. of General Services Information Technology Management Office*, 346 S.C. 158, 174, 551 S.E.2d 263, 272 (2001). Because Petitioners have failed to show prejudice, I find any error was harmless. *See Palmetto Alliance, Inc. v. S. C. Public Service Comm'n.*, 282 S.C. 430, 319 S.E.2d 695 (1984) (holding that to prove the denial of due process, a party must show that it has been substantially prejudiced by the administrative process).

10, 2018, Trident and CMC each respectively notified DHEC of their status as "affected persons" and specifically detailed their grounds for opposition.[11]

DHEC declined to hold an in-person project review meeting and instead accepted written submissions in support or in opposition to the Project. On July 23, 2018, DHEC issued its decision granting MUHA a CON. Petitioners Roper, Trident, and CMC timely requested the DHEC Board conduct a final review of the staff decision. The DHEC Board declined to conduct a final review conference, thereby rendering the staff decision the final agency decision. S.C. Code Ann. § 44-1-60(F) (2018).

Application

MUHA's CON application proposes to construct a 128-bed general acute care community hospital (MUHA Berkeley) on a forty-acre site in the Nexton Community, a planned development located in southern Berkeley County at the Interstate-26 and Highway 17A interchange. Berkeley County is part of the Tri-County service area in the 2017-2018 State Health Plan (SHP). The Tri-County service area includes Berkeley County, Charleston County, and Dorchester County. The 2017-2018 SHP identifies a 147-bed institutional need at MUHA's downtown peninsula campus. Pursuant to Standard 5 of the 2017-2018 SHP, MUHA proposes to transfer 128 beds of this institutional need to create MUHA Berkeley, a new "greenfield" hospital. Because MUHA Berkeley will be a community hospital, it will not offer the specialized tertiary and quaternary services that are offered at MUHA's downtown campus. Nevertheless, MUHA asserts MUHA Berkeley will be a "natural, complementary component" to its downtown facilities.[12] The Project will include the following components:

- 100 medical/surgical beds;
- 12 intensive care beds;
- 16 post-partum beds;

[11] The Regional Medical Center of Orangeburg and Calhoun counties also submitted an affected person and opposition letter to DHEC dated July 13, 2018, but it did not join in requesting a contested case before this Court.

[12] In its application, MUHA notes it plans to open a freestanding emergency department (FSED) approximately two miles from the Project, but that it plans to close the FSED once MUHA Berkeley opens in order to consolidate emergency services into the community hospital and reduce duplication of emergency services in the service area. MUHA therefore incorporated the patients it expected to treat at the FSED in its projected utilization calculations for MUHA Berkeley. However, after DHEC approved MUHA's CON for MUHA Berkeley, MUHA decided not to close the FSED and retain both emergency departments. It did not update its volume totals accordingly.

- 8 labor and delivery rooms;
- Newborn nursery with 8 newborn bassinets; the facility will foster a couplet-care environment similar to Shawn Jenkins Children's Hospital;
- Surgery – 4 operating rooms (ORs), 2 cesarean section ORs;
- 2 endoscopy suites;
- Vascular lab;
- Emergency department;
- Diagnostic and imaging department;
- Non-invasive testing;
- Administration (executive, nursing, general, auditorium, staff facilities);
- Clinical support (laboratory/pharmacy); and
- Logistics and support (food service, technology, building support, central sterile processing, and materials management).

MUHA purchased the Project site for $8,200,000 in October 2018. MUHA has already acquired the requisite environmental permits to begin construction as soon as DHEC approves the architectural plans. The projected total project cost is $325,000,000 and the proposed hospital will be 311,221 square feet. The construction cost per square foot is $538 and the construction cost per bed is $1,307,154. The overall, total cost per bed is $2,539,062. MUHA intends to finance the capital cost of the proposed hospital through loan programs insured by the U.S. Department of Housing and Urban Development (HUD) Section 242 Hospital Mortgage Insurance Program. As part of the application, MUHA included a letter from Armadale Capital indicating Armadale's commitment to helping MUHA secure financing from HUD. MUHA projects the design phase of the Project will take twelve to thirteen months and construction will take approximately twenty-seven months. The estimated time of completion in the application is May 2022.

MUHA cites three reasons for construction of the Project in its application: (1) a large percentage of MUHA's adult inpatients originate from the Berkeley County area and establishing a Berkeley County hospital will provide improved access to these patients; (2) Berkeley County is a dramatically underserved market and only has one acute care hospital planned and one under

construction; (3) increased demand for inpatient services at MUHA and in the Tri-County Area have resulted in capacity constraints and prolonged boarding hours[13] at MUHA.

The application explains MUHA's occupancy rate at its downtown hospital has been above 80% for the three years prior to the application, sometimes exceeding 90%. Thus, MUHA wants to use the Project to address and alleviate its capacity constraints at its downtown campus by shifting lower acuity patients away from its downtown facilities and providing primary and secondary care to those patients in their own communities. MUHA also states it cannot accept all transfer requests from other hospitals because it does not have enough bed capacity. MUHA claims this shift in the treatment location for lower acuity patients will allow MUHA to provide patients with better access to the tertiary and quaternary services it provides at the downtown campus. MUHA notes that even with the Project, its downtown campus will remain full. MUHA specifically predicts that the addition of the Project in will decrease its downtown hospital's utilization in 2023 from over 90% to 77% and diminish further to 72% by 2025.

In choosing to pursue the Project, MUHA considered several alternatives, including the advantages and disadvantages of each alternative. The alternatives included: (1) maintain the status quo, which would not address the excessive demand for inpatients and would not address the operational issues associated with MUHA's increased capacity; (2) further expand MUHA's existing hospital-based inpatient services at its downtown campus, which would require significant renovation cost expenditures approaching the cost of the Project, result in lesser improvements in quality of care compared to the Project, and create disruption in the provision of existing services; and (3) construct the Project, which would improve access to a significant portion of MUHA's existing patients, allow the MUHA downtown hospital to focus on tertiary patients, and increase efficiency of care for the MUHA system.

The proposed hospital will have a more efficient layout than the current facility on the peninsula, which will decrease the overall cost of care while improving collaboration and multidisciplinary care for patients. MUHA asserts the enhanced collaboration will decrease duplicated efforts and promote cost containment. MUHA also asserts the new location will help decant patients from the downtown hospital during flooding events because the elevation of the

[13] Boarding hours refer to the time a patient is waiting (boarding) in the hallway or other area for an inpatient bed.

Project should insulate it from flooding. Additionally, the Nexton location will have sufficient surface parking to allow quick and easy access to the hospital. This will eliminate "way-finding" time experienced on the MUHA peninsula campus.

MUHA Berkeley's primary service area would consist of Berkeley, Dorchester, and Charleston counties. Its secondary service area would consist of Georgetown, Horry, Williamsburg, Florence, Colleton, Orangeburg, and Beaufort counties. The CON application also includes some ZIP codes in tertiary service areas. The need projections in the CON application are based on the redirection of patients who are already "aligned" with MUHA, and the application justifies the need for the new hospital based entirely upon the redirection of these existing patients. Because MUHA justifies the new hospital using its existing patients, MUHA found the Project would have no adverse effect on other providers in the service area. MUHA also predicts no impact on existing facilities "because it is only filling an unmet need identified by the 2017-2018 State Health Plan." Nevertheless, the application notes that Roper Berkeley was under construction at the time of the application and that Trident had been granted a CON for BMC.[14]

A significant portion of MUHA's historic patient volume originates from ZIP codes within the Berkeley County, Dorchester County, and North Charleston markets. According to MUHA's CON application, 56% of its overall adult inpatient population (17,272 patients) in fiscal year 2017 originated from the Tri-county service area and 29% of patients (8,796) originated from the North Charleston, Summerville, and Moncks Corner submarkets that are near the site of the Project.

MUHA's patient utilization calculations are based on a ZIP code analysis of MUHA's historic patient utilization. For example, MUHA projects it will be able to redirect 65% of its current patients who live within zero to fifteen minutes of the proposed hospital, and the percentage shift decreases as drivetime increases.[15] The lowest percentage of redirection is 2% from secondary counties and other areas with a drive-time of over seventy-one minutes. MUHA

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[14] MUHA notes in its application that Trident had yet to begin construction on BMC and its completion appeared uncertain.

[15] On July 23, 2018, the day the Department issued its decision, MUHA's healthcare planning expert, David Levitt, responded to a request from Ms. Murdock and provided additional information concerning MUHA's proposed redirection of patients. Mr. Levitt's email identifies by submarket the actual number (rather than percentages) of MUHA patients treated at MUHA's downtown facilities in fiscal year 2017 and projects the actual number of patients to be redirected to the Proposed Hospital in 2025, its anticipated third year of operation. By applying the correlating redirection percentage and a 1.7% growth rate, Mr. Levitt expected that MUHA would redirect a total of 5,700 patients from its downtown facilities to its new Proposed Hospital in 2025.

predicts the patient shift will result from proximity to the new hospital and patient choice to receive "MUHA-level care" in the lower acute setting. MUHA also predicts a small portion of its patients who are closer to its downtown location will choose the new community hospital because they prefer its less acute, community setting with less traffic and more parking.

In Attachment N to its application, MUHA provides a detailed chart showing patient redirection percentages from each of the 94 ZIP Codes it included in its service area.[16] However, during the litigation preparation for this matter, it was discovered that these re-direction percentages were incorrect. Nevertheless, even though the redirection percentages in Attachment N were incorrect, MUHA based its volume calculations in the application on the correct redirection percentages. MUHA provided a correct version of Attachment N during the litigation. The corrected version predicts 65% of MUHA's current patients from ZIP Codes within zero to fifteen minutes of the Proposed Hospital will redirect to MUHA Berkeley. For the remaining drive time categories, MUHA predicts that redirection will occur as follows: ten to twenty-five minutes – 55%; twenty-six to forty minutes – 35%; forty-one to fifty-five minutes – 30%; fifty-six to seventy minutes – 10%; and for seventy-one minutes and over, and for all of the ZIP Codes that are outside of the Tri-county Service Area – 2%. Thus, for example, in the corrected version of Attachment N, the redirection percentage of patients living in Orangeburg County ZIP Code 29059, which is thirty-one minutes from the Proposed Hospital, is 2% because Orangeburg County is outside the primary service area. On the other hand, MUHA still projects that 35% of patients who live in West Ashley, about thirty-two minutes away, will redirect to MUHA Berkeley. The predicted volume of patients that would redirect in each submarket as follows: North Charleston 1,984; Summerville 1,131; West Ashley 616; East Cooper 522; Sea Islands 500; Peninsula Charleston

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[16] One of the criticisms Petitioners leveled at MUHA was MUHA's failure to include patient volume schedules with its CON application. Petitioners contend these volumes were needed to support the percentages of patients MUHA asserted would redirect under its ZIP code analysis because, without the volumes, MUHA's assertions could not be reviewed for accuracy. I find MUHA's failure to include the patient volume schedules was an oversight, but a significant one. Nevertheless, MUHA remedied this oversight during trial preparation, which allowed the parties and this Court to review all the relevant data underlying MUHA's need analysis. Accordingly, I find the error was harmless in the context of this Court's *de novo* review.

However, MUHA's volume calculations in its CON application were based in part on absorbing the emergency room volumes from its proposed FSED in Nexton and MUHA has not revised its volume predictions consistent with its decision not to absorb the FSED in the Project.

354; Outside Tri-county Area 321; Moncks Corner 252; and Outside South Carolina 0 for a total projection of 5,700 redirected patient admissions in 2025.

The application projects an average length of stay (ALOS) of 5.2 days for med/surg patients at the Project, which is 10% less than 5.73, the ALOS at MUSC Medical Center for non-tertiary patients. The application also projects an OB ALOS of 2.9, which is 10% less than 3.2, the non-tertiary ALOS for OB at MUSC Medical Center. The application also used an estimated population growth of 1.7% per year. Based on these assumptions, the application projects an average daily census (ADC) of 64 or a 57% utilization at year three for med/surg patients. Similarly, it predicts an ADC of 9.8 or 61% occupancy for OB patients.

The MUSC medical staff will have staff privileges at the community hospital and will be on faculty. The primary manner patients will have access to the community hospital is through the emergency department (self-referral) and by physician referral. The Project will provide all types of inpatient hospital services, excluding only the tertiary/quaternary services specifically identified by Diagnosis Related Group (DRG).[17]

The 2017-2018 State Health Plan

The 2017-2018 SHP applies to the application at issue. In accordance with section 44-7-180(B) of the South Carolina Code (2018), the SHP contains

> (1) an inventory of existing health care facilities, beds, specified health services and equipment; (2) projections of need for additional healthcare facilities, beds, specified health services, and equipment; (3) standards for distribution of healthcare facilities, beds, specified health services, and equipment ("Certificate of Need Standards"); and (4) the project review criteria considered to be the most important in evaluating Certificate of Need applications for each type of facility, service and equipment.

2017-2018 SHP at 1-2.

A central aspect of the SHP is predicting the need for additional healthcare facilities and services. The need for hospital beds is based on the utilization of individual facilities, which is derived from Joint Annual Reports (JARs) —annual reports with facility statistics.[18] To predict

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[17] DRG means diagnostic related grouping. A DRG contains a group of similar type patients, such as open-heart surgery, normal delivery, etc. Using DRGs to segregate patients by acuity level is an accepted practice.

[18] The 2017-2018 SHP utilizes the 2015 JAR Reports.

utilization trends, the SHP uses population data from the South Carolina Revenue and Fiscal Affairs Office (RFA).

Calculations of hospital bed[19] need are made for individual hospitals and totaled by county to determine the overall bed need for that service area. For individual hospitals, the methodology for calculating bed need is as follows:

a) Determine the current facility use rate by dividing the current utilization by the current population in each of the three age cohorts.

b) Multiply the current facility use rate by age cohort[20] by the projected population for seven years in the future by age cohort (in thousands) and divide by 365 to obtain a projected average daily census by age cohort.

c) Divide the sum of the age cohort projected facility average daily census by the variable occupancy (.65/.70/.75)[21] to determine the number of beds needed to meet the hospital's need.

d) The number of additional beds needed or excess beds for the hospital is obtained by subtracting the number of existing beds from the bed need.

e) The totals for each hospital in a county or service area are summed to determine whether there is an overall projected surplus or need for additional beds.

2017-2018 SHP at 9.

MUHA applied to create a new hospital pursuant to Standard 5 in the 2017-2018 SHP, which provides:

> A facility may apply to create a new additional hospital at a different site within the same service area through the transfer of existing licensed beds, the projected bed need for the facility, or a combination of both existing beds and projected bed need. The facility is not required to have a projected need for additional beds in order to create a new additional hospital. There is no required minimum number of beds in order to approve the CON application. The applicant must justify, through patient origin and other data, the need for a new hospital at the chosen site and the potential adverse impact a new hospital at the chosen site could have on the existing hospitals in the service area.

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[19] "'Hospital Bed' means a bed for an adult or child patient. Bassinets for the newborn in a maternity unit nursery, beds in labor rooms, recovery rooms, and other beds used exclusively for emergency purposes are not included in this definition." 2017 SHP at 8.

[20] The age cohorts include 0-17, 18-64, and 65 and over, in recognition that different population groups have different hospital utilization rates. 2017 SHP at 9.

[21] The variable occupancy rates represent the occupancy at which a hospital of a certain size is considered full. For a hospital with 0 - 174 beds the variable occupancy rate is 65%; for a hospital with 175 - 349 beds, it is 70%; and for a hospital with 350+ beds, it is 75%. 2017 SHP at 9.

2017-2018 SHP at 10-11.

The 2017-2018 SHP also contains the following project review criteria (PRC) that "are considered to be the most important in evaluating Certificate of Need applications" for hospitals: (1) Compliance with the Need Outlined in this Section of this Plan; (2) Community Need Documentation; (3) Distribution (Accessibility); (4) Acceptability; (5) Record of the Applicant; (6) Cost Containment; and (7) Adverse Effects on Other Facilities. 2017-2018 SHP at 12. Additionally, the 2017-2018 SHP provides that "[g]eneral hospital beds are typically located within approximately thirty (30) minutes' travel time for the majority of the residents of the State" and "[t]he benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for these beds." 2017-2018 SHP at 13.

Although the 2017-2018 SHP states individual counties are the service areas for CON purposes generally, the 2017-2018 SHP combines Berkeley, Charleston, and Dorchester counties into one service area, the Tri-County Service Area, for the purpose of establishing general bed need.[22] According to the 2017-2018 SHP, the Tri-County Service Area has a need for 1,798 beds and an existing supply of 1,811 beds for a total excess of thirteen beds in the Tri-County Service Area. If the fifty beds from BMC are added to this total, then the Tri-County area has an excess of sixty-three beds.

On the other hand, the 2017-2018 SHP shows an institutional need for 147 additional beds at MUHA's downtown campus. In particular, in the 2017-2018 SHP, MUHA's downtown campus

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[22] During the pendency of this action, the DHEC Board adopted the 2018-2019 SHP. Under the CON Act, the Court may consider this SHP. S.C. Code Ann. § 44-7-225 (2018) (providing "the Administrative Law Court . . . shall consider the South Carolina Health Plan in place at the time the application was filed and may consider the current South Carolina Health Plan when making its decision."). The 2018-2019 SHP contains one significant change for the purposes of this case. Specifically, it dissolved the Tri-County Service Area in favor of each county becoming an individual service area. Therefore, Berkeley County, where the Project will be located, is its own service area for the purpose of the 2018-2019 SHP. According to the 2018-2019 SHP, Berkeley County has two fifty-bed hospitals (BMC and Roper Berkeley) for a total of 100 existing beds and a bed need of zero. The bed need is zero because no hospital was open in Berkeley County prior to Roper Berkeley opening its doors during this action; therefore, the bed need of zero is somewhat misleading because it simply represents a lack of historical data from hospitals upon which to calculate the need.

Under the 2018-2019 SHP Charleston County has a bed need of 1,707 with 1,687 existing beds, resulting in a service area bed need of twenty. Dorchester County has a bed need of 126, with 124 existing beds, resulting in a service area bed need of two. Under the 2018-2019 SHP, the individual bed need for MUHA, TMC, and SMC each increased—MUHA to 157, TMC to thirty-seven, and SMC to two.

Additionally, the Court declines to consider either the October 25, 2019, or the November 1, 2019, drafts of the 2019-2020 State Health Plan proffered by the Department and MUHA during the hearing.

has 656 beds and an occupancy rate of a little over 76%, which is considered full for a hospital of its size. Because MUHA has an identified institutional need, it was appropriate for MUHA to apply under Standard 5 to transfer 128 beds of its 147-bed-need to create another hospital in the service area. However, to obtain a CON, MUHA must also meet the other requirements of Standard 5: a need for the new hospital at the chosen site and the potential adverse impact the new hospital could have on existing hospitals in the service area. I will discuss these requirements below in conjunction with other similar requirements in the SHP and PRC.

Need

Need Under Standard 5

Projected Need and Capacity Constraints at MUHA Downtown

Standard 5 allows a party to use "projected bed need for the facility," which is synonymous with "institutional need," to establish a new hospital in a different location in the service area. The parties do not dispute the 2017-2018 SHP properly identifies an institutional need at MUHA's downtown campus for 147 beds. Indeed, MUHA's downtown hospital is overly full on a consistent basis with the result that it must turn patients away and cannot fulfill its mission to take care of all the patients that come to them for care. For the last five years, the MUHA Board has been searching for a solution to the overcrowding. The most crowded part of the hospital is the emergency room (ER) where there are on average fifteen to twenty patients boarding at any given time. Two hours is the median boarding time, but some patients wait for up to twenty hours. The second area of crowding is the lack of beds for people who have come out of the operating room (OR). The third area of crowding is represented by patients who simply do not attempt to come MUHA downtown because of the lack of capacity.

MUHA's utilization downtown is often at or over 100% on Tuesday, Wednesday, and Thursday with the result that the hospital is over-burdened. Additionally, MUHA denies fifty to sixty transfer requests a month and about half of these requests are denied because of a lack of floor beds or ICU beds. Although MUHA denies a relatively small number of its transfer request because of a lack of beds, the percentage of transfers denied for this reason has consistently increased from 2011 to 2017. The need to accept transfers will only increase with MUHA's acquisition of the four CHS hospitals because some of those patients will now redirect to MUHA for tertiary and quaternary care instead of North Carolina hospitals. To free up capacity, MUHA

calls "EP3" status on a weekly basis at the downtown hospital, which means that staff must try to discharge as many patients as possible to move people out of the emergency room and make room for them in the hospital. This weekly occurrence impacts the patient experience and interferes with the hospital's ability to cohort patients with similar illnesses together on specialty units within the hospital.

MUHA's goal in building MUHA Berkeley is to create more capacity downtown by moving patients with lower acuity to MUHA Berkeley. In choosing Berkeley County for the proposed site of the new hospital, MUHA was reacting to the fact that a large percentage of MUHA's adult inpatients originate from the Berkeley County area. Relieving capacity through the new hospital would not only provide better access to patients who originate in the southeastern Berkeley County area, but would allow MUHA to provide better care to all its patients, both low and high acuity, who seek to utilize MUHA's downtown facility and may face difficulty accessing the hospital because of the capacity constraints and prolonged boarding hours. Decanting lower-acuity patients to another hospital would also allow MUHA accept more transfer patients downtown thereby focusing more on its high acuity patients downtown. MUHA is also in need of more clinical rotations for students, and MUHA Berkeley would add a rotation site. MUHA Berkeley, like the downtown hospital, will have a teaching and research component and support MUSC's mission as an academic training facility for physicians, nurses, and other healthcare professionals.

I find that MUHA has presented substantial credible evidence of its capacity constraints at its downtown campus that are reflected by the institutional need identified in the 2017-2018 SHP.

Need for the New Hospital at the Chosen Site

Standard 5 requires the applicant to "justify, through patient origin and other data, the need for a new hospital at the chosen site." 2017 SHP at 10-11. The parties disagree whether MUHA demonstrated a need for the hospital "at the chosen site" under Standard 5. Mark Richardson, who the Court qualified as an expert in healthcare planning on behalf of Roper, opined that MUHA can transfer its institutional need under Standard 5, but it much also show a need for the new facility at the chosen site in southern Berkeley County. Dan Sullivan, Trident's expert in health planning, similarly opined that MUHA must demonstrate a need at the specific site chosen for the new hospital. Mr. Richardson and Mr. Sullivan testified that, in their opinions, MUHA failed to

demonstrate a need at the chosen site. Petitioners argue MUHA can only demonstrate need on the peninsula where its institutional need originated.[23]

Indeed, the institutional need in this case "originates" on the Charleston peninsula, whereas the new hospital will be located near the Berkeley County line in the new community of Nexton. However, Standard 5 refers to justifying need using patient origin and other data. Generally, the SHP calculates need for service areas based upon **hospital utilization**, which does not directly take into account **patient origin**, particularly at a highly specialized hospital like MUHA's downtown campus, which draws people from a very broad geographic area and not just the peninsula where this institutional need, on its face, would seem to "originate." Therefore, Petitioners' argument that the need originates on the peninsula and the resulting new hospital should be confined to that area, in either the form of an expansion, remodel, or construction of a new hospital on the peninsula, ignores where MUHA's patients actually originate from to focus on where they travel to for care.

MUHA's historic patient origin data for its downtown campus reveals that 56% of MUHA's existing adult inpatients originate in the Tri-County Service Area. More specifically, 29% of MUHA's adult inpatients originate in the Summerville, Moncks Corner, and North Charleston submarkets that make-up and surround the chosen site of Nexton. In fact, the highest percentage of MUHA's adult inpatients originate in the submarket of North Charleston (18%) and only 5% of MUHA's adult inpatients come from the peninsula, which diminishes Petitioners' argument that MUHA should locate the additional beds on the peninsula.

In this case, for the purposes of justifying need at the chosen site under Standard 5, which is the Standard that deals with **transferring** institutional need from one site to another within a service area, it is sufficient that MUHA demonstrated a large portion of the patient population it seeks to transfer originates in the Tri-County Service Area, and more particularly the Nexton area, based upon its historic patient origin data. MUHA thus justified the need for its proposed hospital through its patient origin data. Moreover, the population where the proposed hospital is to be built is predicted to grow at a strong rate, as will be discussed further *infra*. Locating the Project amidst MUHA's largest submarkets is also consistent with the health planning tenant of placing healthcare

[23] The Court's interpretation of the phrase "at the chosen site" is different from Petitioners' interpretation as explained in the conclusions of law portion of this order.

facilities where people are and where they can best access it, which is currently the I-26 corridor. In fact, it is much more reasonable to place the new hospital in Nexton—a place from which a large percentage of the patients currently originate; than a site with only 5% of the patient origin population.

Need in the Service Area

Although it is readily apparent that MUHA has a demonstrated institutional need, and a sizeable portion of the patients who have produced that institutional need originate in the Tri-County Service Area, it is also apparent that the Tri-County Service Area has an excess of thirteen beds, and excess of as much as sixty-three beds if BMC is counted.[24] Nevertheless, Standard 5 does not prohibit a bed transfer when the service area has a surplus of beds overall, but that does not mean this fact should not to be considered when, as in this case, there is conflict between MUHA's institutional need and the need within the service area.

The bed surplus in the Tri-County Service Area suggests there are enough hospital beds at non-MUHA providers to absorb all of MUHA's 147-bed institutional need.[25] In other words, the target population MUHA seeks to serve—lower acuity patients who originate near the proposed site—could theoretically decant to the existing providers in the service area, such as Roper Berkeley. However, despite the capacity constraints present at MUHA, these patients have not chosen to seek health care at other providers, nor can this Court or anyone else force patients to choose a certain provider. This fact reflects that many patients choose where to obtain healthcare and are often aligned with a certain provider. Thus, there is tension between the CON Act's goal to ensure beds match need in an efficient manner and the CON Act's inability to actually distribute

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[24] The State Health Plan reflects an excess bed need of thirteen beds in the Tri-County service area. Additionally, if the fifty beds from BMC are added to this total, then the Tri-County area has an excess of sixty-three beds. Unfortunately, it is unclear when, or, more importantly, if, BMC's fifty beds will come to fruition. If BMC is not built, its absence will decrease accessibility in the northern Tri-County Area, increase the maldistribution of beds in the Tri-County Area, and implicitly create a need for fifty beds in the Tri-County Area, which MUHA's proposed hospital could alleviate. In resolving this issue, the Court must also consider the population growth in Berkeley County, patient origin data for MUHA Berkeley, and the projected utilization proposed hospital.

[25] MUHA's institutional need appears to be driven by two factors: patients who need its unique level of care and patient choice. In other words, while some of MUHA's overcrowding is the result of too many patients who need MUHA's unique level of care, another portion of the institutional need is driven by patients who could seek and receive care at other hospitals in the Tri-County area that have capacity but who choose MUHA anyway.

patients in an efficient fashion.[26] Recognizing this tension, the Court must consider whether the surplus in the service area should prevent MUHA from building a new hospital and adding beds to the service area.

To settle this issue, the Court turns to the State Health Plan which sets forth that its purpose 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 (2018). Here, in balancing those purposes, it is clear that if MUHA's CON is denied, the public's need for health facilities, high quality care, and specialty services only MUHA provides, will not be best served. For instance, if the CON is denied, MUHA downtown will continue to be over-capacity to the detriment of **all** patients who seek care there, and particularly to the detriment of those who seek a level of care that only MUHA downtown provides. Accordingly, there is an incontrovertible benefit of improved access[27] to all levels of patients who continue to seek care at MUHA's downtown hospital. Further, to the extent decanting patients allows MUHA's downtown campus to better focus on high acuity patients that only it can serve, this also brings better access to Tri-County Service Area as a whole for this particular sub-set of patients.

Therefore, considering Standard 5 allows the transfer of institutional need, with no prohibition of this transfer tethered to whether the service area has a bed surplus, and considering

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[26] In its Motion for Reconsideration, Roper argues MUHA's theory of patient redirection is faulty because it cannot force its existing patients to decant to the proposed location because patients have a choice in where to receive care. However, the opposite is also true patients cannot be forced to decant to other providers who currently have capacity. Generally, patients are often aligned with a health care system and would be more likely to decant within that same health system.

Roper also argues that the Court's acceptance of the theory of decanting lower acuity patients to another facility is contrary to two other decisions by this Court wherein this theory was rejected. *See Trident Med. Ctr., LLC, et al., v. S.C. Dept. of Health and Envtl. Control*, Docket No. 2017-ALJ-07-0441-CC, 2020 WL 3033191 *38-40 (S.C. Admin. Law J. Div. May 28, 2020). However, those cases dealt with a freestanding emergency department and a pediatric ambulatory surgery center, which have a different patient bases than a hospital and the use of which are driven by different factors than the use of a hospital. Therefore, these cases were significantly different than the case before the Court. But also, as Roper acknowledges, this Court is not bound by the decision of another administrative law judge.

[27] In discussing improved access, the Court recognizes both the improved access to transfer patients who are denied admission due to capacity constraints, patients who do not even try to access MUHA because of its capacity constraints, and the improved access that comes from decreased wait times and boarding hours even if this latter issue does not represent an actual denial of access but merely difficulty in obtaining access.

the benefits to both the target population but also the inescapable benefits to the whole population served by MUHA downtown—and in particular their unique high acuity patients—I find that the surplus in the service area is not determinative as to whether MUHA's proposed hospital is needed. In fact, after thoroughly considering and weighing the evidence in this case, I find that despite the surplus of beds in the Tri-County Area, MUHA demonstrated that its proposed hospital is needed for the reasons already stated and those that follow.

Community Need

Target Population

MUHA's target population to serve at the proposed hospital is lower acuity adult patients originating in the southeastern Berkeley County area. MUHA's goal it to decant (and serve) lower acuity patients who originate near the proposed site in Nexton, which is close to the borders of Charleston and Dorchester Counties.[28]

The proposed primary service area for MUHA Berkeley includes Berkeley, Dorchester, and Charleston counties.[29] MUHA will also serve, to a much lesser extent, a secondary service area that extends to several ZIP codes surrounding the primary service area. In total, MUHA selected 94 ZIP Codes to analyze in its re-direction analysis that complimented its service area. MUHA did not factor in-migration into the CON application because using the broad 94-zip code service area would achieve the same result as using a smaller service area that factored in in-migration.

Mr. Richardson testified on behalf of Roper that MUHA's designated service area for patient origin is too broad and inappropriate for a community hospital. He contended that a service area of eight to ten miles for a community hospital would be more appropriate. Likewise, Mr. Sullivan opined on behalf of Trident that MUHA's service area for MUHA Berkeley is too broad.[30]

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[28] Mr. Sullivan criticized MUHA's patient origin data because it showed the majority of MUHA Berkeley's patient base would come from Charleston and Dorchester counties, not Berkeley County where the hospital it located. Nevertheless, Mr. Levitt made it clear that MUHA Berkeley is intended to serve the Tri-County area, not just Berkeley County. Indeed, the Project will be located only a couple miles from the border of Charleston and Dorchester counties.

[29] This primary service area for the proposed hospital is distinct from the Tri-County Service Area in the SHP even though they include the same counties and similar terminology.

[30] Petitioners' experts did not necessarily find that MUHA's historic patient origin data upon which MUHA relied to define its service area was incorrect, but rather argued MUHA had failed to properly adjust its service area to reflect the draw of a lower-acuity community hospital.

Although MUHA's proposed service area is larger than Petitioners' experts would project for other community hospitals in the Tri-County Service Area, I find MUHA's community hospital will be unique such that its service area is likely to be broader than other community hospitals in the Tri-County Service Area. MUHA's status as a Level 1 trauma center and academic medical center make it a regional draw with a strong reputation. Because of the unique medical services available at MUHA, around 50% of MUHA's patients come from outside the Tri-County area, and MUHA expects that some of these patients will also take advantage of the services offered at MUHA Berkeley. I find this expectation is reasonable. The breadth of MUHA's patient origins is unique compared to other hospitals, and its community hospital is likely to also have a broader patient base consistent with its parent hospital's base. Therefore, I find Petitioners' evidence of what other community hospitals in the area have experienced to be less persuasive than MUHA's historic patient origin data presented in the application.

Population Changes

MUHA Berkeley will be located in the Nexton Community, which will be easily accessible to the surrounding submarkets of Summerville, Moncks Corner, and North Charleston because it will be located a short distance off the I-26 exit at the I-26 and US Highway 17A interchange. This is an area of significant growth in Berkeley County. Berkeley County has a growing population, particularly in the southern portion of the county near the I-26 corridor where the proposed hospital will be located. The growth rate in Berkeley County is approximately 2% per year, which appreciably outpaces the State's average growth rate. In fact, between 2017 and 2022, the overall population in the nearby submarkets of Summerville, Moncks Corner, and North Charleston are projected to grow by 8-9% compared to the State average of 6%. As a result of this growth, the Nexton development is anticipated to have 8,500 new residences and the nearby Cane Bay development could add another 25,000 residents. In contrast, the peninsula, where MUHA's downtown campus is located, is supposed to grow at a rate of only 5%, which is the slowest rate in the Tri-County area and below the State average. MUHA's projected population growth rate of 1.7% is a reasonable projection of the growth in the area. Moreover, that projected rate of growth is in line with accepted demographic methodologies and consistent with the state demographer's data and methodologies.

Identified Need of the Target Population

The target population MUHA chose represents a significant portion of MUHA's existing adult inpatients. These patients are faced with long boarding hours and difficulty accessing the peninsula hospital because it is at capacity; in other words, the target population is part of the institutional need identified in the SHP. Relieving capacity through the proposed hospital would not only provide better access to patients who originate in the southeastern Berkeley County area, but would allow MUHA to provide better care to all its patients, both low and high acuity, who seek to utilize MUHA's downtown facility. Thus, to resolve MUHA's institutional need as allowed under Standard 5, it is reasonable to assume that a significant portion of MUHA's need is driven by, and can be alleviated by, servicing the target population at a different location in the service area. Therefore, MUHA has demonstrated a need in the target population.

Utilization

MUHA projected the Project's utilization from the expected volume that would redirect in its 94-ZIP-code service area using its drive-time analysis, the average length of stay (ALOS), and the average daily census (ADC).

a. Redirection Analysis

Based upon its identified service area, MUHA created a drive-time analysis to predict the percentage of patients that would re-direct from each ZIP code in its primary and secondary service areas to forecast its projected volumes and utilization. The percentages for different travel times were based upon past experience with MUSC patients. This drive-time redirection analysis includes 94 ZIP codes and assumes a blanket two percent redirection for all ZIP Codes outside of the primary service area of Berkeley, Charleston, and Dorchester counties. Both Petitioners' experts disputed MUHA's analysis. For example, in Mr. Sullivan's opinion, MUHA's shift analysis unreasonably assigned a thirty to thirty-five percent shift to the proposed hospital for patients who live on the peninsula or the sea islands (James Island, Seabrook Island, etc.). He opined it made no sense to postulate that thirty-five percent of patients coming from the southern

tip of the peninsula in zip code 29401 would travel thirty-nine minutes to MUHA Berkeley instead of five minutes to MUHA's downtown hospital.[31]

However, the percent shift cannot be looked at in isolation. The highest percentage of MUHA's lower-acuity patients originate in the submarket of North Charleston (18%) and only 5% of MUHA's patients come from the peninsula; thus a 35% shift of an already small percentage of patients coming from the peninsula is not unreasonable, especially given that many of the same doctors who practice at the peninsula hospital will also practice at MUHA Berkeley. Furthermore, MUHA Berkeley is not only overcrowded within the hospital, but parking and wayfinding at MUHA's downtown campus can also be difficult. Because MUHA downtown is often full and has a wait-time for admissions, some patients who are located closer to MUHA downtown, but who do not need immediate access to an emergency room, will likely choose to be seen or have elective surgeries at MUHA Berkeley to avoid the overcrowding and parking issues at the downtown hospital. Notably, the same doctors who practice at MUHA's prestigious hospital downtown will have privileges at the community hospital, which will also draw patients. Accordingly, I find it reasonable for MUHA to predict a thirty-five percent shift of patients from 29401 (the peninsula) in consideration of the above factors.

Overall, I find MUHA's redirection analysis to be sound. While some of MUHA's percentages may overestimate how many patients will travel from some ZIP codes that are closer to MUSC downtown, I also find MUHA's blanket 2% for secondary counties underestimates the draw of MUHA's proposed community hospital because it creates an artificial border that does not exist. It is more likely there will be some gradation in the percentage of patients who redirect from some areas of secondary counties. For example, one Orangeburg County (secondary service area) ZIP code is almost equidistant to the Project as one West Ashley ZIP code, yet a two percent redirection is applied to Orangeburg and a thirty-five percent redirection is applied to West Ashley; this is not entirely logical. Consequently, to the extent MUHA may have overestimated redirection percentages in some areas such as the sea islands, I find it also underestimated them in others,

[31] Although this particular criticism of ZIP code 29401 remains viable after MUHA corrected its redirection percentages, Mr. Sullivan's opinion of MUHA's redirection analysis was based on MUHA's original, incorrect Attachment N.

including some nearby areas of secondary counties, and neither deficiency is great enough to offset the overall justification of the application.

b. Average Length of Stay (ALOS)

In its CON application, MUHA projects patient days by multiplying the volume of patients it expects to redirect by the projected average length of stay (ALOS). MUHA assumed an ALOS of 5.2 days for med/surg patients and 2.9 days for OB patients for a combined ALOS of 4.7 at the proposed hospital. This ALOS represents a ten percent reduction of the non-tertiary ALOS experienced at MUHA's downtown hospital.[32] Specifically, Figure 18 in MUHA's application states that current non-tertiary med/sur adult patients at MUHA's downtown campus have an ALOS of 5.73. When 5.73 is reduced by 10% the result is 5.2. Similarly, MUHA's downtown campus current has a non-tertiary OB ALOS of 3.2 When 3.2 is reduced by 10% the result is 2.9. Therefore, MUHA has taken its patient data for non-tertiary patients and reduced it further to predict the ALOS at the proposed community hospital. I find this is reasonable.

In finding that MUHA's ALOS for the proposed hospital is reasonable, I do not disregard the fact that this predicted ALOS is high compared to other providers in the Tri-County Service Area. MUHA Berkeley's combined ALOS of 4.7 is equal to, or very close to, Roper and Trident's tertiary hospitals. In 2018, Roper reported a combined ALOS of 4.9 days and TMC reported a combined ALOS of 4.7 days. MUHA has not represented its hospital to be a tertiary facility, but its projected ALOS is on par with other tertiary hospitals in the area. In fact, looking at the component parts of the combined ALOS, the predicted ALOS's for MUHA Berkeley are higher than any other hospitals in the area except MUHA's downtown campus.[33]

On the other hand, both Mr. Richardson and Mr. Sullivan opined that an ALOS of around three would better reflect the acuity at a community hospital. I find those estimates unreasonable. Specifically, Mr. Sullivan offered opinions that resulted projected only a need for forty-two/three

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[32] MUHA's Case Mix Index (CMI) is increasing, which means the acuity of its patients is increasing. Increasing case mix correlates with a higher ALOS.

[33] Specifically, MUHA predicts an ALOS of 5.2 for med/surg patients while Roper's downtown tertiary facility has a med/surg ALOS of 4.9 and TMC has a med/surg ALOS of 5.0. Similarly, for OB services, MUHA's downtown hospital, which is a regional perinatal center, and Summerville Medical Center, which has a Level II neonatal nursery, reported the highest ALOS's at 3.1 and 2.6 days, respectively. MUHA Berkeley has a projected OB ALOS of 2.9 days. All other providers were below these numbers and reported ALOS ranging from 2.5 down to 2.2 days.

beds in one scenario and a bed need of thirty-three/four beds and in another scenario. In reaching his opinion of the appropriate size for MUHA Berkeley, Mr. Sullivan applied a modified redirection percentage. I find Mr. Sullivan's redirection percentages underestimated MUHA Berkeley's patient population.

Mr. Richardson reached a similar conclusion by narrowing the service area to a twenty-minute drive or ten-mile radius. He determined these re-adjustments would lead to a decline in utilization from 50-60% down to 40% with the result that MUHA Berkeley should have forty to sixty beds rather than 128 beds. Mr. Richardson also concluded that a more realistic estimate for patient days in year three would be 9,700-14,000 patient days rather than the 26,805 patient days MUHA predicted and on which they based their financial forecasts. I also do not agree with Mr. Richardson's analysis.

In sum, I find MUHA's projected ALOS is reasonable because it is based upon MUHA's historic patient data for non-tertiary patients. Dr. Patrick Cawley, MUHA's CEO, testified that although MUHA Berkeley is expected to have lower acuity patients than MUHA's downtown campus, it will have higher acuity patients than other community hospitals because of its academic function. This testimony is supported by the high ALOS already demonstrated by MUHA's existing non-tertiary patients. Therefore, I find it is reasonable to predict that MUHA's community hospital will have a higher than average ALOS compared to other community hospitals in the area.

c. Patient Days, ADC, and Overall Utilization

Having found MUHA's underlying service area, redirection percentages, and ALOS are reasonable, I now turn to patient days and the utilization of the proposed hospital. Using the volume projections and redirection percentages from its defined service area, MUHA multiplied these volumes by the predicted ALOS to determine the projected patient days for MUHA Berkeley's first three years of operation. MUHA separated calculated patient days for its med/surg and OB patients. For med/surg patients, MUHA projected 12,776 patient days in Year 1 (FY23), 16,261 patient days in Year 2 (FY24), and 23,230 patient days in Year 3 (FY25). These projections incorporated 1.7% population growth rate and gradually redirected patients to the full redirection amount over the course of the three years. The resulting average daily census (ADC) for each year of operation was 35, 45, and 64, respectively. When these ADC are looked at in the context of a

112 med/surg and ICU beds,[34] the utilization of the proposed hospital for med/surg patients is projected to be 31%, 40%, and 57% for each successive year, respectively.

For OB patients, MUHA projected 1,966 patient days in Year 1 (FY23), 2,503 patient days in Year 2 (FY24), and 3,575 patient days in Year 3 (FY25). These projections also incorporated a 1.7% population growth rate and gradually redirected patients to the full redirection amount over the course of the three years. The resulting ADC for each year of operation was 5.39, 6.86, and 9.80, respectively. In the context of 16 OB beds, this translates into projected utilizations of 34%, 43%, and 61% for each successive year, respectively.

MUHA's predicted utilizations of 57% for med/surg and 61% for OB for in Year 3 are sufficient to justify the hospital's proposed size of 128 beds. Petitioners argued that the actual utilization would be lower based upon the alleged problems with MUHA's various assumptions in calculating utilization as discussed above, yet Petitioners failed to show MUHA's predicted utilization in its application is too low for it to be a successful hospital. SMC has been operating successfully below 50% utilization; according to the 2017-2018 SHP, SMC had an occupancy rate of 48.9%. In contrast, MUHA is predicted to operate at a higher utilization than SMC by Year 3, and its utilization predictions are sufficient to justify the proposed hospital, particularly in a location of high population growth. However, it is likely that MUHA will capture some market share because of the Project's proximity to Roper Berkeley, TMC, and SMC. All four hospitals will share portions of their primary service area. I find MUHA's assumption that it will only serve its existing patients to be unreasonable.[35] Because of this, I further find that MUHA underestimated its patient volumes at MUHA Berkeley and, therefore, underestimated its utilization numbers as well. Overall, I find MUHA justified the need for its proposed 128-bed hospital.

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[34] Only 112 beds of the 128 beds proposed are for med/surg patients. The remaining 16 beds are for OB patients.

[35] Mr. Richardson opined that MUHA's error (in his opinion) in making its service area too big was compounded by MUHA's assumption that 100% of patients at the Project would be filled by patients redirected from MUHA's existing patient base without any patient shift from other hospitals and providers. Mr. Richardson cited his recent work on Roper Berkeley as more reasonable, for which he assumed 10% of patients would be cannibalized from other providers. Mr. Sullivan likewise did not think MUHA's 100% redirection was accurate as evidenced by his estimate that MUHA would gain approximately 4-5% in market share as a result of the new hospital. I agree that MUHA Berkeley is likely to capture some market share. This will be discussed more fully in the section discussing adverse effects.

Conclusion

Petitioners suggest that MUHA either (1) inflated its service area and redirection percentages to achieve the volume of its patients necessary to justify the need for a 128-bed hospital or (2) intends to reach the necessary volume numbers to justify the need for a 128-bed hospital by capturing market share from other providers. I find neither of these criticisms to be borne out by the evidence presented. I do not find MUHA's proposed service area is too large; rather, it is reasonable for the community hospital of an academic medical center that draws from an unusually large area itself. I also find MUHA's redirection percentages are reasonable based upon MUHA's historic patient origin data and the likelihood that some patients from some zip codes closer to the downtown hospital will choose elective procedures at Berkeley to avoid congestion. Furthermore, the population in and around the Project site is projected to grow significantly and there is a high likelihood that MUHA will capture market share in that area, but I do not find MUHA is trying to subversively capture market share when it has justified the need for the proposed hospital by using its existing patient base.

I find the greater weight of the evidence justifies the need for a 128-bed hospital as presented in the CON application.[36] MUHA has demonstrated its proposed hospital is needed based upon such factors as: an overwhelming need to redirect patients from the peninsula hospital; the significant population growth in the area; and the reasonableness of its service area, patient redirection percentages, ALOS, and projected utilizations based upon its historic patient origin data.[37]

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[36] MUHA's decision to create a 128-bed hospital considered not only the projected patient volume but also the unit sizes within the hospital needed to efficiently accommodate those projected patient volumes. Nevertheless, while unit size became a consideration for this Court once MUHA explained that it was used, in part, to size the proposed hospital, this consideration was not determinative of this Court's decision.

[37] Although I find MUHA justified the need for its hospital with patient origin data, it must be emphasized that MUHA's application relies in part on patient volumes that will be redirected from MUHA's FSED at Nexton because the application states the FSED will be absorbed by MUHA Berkeley. However, it now appears MUHA plans to keep the FSED open independently. The extent to which this change would affect the volume numbers supporting MUHA Berkeley is unclear, but likely significant. Therefore, my decision in this case is premised on the FSED and its patient volume being absorbed by MUHA Berkeley as premised in MUHA's CON application.

Distribution (Accessibility)

Justified Duplication

A consideration in determining whether a CON project should be approved is the distribution of medical resources. This project review criteria requires consideration of whether the project will unnecessarily duplicate services in the area. Petitioners provided testimony that MUHA Berkeley will offer the same services their respective hospitals already offer.[38] Mr. Richardson opined that MUHA's Project's size, at 2.5 bigger than Roper's or Trident's community hospitals in or near Berkeley County, has the potential to be excessive development. In Mr. Sullivan's opinion, the Project would unnecessarily duplicate services.

The evidence demonstrates MUHA's Project will provide similar services to those provided at Roper Berkeley, TMC, and SMC, with the caveat that TMC will provide more services than MUHA Berkeley and SMC will have a greater focus on OB. However, it also appears that MUHA will be a more acute hospital than other community hospitals in the area based upon MUHA's unique patient mix as an academic medical center. As Mr. Levitt pointed out, there is always duplication when another hospital is added. Here, the more important question is whether that duplication is unnecessary. In this case, because MUHA has demonstrated a need for the new hospital and justified its size with utilization data, I find the duplication is necessary.

Medically Underserved Areas or Populations and Duplication

Another consideration is whether the Project will be located in a medically underserved area or in a location that will serve a medically underserved population.[39] Blended into this consideration is whether the location will result in an unnecessary duplication of services.

In 2010, Berkeley County had 27% of the population, Charleston County had 53%, and Dorchester had 20%. However, Charleston County had 95% of the beds, Dorchester had 5% of the beds, and Berkeley County had 0% of the beds. Using RFA data to predict the distribution for

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[38] James O'Neal Hiott, III, the CEO of CMC, noted he was unsure if MUHA was going to have an invasive vascular lab, which is a service that CMC does not offer. Tr. vol2 at 246.

[39] Included in this consideration is the issue of the extent to which the CON applicant will grant access to "medically underserved groups" such as "low income persons, racial and ethnic minorities, women, the elderly, handicapped persons." *See* S.C. Code Ann. Regs. 61-15 § 802(3)(f). Petitioners did not challenge whether MUHA Berkeley will serve "medically underserved groups." Nevertheless, the evidence established that MUHA Berkeley will serve those groups.

2021, Berkeley County will have 29% of the population, Charleston County will have 51%, and Dorchester County will have 20%. In this scenario, Charleston County has 88% of the beds, Dorchester has 7% of the beds, and Berkeley County has 5% of the beds.

MUHA asserts that "Berkeley County is a dramatically underserved market in the tri-county area that only has one acute care hospital planned and one under construction to service the entire population." MUHA also claims MUHA Berkeley will increase access to its downtown facilities because it will shift lower acuity patients away from the downtown campus. Another component of MUHA's argument is patient choice. MUHA contends patients in Dorchester and Berkeley Counties have limited choices for healthcare in their area and the addition of MUHA Berkeley will increase access to those patients who would choose care at a MUHA facility. In sum, MUHA asserts its new hospital would increase access to its own patients and Berkeley County residents while better distributing healthcare facilities and healthcare choices in the Tri-County area.

Mr. Sullivan averred there is no access problem for the Project to resolve. Mr. Richardson, likewise, contends there is no access problem in Berkeley County. He believes Roper Berkeley, TMC, SMC, and eventually BMC, provide a good distribution of beds for Berkeley County. Both Mr. Sullivan and Mr. Richardson further contended that using county lines to fragment the larger Tri-County Service Area creates artificial barriers to patient travel that do not exist. They opined that patients flow across county lines and artificial borders at county lines cannot be used to determine whether a particular county is underserved or there is a maldistribution of beds.

In Mr. Levitt's opinion, calculating the beds per capita for each county is a useful measure to quantify maldistribution. He calculated that in Charleston County there are 4.33 beds per thousand people and in Dorchester and Berkeley Counties there is less than one bed per thousand people, which is a "very mal-distributed volume of beds." Even counting the 100 licensed or approved beds in Berkeley County, Mr. Levitt testified Berkeley County has 0.5 beds per thousand people, which is five times less than the 2.4 beds per thousand people in the State of South Carolina. Berkeley County clearly has the least beds per capita in the State when the County is considered by itself.

I agree with Petitioners that healthcare is delivered across county lines, and this is particularly true when hospitals are located near county lines. For this reason, I find Berkeley

County is not "dramatically" underserved considering the recent opening of Roper Berkeley and the close proximity of TMC and SMC—only TMC is fully utilized at this time and, overall, the Tri-County Service Area has an excess of beds.[40] However, simply because healthcare crosses county lines does not mean it is not probative to consider the distribution of beds in each county. Beds are clearly maldistributed across the Tri-County Service Area in favor of Charleston County. In consideration of this factor, while I find Berkeley County is not "dramatically" underserved, I do find it is an underserved area.

Moreover, MUHA Berkeley will provide access to an underserved population that originates in the area surrounding the Project. MUHA Berkeley has not been offered as a hospital for Berkeley County alone,[41] but rather as a hospital to serve MUHA's lower acuity patients in the Tri-County Service Area. The proposed site is very close to the border of Charleston and Dorchester Counties and approximately 79-80% of MUHA Berkeley's projected patients trace back to zip codes in Charleston and Dorchester Counties. Additionally, approximately 21% of MUHA Berkeley's projected patient population will come from Berkeley County. Based upon this framework, I find the area surrounding MUHA Berkeley is underserved because a substantial percentage of existing MUHA patients originate from the submarkets near the proposed site and there is clearly a problem with access due to capacity constraints at MUHA downtown.

Furthermore, recognizing that county lines are artificial borders as asserted by Petitioners, the underserved medical need is further highlighted. The patients MUHA seeks to redirect are receiving care from an overcrowded hospital that needs capacity relief to provide the best patient care possible. These MUHA-aligned patients could choose to re-align themselves with Roper

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[40] The effect of the addition of BMC is difficult to assess at this time because of the uncertainty of its completion. If it is built, it will increase access and reduce any maldistribution of healthcare in Berkeley County that may exist, particularly considering it will primarily service an area of Berkeley County in the north where no other hospital is physically present. Therefore, its existence would lessen, to some extent, the need for MUHA Berkeley. However, if it is not built, the addition of MUHA Berkeley will most certainly increase access and improve the distribution of health services in the northern Tri-County area. At this time, I find it most reasonable to consider need without reference to BMC because of BMC's on-going difficulties with moving forward, which will be discussed further as part of the adverse effects analysis.

[41] The Court may consider the 2018-2019 SHP that recognizes Berkeley County as its own service area. However, I chose not to exercise that discretion, in part, because there is not data for Berkeley County to base need calculations on and thus, there is not a reliable forecast of bed need for Berkeley County alone.

Berkeley or SMC, which, more so than TMC, have excess capacity. However, it is unlikely that the vast majority of MUHA-aligned patients will redirect if they are well-established with MUHA.

Conjointly, MUHA Berkeley will increase access to MUHA's downtown hospital for all patients who have difficulty accessing the hospital due to crowding, but particularly those patients who need MUHA's level of care. These patients are also underserved. Petitioners contend the Project will not result in increased capacity downtown because the CON application concedes MUHA Berkeley will only "slightly alleviate these constraints, but MUHA will remain full downtown." However, I do not find this concession to diminish MUHA's argument that MUHA Berkeley will help reduce capacity constraints. The evidence shows MUHA downtown is consistently operating at 90-100% capacity during peak times and even reducing its operation to 85% capacity, which is still "full," would be a significant benefit compared to how it is currently operating. In fact, MUHA predicts the addition of MUHA Berkeley will reduce capacity down to almost 70% as MUHA Berkeley ramps up. Alleviation of the current patient load would allow MUHA to accept more transfers and high-acuity patients and thereby better serve the citizens of South Carolina.

In sum, MUHA Berkeley will increase access to the medically underserved target population and Berkeley County residents while better distributing healthcare facilities in the Tri-County Area. I further find MUHA Berkeley will have the effect of improving access for high acuity patients at MUHA's downtown facility as well. Moreover, based on these findings and the fact that MUHA justified the need for the Project, I do not find a duplication of the services provided by Roper Berkeley, TMC, or SMC, will be unnecessary. Finally, although Petitioners raised a reasonable concern that MUHA Berkeley will result in an expansion of MUHA's base by capturing tertiary referrals, enhancing its brand, and granting it leverage to negotiate for higher prices in its reimbursement from third party payers, the evidence supporting that assertion was merely speculative. Therefore, Petitioners did not prove the geographic spread of a MUHA's system will result in MUHA extracting higher prices from payors and thus result in higher premiums for patients.

Adverse Effects[42]

The Department did not include PRC 23, Adverse Effects on Other Facilities, in its review.[43] Petitioners' experts both asserted the Department was remiss in not including PRC 23. Specifically, both Petitioners' experts testified that because of the Project's size and proximity to TMC, SMC, and Roper Berkeley, it would have an impact on these providers. In particular, Mr. Sullivan opined that Roper Berkeley's ability to grow its market share as projected in its CON would be severely constrained by MUHA's new hospital in the same area. Mr. Sullivan testified he believed the Project would have a material impact on Trident.

100% Redirection

In its application, MUHA asserts its Project will have no impact on existing facilities because MUHA Berkeley's patient base will be 100% redirected from MUHA's existing patients.[44] However, MUHA's assertion that it will not have any impact on other healthcare providers because 100% of its patients will be redirected from its existing patient population is unreasonable. A new hospital is going to have some degree of impact on existing providers, especially when another provider is only four miles away and the new hospital has an emergency room, the use of which is largely driven by patient proximity.

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[42] In this Court's Order on Summary Judgment, the Court found "there is a subtle distinction between Standard 5, which asks for the applicant to justify the potential adverse impact on existing hospitals, and the criterion in PRC 23 requiring the Department to consider adverse effects on other facilities, which is not necessarily limited to hospitals." Order filed May 8, 2019, p. 10. In this case, the expert health planners testified during the hearing that only hospitals can provide inpatient services and they provide different services than outpatient facilities. I find that for purposes of adverse effects on existing facilities under PRC Reg. 61-15 § 802.23, the review is properly limited to the review of MUHA Berkeley's impact on existing hospitals. Even if the word "facility" includes outpatient facilities, I further find that Petitioners presented no credible evidence that any of their existing or proposed outpatient facilities will be materially affected by MUHA Berkeley.

[43] Ms. Murdock testified she did not list Reg. 6-15 § 802.23 as a PRC in the "deemed complete" letter because she interpreted the PRC phrase "existing facilities" as limiting her review only to licensed hospitals and not to approved but not licensed hospitals. In order to consider the adverse effects on both licensed and approved hospitals, Ms. Murdock testified she reviewed potential adverse effects in light of the purposes of the CON Act; specifically, unnecessary duplication of services and establishment of health facilities and services that best serve public needs.

[44] Although, MUHA did not rely upon this assertion at trial, the Court nevertheless addresses the argument. Furthermore, in its application, MUHA acknowledged the pending opening of Roper Berkeley and the speculative construction of BMC but did not engage in any meaningful examination of the possible impact MUHA Berkeley would have on these facilities. Although Roper Berkeley and BMC were not technically existing facilities at the time of MUHA's application, TMC or SMC were existing facilities and were not discussed at all.

Trident, Roper, and MUHA are the three dominant inpatient providers in the Tri-County Service Area.[45] TMC is approximately ten miles from the Project with 296 acute care beds and SMC is approximately eleven miles from the Project with 124 acute care beds. Roper Berkeley is approximately four miles away with 50 beds. Obviously, the closer a project is to existing providers, the more likely it will impact those providers. Patients tend to go to the closest hospital; in particular, emergency rooms drive a substantial portion of hospital admissions and a patient is likely to go to the closest emergency room. The RFA data show 63% of Berkeley County admissions come through the ED. A patient who was previously driving to Trident who now lives closer to MUHA Berkeley is likely to redirect in an emergency situation where time is of the essence.

However, close proximity does not necessarily indicate the impact will be material, significant, or adverse such that a CON application should be denied. Several hospitals successfully coexist in close proximity to each other, including Roper's downtown campus and MUHA's downtown campus whose ERs are less than 1000 feet from each other. Similarly, Richland Hospital, Baptist Hospital, and Providence Hospital in Columbia are all within a few miles of each other. The close proximity of these hospitals reflects a need to put hospitals where people and populations exist and within easy access to those populations. Therefore, while the location of MUHA's proposed project is within four miles of Roper's Berkeley hospital, that does not inherently mean that MUHA Berkeley will have an adverse impact on Roper Berkeley that requires denial of the CON application. MUHA's decision to locate its hospital in the southern part of Berkeley County is reasonable based upon where the growing portion of Berkeley County is located, which is in the southern portion of the county, and the location's proximity to Interstate 26, which provides good access to the hospital for the population living in that area.

Overall, because the proximity of the Project to Roper Berkeley, TMC, and SMC, it is likely to have an impact. All four hospitals will share portions of their primary service area (approximately thirty-minute radius around each hospital). In light of these over-lapping service areas, the impact of MUHA's Project on market share of the existing hospitals is probative in determining potential adverse impacts or effects.

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[45] With the exception of CMC, Petitioners are located in the Tri-County service area.

Market Share

Market share has been fairly stable between the three health systems in the Tri-County Service Area with each having about thirty percent of the overall market share. However, Trident has 50% of the market share in Berkeley County and 60% of the market in Dorchester County. Generally, the first provider into a market has an advantage because it can establish its patient based first and, essentially, develop some loyalty and familiarity in the community. Trident, having been in the northeastern Tri-County area since the 1970s, has the advantage of an established patient base. Similarly, Roper Berkeley is the first hospital in Berkeley County in approximately forty years and will have an advantage as a result. Even if MUHA's Project is approved, Roper Berkeley will have approximately five years to establish and grow its patient base before the Project comes online.

Trident

Because of Trident's longstanding presence in, and commitment to, the northeast portion of the Tri-County, and its current utilization levels, I find any adverse impact to Trident will be minimal and the impact is justified by the increased accessibility MUHA Berkeley will offer. The likely impact is demonstrated by the already quantifiable impact Roper Berkeley has had on Trident's volume.[46] Trident compared the thirty days prior to Roper Berkeley opening to the thirty days after and found a significant change in admission patterns as well as ER visits. Trident was down an average of five admissions per day during this period, which equates to approximately 150-155 patients a month and would result in an almost $10 million decrease in margin per year.

The loss of five admissions per day, or even ten, will undoubtedly affected Trident's bottom line, but it is not a large percentage of Trident's overall ADC. According to the 2018-2019 SHP, TMC has a projected ADC of 233 and SMC has a projected ADC of 82 compared to existing beds of 296 and 124, respectively. Both facilities have an institutional bed need of thirty-seven and two, respectively. Therefore, even if ten patients are redirected to MUHA, this is only three percent of Trident's overall projected ADC in the 2018-2019 SHP and a fraction of Trident's

[46] It appears the impact was to Trident Health System as a whole rather than just TMC, but the record is unclear.

institutional need. Moreover, in 2018, TMC's utilization was around 82%.[47] Additionally, TMC typically reaches 90% capacity at least once a week, usually on Wednesday or Thursday. For a hospital of its size, TMC is considered full at a utilization of 70%; therefore, TMC is running at, and even above, full capacity much of the time. The need for more capacity at TMC is demonstrated by Trident expanding TMC's ER over the last five years to give an additional 25% capacity in response to growth in the area. SMC is going through a similar addition to expand capacity.[48]

Trident's situation is not one in which a new provider will enter a market where the existing provider is only at 50% capacity and has excess beds, which could result in a material adverse impact to both providers. As evidenced by TMC's high utilization, more capacity would likely be a benefit to patients and ease the burden on TMC. Although hospitals can run at higher utilizations than the percent that deems them "full" under the SHP, utilization demonstrating a hospital is full remains an indicator that the addition of more capacity could be advantageous rather than adverse.[49] Additionally, the impact of Roper Berkeley is small relative to Trident's overall ADC; and, although it is a measurable impact, it has not been tested over a long period of time to show a sustained, or increasing impact. Trident has a well-established and strong presence in the area where the Project is proposed and, for these reasons, is likely to have strong patient-alignment to insulate it somewhat from a new provider in the area. Overall, I find the evidence in the record demonstrates Trident will only be marginally adversely impacted by MUHA Berkeley. It will lose some market share, but that adverse impact is not the kind of material adverse impact that justifies denying MUHA's application in light of Trident's strong presence in the region and current utilization. Moreover, when balanced against the benefits of increased access at MUHA Berkeley, the benefits of access outweigh the small impact to Trident.

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[47] The data in the 2017-2018 and 2018-2019 SHPs has lower occupancy rates for TMC; however, the data in these plans comes from 2015 and 2016, respectively. Specifically, the 2017-2018 SHP shows TMC had a 2015 occupancy rate of 66.6%. The 2018-2019 SHP shows TMC had an occupancy rate of 68.73%.

[48] Pursuant to the 2017-2018 SHP, SMC had an occupancy rate of 48.9% in 2015. Pursuant to the 2018-2019 SHP, SMC had an occupancy rate of 52.87% in 2016.

[49] The State Health Plan has a specific disclaimer that use of the term "hospital bed need" in the Health Plan "does not suggest that facilities cannot operate at higher occupancy rates than used in the calculations without adding additional beds." 2017-2018 SHP at 9.

Notably, I have not discussed BMC although it is also part of Trident Health System. I find the impact of MUHA Berkeley on BMC (if any, considering BMC's construction is not underway or assured) is speculative at this time. In applying for the CON application to build a fifty-bed hospital in Moncks Corner, Trident was concerned about the possible adverse impact of Roper Berkeley's fifty-bed hospital being located so close to BMC and whether both hospitals would have a large enough patient base to be sustainable. Both Trident and Roper received CONs to build their hospitals; however, while Roper Berkeley is now open, Trident has yet to break ground on BMC.[50] Trident has received approval from the Army Corps of Engineers to modify drainage on the site, and Trident is in the process of letting the contract out to start the site work to resolve the drainage issue per the Corps' plan. However, Trident is still three years away from resolving the drainage issue and starting on architectural and engineering plans for the site.

Based on the status of BMC, it is difficult analyze the impact of the Project in any material way. The only foreseeable impact at this time is Trident's inability to capitalize on the fact that its CON was approved first, which would theoretically give it the advantage of coming to the market first in the northern part of Berkeley County. However, at this point it is difficult to determine when, and if, BMC will be built, and I find it would be unreasonable to prohibit MUHA from entering the market solely based upon the speculative impact on the uncertain development of another hospital several years in the future.

Roper

Petitioners contend that MUHA's project will adversely impact Roper Berkeley because it will decrease Roper Berkeley's market share. In 2017, prior to the CON application in this case, Roper prepared a report or impact analysis predicting what would happen if MUHA entered the market in Berkeley County. The analysis showed different scenarios in which MUHA captured patients from other providers—one where 70% of captured patients came from Trident's patient base and 30% from Roper Berkeley's patient base and another scenario where the split was 50/50. Specifically, Roper reflected the projected capture in market share through discharges. In the

[50] Interestingly, in its application for BMC, Trident justified the need for the hospital using its existing patients – in other words, like MUHA's current application, it premised its application on 100% redirection of its existing patients. Based upon that premise, Trident argued its new hospital would not have an impact on other systems. However, Trident now argues MUHA's new hospital, also based upon 100% redirection, will affect it and BMC. The irony is inescapable.

70/30 scenario, Roper predicted MUHA Berkeley would "ramp up" beginning in 2021, and Roper Berkeley would go from 7,405 discharges in 2021 to 7,145 discharges in 2025, a decline of 4%. In the 50/50 scenario, Roper predicted it would go from to 7,405 discharges in 2021 to 6,594 discharges in 2025, a decline of 11%. Under both scenarios, Roper determined there would be a material impact to Roper Berkeley. I find that this internal impact analysis over-predicts the impact on Roper Berkeley because Roper Berkeley will have more time to establish itself before MUHA Berkeley comes online based upon the current timeline. Although MUHA Berkeley initially forecast that it would come online in 2021, this litigation has pushed back this timeline by almost a year thus far. Roper Berkeley will be able to capitalize on its successful bid to be first-to-market in Berkeley County for longer than predicted in its analysis, thus building a larger base of aligned patients. Additionally, population growth in the area during this time will also benefit both Roper Berkeley and lessen the impact of MUHA Berkeley eventually entering the market.

Mr. Richardson also analyzed the impact of MUHA on Roper. His impact analysis was premised on MUHA not being able to redirect enough existing patients to meet its projected number of patient days in Year 3 (26,805) and instead fall short by 12,000 to 17,000 patient days. To make up that deficient, Mr. Richardson looked at how many patients would probably be poached from Roper Berkeley based upon Roper's market share in the area and its proximity to the proposed hospital. Mr. Richardson testified he expects between 33% and 50% of the patient days projected by MUHA would come from Roper Berkeley and that, in his opinion, Roper Berkeley would lose between 3,000 to 8,000 patient days to MUHA Berkeley. He opined that with a Year 3 patient day forecast for Roper Berkeley of 12,775, the loss would represent at least 25% and upwards of 50% to two-third of Roper Berkeley's projected volume. Similarly, Mr. Sullivan, without predicting how many patient days are likely to be redirected, simply averred that MUHA will capture less days than it predicted and will then specifically seek to redirect patients from Roper to fill its deficit.

As already discussed, I found MUHA's proposed service area and redirection analysis to be reasonable; therefore, I do not agree with the premise of Petitioners' adverse impact analysis. Specifically, I do not agree with Mr. Richardson's estimation of MUHA's deficit and market capture in Year 3 because I find the underlying premise of a large deficit in patient days to be flawed. Moreover, even if MUHA were to fall short of its patient days in Year 3, the evidence did

not reflect that MUHA Berkeley would or could single-handedly poach as many patients as it wants to fill a patient deficit. Patients have a choice in where they go. Therefore, I do not find Petitioners experts' analyses to be helpful. Further, while Roper Berkeley's internal analysis described the projected impact of a MUHA hospital as a "material" impact, I disagree. This analysis over-estimates the impact since Roper Berkeley will have the benefit of more time than this analysis predicted before MUHA Berkeley comes online and it will have the benefit of strong population growth in the area. BMC is likewise delayed and will probably take even longer than MUHA Berkeley to come online **if** it ever does.

Overall, MUHA's project is more likely to have an impact on Roper Berkeley because Roper Berkeley is new and less well-established compared to TMC and SMC. The Project will be located less than four miles away from Roper Berkeley and, as a result, it will share a larger part of its primary service area with MUHA Berkeley. Nevertheless, I do not accept the impact to Roper Berkeley will be significant. While I agree that MUHA Berkeley's entry into the market will result Roper Berkeley losing some market share, which is an adverse impact, the loss of market share will be minimal. Furthermore, I do not find this impact outweighs the benefits of increased access that MUHA Berkeley will provide to its target patient population who continue to receive care at MUHA Berkeley's downtown campus. Because it is first in the market, and considering the strong population growth in the area, these factors should significantly reduce any impact on Roper Berkeley. Moreover, while I find that MUHA's reliance upon **100%** redirection is unreasonable, the preponderance of the evidence demonstrates that the vast majority of MUHA's patients will be redirected and the impact to market share will be small. Balanced against the increased access MUHA Berkeley will provide, I do not find Petitioner Roper presented convincing evidence that MUHA will have an adverse impact on Roper Berkeley such that MUHA's application should be denied.

CMC

Lastly, I find that the extent to which MUHA Berkeley has an adverse effect on CMC, this impact would be more of a product of CMC's already precarious financial situation rather than a product of bad healthcare planning. This finding is not intended to suggest that under the appropriate circumstances, a CON application should not be denied because of the adverse impact on an existing provider that is struggling financially. However, here the evidence demonstrates

that CMC has lost money every year since 2015. CMC currently has 116 beds but a bed need of only sixty-eight, resulting in an excess of forty-eight beds. CMC's 2016 occupancy rate was 38.5%. Its utilization went down in 2018 compared to 2017. Like many rural hospitals, CMC is struggling with a relatively stagnant population in its service area. And, while MUHA is CMC's biggest competitor for patients, CMC's primary service area will be in MUHA Berkeley's secondary service area. MUHA Berkeley is likely to draw some patients away from CMC and I do not discount this impact to CMC. Nevertheless, although Mr. Hiott concluded even a 10% loss would result in a financial loss of $168,030 to this struggling hospital,[51] his analysis was based upon a 30% redirection of MUHA's patients from the secondary area when the evidence reflects a 2% redirection is the more likely scenario. Therefore, I do not find Mr. Hiott's analysis to be persuasive.

In sum, the number of patients that will redirect is likely to be small. The Court nevertheless recognizes that because CMC is already in a vulnerable position, what would be a relatively insignificant redirection of patients may be more material to CMC. However, the impact to a hospital teetering on insolvency must be weighed against the benefits of increasing access to the target population and MUHA's patients at its downtown hospital. This factor when viewed in combination with CMC's location outside the service area, leads the Court to conclude that the minimal adverse impact to CMC does not outweigh the benefits of increased accessibility provided by MUHA. For these reasons, I find any adverse impact to CMC is justified and the benefits of MUHA's proposed hospital outweigh any adverse impact to CMC.

FSED

Despite the above findings concerning lack of adverse impact, the Project would result in an unacceptable adverse impact if MUHA's proposed Nexton FSED is not absorbed by the Project. Originally, MUHA set forth in its CON application that upon opening the new hospital, MUHA would close the FSED the Department had approved for Berkeley County. However, after Petitioners objected to this CON for this Project, MUHA changed its position and now seeks to keep the FSED open. Presumably, MUHA's FSED's physicians would be apt to refer patients to

[51] To estimate the losses, Mr. Hiott looked at the contribution margin, which is net revenue minus operating expenses associated with the care of a patient.

MUHA Berkeley. Thus, MUHA Berkeley would potentially receive the benefit of duplicate emergency room referrals, thereby increasing its patient volumes and revenues for the Project. Although the increase in patient referrals would make MUHA Berkeley more financially feasible, it would do so at the financial harm to the existing local hospitals—specifically to Roper Berkeley. I find this impact would be a material adverse effect. This is especially pertinent in light of MUHA's contention that it did not intend to redirect patients from those existing hospitals. Therefore, I find the granting of the CON must be dependent upon MUHA honoring its original declaration that upon opening MUHA Berkeley, its FSED, if operating, will be closed. Otherwise, the Project will create an adverse impact to existing hospitals in violation of Standard 5.

Staffing

Nursing Shortage

Petitioners presented evidence that there is a nursing shortage in South Carolina and Tri-County area and the opening of MUHA Berkeley will adversely impact Petitioners' ability to staff their hospitals. MUHA did not necessarily disagree with the existence of a nursing shortage; however, it argued the nursing shortage has been an on-going issue for several years and has not prevented any of the providers in this case from expanding or building new facilities.

The evidence reflects that although there may be a shortage of permanent, full-time nurses at many hospitals, this shortage can be compensated for using temporary nurses or "travelers." All hospitals have been relying, to some extent, upon traveling nurses to fill areas where a provider is under-staffed. Hiring traveling nurses is not ideal for a provider because travelers are not conditioned to the protocols and culture of the hospitals they serve and they cost up to three times more than a regular nurse; however, they are a part of a hospital's administration in today's climate.

If MUHA Berkeley's CON is granted, there will be some nurses who leave another provider to work at the Project. For example, Trident lost eight RNs to Roper Berkeley; nevertheless, Trident continues to expand. I find that similar losses are likely to occur upon the opening MUHA Berkeley. However, because traveling nurses have been developed as a means by which to address the nursing shortage, the impact is likely to be immaterial overall.

Similarly, Trident raised the concern that the addition of MUHA Berkeley will drive up hiring costs for nurses. In order to retain staff, Trident has increased nursing pay three times in the last year to be more competitive in the market. Trident's Vice President of Human Resources,

Victoria Cummings,[52] testified MUHA is currently offering $20,000 sign-on bonuses for the Florence and Marion County markets in which MUHA operates. She is concerned that if MUHA offers significant sign-on bonuses for the Project, her staff would be interested in leaving. Again, I do not find that this concern established a material adverse impact that distinctly exacerbates the existing market conditions.

In sum, although MUHA Berkeley is likely to exacerbate the issues associated with hiring and retaining nurses, including the cost, Trident's own evidence shows that costs are increasing whether MUHA Berkeley is built or not. If the nursing shortage alone were material, then no new CONs should be granted in the Tri-County area for any facilities requiring nurses to be hired. I do not find that to be the case.

Physician Staffing

As with the nursing staffing, Petitioners also raised concerns that the opening of MUHA Berkeley would adversely affect their physician staffing. However, the evidence established that each health system has strong physician-alignment, and, unlike the nursing shortage, there is no evidence of a physician shortage. Roper has a strong, well-established physician network in the Tri-County area. The Medical Society of South Carolina is a large physician group that is a support organization for Roper and has a large presence in the service area. Trident has been serving northern Charleston, Berkeley, and Dorchester counties since 1975 and it also has a well-established physicians' referral networks.

Although challenges in physician staffing do exist, the evidence did not establish that the addition of MUHA Berkeley will trigger a loss of physicians from other providers that will create a material adverse impact upon the existing hospitals. In fact, the staffing of MUHA Berkeley will be unique because MUHA requires that every physician on staff at MUHA Berkeley be a member of the academic faculty. Moreover, each physician is expected to engage in clinical care, teaching, and research or some kind of academic productivity. This requirement will limit any potential impact of physicians leaving the existing hospitals systems because many physicians will not want the additional burden of teaching.

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[52] The Court qualified Victoria Cummings as an expert in clinical human resources. Tr. vol2 at 303.

Additionally, like Roper and Trident, MUHA's existing physicians will practice across its system and, therefore, some of the physicians who currently practice at the downtown campus will also practice at MUHA Berkeley. Also, some physician practices have privileges across health systems. For example, certain group practices like Lowcountry Women's Specialists and Lowcountry Orthopedics practice at both Trident and Roper locations. Furthermore, the majority of referrals to hospitals systems come from physicians who are not employed by hospitals and there are no restrictions as to which hospital they can refer patients. Overall, I find no evidence to indicate the Project will cause a material adverse impact to physician staffing in the area.

Financial Feasibility

Petitioners contend the Project is not financially feasible. To show the Project's financial feasibility, Lisa Goodlett, CPA and MUHA CFO, and Mr. Levitt, both testified as to its feasibility. MUHA's pro forma for MUHA Berkeley projects it will lose $11,442,000 in year one, become negligibly profitable at $39,000 in year two, and make a reasonable profit of $14,029,000 in year three.[53] Ms. Goodlett testified the pro formas are reasonable, accurate, and based upon data from MUHA's historic performance.

MUHA submitted three pro formas that were certified by Ms. Goodlett. The three pro formas reflect the time period of July 1, 2019, through June 30, 2025, with 2023-2025 reflecting the first three years of operation of the project. The first pro forma predicts the financial position of MUHA with the addition of the project, the second pro forma predicts the financial position of MUHA without the hospital, and the third pro forma predicts the position of the project alone. The pro formas show that the addition of the hospital is predicted to increase net operating revenue by $94,755,000 in 2023,[54] $126,388,000 in 2024, and $176,348,000 in 2025. Petitioners criticized the incremental revenue shown by the pro formas with the addition of the Project because MUHA has premised its project on a 100% redirection of its own patients, which suggests that MUHA

[53] Mr. Levitt testified outpatient revenue in the CON application was a conservative estimate because it assumed a 65/35% split between inpatient and outpatient respectively when the split is usually more like 50/50% for a community hospital. When Mr. Levitt modified the outpatient volumes to be higher and more realistic and increased personnel expenses accordingly, he calculated a $30 million profit.

[54] When non-patient income is subtracted from the operating revenue of $94,755,000 in 2023, the result is approximately $92 million in patient-driven revenue the new hospital would add in year one. In other words, the pro formas show the new hospital would have $92 million in incremental income in year one.

should make the same amount of revenue with or without the project. Petitioners argue MUHA's pro formas show MUHA anticipates the Project will capture new patients rather than redirect existing ones.

Initially, MUHA's pro formas conflict with their assertion that this project will be supported only by patients redirected from MUHA's existing patients. However, although MUHA's pro formas conflict with its assertion that it will redirect 100% of the patients at the new hospital, MUHA's assertion that 100% of its patients will be redirected from its own patient population is unreasonable. Moreover, the important question is not just whether 100% of MUHA will redirect to MUHA Berkeley, but also whether MUHA will obtain additional patients and thus increase its revenue. In that light, it is important to recognize that while MUHA's pro formas are not necessarily consistent with how they framed their project, the evidence reflected that MUHA will receive incremental income from a shift in market share.

Petitioners nevertheless contend MUHA's assumptions do not adequately take into account the differences between a tertiary/quaternary hospital and a community hospital. Specifically, Petitioners assert MUHA's financial projections are based on an estimated ALOS that is too high for a community hospital and average adjusted net revenue per discharge that is also too high for a community hospital. For instance, Petitioners presented evidence that Roper usually has a net revenue per adjusted discharge of less than $10,000 for its community hospitals. Roper's tertiary hospital has a net revenue per adjusted discharge of about $14-15,000. Similarly, Trident's net revenue per adjusted discharge is approximately $13,000. In contrast, MUHA Berkeley's projected net revenue per discharge is $18,500. And, when MUHA downtown's net revenue per adjusted discharge ($21,808) is discounted by 15%, the net revenue is approximately $18,500 or approximately the amount projected by the pro formas.

Although this discount does not produce a charge that is consistent with the charges at other community hospitals in the Tri-County area as demonstrated by the adjusted charges at Roper and Trident, it is equally clear that MUHA is a unique provider in this State and its community hospital will reflect that uniqueness to some extent. In particular, although Roper's downtown facility is a tertiary hospital, its net revenue per adjusted discharge is significantly lower than MUHA's net revenue per adjusted discharge at its tertiary hospital. Throughout this case, it has been evident that MUHA's numbers are significantly higher than other hospitals in the area. It thus stands to

reason that its community hospital will also reflect higher than average numbers based on the type of patients MUHA tends to draw, which is a higher acuity mix. Therefore, while the Court recognizes the Project will be a community hospital, the Court reasonably expects a MUHA community hospital, even one purporting to decant lower acuity patients from its downtown facility, will still retain elevated numbers because it will reflect its parent hospital. For this reason, the Court is not persuaded MUHA's pro formas are not reasonable projections of the financial feasibility of the Project, even if they might be unreasonable for another hospital system in the area.[55]

Therefore, I find Petitioners failed to meet their burden of proof to establish the Project is not financially feasible.

Ability to Complete the Project

Timeframe

MUHA's time frame to initiate and complete the project is two years from beginning of construction and three years and seven months from architectural contract to project completion. Roper Berkeley was fifty beds and the projected timetable was three years. BMC's proposed construction timeline was thirty-eight months. MUHA has completed each of the projects for which it has received a CON. Petitioners presented no evidence to the contrary. I find MUHA Berkeley has demonstrated that it can initiate and complete the project within the application time frame.

Financing

MUHA asserts that to finance the project it will seek out either a FHS-insured tax-exempt loan or a GNMA-insured tax-exempt loan, both of which are insured under HUD Section 242 Hospital Mortgages Insurance. MUHA has an established history of financing its strategic projects

[55] Whether or not MUHA's significantly larger charges would result in a higher cost to patients was unclear. Ms. Goodlett opined that expanding MUHA's footprint, and thus servicing more patients, would allow MUHA to protect or defend its pricing power. As the Court understands it, this means MUHA will be able to extract more from private insurers. It was not clear whether this would also increase patient payments to compensate for the higher insurance payouts. Additionally, although MUHA's parent hospital would appear to have the highest charges in the area, no evidence was introduced as to whether that led to higher costs for patients at MUHA downtown than at other providers in the area for comparable services.

through HUD and there was no evidence presented that MUHA has struggled to obtain HUD financing in the past or has failed to meet its obligations under HUD in the past.

MUHA submitted a letter from Armadale Capital, a licensed FHA multifamily lender and SEC-registered municipal advisor. In the letter, Armadale states it is committed to helping MUHA secure FHA mortgage insurance approval for the project and indicates that a preliminary review of the project was favorable. Armadale's letter is not a guarantee to extend financing, but it is not the usual practice to acquire guaranteed financing prior to having a project approved. Indeed, Roper's own witness, Mr. Johnson, acknowledged that in Roper's 2008 CON application for its Berkeley Hospital, it submitted a letter from Wachovia Bank that was not a guarantee to finance but was rather subject to their subsequent review of revenues and expenses. Similarly, for MUHA to receive financing, a feasibility study will have to be performed in accordance with HUD requirements.

Although Petitioners presented evidence suggesting that HUD financing is financing of last resort that requires higher fees with more conditions placed upon the loan, I do not find this evidence to be persuasive in this particular case. The evidence showed MUHA can obtain good interest rates from HUD and it has been able to secure loans from private banking entities in the Wohl past; nevertheless, HUD is its preferred lender.[56] If MUHA cannot get HUD financing, it has five to six banks it works with for lending.[57] Additionally, MUHA most recently successfully used HUD financing to finance $316 million to build Shawn Jenkins and the purchase of the four CHS hospitals in 2019. Therefore, I do not find MUHA's decision to seek HUD financing indicates MUHA is in a poor financial position or otherwise unable to successfully finance and complete the Project.

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[56] Petitioners also presented evidence that six lending institutions would not service a previous MUHA request for $38 million in unsecured financing. The Court does not find this evidence convincing considering the nature of the debt requested and MUHA's status as a governmental organization for which different standard apply.

[57] Petitioners presented evidence that several commercial banks would not extend financing to MUHA for a smaller project of $38 million because of factors related to its financial position; however, I find that MUHA successfully rebutted this evidence because MUHA, as a government entity, is not judged by the market the same way as a regular for-profit or non-profit entity might be and rejection of this type of financing does not necessarily reflect that MUHA is a bad risk or in a poor position.

MUHA's Capacity for Debt Service

Petitioners argue MUHA's ability to complete the project is jeopardized by its recent acquisitions and increased debt load which they argue is over-taking MUHA's ability to fund all the projects it seeks to complete. Specifically, Mr. Sullivan questioned whether it makes "sound heath planning sense" for MUHA to pursue this project from a financial standpoint. Mr. Sullivan opined the Project's financial feasibility is already questionable and will probably drain MUHA's resources, especially in light of the other strategic projects it is undertaking at the same time, including the purchase of the four new hospitals.

According to Dr. Cawley, MUHA has a three-phase strategic plan that has been developed by the MUHA Board. Approximately every ten years, MUHA begins a new phase. The first phase was the Ashley River Tower (ART), the second phase was Shawn Jenkins, and the third phase is a replacement hospital for the downtown campus. Although this three-phase plan is the overall plan that was developed and has been updated by MUHA since the early 2000's, lately MUHA's expansion efforts have extended well beyond the projects outlined in this plan. Indeed, it was difficult to keep up with the number of projects MUHA has recently undertaken during the pendency of this action. For instance, in addition to this Project, MUHA has purchased the CHS hospitals and taken on the Shawn Jenkins project, a pediatric imaging project, the Nexton FSED, the Johns Island FSED, and a joint venture in Beaufort.

Based upon MUHA's 2019 audited financials, MUHA has approximately $1.7 billion in revenue and about $2 billion in assets. MUHA's balance sheet from its 2019 audited financials shows it has $2.1 billion in assets and $2.7 billion in liabilities resulting in a $623 million deficit in equity or "net position" for MUHA. Despite this deficit, Ms. Goodlett characterized MUHA's financial position as of June 2019 as "very strong" with operating revenue of $55 million and eighty-one days' cash on hand or approximately $420 million in the bank.

Nevertheless, MUHA's recent acquisitions have increased its debt load. Mr. Johnson testified MUHA's current debt load, including debt for Shawn Jenkins, equals approximately $1 billion. He estimated that $1 billion of debt at a 4% interest rate for thirty years will result in $125 million a year in annual debt service and MUHA's income statement shows $92 million of income available to pay debt service. However, on cross, Mr. Johnson conceded that MUHA's 2019

audited financials show it has $400+ million in restricted and unrestricted cash in the bank, an operating income of $35 million, and free cash flow of $150 million.

Additionally, Mr. Johnson's concerns must be evaluated in view of the timing when different debts will accrue. Not all of these projects will come online at the same time. In fact, it is notable that MUHA's method of funding its projects, including the Project at issue, is similar to other health systems in the area. Roper engages in major strategic projects approximately every five years and funds its projects through tax-exempt bond debt and substantial contributions from its founding members (Medical Society of South Carolina, Bon Secours Health System, and Atrium Health). Roper, like MUHA, spaces out its strategic projects to allow time to pay down the last project and increase its debt capacity again.

Furthermore, Ms. Goodlett testified MUHA's outstanding debt projected as of 6/30/20 is $750 million. In addition, MUHA's OPEB[58] and pension liabilities are a significant contributor to its overall negative financial position on the balance sheet, but it is unlikely MUHA will ever have to pay out these liabilities that it is carrying for the State. Because of these OPEB and pension liabilities, in part, MUHA does not satisfy HUD's debt to capitalization standard; however, MUHA is only required to meet three of five standards, which it does.

Specifically, HUD requires an applicant to have twenty-one days cash on hand. MUHA traditionally maintains around fifty to sixty days cash on hand. MUHA deems anything above sixty days cash on hand to be strategic reserves that can be reinvested in MUHA since they have no stockholders. Based upon HUD's requirements and MUHA's self-imposed requirements, MUHA clearly meets the cash on hand criteria.

HUD also requires an applicant to have a debt service ratio of 1.4. This means MUHA must have 1.4 times more cash than debt for a mortgage payment, and MUHA usually runs at around 2.8-3. Ms. Goodlett testified that if MUHA remained within the requirement of a 1.4 debt to cash ratio, MUHA would have the capacity to take on approximately $1.4 billion more in debt serviced over twenty-five years at 5% interest. This is based upon MUHA having approximately $149 million in unrestricted income in 2019 that could be applied towards the re-payment of any

[58] OPEB stands for "Other Post-Employment Benefits."

additional debt needed to build the proposed hospital. This Project only amounts to $325 million, which is a large expense, but about 25% of 1.4 billion.

Finally, MUHA does not rely on debt-financing alone to support its acquisitions and expansions. MUHA receives between $24-46 million in State funds every year, primarily for telehealth and innovation, but it occasionally receives grants for other projects like the $25 million it received for Shawn Jenkins. MUHA also receives funding through revenue from its clinical care, disproportionate share funding through Medicaid, and private donations and fundraising. And, because MUHA does not have shareholders, it is able to reinvest its revenues back into its healthcare system to improve the quality of care for patients.

Overall

While MUHA's increasing financial commitments are concerning, I find that questioning the impact of future projects that may change or not come to fruition is less probative than focusing on MUHA's financial position at the time this application was submitted. This does not mean the Court is ignoring, for example, the acquisition of the four hospitals which has already occurred. However, the Court finds the financial metrics presented by Ms. Goodlett to be credible and to indicate that despite MUHA's balance sheet deficit, it is well-positioned based upon its other metrics, including cash on hand and ability to service additional debt. I also find it remains well-within the parameters required by HUD. It is also significant that no evidence was presented showing that MUHA has ever previously failed to complete a project or defaulted on a project. Rather, the evidence presented shows that MUHA has always fulfilled its obligations.

Alternatives to the Project

In its application, MUHA considered three alternatives regarding its bed need: (1) maintain the status quo and not proceed with the project; (2) renovate and expand its inpatient services at its downtown campus; or (3) construct MUHA Berkeley for $325 million. MUHA found maintaining the status quo with its capacity constraints was not a viable option. It also found the cost to renovate various buildings on its campus was comparable to the cost of building the Project, but the quality of care would less if delivered in downtown Charleston. For this reason, it concluded building the Project was the best option.

Petitioners criticized MUHA for not further exploring alternatives to the Project—in particular, for not further exploring the option to add 128 beds downtown. Mr. Sullivan opined

that adding more beds downtown would reduce the need to duplicate administrative and overhead expenses that would be associated with a new hospital, it would be more convenient for MUHA faculty and students, and it would give patients access to MUHA's specialized equipment downtown. Mr. Sullivan suggested there may be space to add additional beds in the recently vacated children's hospital.[59]

However, there are numerous needs for the vacated space that is now available. In fact, MUHA intends to transfer some transplant services and imaging equipment to that area. Therefore, MUHA has submitted two CONS for thirty-three beds and twenty-nine beds respectively to backfill the old children's hospital. Furthermore, the old children's hospital, because of its age and construction, is simply unsuitable for adding 128 new beds. Rebecca Smith, AIA, MUHA's expert in health design and space planning, explained the array of problems associated with locating 128 additional beds on the downtown campus in existing facilities such as the recently evacuated old children's hospital.[60] Specifically, limitations on room size, construction challenges such as low ceiling height, ability to meet standards for air exchange, wiring and running cable for computer dependent equipment, and the increased burden on clinical services and therapies would result in a failure to meet the appropriate standard of care for hospitals if the beds were squeezed onto the downtown campus. In 2008, Roper, itself, addressed similar problems. It considered upfitting old buildings on the peninsula instead of building Roper Berkeley but found it would be much more expensive for Roper to upfit old buildings downtown from the 40's and 60's than to build a new greenfield project.

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[59] Mr. Sullivan also alluded to a MUHA master facilities plan that shows the potential for developing another tower downtown; however, this new tower is intended to be a replacement tower for the existing main hospital downtown. Dr. Cawley explained that MUHA developed a three-phase plan to build the Ashley River Tower ("ART") as phase I, the Shawn Jenkins Children's Hospital, phase II, and a future, potential replacement for the main hospital, phase III. ART was opened in 2008. The Children's Hospital will open in early 2020. Phase III would replace, in the future, the current main hospital, but no plans have ever been developed concerning this Phase.

[60] Ms. Smith conceded she had not been retained to, nor did she, perform any formal studies to determine the costs associated with expanding downtown or renovating/modernizing the soon-to-be empty old Children's Hospital as an alternative to establishment of a new hospital. However, I find Ms. Smith visited the old children's hospital and was familiar enough with its size and specs to credibly comment on the practicality of renovating the old children's hospital.

Additionally, the need for parking is already overburdened on the peninsula campus. Adding an additional 128 beds, with the required additional staffing and need for patient related parking, would thus further burden parking on the campus.

Flooding is also a concern on the peninsula. Although flooding did not prevent MUHA from constructing Shawn Jenkins on the peninsula, the Court recognizes that flooding is a serious concern for some aspects of hospital infrastructure. For example, Roper moved its data center off the Charleston peninsula in 2012 for several reasons, including flooding and the inability to get redundant power and fiber to ensure the reliability of the system. MUHA did the same. These movements off the peninsula were an appropriate response to this issue. Therefore, it is a reasonable response by MUHA to seek to move some of its hospital operations off the peninsula because of flooding. This is especially true since it gives MUHA the option to move patients to MUHA Berkeley in the case of a hurricane.

In sum, Petitioners' evidence failed to rebut MUHA's reasons for choosing to locate MUHA Berkeley at the proposed location. Rather, the evidence supporting MUHA Berkeley's location was more persuasive.

Cost Containment

Petitioners argue the Project's construction costs are too high and the Project will be the most expensive hospital ever built in South Carolina. Mr. Sullivan testified that the Project was going to cost 68% more per square foot compared to the new Shawn Jenkins tower. Shawn Jenkins had a construction and equipment cost per bed of $1,167,377 and a construction cost per square foot of $404 even with demolition of an existing hospital structure, as opposed to the $1,307,154 cost per bed and $538 per square foot construction cost in the CON Application for the Proposed Project. I do not find the difference in cost between the projects to be materially significant. Moreover, the overall cost per bed for the Project is 2.5 million, which is comparable with Roper Berkeley and BMC at $2.3 million $2.4 million per bed, respectively. Overall, I find the projected cost for the Project are not outside the bounds of comparable projects in the area, even if MUHA Berkeley will be at the higher end of the spectrum. It is expected that the cost will be slightly higher due to inflation compared to prior projects, like Shawn Jenkins.

CONCLUSIONS OF LAW

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

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). Therefore, 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).

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." 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 (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).

Here, Petitioners timely filed requests for contested cases challenging DHEC's decision to approve MUHA's CON application. As a result, Petitioners, as the moving parties, bear 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, Petitioners must prove by a preponderance of the evidence that DHEC erred in approving MUHA'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).

CON Law

The State Certification of Need and Health Facility Licensure Act, S.C. Code Ann. §§ 44-7-110 to -394 (2018 & Supp. 2019) (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) (2018). 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 (2018).

DHEC is responsible for administering the CON program in South Carolina. S.C. Code Ann. § 44-7-140 (2018). As such, DHEC's duties include promulgating regulations, S.C. Code Ann. § 44-7-150(3) (2018), and preparing a South Carolina Health Plan, S.C. Code Ann. § 44-7-180(B) (Supp. 2018). 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) (2018). 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(B) (2018); *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).

Regulation 61-15 § 802 sets forth thirty-three 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. Specifically, the CON Act provides:

> [the PRC] promulgated in regulation must be used in reviewing all projects under the Certificate of Need process. When the criteria are weighted to determine the relative importance for the specific project, the department may reorder the relative importance of the criteria no more than one time after the project review meeting. When an application has been appealed, the department may not change the weighted formula.

S.C. Code Ann. § 44-7-190(B) (2018). The CON Regulations further provide that "[t]he criteria listed in Section 802 are to be used in reviewing all projects under the Certification of Need program." S.C. Code Ann. Regs. 61-15 § 801(1) (2011). Moreover, "[t]he relative importance assigned to each specific criterion is established by the Department depending upon the importance of the criterion applied to the specific project" and "[a] project does not have to satisfy every criterion in order to be approved, **but no project may be approved unless it is consistent with the South Carolina Health Plan**." S.C. Code Ann. Regs. 61-15 § 801(2) & (3) (emphasis added).

Taking into consideration the language of the CON Act and Regulations, every PRC "must be used" when evaluating a project, even if some are weighted more than others. § 44-7-190(B); Reg. 61-15 § 801(1). Moreover, in order to comply with the SHP, the PRC listed in the applicable SHP as the "most important" criteria must be considered. *See* Reg. 61-15 § 801(3); *see also* S.C. Code Ann. § 44-7-210(C). In this case, the 2017-2018 SHP lists the following PRC as the most important in evaluating CON applications for hospitals: (1) Compliance with the Need Outlined in this Section of this Plan; (2) Community Need Documentation; (3) Distribution (Accessibility); (4) Acceptability; (5) Record of the Applicant; (6) Cost Containment; and (7) Adverse Effects on Other Facilities. 2017-2018 SHP at 12. However, the Department is authorized to establish the relative important of the PRC for a particular project. § 44-7-190(B); Reg. 61-15 § 801(2). For this Project, the Department identified and ranked the following PRC as most important: (1) Compliance with the Need Outlined in the South Carolina Health Plan; (2) Community Need Documentation; (3) Distribution (Accessibility); and (4) Ability to Complete the Project.

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 (2018). Thus, this Court must consider the 2017-2018 South Carolina Health Plan and may also consider the 2018-2019 South Carolina Health Plan.

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) (2018). 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). The following issues were raised by Petitioners when they expressed their opposition to the Project to DHEC and will be addressed below:

(a) the need for the proposed hospital;

(b) the unnecessary duplication of services;

(c) the adverse effects of the proposed hospital;

(d) the financial feasibility of the proposed hospital;

(e) the ability to complete the Project; and

(f) alternatives to the proposed Project

Each of Petitioners' issues are considered below within the applicable legal framework.

Standard 5

MUHA applied to create a new hospital pursuant to Standard 5 of the SHP. Standard 5 provides:

> A facility may apply to create a new additional hospital at a different site within the same service area through the transfer of existing licensed beds, the projected bed need for the facility, or a combination of both existing beds and projected bed need. The facility is not required to have a projected need for additional beds in order to create a new additional hospital. There is no required minimum number of beds in order to approve the CON application. The applicant must justify, through patient origin and other data, the need for a new hospital at the chosen site and the potential adverse impact a new hospital at the chosen site could have on the existing hospitals in the service area.

2017-2018 SHP at 10-11.

MUHA proposed to transfer its "projected bed need" (institutional need) for MUHA's downtown campus to a new hospital/site within the Tri-County Service Area. Specifically, it seeks to transfer 128 beds of its 147-bed institutional need identified in the 2017-2018 SHP to a new hospital at the Nexton site in southeastern Berkeley County. This transfer is allowed under Standard 5 as long as MUHA meets the other two requirements in the Standard. First, it must "justify, through patient origin and other data, the need for a new hospital at the chosen site."

Second, it must "justify, through patient origin and other data . . . the potential adverse impact a new hospital at the chosen site could have on the existing hospitals in the service area." Based on the reasons below, I conclude MUHA's application complies with Standard 5 in the 2017-2018 SHP.

Projected Bed Need/Institutional Need

Initially, I find that "projected bed need for the facility" under Standard 5 is synonymous with the "institutional bed need" established for general hospitals by the State Health Plan. Petitioners' nevertheless suggest that in assessing need under Standard 5 this Court should basically ignore the State Health Plan's determination of a 147-bed institutional bed need of MUHA's peninsula hospital. Specifically, they contend that determining need "at the chosen site" under Standard 5 requires the court to assess the need of the population found at the chosen geographical site without reference to the institutional need of the facility which seeks to transfer beds.

Although I agree with Petitioners that the institutional bed need is not **the** determining factor, it nonetheless is a consideration, along with other factors that reflect a bed need in the service area. If institutional bed need were not a factor, then Standard 5 would be rendered meaningless, in part, because one of its basic premises is that a hospital can use its institutional need to create a new hospital. The other premise being that a hospital can transfer its existing beds (or some combination of existing beds and institutional need). Thus, institutional need is a basic tenant of Standard 5.

Nevertheless, although the ability to transfer its institutional need to create a new hospital still requires a further evaluation of need, it is also important to note Standard 5 does not prohibit the transfer of institutional need when there is an overall surplus in the service area. Thus, the ability to transfer of institutional need when the service area has a surplus of beds functions to accommodate, to an extent, overcrowding that is the result of patient choice. For example, Standard 3 allows a hospital with institutional need to add beds when the service area, as a whole, has a surplus. 2017-2018 SHP at 10 ("If the service area indicates a surplus of beds, then no additional beds will be approved unless an individual hospital in the service area indicates a need for additional beds.").

Thus, while patient choice is not an explicit consideration under the 2017-2018 SHP, the SHP allows some expansion that reflects patient choice for a particular provider rather than need in the service area. While MUHA did not apply under Standard 3, it is relevant to show that additional beds can be approved even when the service area as a whole has a surplus. *See Trident Med. Ctr. v. S.C. Dep't of Health & Envtl. Control*, 412 S.C. 341, 357–58, 772 S.E.2d 177, 185–86 (Ct. App. 2015) (noting provisions of Chapter 2 of the SHP governing General Hospitals should not be read in isolation). More importantly, Standard 5 does not contain a prohibition against approving the transfer of beds if the service area as a whole has a surplus. Consequently, institutional need is an important factor in this case that is an essential part of Standard 5.

Need at the Chosen Site

Petitioners argue the phrase "at the chosen site" means that the hospital transferring beds must show that there is a need "near" the geographic site of the new hospital. More specifically, in its Motions for Reconsideration, Trident contends that: "The Court's attempt to extend Standard 5's reference to 'the chosen site' to include the entire Tri-County Service Area and beyond ignores the plain language of that Standard." Similarly, Roper contends that the Court's determination that need for MUHA Berkeley exists based upon the patients that would decant from the peninsula hospital "ignores the plain language of the Health Plan that the patient origin data must be the data demonstrating need at the chosen site."

The South Carolina Supreme Court held that "it is clear the legislature intended for the State Health Plan to be an enforceable document." *Trident Med. Ctr. v. S.C. Dep't of Health & Envtl. Control*, 412 S.C. 341, 350, 772 S.E.2d 177, 182 (Ct. App. 2015). Accordingly, interpretation of the State Health Plan is comparable to the interpretation of a DHEC regulation. "Regulations are interpreted using the same rules of construction as statutes." *Murphy v. S.C. Dep't of Health & Envtl. Control*, 396 S.C. 633, 639–40, 723 S.E.2d 191, 195 (2012). "The first question of statutory interpretation is whether the statute's meaning is clear on its face." *Wade v. Berkeley Cty.*, 348 S.C. 224, 229, 559 S.E.2d 586, 588 (2002).

Petitioners' interpretation of this phrase ignores the plain meaning of this phrase within the context of the Standard as a whole. *See Hodges v. Rainey*, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000) ("Where the statute's language is plain and unambiguous, and conveys a clear and definite meaning, the rules of statutory interpretation are not needed and the court has no right to impose

another meaning."); *S.C. State Ports Auth. v. Jasper Cty.*, 368 S.C. 388, 398, 629 S.E.2d 624, 629 (2006) ("In construing statutory language, the statute must be read as a whole and sections which are a part of the same general statutory law must be construed together and each one given effect."). "At the chosen site" merely functions as an adjectival prepositional phrase to describe the noun "hospital" that precedes it, just like "at a different site" describes the "hospital" discussed in the first sentence in this Standard. In both cases, the phrases "at a different site" and "at the chosen site" describe the hospital that will be created under the Standard and differentiate it from the existing hospital from which the need will be transferred. The phrase "at the chosen site" answers the question of which hospital (the hospital at the existing site or the new site) is being discussed rather than identifying the geographic area from which the need for the new hospital must be justified. Indeed, if there was any doubt that "at the chosen site" functions as an adjectival prepositional phrase, the second time "at the chosen site" is utilized in the last sentence of Standard 5 is conclusive. Additionally, the word "new" identifies the hospital which will receive the transferred beds and "at the chosen site" identifies where that hospital is situated thus distinguishing it from the site of the existing hospital.

In contrast, Petitioners' interpretation, although a fair reading of a portion of the last sentence of Standard 5 in isolation, would force the Court and the parties to conjecture about the geographic scope of "the chosen site" in a way that is inconsistent with the State Health Plan, which always discusses need for general hospitals within the context of the service area—the county, or counties in this case. *See Jasper Cty.*, 368 S.C. at 398, 629 S.E.2d at 629 ("A statute should not be construed by concentrating on an isolated phrase."); *State v. Sweat*, 379 S.C. 367, 376, 665 S.E.2d 645, 650 (Ct. App. 2008), *aff'd as modified*, 386 S.C. 339, 688 S.E.2d 569 (2010) ("A statute as a whole must receive a practical, reasonable, and fair interpretation consonant with the purpose, design, and policy of the lawmakers."). Presumably, if the drafters of the State Health Plan intended to introduce a new geographical term— "at the chosen site" —to define the scope of where "the patient origin and other data" could come from to justify the need for the new hospital, it seems likely that they would have defined the term. Indeed, throughout the State Health Plan, the geographical and numerical consideration for determining need is the service area. The accompanying regulations also provide a structure for that consideration. Moreover, the context of the consideration of a facility's right to transfer beds pursuant to Standard 5 is a transfer "within

the same service area." Therefore, Standard 5, in its essence, requires MUHA to justify the need for its new hospital through patient origin and other data. The geographic context for this justification is the service area, just like the service area remains the context for analyzing the potential adverse impact of the "new hospital at the chosen site" under Standard 5.

Petitioners' construction also concentrates on the isolated definition of "at" to mean "near" without reading the Plan as a whole. Clearly, the rules of statutory construction provide that in construing regulatory language, the Court "should not concentrate on isolated phrases" but should read the law "as a whole and in a manner consonant and in harmony with its purpose" *CFRE, LLC v. Greenville County Assessor*, 395 S.C. 67, 74, 716 S.E.2d 877, 881 (2011). Furthermore, "[a] statute as a whole must receive practical, reasonable, and fair interpretation consonant with the purpose, design, and policy of lawmakers." *Trident Med. Ctr. v. S.C. Dep't of Health & Envtl. Control*, 412 S.C. 341, 357, 772 S.E.2d 177, 185 (Ct. App. 2015) (quoting *Sparks v. Palmetto Hardwood, Inc.*, 406 S.C. 124, 750 S.E.2d 61 (2013)). Here, the definition of "at" can mean an object is "in" or "on" or "near" a location. *See* MERRIAM-WEBSTER ONLINE DICTIONARY, https://www.merriam-webster.com/dictionary/at (last visited Aug. 27, 2020); *Lee v. Thermal Eng'g Corp.*, 352 S.C. 81, 572 S.E.2d 298 (Ct. App. 2002). ("Where a word is not defined in a statute, our appellate courts have looked to the usual dictionary meaning to supply its meaning."). Petitioners construction relies on interpreting "at" as "near." However, even if the Court were to narrowly find that the issue before this Court is the meaning of the word "at," rather than identifying the contested words as an adjectival prepositional phrase, Petitioners' argument fails.

The word "near" means "at, within, or to a short distance or time." MERRIAM-WEBSTER ONLINE DICTIONARY, https://www.merriam-webster.com/dictionary/near (last visited Aug. 27, 2020). Obviously, it would be unreasonable to require that the patient origins and data be from "within" the geographical footprint of the hospital site. Accordingly, Petitioners must be relying upon the interpretation that the patient origin and data must derive a short distance from the hospital site. Yet, Petitioners propose that that the Court consider a "seven or eight mile radius around the hospital as a primary service area, extending to ten miles out for a combined primary and secondary service area" to be the area from which the patient origin and data should come from to determine need under Standard 5. Thus, under their interpretation, a distance of ten miles,

which many would perceive as a substantial distance, would be considered "near" to the chosen site.

Petitioners' interpretation is even more problematic in light of the Court's factual determination that if the Court does not consider the Tri-County Service Area as a whole, the primary geographical area to be considered in determining patient origin should be a 30-minute drivetime. Indeed, in the same chapter of the State Health Plan which sets forth Standard 5, the plan provides that: "General hospital beds are typically located within approximately 30 minutes' travel time for the majority of the residents of the State." 2017-2018 SHP at 9. Utilizing this assessment, Petitioners ten-mile limitation would presume automobile travel at an average of only 20 mph, which is unreasonable. Construing the phrase to require consideration of only patient origin and other data a "short distance" from the proposed hospital is thus not a practical or reasonable interpretation of "at the chosen site."

In sum, the plain meaning of Standard 5 sets forth that a hospital seeking to transfer beds must establish that the receiving hospital has a need based upon patient origin and other data. And, the patient origin and other data for a hospital should be based upon the service area as set forth in the State Health Plan. This interpretation is the most practical and reasonable interpretation that is consonant with the purpose, design, and policy of lawmakers.

Need Conclusion

MUHA clearly has a large institutional need of 147 beds as set forth in the State Health Plan. Therefore, considering Standard 5 allows the transfer of institutional need, with no prohibition even if the service area has a bed surplus, and considering the benefits to both the target population but also the inescapable benefits to the whole population served by MUHA downtown—and in particular their unique high acuity patients—I find MUHA has demonstrated a need. Furthermore, the evidence shows MUHA justified the need for a 128-bed hospital based upon the significant percentage of its patient that originate in the Tri-County Service Area (including the submarkets near the Project), the significant population growth in the area; and the reasonableness of its service area, patient redirection percentages, ALOS, and projected utilizations. However, in this case, it ultimately does not matter whether the factual analysis is based upon Petitioners' interpretation that the Court consider only patient origins and data "near" the chosen site or the State Health Plan's geographical service area because, under either scenario,

MUHA established a bed need for MUHA Berkeley based upon patient origins and other data. For instance, the evidence established 29% of MUHA's existing patients originates in the submarkets "near" the proposed site and this baseline need, along with numerous other facts cited in this case that reflect the patient need in the area, is sufficient to justify a need near MUHA Berkeley. Accordingly, MUHA established a need for the proposed hospital in accordance with Standard 5 in the 2017-2018 SHP.

Adverse Impact (Burden of Proof)

Under Standard 5, MUHA is required to justify "through patient origin and other data . . . the potential adverse impact a new hospital at the chosen site could have on the existing hospitals in the service area." Petitioners contend MUHA failed to quantify that potential impact because MUHA simply determined its Project, based upon the redirection of its own patients, would have no adverse impact. In their Motions for Reconsideration, Petitioners contend MUHA's failure to conduct any adverse impact analysis based on its theory of redirection is equivocal to a failure to justify the potential adverse impact of its Project such that it did not meet its burden of proof before the agency. Petitioners complain that since they are placed in the position to seek contested case review of that failure, the burden of proof has been shifted to them to both conduct the adverse impact analysis and show how they are adversely impacted. Accordingly, Petitioners contend MUHA's request for a CON should, be denied because MUHA failed to conduct an adverse impact analysis to justify its Project in compliance with Standard 5.

Petitioners conflate MUHA's theory of redirection with a failure to justify adverse impact. The evidence demonstrates MUHA considered an adverse impact analysis, but determined that because it would be "only filling an unmet need identified by the 2017-2018 State Health Plan" through the redirection of its existing patients, it would not impact other providers by taking market share from them to cause an adverse impact on existing providers. MUHA also theorized that Berkeley County is a substantially underserved market with a lack of patient access such that more access was needed and would not have an adverse impact. Whether MUHA's theories were sound or not does not negate the fact that they conducted an analysis of various factors that could contribute to adverse impact and ultimately concluded that there would be no adverse impact. Thus, MUHA complied with the requirements of Standard 5 to present a justification for its project at the agency level.

Moreover, in this case, the Department determined that MUHA's CON should be granted. Following that decision, Trident took advantage of its legal privilege as an "affected person" to file a contested case with the ALC to challenge the Department's determination. Therefore, Trident erroneously characterizes this review as a review of MUHA's application rather than a review of the Department's determination. When considered in light of the correct legal review, it is clear why Trident holds the burden of proof and that is because it is seeking to establish that the Department's decision was in error. *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).

Justified Adverse Impact

In the case before this Court, Petitioners showed MUHA's theory of 100% redirection is unreasonable and, therefore, it is also unreasonable to assume there would be no impact on other providers in the service area. Petitioners have also shown, particularly regarding Roper Berkeley, that there is the potential for an adverse impact in terms of market share. However, although Petitioners' successfully poked holes in MUHA's theory, this is a *de novo* hearing and the Court must review all the evidence to determine whether MUHA failed to meet the requirements of Standard 5. And, ultimately, Petitioners failed to show by a preponderance of the evidence that MUHA's application does not meet the requirements of Standard 5. Rather, the evidence established that any potential adverse impact is justified by the benefits of accessibility MUHA Berkeley will offer.

In reaching this determination, the Court recognizes that any impact to another hospital's market share is going to be "adverse" to that hospital, but it does not immediately follow that the CON must be denied. Such is the case here. Trident will suffer some loss of market share, but the impact will be minimal compared to its operations as a whole and, since TMC already has high patient volumes, there is room for another provider in the area, especially considering the strong population growth in the area. In other words, even if Trident loses a few patients to MUHA Berkley, that loss will likely to be incidental and not be a material financial harm to Trident, especially in light population growth and this Court's restriction of MUHA not operating its proposed FSED. Additionally, the potential for impact to Trident must be viewed in light of the demonstrated need for the new hospital. The clear existence of MUHA's need by its current patient

base will allow MUHA Berkley to successful operate without cannibalizing Trident's patients. Thus, while there is a potential adverse impact to Trident, that impact would be minimal and is justified in light of the benefits the Project will provide to patients in the area.

Similarly, although sufficient data for Roper Berkeley's utilization does not exist yet, Roper will also have several years to establish itself before MUHA Berkeley comes online and it will be able to take advantage of strong population growth. Indeed, Roper's analysis did not account for MUHA Berkeley's delayed timeline and although Roper identifies the impact as "material," the Court did not find this analysis convincing. Similarly, the adverse impact analysis presented by Mr. Richardson was unconvincing because it was based upon an unreasonable premise. Moreover, MUHA's proposed hospital is justified by the redirection of its existing patients alone. While there is likely to be some loss of market share, the evidence established that it would most likely be small and completely offset by the population growth. Therefore, MUHA justified any potential adverse impact by showing its hospital is needed and can be supported by its existing patient base.

Balancing Adverse Effects of Duplication with Accessibility

The 2017-2018 SHP also proclaims "[t]he benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for these beds." 2017-2018 SHP at 13. I find MUHA's application complies with the SHP in this regard. Although, Roper Berkeley, TMC, and SMC provide similar services in the area, I do not find the any duplication of services to be unnecessary. MUHA's proposed hospital will improve accessibility in the Tri-County Area for the target population and reduce capacity constraints for the patients who continue to utilize MUHA's downtown campus. Any potential adverse effects will be likely be small. Weighing these considerations equally, I do not find the potential adverse effects of duplication necessitate denying the CON.

In addition, Petitioners have raised the issue that there is excess bed capacity in the Tri-County area and thus, MUHA Berkeley should not be approved. However, as discussed above, simply because a service area has a surplus of beds does not mean the SHP prohibits additional beds from being granted.

Need: PRC 1, PRC 2

Both PRC 1 and PRC 2 are listed in the 2017-2018 SHP as two of the most important criteria in evaluating CON application for hospitals. 2017-2018 SHP at 12. PRC 1, entitled "Need," provides "[t]he proposal shall not be approved unless it is in compliance with the South Carolina Health Plan." S.C. Code Ann. Reg. 61-15 § 802(1) (Supp. 2019). Additionally, PRC 2 sets forth the Community Need Documentation criteria. PRC 2 requires an applicant to:

> (a) clearly identify the project's target population as to the size, location, distribution, and socioeconomic status (if applicable);
>
> (b) present reasonable projections of anticipated population changes based upon accepted demographic or statistical methodologies, which are consistent with those generated by the state demographer, with assumptions and methodologies clearly presented in the application;
>
> (c) demonstrate that the project provides services that meet an identified (documented) need of the target population using assumptions and methods specified in the application and based on a reasonable approach;
>
> (d) for projects involving the reduction, relocation, or elimination of a facility or service, address the need that the population presently has for the service, the extent to which that need will be met by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination, or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, the elderly, handicapped persons, and other underserved groups, to obtain needed health care; and
>
> (e) demonstrate current and/or projected utilization sufficient to justify the expansion or implementation of the proposed service.

S.C. Code Regs. Ann. 61-15 § 802(2) (Supp. 2019). However, subsection (d) is not applicable to this Project.

I find MUHA's application complies with need outlined in the State Health Plan. The 2017-2018 SHP shows MUHA has an institutional need for 147 beds. Under Standard 5, MUHA is allowed to transfer a portion of that institutional need to new hospital as long as it justifies a need for the proposed hospital at the chosen site. MUHA met the criteria of Standard 5.

Additionally, MUHA clearly identified the Project's target population, including its size, location, and distribution. MUHA used industry acceptable population data consistent with the State Demographer's methodology to sufficiently explain its assumptions and methodologies, and it remedied its oversight of failing to attach its volume schedules during this litigation. MUHA demonstrated an identified need in the target population and its approach to identifying the need

was reasonable. Finally, MUHA used appropriate and reasonable assumptions to project the utilization of its Project, and the projected utilization is sufficient to justify the Project. Therefore, the evidence supports approval of MUHA's proposed 128-bed hospital.

Distribution and Accessibility: PRC 3, PRC 22

Another important criterion for review is PRC 3, Distribution (Accessibility), which provides in relevant part:

> (a) Duplication and modernization of services must be justified. Unnecessary duplication of services and unnecessary modernization of services will not be approved.
>
> (b) The proposed service should be located so that it may serve medically underserved areas (or an underserved population segment) and should not unnecessarily duplicate existing services or facilities in the proposed service area.
>
> * * *
>
> (h) Potential negative impact of the proposed project upon the ability and/or resources of existing providers to serve medically underserved groups must be considered.

S.C. Code Regs. Ann. § 61-15 § 802(3) (Supp. 2019). This PRC is also designated as one of the most important criteria in evaluating CON applications for hospitals under the 2017-2018 SHP. 2017-2018 SHP at 12.

I conclude MUHA's application complies with PRC 3. MUHA has demonstrated its hospital is needed, and the services provided at it will not be an unnecessary duplication. The Project will be located in a growing area of southern Berkeley County. MUHA Berkeley will improve the distribution of health care services in the Tri-County area by adding another provider outside the bounds of Charleston County where the overwhelming number of hospital beds are currently located. Additionally, the Project will service a population of patients that are underserved because these patients are experiencing trouble accessing health care due to capacity constraints at MUHA's downtown campus.[61] This population is reflected by the institutional need for 147 more beds at MUHA's downtown campus. A significant portion of these patients originate

[61] Just because MUHA's existing patients receive care does not mean they are not facing access challenges or are not underserved. Lengthy boarding hours and over-crowding affect timely access and the quality of care patients receive. While there is no contention in this case that MUHA does not provide quality care, over-crowding certainly does not improve the quality of care.

in the Tri-County area and 29% originate from the submarkets near the hospital. The decanting of MUHA's lower-acuity population to MUHA-Berkley will allow all patients within this population to receive better care and allow MUHA to focus more on the patients who require MUHA's unique level of care at its downtown campus. Although the Project will likely have a small impact on surrounding providers, particularly Roper Berkeley, Petitioners failed to show by a preponderance of the evidence that the potential impact requires denial of MUHA's CON application in light of the benefit of increased accessibility.

Financial Feasibility: PRC 15

PRC 15 sets forth criteria for considering the financial feasibility of a proposed project and provides in relevant part that "the applicant must have projected both the immediate and long-term financial feasibility of the proposal [and] such projection should be reasonable and based upon accepted accounting procedures." S.C. Code Regs. Ann. 61-15 § 802(15) (Supp. 2019). This PRC was not listed by either the SHP or DHEC as one of the most important PRC for hospital CON applications or this Project. However, it was raised to DHEC by the opposition during the review process and is therefore properly before the Court.

I conclude MUHA's application complies with PRC 15. MUHA demonstrated its Project would produce significant net revenue by year three of operations and it utilized accepted accounting methods and procedures to project its expenses and revenues on the pro formas it submitted with its application.

Ability to Complete the Project: PRC 14

PRC 14 provides:

> (a) The applicant should have demonstrated that the project can be initiated and completed within the proposed time frame specified in the application.
>
> (b) The financial schedules and time frames contained in the application should be consistent with those usually experienced in the development of similar facilities or services.

S.C. Code Regs. Ann. 61-15 § 802(14) (Supp. 2019).

I conclude MUHA's application complies with PRC 14. Indeed, MUHA has never failed to complete a project, and Petitioners failed to show MUHA was likely to fail to complete this Project. The financial schedules and time frames were consistent with those for the development of other similar facilities.

Cost Containment: PRC 16

PRC 16, Cost Containment (Minimizing Costs), is designated in the 2017-2018 SHP as one of the most important criteria for general hospitals. PRC 16 provides, in relevant part:

> (a) The applicant should have identified and sought alternative sources and/or methods of funding and demonstrated that the method chosen was the most feasible option.
>
> * * *
>
> (c) The impact of the project upon the applicant's cost to provide services and the applicant's patient charges should be reasonable. The impact of the project upon the cost and charges of other providers of similar services should be considered if the data are available.

S.C. Code Regs. Ann. 61-15 § 802(16) (Supp. 2019).

MUHA adequately demonstrated that it has a viable source of financing with HUD. MUHA has been successful using HUD financing in the past and, in this instance, it meets all of HUD's requirements to obtain financing. Furthermore, as a result of HUD financing, MUHA would receive a good interest rate. Additionally, if MUHA fails to receive financing from HUD, then it has other banks from which it can seek financing.

MUHA's proposed charges for its patients at the Project are based on its historic patient charges at its downtown hospital but properly discounted to account for the lower patient acuity. Also, Petitioners could not provide sufficient evidence that MUHA's proposed charges at the Project would impact, if at all, other similar providers' charges.

Alternative Methods: PRC 19

PRC 19, Alternative Methods, provides:

> (a) the applicant should have considered any available or more effective alternatives which exist to the proposed service such as the use of less costly alternative, outpatient services, shared services, or extended hours of service.
>
> (b) For new construction projects, modernization of existing facilities should be considered as an alternative, and the rejection of this alternative by the applicant should be justified.

S.C. Code Regs. Ann. 61-15 § 802(19) (Supp. 2019). This PRC was raised by Petitioners in their opposition. However, it is not listed in SHP as one of the most important criteria for hospitals.

I find the application complies with PRC 19. MUHA considered alternatives and reasonably concluded there is no better alternative than to build the Project. Renovating existing buildings on the peninsula would be as costly as building the Project and provide a lower standard

of care. MUHA has also clearly demonstrated that continuing to serve patients under the status quo is untenable and results in many patients being turned away from care. In addition, MUHA Berkeley could be an important resource to assist in relocating patients off the peninsula hospital in the event of a hurricane.

Adverse Effects on Other Facilities: PRC 23

PRC 23, Adverse Effects on Other Facilities, provides:

> a. The impact on the current and projected occupancy rates or use rates of existing facilities and services should be weighed against the increased accessibility offered by the proposed services.
>
> b. The staffing of the proposed service should be provided without unnecessarily depleting the staff of existing facilities or services or causing an excessive rise in staffing costs due to increased competition.

S.C. Code Regs. Ann. 61-15 § 802(23) (Supp. 2019). This PRC is identified as one of the most important criteria in the 2017-2018 SHP.

For the reasons already stated in the conclusions of law section discussing adverse impact under Standard 5 and in the section weighing adverse impacts with accessibility, I conclude MUHA's project complies with PRC 23 despite MUHA's faulty theory of 100% redirection in its application.[62]

Moreover, while a nursing shortage exists in the Tri-County area and across South Carolina, this shortage has not prevented any provider in the Tri-County area from expanding and all providers have used traveling nurses to resolve shortage issues, even if this is not the preferred way to resolve the problem. There was also no evidence of a physician shortage. In addition, there was no evidence that the addition of MUHA Berkeley would materially exacerbate staffing costs that have already risen, at least in the nursing field, due to ongoing competition.

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[62] Interestingly, although Roper took issue with this Court's determination that no "material" adverse impacts would occur as a result of MUHA Berkeley because "material" was not used in Standard 5 as a threshold, Roper argues in its Motion for Reconsideration that adverse effects under PRC should be interpreted as follows: "[a]n 'adverse impact,' for CON purposes, can generally be construed to mean a **material** decrease in the present or future use or occupancy rates of existing providers for like procedures." *Roper Hosp., Inc. v. S.C. Dept. of Health and Envtl. Control*, Docket No. 01-ALJ-07-0378-CC, 2002 WL 31423787 *14 (S.C. Admin. Law J. Div. Sept. 5, 2002) (citing S.C. Code Ann. Regs. 61-15 § 802(23)(a)) (emphasis added). Yet PRC 23, like Standard 5, does not use the word "material."

Finally, it is important to note that even though the Department can re-order the PRC criteria, the Department's failure to specifically address this PRC in its decision when it is identified as one of the most important PRC in the 2017-2018 SHP was error. *See Trident Med. Ctr. v. S.C. Dep't of Health & Envtl. Control*, 412 S.C. 341, 350, 772 S.E.2d 177, 182 (Ct. App. 2015) (holding "it is clear the legislature intended for the State Health Plan to be an enforceable document"). However, because this is a *de novo* proceeding before this Court, the Department's error was cured by its consideration by this Court.[63] *See Ross v. Med. Univ. of S.C.*, 328 S.C. 51, 492 S.E.2d 62 (1997) ("Article I, § 22 requires an administrative agency provide notice and an opportunity to be heard, but does not require notice and an opportunity to be heard at each level of the administrative process. It mandates notice and opportunity to be heard at some point before the agency makes its final decision.").

Section 501: Findings of the Department

Section 501 provides that that:

> In the case of any proposed new institutional health service[64] for the provision of health services to inpatients, the Department shall not grant a Certificate of Need, or otherwise make a finding that such proposed new institutional health service is needed, unless:
>
> (1) The capital and operating costs of the proposal and their potential impact on patient charges are reasonable;
>
> (2) Superior alternatives to such services in terms of cost, efficiency, or appropriateness do not exist and that the development of such alternatives is not practicable;
>
> (3) In the case of new construction, alternatives to new construction (e.g., modernization or sharing arrangements) have been considered; [and]
>
> (4) Patients will experience serious problems in terms of costs, availability or accessibility, or such other problems as may be identified by the Department, in obtaining care of the type proposed in the absence of the project.

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[63] Moreover, despite the Department's failure to address this criterion, Petitioners raised the issue in their opposition, which allowed the issue to be reviewed by the Department and addressed before this Court. Therefore, the Court does not find Petitioners were so prejudiced by this failure at the agency level that MUHA's application must be denied or the issue remanded.

[64] S.C. Code Regs. Ann. 61-15 § 103.15 (Supp. 2019) defines institutional health services as "health services provided in or through health care facilities and includes the entities in or through which such services are provided."

S.C. Code Ann. Regs. 61-15, § 501 (Supp. 2019).

The Department concluded MUHA's application complied with section 501. I, likewise, find the evidence showed MUHA's application complies with section 501. I find the capital and operating costs of the Project are reasonable and the patient charges are reasonable and consistent with MUHA's historic charges when discounted for lower-acuity patients. MUHA demonstrated there were no superior alternatives to building the Project in terms of cost, efficiency, or appropriateness. MUHA considered alternatives to new construction and provided logical reasons why up-fitting or remodeling were inappropriate; Petitioners failed to carry their burden to show otherwise. Lastly, MUHA showed that its Project will improve access for patients who currently struggle to gain access at MUHA's over-capacity downtown location. MUHA demonstrated that its patients at its downtown hospital do not always receive the highest level of care possible due to capacity constraints and, therefore, the lower-acuity patients that are decanted to MUHA Berkeley will obtain better care with the Project. Moreover, increased access is especially important for those patients who seek a level of care only MUHA can provide. The Project will provide extra capacity to allow MUHA to focus on its higher-acuity patients and better serve the citizens of South Carolina. While it is true that capacity currently exists at other providers in the service area to help alleviate capacity constraints; the evidence shows patients are not choosing to decant to other providers and continue to face access issues at MUHA. Therefore, although the access problem appears to be the result of patient choice, in balancing the needs of the public, particularly the need for high quality health care, with duplication, in this case, the benefits of increased accessibility outweigh the adverse effects of duplication. *See* § 44-7-120. Further, MUHA Berkeley will increase the accessibility and distribution of health care in the northern Tri-County where there is currently a maldistribution of beds.

Overall Conclusion

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." § 44-7-120. Petitioners have failed to meet their burden to show MUHA's application does not meet the requirements or fulfill the purposes of the CON Act, the

PRC, and the State Health Plan. As a result, I conclude MUHA should be granted a CON for the construction of MUHA Berkeley.

ORDER

IT IS THEREFORE ORDERED that a Certificate of Need for MUHA's proposed 128-bed MUHA Berkeley hospital in Berkeley County, South Carolina, is **APPROVED**. The Department shall issue a Certificate of Need to MUHA.

AND IT IS SO ORDERED.

Ralph King Anderson, III
Chief Administrative Law Judge

September 4, 2020
Columbia, South Carolina

CERTIFICATE OF SERVICE

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

Stephanie Perez
Judicial Law Clerk

September 4, 2020
Columbia, South Carolina