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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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APPEAL FROM
THE ADMINISTRATIVE LAW COURT

Shirley C. Robinson, Administrative Law Judge

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Case No. 17-ALJ-07-0441-CC
Case No. 17-ALJ-07-0444-CC
Appellate Case No. 2020-001072

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| Trident Medical Center, LLC d/b/a Trident Medical Center and Summerville Medical Center,..... | Petitioner/ Respondent, |
| v. | |
| South Carolina Department of Health and Environmental Control and Medical University Hospital Authority d/b/a MUSC Health Emergency Services,..... | Respondents, |
| Of Whom, Medical University Hospital Authority d/b/a MUSC Health Emergency Services is …….. | Appellant. |
| CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital, ..... | Petitioner/ Respondent, |
| v. | |
| South Carolina Department of Health and Environmental Control and Medical University Hospital Authority d/b/a MUSC Health Emergency Services,..... | Respondents, |
| Of Whom, Medical University Hospital Authority d/b/a MUSC Health Emergency Services is …….. | Appellant. |

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**RECORD ON APPEAL**
**VOLUME 1**

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CERTIFICATE OF COUNSEL

**STATE OF SOUTH CAROLINA**
**ADMINISTRATIVE LAW COURT**

| | |
|---|---|
| Trident Medical Center, LLC, d/b/a Trident Medical Center and Summerville Medical Center,<br><br>Petitioners,<br><br>vs.<br><br>South Carolina Department of Health and Environmental Control and Medical University Hospital Authority, d/b/a MUSC Health Emergency Services,<br><br>Respondents. | Docket No.: 17-ALJ-07-0441-CC<br>(consolidated)<br><br>**ORDER DENYING MUHA'S MOTION TO ALTER AND AMEND** |
| CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital,<br><br>Petitioners,<br><br>vs.<br><br>South Carolina Department of Health and Environmental Control and Medical University Hospital Authority, d/b/a MUSC Health Emergency Services,<br><br>Respondents. | Docket No.: 17-ALJ-07-0444-CC |

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FILED
July 6, 2020
SC ADMIN. LAW COURT

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## I. INTRODUCTION

This consolidated matter was before the Administrative Law Court (ALC or Court) pursuant to requests for contested case hearings filed by Petitioner Trident Medical Center, d/b/a Trident Medical Center and Summerville Medical Center (collectively referred to as "Trident") and Petitioner CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital (collectively referred to as "Roper St. Francis"). Roper St. Francis and Trident challenged the decision of the South Carolina Department of Health and Environmental Control (Department) approving Respondent Medical University Hospital Authority, d/b/a MUSC Health Emergency Services (MUHA)'s Certificate of Need (CON) application for a freestanding emergency room department (FSED) in Berkeley County. A contested case hearing was held from July 22, 2019 through August 2, 2019. On May 28, 2020, a final order was issued denying MUHA's request for a FSED.

On June 8, 2020, MUHA filed a Motion to Alter or Amend the Court's order requesting that the Court make additional findings of fact and amend that portion of its order addressing the Department's authority to reorder project review criteria. MUHA also asked the Court to amend it conclusions that the FSED application failed to satisfy Standard 6 in the 2015 Plan and Drive Time and Access Standards in the 2017-2018 Plan, and various project review criteria. On June 19, 2020, Roper St. Francis (and then on June 22, 2020, Trident) submitted responses opposing MUHA's motion. On June 23, 2020, the Department filed a "Memorandum in Response to Motion to Alter or Amend" asking the Court to amend its order to conclude that the Department has the authority to change or reorder the priority criteria for a CON project." The Department

did not file its own motion. After careful review and consideration of the parties' submissions and the applicable law, the Court denies MUHA's motion.

## II. APPLICABLE STANDARD

MUHA's motion asserts that it is based on Rule 29(D) of the SCALC Rules and 59(e) of the South Carolina Rules of Civil Procedure, and asks that the Court's order of May 28, 2020, "be reconsidered, altered, and amended." SCALC Rule 29(D) provides that a party may move for reconsideration of an order by way of a motion to alter or amend a final order of the Court, "subject to the grounds for relief set forth in Rule 59(e), SCRCP." Rule 59(e), SCRCP, is identical to Rule 59(e) of the Federal Rules of Civil Procedure with the exception of the time limitation for filing. While neither rule expressly sets forth standards for requesting relief, "courts interpreting Rule 59(e) have recognized three grounds for amending an earlier judgment: (1) to accommodate an intervening change in controlling law; (2) to account for new evidence not available at trial; or (3) to correct a clear error of law or prevent manifest injustice." *Hutchinson v. Staton*, 994 F.2d 1076, 1081 (4th Cir. 1993) (discussing Rule 59(e), FRCP). "In the context of a motion for reconsideration, a 'manifest injustice' is defined as an error by the court that is 'direct, obvious, and observable.'" *Register v. Cameron & Barkley Co.*, 481 F.Supp.2d 479, n. 1 (D.S.C. 2007) (finding the fact that plaintiff incurred significant costs but have no remedy for recovery is not a "manifest injustice" warranting relief under Rule 59(e), FRCP); *see also* 11 Wright & Miller § 2810.1 ("The rule 59(e) motion may not be used to relitigate old matters . . . ."). It is "an extraordinary remedy which should be used sparingly..." 11 Wright & Miller § 2810.1.

## III. DISCUSSION

A. MUHA's Request to Include Additional Findings of Fact

MUHA asks the Court to amend its order to include numerous additional factual findings without providing arguments in support of their inclusion. MUHA's motion fails to identify any of the findings and conclusions in the order that directly contradict MUHA's requested findings, and fails to acknowledge many similar findings that are already reflected in the order (and a statement as to why those findings are inadequate or incorrectly stated).

For example, MUHA asks that the order be amended to find as follows: "Six EDs are currently operational in the North Area (Berkeley County, Dorchester County, and northern

Charleston County), all owned by Trident or Roper." MUHA appears to have overlooked the Court's analysis of the existing and proposed emergency departments in MUHA's proposed service area which not only clearly identifies the providers of Roper St. Francis and Trident, but also details treatment spaces, capacity metrics, and historical utilization. MUHA also asks the Court to include information regarding emergency department utilization from previous CON applications submitted by Petitioners. As noted in the order, those CON applications were not before the Court and are irrelevant to this matter.

MUHA requests that the Court amend the order to reflect population growth along the I-26 corridor near Summerville and the site of the proposed FSED. The Court's order considered the population growth in the area and analyzed that growth in conjunction with the declining trend in emergency department visits, a trend that MUHA acknowledged. Paragraph 93 of the findings of fact stated:

> [W]hile the Court does not dispute population and emergency room visit growth in the tri-county area, the trend in the growth of emergency department visits indicates that it slowed in 2016, and that it actually declined in 2017. There is no indication that there is going to be a consistent dramatic increase in emergency department visits going forward. Moreover, there are additional facilities that will soon be coming online such as Roper St. Francis Berkeley Hospital and Trident Summerville F[S]ED.

(internal citations omitted).

Similarly, MUHA requests that the order be amended to include several factual findings related to its health care planner's analysis of need and projected utilization of the proposed FSED, and drive times. The Court's factual findings already address the utilization projected by MUHA 's health planner and the reasons offered such as "shorter travel time" for redirecting patients from MUHA downtown to the proposed FSED. MUHA asserts no reason or legal authority to support reversal of the following finding of fact in Paragraph 68 of the order:

> MUHA provided no basis, insight, or information for its assumption as to why some of its patients who resided in Berkeley, Charleston, and Dorchester Counties were already bypassing other hospital-based emergency rooms as well as F[S]EDs to seek treatment at MUSC on the peninsula. While pertinent to Standard 6's requirement that an applicant demonstrate why patients are not being adequately served by existing services in the area, the fact that a patient chooses to bypass an existing provider does not mean that existing health resources in the service area are inadequate.

There are other findings requested by MUHA that upon review of MUHA's motion and the order, were clearly considered and specifically rejected by the Court including those relating to MUHA's shift projections and triage acuity levels. Additional examples are outlined in Roper St. Francis and Trident's responses in opposition to MUHA's motion. MUHA provides no insight or reason as to why it believes the order should be amended to add these additional findings and includes no statement as to why the Court's findings are inadequate, not founded in evidence, or otherwise, incorrectly stated.

Finally, none of the additional findings proposed by MUHA change the Court's conclusion that there is no need for another FSED in the service area and that an additional FSED would present an unnecessary duplication of services. Residents in the service area already have ample access to emergency services. Every hospital provider in the service area is required to treat all individuals under the federal Emergency Medical Treatment and Labor Act regulations,[1] and every hospital provider, including Roper St. Francis and Trident, provide charity care for the indigent. Health Insurance Portability and Accountability Act regulations allow for the disclosure of patient protected health information for the coordination of care, and patients have the right to have copies of their medical records transferred to any provider of their choosing, including MUHA.[2] There is nothing about the coordination of care through MUHA's Accountable Care Organization (ACO) or the projected amount of charity care to be provided that changes the ultimate factual finding and conclusion of law - that MUHA's proposed project does not comply with the CON Act, the Plans, or the CON Regulations and, therefore, cannot be approved. Here, the Court already considered the matters raised in MUHA's motion, and the order already addresses the issues for which MUHA seeks to include additional factual findings with the exception of MUHA's ACO which is addressed herein.[3] Because the Court chose not to draw the

[1] *See generally*, 42 C.F.R. § 489.24.
[2] *See generally*, 45 C.F.R. § 489 Part 164.
[3] "A judicial opinion should identify the issues presented, set out the relevant facts, and apply the governing law to produce a clear, well-reasoned decision of the issues that must be resolved." FEDERAL JUDICIAL CENTER, JUDICIAL WRITING MANUAL: A POCKET GUIDE FOR JUDGES, § IV, p. 10 (2d ed. 2013). The need for a full and fair statement of the facts is of foremost importance in drafting an opinion, and "[f]acts significant to the losing side should not be omitted." *Id*. at p. 12. However, only the facts necessary to explain the court's decision should be included. *Id*. at p. 15. A judicial opinion should not be a recitation of every piece of evidence or testimony entered into the record. The inclusion of numerous, irrelevant facts does nothing to elucidate the Court's reasoning behind its decision and serves to confuse the issues. The recitation of evidence and arguments presented at the hearing, which are not germane to the Court's decision and which have been considered and addressed would serve no purpose other than to create confusion.

same legal conclusions in its consideration of the factual evidence is not a sufficient reason to amend the order. *See BECA Social Club v. S.C. Dep't of Revenue*, Docket No.: 04-ALJ-17-0014-CC, 2004 WL 3154763 at * 2 (S.C. Admin. Law Judge Div.) ("Rule 59(e) provides a procedure for correcting manifest errors of law or fact or considering the import of newly discovered evidence. . . . A motion under Rule 59(e) is not intended to be utilized to relitigate issues previously considered. . . ."). *See also Brown v. S.C. Dep't of Health & Envtl. Control*, Docket No.: 07-ALJ-08-0180-AP, 2009 WL 8167885 (S.C. Admin. Law Judge Div.) (denying Appellant's Motion because "Appellant, in his Motion attempts to re-argue the merits of his case.").

B. MUHA's Request to Alter and Amend Regarding the Department's Reordering of Priority Criteria

MUHA's motion states, "The Order should be considered, altered, and amend[ed] to conclude that DHEC has the authority to change or reorder the priority criteria for a CON project." MUHA provided no argument in support of its assertion that the Court's statutory interpretation, construction, or analysis of this issue was in error.[4] The CON Act requires that the Department prepare a State Health Plan (Plan) with the advice of the State Health Planning Committee. S.C. Code Ann. § 44-7-180(B) (2018). The draft Plan is then submitted to the Department Board for review and approval. *Id*. at § 44-7-180(C). At a minimum, the Plan must include the following:

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

(emphasis added). Without reiterating the Court's analysis of the law in the final order, the plain

[4] While the Department did not file a motion to alter or amend, its memorandum in response to MUHA's motion to alter or amend asserts that the Department's interpretation of a statute or regulation that it must administer should be given deference. The Court concurs with this premise but as provided by law, not when an agency's interpretation is arbitrary, capricious, or manifestly contrary to the statute. *Kiawah Dev. Partners v. S.C. Dep't of Health& Envtl. Control*, 411 S.C. 16, 34, 766 S.E.2d 707, 718 (2014).

language of the statute requires the inclusion of the project review criteria deemed most important in evaluating a particular health care facility or service. *Id*. (emphasis added).

The plain language of the statute does not give the Department the authority to ignore those criteria once they have been decided upon and approved by the Department's Board. *See Hodges v. Rainey*, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000) ("Under the plain meaning rule, it is not the court's place to change the meaning of a clear and unambiguous statute."). To allow the Department the discretion to alter the requirements of a validly adopted Plan would render the statutory requirements for what must be included in the Plan superfluous and the adoption of the Plan futile. It is presumed that the legislature does not intend to create acts of futility. *See Florence Cnty. Democratic Party v. Florence Cnty. Republican Party*, 398 S.C. 124, 128, 727 S.E.2d 418, 420 (2012). Given that the cardinal rule of statutory construction is to ascertain and effectuate the intent of the legislature, the Court must reject any argument which undermines the plain language of a statute and absurdly results in a meaningless act of futility. *See Hodges*, 341 S.C. at 85, 533 S.E.2d at 581 ("The cardinal rule of statutory construction is to ascertain and effectuate the intent of the legislature."). Finally, any error raised by MUHA in this regard would not affect the outcome of this matter as the Court considered the criteria set forth in both the Plan and by the Department prior to reaching its decision that there is no need for an additional FSED in the proposed service area.

C. MUHA's Request for Changes to the Court's Conclusions

Paragraph 3 of MUHA's motion makes a sweeping request for changes to the conclusions of law set forth in the order. The motion states in part:

> 3. The Order's conclusions that MUSC's FED CON application does not satisfy Standard 6 in the 2015 State Health Plan and the Drive Time and Access Standard in the 2017-2018 State Health Plan; does not comply with project review criteria Community Need Documentation, Distribution (Accessibility), and Medically Underserved Groups; and does not further the purposes of the CON Act are erroneous and should be reconsidered, altered, and amended because:
>
> a. These conclusions are affected by errors of law, including erroneous interpretations of these standards, criteria, and purposes;
> b. These conclusions are clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; and
> c. These conclusions are arbitrary, capricious, characterized by abuse of discretion, and clearly unwarranted exercise of discretion.

Like MUHA's other requests for amendment, MUHA provides no identification or detail as to which conclusions it believes are affected by errors of law much less what it contends those errors of law to be; which conclusions it believes are erroneous or unsubstantiated by the evidence on the whole record; or which conclusions are arbitrary or capricious.

As the trier of fact, this Court "has the task of assessing the credibility, persuasiveness, and weight of the evidence presented." *Jones v. Leagan*, 384 S.C. 1, 12, 681 S.E.2d 6, 12 (Ct. App. 2009). The Court weighed the evidence and applied the law. The grounds for the Court's decision are plainly set forth in detail and in the order. Bare allegations of errors of law and arbitrary and capricious application of the law are wholly insufficient for amending an order, and MUHA's attempt to re-litigate its case by means of a motion to alter or amend is inappropriate and must be denied. *See, e.g., BECA Social Club*, Docket No.: 04-ALJ-17-0014-CC, 2004 WL 3154763 at * 2.

"Mere disagreement with how the law is applied does not support a Rule 59(e) motion." *McCall v. Williams*, 59 F.Supp.2d 556, 558 (D.S.C. 1999) (*citing Hutchinson v. Staton*, 994 F.2d 1076, 1081 (4th Cir. 1993). *See also, F.D.I.C. v. Cage*, 810 F.Supp. 745, 747 (S.D.Miss. 1993) (When a Rule 59(e) motion "merely expresses disagreement with the findings of the Court and fails to demonstrate a 'clear error of law' or 'manifest injustice,'" the motion is not "well taken" and must be denied.). Because MUHA has failed to identify any clear error or manifest injustice, the motion must be denied.

## IV. ORDER

Based on the foregoing,

**IT IS HEREBY ORDERED** that Respondent Medical University Hospital Authority, d/b/a MUSC Health Emergency Services' Motion to Alter and Amend, is **DENIED**.

**AND IT IS SO ORDERED**.

_____

**SHIRLEY C. ROBINSON**
Administrative Law Judge

July 6, 2020
Columbia, South Carolina

**CERTIFICATE OF SERVICE**

I, Ti'a Smith, 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).

Ti'a Smith
Judicial Law Clerk

July 6, 2020
Columbia, South Carolina

**STATE OF SOUTH CAROLINA**
**ADMINISTRATIVE LAW COURT**

| | | |
|---|---|---|
| Trident Medical Center, LLC, d/b/a Trident Medical Center and Summerville Medical Center,<br><br>Petitioners,<br><br>vs.<br><br>South Carolina Department of Health and Environmental Control and Medical University Hospital Authority, d/b/a MUSC Health Emergency Services,<br><br>Respondents. | ) | Docket No.: 17-ALJ-07-0441-CC<br>(Consolidated)<br><br>**ORDER** |
| CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital, and Roper St. Francis Berkeley Hospital,<br><br>Petitioners,<br><br>vs.<br><br>South Carolina Department of Health and Environmental Control and Medical University Hospital Authority, d/b/a MUSC Health Emergency Services,<br><br>Respondents. | ) | Docket No.: 17-ALJ-07-0444-CC |

**APPEARANCES:** David B. Summer, Jr. Esquire
William R. Thomas, Esquire
Amy Flanary-Smith, Esquire
For Petitioner Trident Medical Center, LLC, d/b/a Trident Medical Center and Summerville Medical Center

Jennifer J. Hollingsworth, Esquire
Emily L. Glober, Esquire
For Petitioner CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital, and Roper St. Francis Berkeley Hospital

Ashley C. Biggers, Esquire

FILED

May 28, 2020

SC ADMIN. LAW COURT

For Respondent South Carolina Department of Health and Environmental Control

Daniel J. Westbrook, Esquire
Travis Dayhuff, Esquire
For Respondent Medical University Hospital Authority, d/b/a MUSC Health Emergency Services

## I. STATEMENT OF THE CASE

This consolidated matter is before the South Carolina Administrative Law Court (ALC or Court) pursuant to requests for contested case hearings filed by Petitioners Trident Medical Center, LLC, d/b/a Trident Medical Center and Summerville Medical Center (Trident) and CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital, and Roper St. Francis Berkeley Hospital (Roper St. Francis). Petitioners challenge a decision by Respondent South Carolina Department of Health and Environmental Control (Department or DHEC) approving a Certificate of Need (CON) application filed by Respondent Medical University Hospital Authority, d/b/a MUSC Health Emergency Services (MUHA) to establish a freestanding emergency department in Berkeley County, South Carolina. A contested case hearing was held from July 22, 2019 through August 2, 2019. After careful consideration of extensive testimony, more than two-hundred exhibits including deposition designations, the applicable law, and the parties' arguments and proposed orders, the Court denies MUHA's CON application for a freestanding emergency department.

## II. BACKGROUND

On April 12, 2017, Trident submitted a CON application for the construction of a 12,200 square foot freestanding emergency department (FED or FSED) in Berkeley County at a cost of $13,079,900. On June 6, 2017, MUHA submitted a CON application for the construction of a 15,300 square foot FED in Berkeley County at a cost of $13,584.161. Both FEDs were to be located near the Nexton Community accessible from I-26 via Exit 199.[1] Roper St. Francis timely notified the Department of its status as an affected person, and its opposition to MUHA's project; Trident similarly opposed MUHA's project. Pursuant to Regulation 61-15 § 802 of the South Carolina Code of Regulations, and by letter dated July 10, 2017, the Department advised MUHA

[1] A new exit, Exit 197, was to be developed later.

of the specific review criteria that would be used in reviewing its project: (1) Community Need Documentation; (2) Distribution (Accessibility); (3) Medically Underserved Groups; and (4) Financial Feasibility. S.C. Code Ann. Regs. § 61-15 § 802 (Supp. 2019); (Joint Ex. 001-545). On August 24, 2017, the Department held a project review meeting and all parties to this action participated. On September 25, 2017, the Department issued decisions concluding that MUHA and Trident's CON applications for FEDs were not competing; the Department approved both applications. The Department's letter to MUHA stated that MUHA had "presented substantial evidence that the Project complies with the relevant project review criteria and with the *South Carolina State Health Plan*, enacted August 13, 2015 …"

On October 6, 2017, Roper St. Francis filed a written request for the Department's Board to conduct a final review of the staff decision approving MUHA's CON. On October 10, 2017, Trident likewise asked the Department to conduct a final review. On November 15, 2017, the Department declined to conduct a final review conference thereby rendering its staff decision approving MUHA's project as a final agency decision. *See* S.C. Code Ann. § 44-1-60(F) (2018).

On December 14, 2017, Trident filed a Petition for Administrative Review and Request for a Contested Case Hearing. In its Petition, Trident argued that MUHA's application and its own application for FEDs were competing,[2] and that the Department incorrectly found otherwise. Trident posited that the Department was required to grant the application that most fully complied with the requirements, goals, and purposes of the CON Act, the State Health Plan (Plan), and the established project review criteria, and that Trident's application most fully complied. On December 15, 2017, Roper St. Francis also filed a Request for a Contested Case Hearing asking the Court to reverse the Department's decision to approve MUHA's CON for a FED. On April 18, 2018, the Court issued an order consolidating these cases.[3] On May 4, 2018, MUSC's motion to lift the automatic stay was denied.

[2] The Department's regulations define "competing applicants" as "two or more persons and/or health care facilities … who apply for Certificates of Need to provide similar services and/or facilities in the same service area and whose applications if approved would exceed the need for this facility or service." S.C. Regs. 61-15 § 103(6) (Supp. 2019). The regulation further provides: "Any application received by the Department later than the fifteenth day following publication of the Notice of Affected Persons in the State Register for the first application(s) will not be considered to be competing with the(se) application(s)."

[3] This statement is somewhat of an oversimplification of what occurred. There was also a third related case filed under Docket No. 17-ALJ-07-0433-CC in which Roper St. Francis filed a Request for a Contested Case Hearing challenging the Department's approval of Trident's CON application for a FSED. MUHA's Motion to Intervene in that case was denied but its request to consolidate all three cases including Docket Nos. 17-ALJ-07-0441-CC and 17-ALJ-07-0444-CC, was granted by Order of this Court on April 18, 2018. The case filed by Roper St. Francis under Docket No. 17-ALJ-074-0433-CC contesting the Department's approval of Trident's CON application for a FSED was dismissed by consent of Roper St. Francis, Trident and the Department.

On June 6, 2018, the parties agreed to a Consent Scheduling Order which established a hearing date of November 26, 2018. On November 7, 2018 and per request of the parties, the Court issued an Amended Consent Scheduling Order providing that discovery be completed by February 8, 2019 and scheduling the trial to commence on March 18, 2019. On April 23, 2019, the parties requested, and the Court issued a Second Amended Scheduling order providing that discovery be completed by June 14, 2019, and that trial commence on July 22, 2019. *See* S.C. Code Ann. § 44-7-210(G) (2018) ("Notwithstanding any other provision of law, in a contested case arising from the department's decision to grant or deny a Certificate of Need application, grant or deny a request for exemption under Section 44-7-170, or the issuance of a determination regarding the applicability of Section 44-7-160, the Administrative Law Court shall file a final decision no later than eighteen months after the contested case is filed with the Clerk of the Administrative Law Court, unless all parties to the contested case consent to an extension or the court finds substantial cause otherwise).[4] S.C. Code Ann. §§ 44-7-160 and -170 (2018 and 2019 Supps.).

Prior to the merits hearing, this Court entertained multiple discovery motions, and three motions for summary judgment. Over the course of the approximately ten-day hearing, the Court received direct testimony from twelve witnesses, seven of whom were qualified as expert witnesses:

1. Gregory A. Hall, MD testified on behalf of MUSC and was qualified as an expert in emergency medicine and in the administration and operation of emergency departments;

2. Stephen D. Porter testified on behalf of Roper St. Francis as its former Chief Executive Officer;

3. Joy Huntington testified on behalf of Roper St. Francis and was qualified as an expert on emergency service operations in the tri-County area (Charleston, Berkeley, and Dorchester Counties);

4. Kathryn M.T. Platt testified on behalf of Roper St. Francis and was qualified as an expert in healthcare planning and finance, and the State Health Plan;

5. Lisa Valentine testified on behalf of Trident as Summerville Medical Center's Chief Executive Officer;

[4] The parties also requested an extension of time within which to provide the Court with proposed orders in this matter following receipt of the transcript.

6. Joan Eccleston testified on behalf of Trident and was qualified as an expert in emergency department administration, leadership, and nursing care;

7. R. Preston Wendell, MD testified on behalf of Trident and was qualified as an expert in emergency medicine and in the administration and operation of emergency departments.;

8. Daniel Sullivan testified on behalf of Trident and was qualified as an expert in healthcare planning and finance, and the South Carolina CON Program;

9. Margaret P. Murdock testified on behalf of the Department as its Director of the CON Program, the primary reviewer of MUHA's application for a FED, and the developer of the Department's decision;

10. Patrick J. Cawley, MD testified on behalf of MUHA as the Chief Executive Officer of MUSC Health;

11. David S. Louder, III, MD testified on behalf of MUHA as the Executive Director of the MUSC Health Alliance; and

12. David Levitt testified on behalf of MUHA and was qualified as an expert in healthcare planning and finance, and the South Carolina CON Program.

More than two-hundred exhibits were entered into evidence, many of which had multiple pages.

## III. STANDARD OF REVIEW

In reviewing contested case actions involving Certificates of Need, the Court uses a *de novo* standard. *Marlboro Park Hosp. v. S.C. Dep't of Health and Envtl. Control*, 358 S.C. 573, 579, 595 S.E.2d 851, 854 (Ct. App. 2004). While the issues that can be raised in a contested case involving a CON are limited to those presented to or considered by the Department during its review and decision-making process, this Court may receive and consider new evidence during the contested case. *Id.*; S.C. Code Ann. 44-7-210(E) (2018). Petitioners bear the burden of proof by a preponderance of the evidence. *Nat'l Health Corp. v. S.C. Dep't of Health and Envtl. Control*, 298 S.C. 373, 379, 380 S.E.2d 841, 844 (Ct. App. 1989).

## IV. FINDINGS OF FACT

Having carefully considered the evidentiary record developed in these consolidated proceedings, and taking into account the credibility of the witnesses and reliability of the evidence, I make the following Findings of Fact by a preponderance of the evidence:

### A. The Parties

1. Trident consists of the following inpatient facilities and FEDs:

a. Trident Medical Center:[5] 296-bed tertiary care hospital in North Charleston, South Carolina (Charleston County), which includes an emergency department with 46 treatment spaces;

b. Summerville Medical Center: 124-bed acute care hospital in Summerville, South Carolina (Dorchester County), which includes an emergency department with 46 treatment spaces;

c. Moncks Corner Medical Center: freestanding emergency department in Moncks Corner, South Carolina (Berkeley County) with 8 treatment spaces;

d. Centre Pointe Emergency: freestanding emergency department in North Charleston, South Carolina (Charleston County) with 12 treatment spaces;

e. Summerville FED: freestanding emergency department under construction in Summerville, South Carolina (Berkeley County) with 12 treatment spaces; and

f. Berkeley Medical Center: 50-bed acute care hospital approved to be developed in Moncks Corner, South Carolina (Berkeley County) that will include an emergency department with 13 treatment spaces.

2. At the time of the hearing, the Department had approved a CON for both Trident's Summerville FED and Berkeley Medical Center but construction had not commenced for either. It was unknown as to when or whether construction would commence for the Berkeley Medical Center. (Tr. 941:9-942:9).

3. In its emergency departments, Trident has demonstrated efficient operation which the parties referred to as "throughput,"[6] as measured by no more than 2% of patients who leave without treatment; average door-to-doctor time of eight minutes or less; door-to-discharge times of 155 minutes in its hospital emergency department and 80 - 90 minutes in its freestanding emergency departments. (Tr. 1034:10-1035:24).

4. Roper St. Francis is a non-profit healthcare system comprised of the following inpatient facilities and FEDs:

a. Roper Hospital: 316-bed tertiary care hospital located in downtown Charleston, South Carolina (Charleston County), which includes an emergency department with 27 treatment spaces;

b. Bon Secours-St. Francis Xavier Hospital: 204-bed acute care hospital located in the West Ashley area of Charleston, South Carolina (Charleston County), which

[5] Trident Medical Center is a Level II trauma center.

[6] Throughput means the ability to move a patient through the emergency department, from the time the patient arrives at the facility until the patient leaves after receiving needed services. (Tr. 122:18-21; 480:4-8).

includes an emergency department with 30 treatment spaces;

c. Roper Mount Pleasant Hospital: 85-bed acute care hospital in Mount Pleasant, South Carolina (Charleston County), which includes an emergency department with 12 treatment spaces;

d. Roper St. Francis Berkeley Hospital: 50-bed acute care hospital in Summerville, South Carolina (Berkeley County), which includes an emergency department with 15 treatment spaces;

e. Roper Hospital Diagnostics & ER – Berkeley: freestanding emergency department located in Moncks Corner, South Carolina (Berkeley County) with 12 treatment spaces; and

f. Roper Hospital Diagnostics & ER – Northwoods: freestanding emergency department located in North Charleston, South Carolina (Charleston County) with 15 treatment spaces.

5. At the time of the hearing, the Department had approved a CON for Roper St. Francis Berkeley Hospital and construction had commenced.

6. Roper St. Francis has demonstrated efficient throughput in its emergency departments, as indicated by 1.5% of patients who leave without treatment from hospital departments, and fewer than 1% of patients who leave without treatment from freestanding emergency departments; average door-to-doctor time of six minutes or less; and door-to-discharge times of 120 - 180 minutes in the hospital emergency departments and sixty minutes in freestanding emergency departments. (Tr. 480:1-2; 519:15-24; 521:1-13; Tr. 521:23- 522:4).

7. MUSC[7] is not a party to this case but it is relevant for purposes of identifying the Medical University Hospital Authority, d/b/a MUSC Health Emergency Services. MUSC is a State entity that consists of three main bodies: an academic medical school, the hospital, and a physician practice group. In 2000, MUHA was established by the South Carolina General Assembly as a separate State agency. Through powers enumerated in its enabling legislation, MUHA has the authority to manage, regulate, and operate the healthcare functions of MUSC. MUHA is authorized to establish not-for-profit entities as the board finds necessary to facilitate the healthcare operations of MUSC. S.C. Code Ann. § 59-123-60(E)(13) (2020). MUSC includes the following inpatient facilities:

a. MUSC Medical Center: 656-bed tertiary/quaternary care hospital in downtown

[7] MUSC is the State's highest ranked hospital by *U.S. News and World Report*. (Tr. 2380: 17-20); (Joint Ex. 01-008). It is a Level I trauma center and has more than one-hundred outreach locations and operates a Medicare Accountable Care Organization (ACO). (Tr. 1460:12-16; 1876:6-8); (Joint Ex. 001-008).

Charleston, South Carolina (Charleston County), which includes an adult "main" emergency department with 41 treatment spaces although 12 are reserved for mental health patients, and a separately located emergency department in the Ashley River Tower with 10 treatment spaces designated the Chest Pain Center; and

b. MUSC Children's Hospital (Shawn Jenkins Women and Children's Hospital): a newly constructed replacement facility for the MUSC Children's Hospital specializing in pediatric and women's care that is soon to open on the peninsula of downtown Charleston, South Carolina (Charleston County) and will include an emergency department with 20 treatment spaces. At the time of the hearing, the pediatric emergency department had 16 treatment rooms although four treatment rooms were used only for pediatric mental health patients.

In short, at the time of the trial, MUSC's emergency department consisted of 67 treatment rooms but 16 were reserved for mental health patients.

8. MUSC's adult and pediatric emergency rooms are Level I trauma centers, the highest level of trauma. MUSC's emergency rooms are the only Level I trauma centers in Charleston, Berkeley, or Dorchester counties, and have the ability to treat the most acute patients and complex cases. (Tr. 136:19-137:6); (Joint Ex. 001-008).

9. MUSC's emergency department has experienced negative efficiency indicators, as measured by 5% of patients who leave without treatment; average door-to-doctor time in excess of forty-five minutes; and door-to-discharge times above 200 minutes. (Tr. 158:12–160:25). Typically, twenty to thirty patients are "boarders" at any given time, meaning they are awaiting a bed for inpatient admission or awaiting discharge from the emergency department. (Tr. 1776:14-18). MUSC's existing downtown emergency department has design and physical plant challenges that decrease treatment efficiency and frustrate treatment providers. (Tr. 170:4-12; 324:3-325:1).

10. MUSC has neither redesigned nor renovated its emergency department in at least seven years partly because of the exorbitant cost. (Tr. 301:3-8; 329:1-23). MUSC has applied for a CON to add additional inpatient beds to alleviate some of its boarding problems in its emergency department. (Tr. 1810:16-19; 1812:4-7). Inpatient capacity has had a significant effect on emergency department wait times and throughput. (Tr. 221:23-222:15).

11. All of the hospital parties to this contested case are subject to the federal Emergency Medical Treatment and Active Labor Act (EMTALA), which requires on and off-site emergency departments to perform an emergency medical screening examination on any person who presents requesting such assistance. *See* 42 U.S.C.A. § 1395dd *et seq*. EMTALA prohibits emergency departments from conditioning an emergency screening examination on a patient's ability to pay.

(Tr. 1206:6-20). Emergency services at all emergency departments operated by all parties to this case do so with competent, qualified emergency service professionals. (Tr. 332:2-9; 404:3-5; 538:18-22).

12. Lastly, the Department is the State agency charged with implementing South Carolina's CON program and includes promulgating the Plan, reviewing and approving CON applications, issuing CONs, and monitoring the implementation of CON projects. S.C. Code Ann. § 44-7-140 (2018). By statute, the Department is "the sole agency for control and administration of the granting of [CONs] and licensure of health facilities." *Id.*

B. **The Regulatory Process and State Health Plans**

13. The purpose of the State Certificate of Need and Health Facility Licensure Act (CON Act) is to "promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities" in South Carolina. S.C. Code Ann. § 44-7-120 (2018).

14. The primary vehicle by which the CON program is implemented, and its stated goals achieved, is the requirement that a certificate of need be obtained by a person or health care facility before undertaking "the offering of a health service by or on behalf of a health care facility which has not been offered by the facility in the preceding twelve months and for which specific standards or criteria are prescribed in the South Carolina Health Plan." S.C. Code Ann. § 44-7-160(5) (2018). In determining whether to grant or deny an application for a CON, the Department evaluates the proposed project as provided for in the CON Regulations, including the project review criteria, and considers the policies and standards set forth in the applicable Plan. *See* S.C. Code Ann. § 210(B) and (C) (2018).

15. The Plan is a document that the Department is required to promulgate in furtherance of the CON Act's purpose. S.C. Code Ann. § 44-7-120(3) (2018). The Plan which the Department is required to publish at least once every two years, contains specific standards and criteria for the review and approval of covered services, including as relevant here the establishment of outpatient facilities such as the FED proposed by MUHA. *See* S.C. Code Ann. § 44-07-180(C) (2018).

16. Project review criteria are adopted by the Department in regulations and "must be used in reviewing all projects under the Certificate of Need process." S.C. Code Ann. § 44-7-190(B) (2018). There are thirty-three project review criteria: Need; Community Need Documentation; Distribution (Accessibility); Acceptability; Financial Entries and Assumptions;

Projected Revenues; Projected Expenses; Beginning Cash Flow; Net Income; Debt Service; Methods of Financing; Ability to Obtain Capital; Record of the Applicant; Ability to Complete the Project; Financial Feasibility; Cost Containment (Minimizing Costs); Efficiency; Physical Design; Alternative Methods; Staff Resources; Support Services and Equipment; Distribution; Adverse Effects on Other Facilities; Adverse Effects on Training Programs; Access; Zoning; Utilities; Site Size; Environmental Hazard; Square Footage; Medically Underserved Groups; Other Entities; Elimination of Safety Hazards. S.C. Code Ann. Regs. 61-15 § 802 (Supp. 2019).

17. The Department must advise an applicant which of the Project Review Criteria it considers to be most important, and in what priority order those Project Review Criteria will be evaluated. S.C. Code Ann. Regs. 61-15 § 304 (Supp. 2019). "When an application has been appealed, the Department may not change the weight of the importance of the project review criteria." *Id*.

18. The Plan contains an inventory of existing health services, the projections of need for additional services and facilities, and the standards for distributing the facilities and services across the state's regions, known as "service areas." *See* S.C. Code Ann. § 44-7-180(B) (2018).

19. FEDs are hospital-based outpatient facilities that serve patients who do not require hospitalization. (Tr. 599:12-20); (Roper St. Francis Ex. 55-019).[8] The Standards applicable to FEDs are located in the Outpatient Facilities Chapter of the South Carolina Health Plan. (Roper St. Francis Ex. 55-019).

20. FEDs do not have "service areas" defined in the Plan, so applicants seeking to provide freestanding emergency services must define the geographic bounds, or "service area" which they intend to serve. (Tr. 1340:7-12).

21. Need calculations for freestanding emergency services differ from calculations for hospital beds because freestanding emergency services do not have a facility-specific need calculation within the Plan. (Tr. 1486:12-1487:9).

22. In determining whether to grant or deny a CON Application, the Department evaluates a proposed project under the review criteria found in the CON regulations, and under the policies and standards set forth in the applicable Plans. *See* S.C. Code Ann. § 44-7-210 (2018); S.C. Code Ann. Regs. 61-15 (2018 and Supp. 2019). The Department must consider the policies and standards of the Plan in effect at the time a CON Application is filed, and the Department may

[8] Roper St. Francis Ex. 55 is the 2015 State Health Plan.

consider the policies and standards of a subsequently promulgated Plan. *See* S.C. Code Ann. § 44-7-225 (2018).

23. Even if an application complies with the State Health Plan, the Department can refuse to issue a CON based on the Project Review Criteria and other regulations it identifies. *See* S.C. Code Ann. § 44-7-210(B).

24. The CON Act dictates that "[t]he department **may not** issue a Certificate of Need **unless** an application complies with the South Carolina Health Plan, Project Review Criteria, and other regulations." S.C. Code Ann. § 44-77-210(B) (2018) (emphasis added). *See also MRI at Belfair LLC v. S.C. Dep't of Health and Envtl. Control*, 379 S.C. 1, 9, 664 S.E.2d 471, 475 (2008) (holding that compliance with the State Health Plan and the Project Review Criteria are independent requirements for approval of a CON).

25. MUHA's CON Application to construct a FED in Berkeley County was filed on June 6, 2017, when the *2015 South Carolina Health Plan* was still in place (2015 Plan). The Outpatient Facilities Chapter, and therein the Standards for Freestanding Emergency Services, are found at Chapter XI of the 2015 Plan. (Roper St. Francis Ex. 55-021). The *2017-2018 South Carolina Health Plan* (2017-2018 Plan) was enacted on June 9, 2017, three days after MUHA's CON Application was filed. (Roper St. Francis Ex. 56). The Department's decision letter states that the CON Application was reviewed under the 2015 Plan.[9] (Joint Ex. 001-551).

26. The 2015 Plan contains the following six Standards that must be satisfied in order to establish services in a FED:

1. A Certificate of Need is required to establish a freestanding emergency service (also referred to as an off-campus emergency service).

2. All off-campus emergency services must be an extension of an existing hospital's emergency service in the same county unless the applicant is proposing to establish a freestanding emergency service in a county that does not have a licensed hospital. The hospital must have a license that is in good standing and must be in operation to support the off-campus emergency services.

3. Regulation 61-16 will be used to survey off-campus emergency services, specifically including 24 hour/7 day per week physician coverage on site.

[9] The CON Act states: "The department, the Administrative Law Court, and the Court of Appeals shall consider the South Carolina Health Plan in place at the time the application was filed and may consider the current South Carolina Health Plan when making its decision." S.C. Code Ann. § 44-7-225 (2018).

4. An off-campus emergency service must have written agreements with Emergency Medical Services providers and surrounding hospitals regarding serious medical problems, which the off-campus emergency service cannot handle.

5. The physical structure must meet Section 12-6 of the Life Safety Code, New Ambulatory Health Care Centers, and must specifically have an approved sprinkler system.

6. The applicant must demonstrate need for this service by documenting where the potential patients for this proposed service will come from and why they are not being adequately served by existing services in the area.

The only standards that were disputed in this case were Standards 2 and 6.

27. The 2015 Plan also provides that the following project review criteria are considered to be the most important in evaluating CON applications for this service:

1. Compliance with the Need Outlined in this Section of the Plan;
2. Community Need Documentation;
3. Distribution (Accessibility);
4. Resource Availability; and
5. Financial Feasibility.

(Roper St. Francis Ex. 55-023).

28. Finally, the 2015 Plan provides that the "benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating [CON] applications for this service." *Id*.

29. On June 9, 2017, the 2015 Plan was replaced by the 2017-2018 Plan. (Tr. 597:21-25). Standards 5 and 6 outlined in the 2015 Plan were not restated. Instead, the following new paragraph was added:

> The applicant must demonstrate need for this service by documenting capacity constraints within existing emergency departments in the service area and/or a travel time of greater than 15 minutes to an existing emergency department in the service area.

(Roper St. Francis Ex. 56-026).

30. The project review criteria for FEDs were also changed in the 2017-2018 Plan and the following were considered to be the most important in evaluating CONs for FEDs:

1. Community Need Documentation;
2. Distribution (Accessibility);
3. Medically Underserved Groups;
4. Record of the Applicant; and
5. Staff Resources.

(Roper St. Francis Ex. 56-026).

31. The 2017-2018 Plan further provided that "Access to emergency medical services should be available within fifteen (15) minutes travel time for the majority of residents of the State. The benefits of improved accessibility will outweigh the adverse effects of duplication in evaluating applications for [freestanding emergency hospital services]." (Roper St. Francis Ex. 56-026).

32. The 2018-2019 Health Plan standards and requirements for Freestanding Emergency Hospital Services are unchanged from the 2017-2018 Health Plan. (Roper (St. Francis Ex. 56-026; 57-026).[10]

**C. MUHA's CON Application**

33. On April 12, 2017, Trident filed a CON application for the Summerville FED to be located in front of the Nexton community development in Summerville, (Berkeley County), South Carolina. (MUSC Ex. 8 at M08.001; M08.034). On June 6, 2017, MUHA filed an application for a FED in order to meet the deadline for the Department to review its application comparatively with Trident's FED application in the event the Department determined the applications to be competing. MUHA's FED was to be located in the Nexton community development in Berkeley County, South Carolina on a medical campus under development by Palmetto Primary Care Physicians that would also include primary care, specialty care, imaging, and lab services. (Joint Ex. 001-010 through -022). At the time both applications were filed, the 2015 Plan was in effect. (Tr. 1333:4-8).

34. MUHA's CON application described the project as a FED totaling 15,300 square feet to include ten private treatment areas, one isolation treatment area, and one resuscitation area. Space for a Clinical Decision Unit (CDU) for purposes of observation was also included. MUHA's proposed FED was also to have a helipad which MUHA stated would enable it to serve higher acuity patients. The land on which MUHA's FED was to be built and its building were to be funded and developed by Nexton FED, LLC. (Joint Ex. 001-081). MUHA's application described the need for the project as being to "increase access to care for service area residents while alleviating capacity constraints at the hospital-based ED."[11] (Joint Ex. 001-010; -022). MUHA

[10] Roper St. Francis Ex. 57 is the 2018-2019 State Health Plan.

[11] The evidence indicates that MUSC's emergency department has seen fewer rather than more patients since MUHA's CON application for a FED was filed. (Tr. 740:3-11); (MUSC Ex. 34; 60-23). In fact, the 2017 Joint Annual Report

also represented that the FED would improve access for MUSC patients residing in the North Area. (Tr. 158:2-7; 1711:23-1712:6; 1977:14-1979:23); (MUSC Ex. 60-3). It also stated that both would improve operations and help further MUSC's mission as a teaching hospital. (Tr. 158:2-7; 1711:22-1712:6; 1977:12-1979:23); (MUSC Ex. 60-3).[12]

35. MUHA's application provided that as an academic medical center and Level I trauma center, MUSC's emergency department must manage complex cases and deliver specialized care in a teaching environment. (Joint Ex. 001-008; -009). At the hearing, MUHA represented that MUSC is different from other providers and sees fewer patients per emergency room bed because it is in an academic medical center that treats many high acuity patients. (Tr. 2102:16-19).

36. MUSC's hospital-based emergency department consists of three separately identified departments: the adult emergency department in the main hospital, the Chest Pain Center emergency department in Ashley River Tower, and the pediatric emergency department in the Children's Hospital, the latter of which is soon to be relocated to the Shawn Jenkins Women and Children's Hospital. (Tr. 210-213). In MUHA's CON application, the historical volume used as the baseline to project emergency room utilization was all emergency room visits for all patient types (including pediatric and trauma) seen at the hospital-based emergency rooms downtown. (Joint Ex. 001-025); (Tr. 617:22-619:21). MUHA's CON application proposed that "a portion of MUSC's hospital-based ED patients from the service area will shift to the FED for services." (Joint Ex. 001-025). MUHA stated "the majority of patients shifting to the FSED originate from Berkeley and Dorchester Counties." (Joint Ex. 001-026). MUHA's utilization methodology resulted in an overall assumption that 21% of all emergency visits to MUSC's tertiary, quaternary Level I trauma center downtown will shift to the FED in Berkeley County. (Joint Ex. 001-026); (Tr. 621:7-622:11). In the first year of the proposed project which was anticipated to be 2019, MUHA represented that 15,129 patient visits were projected to shift to the FED. (Joint Ex. 001-026).

37. In addressing impact on existing facilities, MUHA's application stated "MUSC's proposed project will not represent unnecessary duplication of services and will not adversely

indicates that Trident's emergency department visits declined despite the population growth in the proposed service area. (Tr. 1467:24-1468:4).

[12] MUSC's mission as a teaching hospital is laudable but is not a criterion listed in any Plan or regulation. *See* (Tr. 2288:18-2289:1; Tr. 2289:10-13).

affect existing facilities in the service area … [T]he proposed project will serve to address the existing challenges at MUSC, and will have no adverse impact on the programs of competitors in the area. Existing patient volume will shift to the freestanding ED. The existing patient population and population growth can fully support the proposed project." (Joint Ex. 001-028).

38. In further addressing impact on existing facilities, MUHA's application stated that the proposed project "will not represent unnecessary duplication of services and will not adversely affect existing facilities in the service area ... The proposed project will serve to address the existing challenges at MUSC [as] existing patient volume will shift to the freestanding ED." (Joint Ex. 001-028). The application additionally provided that "The proposed freestanding ED will alleviate capacity constraints and enhance access." (Joint Ex. 001-028). MUHA also represented that the existing patient population and population growth could fully support the proposed project. (Joint Ex. 001-028). MUHA expounded on the unique nature of MUSC's downtown hospital-based emergency departments stating that because it "[was] an academic medical center and Level I trauma center, the emergency department at MUSC Health [was] unique compared to other providers." (Joint Ex. 001-028).

39. In response to being asked to discuss alternative facilities and/or services considered as required by Regulation 61-15 § 202(2)(b)(12), MUHA stated that under the status quo, MUSC patients and physicians would continue to experience capacity challenges associated with the existing emergency department, and that expansion or renovation were not viable options for a myriad of reasons including that the cost of renovation "far outweigh the costs of developing the proposed project." S.C. Code Regs. 61-15 § 202 (Supp. 2019); (Joint Ex. 001-029).

**D. <u>The Department's Staff Review and Approval of MUHA's CON Application</u>**

40. By letter dated July 10, 2017, the Department advised MUHA that the CON application was deemed complete, and listed the following project review criteria as the most important:

> The specific criteria to be used [in reviewing the application] are set forth below and are ranked according to their relative importance, with the most important being listed first. All other relevant criteria will be given equal importance.
>
> a. Community Need Documentation;
> b. Distribution (Accessibility); and
> c. Medically Underserved Groups; and
> d. Financial Feasibility.

(Joint Ex. 001-545 through 546).

41. The Department did not identify "Compliance with Need Outlined in [the] Plan or "Resource Availability," which are set forth in the 2015 Plan as project review criteria considered the most important in evaluating CON applications for FEDs. (Roper St. Francis Ex. 55-023).

42. On July 6, 2017, Trident notified the Department of its status as an affected person and opposition to MUHA's CON application. (Joint Ex. 001-440 through -441). On July 21, 2017, Roper St. Francis provided similar notice to the Department. (Joint Ex. 001-442 through -443).

43. Trident's opposition to MUHA's application, as outlined in its letter of July 6, 2017 to the Department, focused on the absence of community need for the proposed FED, the lack of improvement in access, the lack of a detailed patient origin zip code analysis, and the belief that MUHA's motivation was to capture market share from existing providers of similar services and not simply redirect existing patient volume. (Joint Ex. 001-440). Trident also addressed the adverse impact its multiple emergency departments in the service area would experience if the CON application was approved. *Id.*

44. By letter dated July 21, 2017 and on behalf of Roper St. Francis, Ms. Platt provided a health planning analysis identifying a number of problems with MUHA's application, which generally included that: (a) the CON application did not satisfy Standards 2 or 6 of the 2015 Plan; (b) there was no community need to be addressed by the proposed FED given the abundance of capacity in the proposed service area; (c) the methodology and assumptions used to support the proposed Project were unreasonable and flawed; and (d) the proposed Project did not improve access and failed to promote cost containment. (Joint Ex. 001-442).

45. At the request of the affected persons, the Department conducted a project review meeting on August 24, 2017. All three parties appeared to present their positions. Copies of presentation materials are included in the Department's record. (Joint Ex. 001-0457 through -490; 001-512 through -543).

46. At the project review meeting, MUHA identified by zip code, the number of historical patient visits it assumed would shift to the proposed Project; its data evidenced that of the 14,366 patient visits it projected to shift to the FSED, 5,020 would originate from Berkeley County, 3,603 would originate from Charleston County, and 5,749 from Dorchester County. (Joint Ex. 001-530). Thus, 35% of the emergency department visits are Berkeley County residents, compared to 40% from Dorchester County and 25% from Charleston County. (Joint Ex. 001-530).

47. MUHA represented that the FED's helipad would enable it to serve a higher acuity patient base and that its FED was unique because its CDU would "eliminate bottlenecks in the ED and result in more efficient usage of treatment rooms."[13] (Tr. 1641:19-23; 1643:12-17; Tr. 1653:19-1654:5; Tr. 1777:11-21; Tr. 2175:20-2176:12; Tr. 2176:2-16) (Joint Ex. 001-011; -020 through 021; -516).

48. Written submissions were made to the Department following the project review meeting. (Joint Ex. 001-493 through 495; 001-496 through 504; 001-506 through 511).

49. The post project review meeting submissions included a letter dated September 7, 2017 from Mr. Levitt on behalf of MUHA to the Department in response to opposition and included data addressing the acuity level of MUSC's emergency department patients. (Joint Ex. 001-507). The acuity level was explained at the contested case hearing as the severity of a patient's condition upon presenting to an emergency department. (Tr. 474:2-23). The data provided by Mr. Levitt categorized MUSC's 2016 historical emergency room volume by six types, which MUHA asserted was evidence that "high acuity trauma visits are less than one percent of MUSC's total ED volume." (Joint Ex. 001-507). The figure shown was that 712 of 81,260 visits (or 0.9%) were "HB ER VISIT CRITICAL CARE." *Id.*

50. Ms. Murdock served as the primary reviewer of MUHA's CON Application and developed the staff decision. (Tr. 1316:24; 1328:22-1329:1). She testified that she reviewed MUHA's proposal in the application and conducted her own analysis of the effect the FED proposed by MUHA would have on existing and approved projects in the area. (Tr. 1347:21-1348:19).[14] Ms. Murdock additionally testified that she identified the project review criteria for the deemed complete letter that she believed were "most important based on [the CON Program's] mission." (Tr. 1331:1-1332:6). According to Ms. Murdock, the Department interprets Regulation 304 as giving Department staff the authority to identify project review criteria for a project that may or may not include all of the project review criteria identified in the Plan for that particular facility or service. (Tr. 1426:1-11; 1431:17-21; 1433:5-1434:5).

51. On September 25, 2017, the Department approved MUHA's application finding that the application "sufficiently complies" with the Standards in the 2015 Health Plan and the

[13] MUHA's application stated that "A unique aspect of the proposed project is the proposed inclusion of a clinical decision unit (CDU)." (Joint Ex. 001-021).

[14] The Court questions Ms. Murdock's analysis as she was unaware of several relevant projects as they "were not [her] cases" and while capacity was an issue in this matter, she was unaware of the number of beds at Centre Pointe FED which is located in the proposed service area. (Tr. 1348:11-19; 1455:7-1457:6; 1446:18-1147:1).

identified relative importance of the project review criteria. (Joint Ex. 001-551 through -0555). No other project review criteria were discussed. The Department summarily stated, "that the opposition has not provided evidence sufficient to require denial of a CON for the Project." (Joint Ex. 001-552).

**E. Changes to the Project after Review**

52. After the Department approved MUHA's CON application but prior to the contested case hearing, MUHA made changes to its project. Roper St. Francis and Trident argued that the changes were so substantial as to constitute a new project requiring a new application. The Court disagrees.

53. It is not uncommon for CON projects to change after Department approval. (Tr. 1984:20-23; 1396:24-1398:4). The Department requires a CON applicant to certify the veracity of the statements in the application, but the certification is limited to the time the application is submitted to the Department. (Tr. 1395:25-1396:23). For example, by letter dated February 24, 2017 (which served as its quarterly report to the Department), Roper St. Francis identified several changes to the Roper St. Francis Berkeley Hospital project. (Roper St. Francis Ex. 5). These changes included reducing the size of the lobby, eliminating an atrium, moving administrative offices and infusion space out of the hospital, adding ultrasound equipment, reducing the number of emergency treatment rooms and operating rooms, changing the configuration of the post-anesthesia care unit, adding a special procedures lab, eliminating 12 medical-surgical beds and four LDRP (labor, delivery, recovery, and post-partum) beds, adding 16 postpartum gynecological rooms, and reducing the overall size of the hospital from 138,750 to 115,194 square feet. (Tr. 1999:21-2002:90); (MUSC Ex. 60-4); (Roper St. Francis Ex. 5) .

54. The primary changes to MUHA's proposed FED are a relocation of the site, a reduction in size and cost, and the elimination of the CDU and helipad. (MUHA Ex. 60:5). Relocation changes are not uncommon for CON projects. (Tr. 1374:4-5). MUHA's new location is less than one mile from the original site. (Tr. 2003:21-22); (MUSC Ex. 60-6). The original and new location sites are in the same zip code. (Joint Ex. 001-004); (MUSC Ex. 42); (Trident 056-005). Both sites are in the Town of Summerville and in Berkeley County. (Tr. 1330:10-12; 2033:1-2); (Joint Ex. 001-004). The original site was on the edge of the Nexton development, while the new site is on the other side of I-26 on Summerville's North Main Street (Highway 17A).

(Tr. 2005:17-19; 2008:20-22; 2009:12-13).[15] When MUHA submitted its application, the original site was within a planned medical campus with several different medical services. (Tr. 2021:8-15). Since then, however, many of these planned projects have been abandoned or are not moving forward. *Id*. The new site is in a shopping center and has greater visibility and access than the original site. (Tr. 1867:2-6; 2009:9-2010:2; 2011:6-20); (MUSC Ex. 60-6). No evidence was presented showing that MUHA's relocation will have any impact on the FED project from a clinical, operational, or patient safety perspective.

55. The decision to relocate has resulted in some additional changes. The original site was owned by an Ohio company called Nexton FSED, LLC. (Joint Ex. 001-005). The new site is owned by a company called Luco Realty, with whom MUHA has negotiated and executed a new lease.[16] (Tr. 2014:2-5); (MUSC Ex. 59). The Department's practice is to permit flexibility with respect to lease changes. (Tr. 1373:6-1374:5). Here, the original lease was for ten years, while the Luco lease is for five, and both contain multiple renewal options. (Tr. 2014:6-18); (Trident Ex. 72-006). The acreage leased is slightly smaller on the new lease. (Tr. 2015:8-20). After MUHA eliminated the CDU and helipad, not as much acreage was needed. (Tr. 1794:6-17).

56. The changes also affected the project's financing. Under the original proposal, the financing was to be the joint responsibility of Nexton FSED, LLC and MUHA. (Joint Ex. 001-081 and -082). As Nexton FSED, LLC is no longer involved in the project, MUHA plans to finance the project through a new developer, a loan, or MUSC's operational cash flow. (Tr. 1755:6-9). If the CON is issued, MUHA will commit to a funding mechanism, based on current interest rates. (Tr. 1755:17-1756:2). The funding mechanism proposed by MUHA at the hearing is not materially different from the financing options it outlined in its CON application. MUHA's application included a letter from the chief operating officer that provides "MUHA may fund the project through operating income, cash reserves, existing lines of credit or through issuance of debt. If necessary, MUHA will fund the project through operations and existing reserves." (Joint Ex. 001-082). Although MUHA's 2018 unaudited interim financial statement shows an operating

[15] In its recently approved FED application, Summerville Medical Center stated that its FSED was "ideally situated near I-26 and along Highway 17A to enhance access." (MUSC Ex. 8-24). Summerville Medical Center and MUHA's FED sites are slightly over a mile away from each other. (Tr. 2160:8-14). The two sites are equally close to Highway 17A and I-26. (MUSC Ex. 42). The MUHA site is as ideal as the Summerville Medical Center site.

[16] The parties to the new ground lease are Luco Realty and MUSC-Strategic Ventures (MUSC-SV). The lease provides that MUHA shall be automatically substituted for MUSC-SV as a party in the event a final, non-appealable order is issued holding that MUSC-SV is *ultra vires* or must be dissolved. (MUSC Ex. 59).

loss of $2,888,383 million,[17] Dr. Cawley testified that MUSC has sufficient capital or debt capacity to fund the project. (Tr. 1874:2-16); (Roper St. Francis Ex. 47-003). The same financial statement shows that MUHA has $18,584,383 million in operating income. (Tr. 2159:2-6); (Roper St. Francis Ex. 47-004).

57. Finally, the relocation has affected the project's zoning. The original site would have been zoned as part of the Nexton planned unit development. (Tr. 2016:8-11). The best evidence presented to the Court on the new site's zoning is a local draft ordinance showing the site would be B-3, which includes hospitals, medical clinics/urgent care, and other health care facilities. (MUSC Ex. 60-12 and -13; Tr. 2016:12-2017:8; 2191:17-2193:12).

58. The second principal change to MUSC's project is a size and cost reduction. MUHA reduced the size of the FED building from approximately 15,000 to 10,700 square feet and the project cost from approximately $13.6 million to $11 million. (Tr. 2004:1-5); (MUSC Ex. 29). The FED still contains 12 emergency treatment rooms. (Tr. 2024:5-12; MUSC Ex. 29). Five of the treatment rooms will be "fast track" rooms, which are designed primarily for lower acuity patients. (Tr. 2026:12-23). The Department does not usually focus on changes in schematic designs or layouts, as such aspects of the project will be examined in detail later by the Department's Construction and Licensing Division to ensure regulatory compliance. (Tr. 1372:6-19). There was no evidence that the design changes would affect patient safety.

59. MUHA's application stated that its FED would have a helipad and a CDU. (Joint Ex. 000-011). Interestingly, Petitioners originally criticized both features. *See, e.g.*, Trident's Petition for Administrative Review at Page 8, ¶28 ("the construction of a helipad … creates serious questions as to the financial feasibility of MUSC's Proposed Project"); at P. 9, ¶30 ("MUSC presented no evidence of any clinical benefits … from the establishment of the CDU because there are none"). MUHA decided that the costs of the CDU and helipad outweighed their benefits and eliminated both from the project. (Tr. 198:7-200:10; 1725:18– 1726:8; 2028:5-17). The decision to eliminate the CDU and helipad was the primary reason for the over $2 million decrease in project costs. (Tr. 1725:8-11).

60. Roper St. Francis argued that the Department based its decision to approve the application partially on MUHA's assertions that the CDU and helipad were critical factors differentiating MUHA's project from other FEDs. (Tr. 784:2-785:2). MUHA entitled one section

[17] The operating loss of $2.8 million is based upon pension liabilities. (Tr. 2159:2-8). While there is a loss, MUHA still has $18 million in operating income and a positive cash flow is being produced. (Tr. 2159: 6-10).

of its application "MUSC Emergency Services and Differentiating Factors." (Joint Ex. 001-008 through -009). The section references many aspects of the project that differentiate it from other FEDs, but no mention is made of the CDU or helipad. *Id.*; (Tr. 2028:22-2030:24); *see* (Tr. 2031:1-20). Also, the Department's decision letter approving the project did not mention either the CDU or the helipad. (Joint Ex. 001-551 through -555). Without objection, the Department's director testified that neither the CDU nor the helipad affected the Department's decision. (Tr. 1366:7 – 1367:5). *See also* (Tr. 1371:7-9; 1372:25-1373:4). Trident's expert testified that he did not believe the CDU or helipad were necessary or important parts of the project and did not know what weight the Department may have ascribed to them in its evaluation. (Tr. 1273:13-21). For these reasons, I find that the proposed CDU and helipad had little influence on the Department's decision to approve the application and were not important aspects of the project. Also, MUHA can still conduct the same functions of a CDU within the 12 beds at the FED. (Tr. 2028:14-17).

**2015 STATE HEALTH PLAN**

**F. <u>Standard 2 of the 2015 State Health Plan</u>**

61. Pursuant to Rule 201, SCRCP, Roper St. Francis and Trident have asked that the Court take judicial notice that as of October 4, 2019, Roper St. Francis Berkeley Hospital opened. The Court declines to do so. Roper St. Francis Berkeley Hospital was not open at the time of the filing of MUHA's application or at the conclusion of the hearing on August 2, 2019, and no party filed a motion to re-open the record and supplement it with the same.

62. The Court views this request as a veiled attempt by the parties to circumvent this Court's ruling denying Roper St. Francis and Trident's Motion for Summary Judgment as to Standard 2 in the 2015 Plan, and to further bolster any argument as to Standard 2 on appeal of this case.[18] However, as detailed below, the Court finds that Roper St. Francis and Trident have established by a preponderance of the evidence that MUHA's proposed FED does not meet Standard 6 of the 2015 Plan; does not meet all of the project review criteria deemed most important for evaluating a FED application; and is inconsistent with the CON Act. Thus, there is no need to address Standard 2 of the 2015 Plan.

[18] Also, MUHA's CON application in this case was submitted on June 6, 2017 and approved on September 25, 2017. The parties should not benefit as a result of their own lack of diligence in aggressively pursuing discovery and the hearing of this matter which did not commence until July 2019.

**G. Standard 6 of the 2015 State Health Plan**

63. Standard 6 of the 2015 Plan requires that an applicant demonstrate a need for a FED by documenting where the potential patients for this proposed service will come from and why they are not being adequately served by existing services in the area.

1. Patient Origin and Utilization

64. MUHA defined the service area for its FED as the tri-county area of Berkeley, Dorchester, and Charleston counties. (Joint Ex. 001-022). The Department considered this to be a very large service area as did Ms. Platt who said it was too broad. (Tr. 738:23-739:3; 1515:7-20). According to Mr. Porter, a former chief executive officer of Roper St. Francis with more than 30 years of health care experience, most patients of a freestanding emergency department originate from a relatively close proximity such as a five to seven-mile radius of the freestanding emergency department. (Tr. 379:9-17). Ms. Huntington, a registered nurse with 35 years of nursing services experience and the director of emergency services for Roper St. Francis, testified that a six to ten-mile radius was appropriate. (Tr. 441:24-442:4; 447:13-17; 458:2-4; 463:24-464:1; 477:21-478:3; 479:1-6: 2343:16-18). The Department considered Trident's use of a four zip code primary service area for Trident's Summerville FED to be reasonable. (Tr. 1465:2-16).

65. MUHA's expert's approach was to identify seven zip codes from which MUHA's proposed FED would expect to draw almost 80 (78.4) percent of its patients, with the remaining 20 (21.6) percent to in-migrate from eighteen other zip codes in the service area. (Tr. 2059:10-2060:1); (MUSC Ex. 44).

66. MUHA submitted patient origin information for its FED to the Department at the project review meeting. (Tr. 733:13-16); (Joint Ex. 001-530). MUHA estimated that Dorchester County would supply 40% of the project's patients, more patients than either Berkeley or Charleston Counties. MUHA further projected that the FED would draw the most patients by number from a zip code in Charleston County; specifically, zip code 29406. (Joint Ex. 001-0530); (Tr. 1478:7-24).

67. Additionally, MUHA represented to the Department that the FED would serve only patients who previously drove to MUSC's downtown location, saying "existing patient volume will shift to the freestanding ED" and calculated proposed patient visits based on "volume shift from MUSC only." (Joint. Ex. 001-0026; 001-0028). At the contested case hearing, MUHA assumed its patients would "choose the shorter travel time" and utilize the FED rather than travel to MUSC's hospital-based emergency department in downtown Charleston. (Tr. 2043:21-2044:8).

68. MUHA provided no basis, insight, or information for its assumption as to why some of its patients who resided in Berkeley, Charleston, and Dorchester Counties were already bypassing other hospital-based emergency rooms as well as FEDs to seek treatment at MUSC on the peninsula. (Tr. 1663:1-24).[19] While pertinent to Standard 6's requirement that an applicant demonstrate why patients are not being adequately served by existing services in the area, the fact that a patient chooses to bypass an existing provider does not mean that existing health resources in the service area are inadequate. (Tr. 1664:14-24).

69. Roper St. Francis and Trident asserted that the utilization set forth in MUHA's application which used the historical patient utilization of MUSC's downtown emergency departments as the basis for its projected utilization (and proposed three-county service area of Berkeley, Charleston and Dorchester Counties) for the FED, was unreasonable and flawed. Petitioners' experts stated that MUHA's projections did not account for the acuity or age of the patient populations treated at MUSC downtown before making assumptions as to redirection to the FED in Berkeley County. (Tr. 635:12-19; 734:1-10; 7431-25; 1185:3-8; 1185:21-25; 2263:21-2264:7); (Roper St. Francis Ex. 59-011).

70. Acuity refers to the severity of a patient's condition upon presenting to an emergency department. (Tr. 474:1-12). The "emergency severity index" or "ESI" is a five-level index where level one is the most critical and level five is the least critical. (Tr. 474:24-475:8). Ms. Huntington testified that the ESI level is based on the anticipated resource utilization for a patient's needs, with the level ones and twos being the most acute patients that likely require hospitalization. (Tr. 475:1-8). Dr. Hall, MUSC's Medical Director for the main emergency department similarly testified that "three, four and fives" were the acuity levels of the patients that would show up at the FED. (Tr. 270:6-12).

71. As noted above, after the project review meeting, MUHA's expert witness submitted a letter to the Department in response to the opposition and included data addressing the acuity level of MUSC's emergency patients. (Joint Ex. 001-507). The data provided by Mr. Levitt categorized MUSC's 2016 historical emergency room volume by six types, which MUHA asserted was evidence that "high acuity trauma visits are less than one percent of MUSC's total ED volume." (Joint Ex. 001-507).

[19] Mr. Sullivan testified that "[I]f patients are traveling downtown now to the Medical University, they're not doing it because of lack of access to emergency care, they're doing it for other reasons." (Tr. 1205:16-22).

72. However, at the hearing, Dr. Hall testified that these six codes were actually billing codes and stated that "[b]illing codes don't necessarily accurately reflect the patient that's coming in through the door. How sick patients are when they show up and how quickly you need to see them is usually reflected in your ESI level." (Tr. 267:16-268:4). Ms. Huntington corroborated that emergency department nurses are focused on triage acuity (ESI) or the severity of the level with which a patient presents. (Tr. 474:1-23). After the patient has been treated, medical coding for billing may be completely different than how the patient presented at the facility. *Id*. Roper St. Francis' health planning expert, arrayed data for MUSC's 2018 emergency department patients to show the disconnect between acuity levels at triage versus emergency department billing codes. (Tr. 742:11-743:17); (Roper St. Francis Ex. 59-17).

73. While there is some overlap in that the most acute patients tend to have a need for utilization of higher-level resources, and therefore, would appear at the uppermost billing level,[20] MUHA's utilization of billing codes does not depict the most accurate reflection of the acuity levels of patients. It follows that MUHA's shift projections based on billing codes are inaccurate even though a FED must be equipped to stabilize all acuity levels.[21] *See* (Tr. 2260:9-2264:7).

74. Additionally, Ms. Platt's analysis of MUSC's historical patient data evidences that the three-year trend in patient acuity showed a decline in all but Level II, which increased by 22% over the three-year period. (Roper St. Francis Ex 59-018).

75. While a FED can stabilize a patient of any age or acuity level, the testimony rendered indicated that "three, four and fives" were the acuity levels of the patients that would seek services at the FED. (Tr. 270:6-12; 272:23-25; 2065:24 – 2066:19; 2093:9-18).

76. Actual experiences of Roper St. Francis' freestanding emergency services contradict MUHA's prediction that patients in a FED and patients in a main hospital emergency department will be similar in acuity. (Tr. 2261:6-14; 2262:16-23). A freestanding emergency department is more likely to serve lower acuity patients and unlikely to simply serve a subset in similar proportion to all acuities seen at the main campus. (Tr. 2263:11-18). All of the parties' experts agreed that freestanding emergency services provide care to proportionally more low-acuity patients than emergency departments located on a hospital campus. (Tr. 382:10-21; 888:11-

[20] (Tr. 2260:24-226:4).
[21] MUHA noted that in prior CON applications, neither Roper St. Francis nor Trident included calculations for age or acuity adjustments in their shift projections. Those applications are not before the Court.

13; 1062:16-20). Ideally, the most seriously ill patients bypass a freestanding emergency room and go directly to a hospital. (Tr. 475:23-476:2; 832:20-834:4; 2383:13-15).

77. This is consistent with Dr. Hall's testimony that the admission rate for the adult main emergency room downtown is approximately 25-26%, which is higher than the national average of 20%, reflecting in his opinion that MUSC's ED patients "tend to be a little more complicated and the admission rate shows that." (Tr. 141:19-142:4); *see also* (Tr. 214:23-215:4). The rate of admission for the Chest Pain Center is even higher at 40%, reflecting a patient population with a much higher rate of converting to an inpatient admission from the emergency department visit. (Tr. 215:5-19). In contrast, the admission rate of a freestanding emergency department is very low, more like 2-3%. (Tr. 419:2-7; Tr. 1187:5-11; 2347:3-6).

2. Whether Patients Adequately Served by Existing Services in the Area – Capacity

78. MUHA's initial application did not identify any other providers of emergency services in the proposed service area although there are several and did not address capacity constraints or lack of access in the area to be served. (Tr. 1463:3-1464:9). Following the project review meeting and after Petitioners objected to the approval of the application given the existing and approved emergency room capacity in MUHA's proposed service area, Mr. Levitt submitted a chart asserting to be a "much more realistic capacity volume" for pending and approved emergency departments in the planning area, than was that of Roper St. Francis. (Joint Ex. 001-449; -465; -509; -510).

79. In materials submitted after the project review, Roper St. Francis represented that 3,000 patients per treatment space was the appropriate number to use for determining capacity in existing and proposed emergency departments in Berkeley County. (Joint Ex. 1-454; -465).[22] Mr. Levitt stated that this was extremely high and concluded that 1,500 visits per bay was a more realistic capacity volume for evaluating emergency department capacity in the market "which is extremely conservative for facilities like MUSC which experience visits from more complex, higher acuity patients." (Joint Ex. 001-509). Mr. Levitt maintained a similar position at the hearing opining that 1,250[23] to 1,500 visits per treatment bay was accepted as capacity for an emergency room department. (Tr. 2102:7-2104:15). Mr. Levitt's opinion was based upon (1) the

[22] At the hearing, Roper St. Francis' health care expert posited that 2,000 visits per space should be utilized for purposes of determining capacity. (Roper St. Francis Ex. 59-007).

[23] Mr. Sullivan testified that he believed 1,250 was a low number for purposes of measuring capacity even for an academic medical institution, and particularly for MUSC which has separate emergency departments for pediatric and adult patients, and then another dedicated to chest pain patients. (Tr. 1155:2-23).

fact that MUSC is an academic medical center and treats much higher acuity patients, (2) MUSC's experience with a significant volume of behavioral health patients that had long lengths of stays in the emergency department (boarders); and (3) emergency room planning and guidelines published by Jon Huddy. *Id*. For planning purposes,[24] or for a new facility that has no actual data on its capacity, the use of 1,500 visits per bed may be within the range of what is appropriate for assessing capacity, particularly in MUSC's experience on the peninsula (including its negative efficiency indicators in its emergency department).

80. While the parties presented testimony estimating what anticipated capacity might be for an emergency department similar to that proposed by MUHA,[25] I find that substantial evidence at the contested case hearing establishes that a threshold of 1,500 visits per treatment space understates the capacity for FEDs and community hospital-based emergency departments when there is actual historical data indicating otherwise. Similarly, the utilization of 2,000 visits per treatment space is improper for purposes of planning when there is historical data that indicates otherwise.

81. Freestanding emergency rooms typically see patients of lower acuity than hospital-based emergency rooms. (Tr. 382:10-18; 908:13-18; 1067:25-1068:8). Because of the difference in acuity between patients, hospital-based emergency departments typically see fewer patients per bed than freestanding emergency departments. (Tr. 377:14-378:17). An average community hospital emergency room capacity is 1,200-1,500 patients per space per year. (Tr. 481:11–13). MUSC's downtown hospital location reports a capacity of 1,250 per room per year. (Tr. 312:5-20). There are valid reasons for different facilities to adopt different capacity measures based on actual and historical experiences. (Tr. 2352:1-22). Thus, Mr. Levitt's use of 1,500 and Ms. Platt's use of 2,000[26] (or any figure) for visits per treatment bed for purposes of calculating capacity for

[24] (Tr. 2352:4-22).

[25] Dr. Hall testified it was possible that the volume capacity for a FSED such as the one proposed by MUHA could see greater than 2,000 patients per treatment space per year which was consistent with the number of patients seen per treatment space at the community hospital where he was formerly employed. (Tr. 269:17-270:2; 297:5-298:6). Ms. Huntington testified that a FED treating patients with ESI levels of 3, 4 and 5 would have capacity expectations of 2,500 to 3,000 per treatment space per year, with that number reducing in proportion to more complicated patients being treated, thereby reducing the facility's efficiency. (Tr. 482:16-25). Joan Eccleston, Trident's Nurse Director of Emergency Services, testified to a conservative capacity of 2,200 ED visits per treatment space per year but at a community-based hospital. (Tr. 996:6-17; 997:21-23).

[26] During the project review process and for purposes of calculating capacity, Ms. Platt on behalf of Roper St. Francis, utilized the figure of 3,000 visits per treatment bed. (Joint Ex. 001-465). At the hearing and during her direct testimony, Ms. Platt used 2,000 visits per space in calculating capacity during her direct testimony. (Roper St. Francis Ex. 59-007). She then utilized a third set of figures later in the trial after Mr. Levitt's direct testimony. (Roper St. Francis Ex. 63-006 and -008).

all facilities (existing and proposed) irrespective of their actual historical experience, is improper. Capacity and utilization can be easily manipulated depending upon the number of visits assigned per treatment bed, as well as the number of treatment beds one considers (e.g., beds for which CON applications have been approved versus only operational facilities).

82. When determining compliance with the Plan, the Department stated that it looked at both facilities that were operational and projects that had been approved. (Tr. 1521:3-7).

83. Ms. Murdock testified that while certain project review criteria address "existing" facilities, the Department looked at approved facilities for purposes of planning: "as part of our general purposes of CON and guiding establishment where these services are needed, I think we need to look towards what will exist in the future [e.g., approved facilities] in addition to what exists now." (Tr. 1353:11-1354:5). Ms. Platt concurred with this approach. (Tr. 726:1-18; Tr. 2240:14-2241:25.)[27] The Court concurs with the Department and Roper St. Francis that approved facilities should be considered for purposes of health care planning as it is consistent with the stated purpose of the CON Act outlined in Section 44-7-120 of the South Carolina Code:

> [The purpose of the CON Act is to] promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure high quality services are provided in health facilities in this State.

S.C. Code Ann. § 44-7-120 (2018).

84. At the time MUHA's application was submitted and approved and as of the date of the conclusion of the hearing, the following projects and facilities that provide similar services and are within a 20-mile radius of MUHA's proposed service area[28] were operational, under construction, and/or had been approved by the Department.[29] After consideration of all of the facts and expert witness testimony from each of the parties regarding their own experiences and capacities, the Court finds the following a reasonable measure of capacity of patients per bed for each existing facility:

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[27] Mr. Levitt testified that it depended upon the project and standards and opined that one should only consider existing providers. (Tr. 2203:7-21).

[28] (Tr. 726:19-727:9); (Roper St. Francis Ex. 59-007).

[29] While Berkeley Medical Center, a 50-bed acute care hospital had likewise been approved and was scheduled to be developed in Moncks Corner, South Carolina (Berkeley County) and was to include 13 treatment spaces, the Court did not consider it. At the hearing, testimony was rendered that the project was stalled with the Army Corps of Engineers because of a wetlands issue and it was unknown as to when, if ever, construction would commence. Should the facility open, it would result in additional capacity in the proposed service area. (Tr. 941:9-942:6). Similarly, the Court did not include MUHA's Berkeley Hospital; while its CON application was approved, the parties did not provide information regarding the number of emergency room beds during the course of the trial. (Tr. 2146:9-130; (Trident Ex. 101.006). If either or both had been included, there would be additional service capacity in the area.

| Facility | Capacity | Source |
|---|---|---|
| Trident Medical Center | 1,850[30] | Tr. 995:9-20 |
| Summerville Medical Center | 2,200[31] | Tr. 250:19-21; 995:23-996:8; 997:21-23 |
| Roper Northwoods FED | 2,500 | Tr. 482:16-22 |
| Trident Moncks Corner FED | 2,200 | Tr. 996:6-11 |
| Trident Centre Pointe FED | 2,200 | Tr. 996:6-8 |
| Roper Moncks Corner FED | 2,500 | Tr. 482:16-22 |
| Roper St. Francis Berkeley Hospital[32] | 1,500[33] | Tr. 2352:4-22 |
| Trident Summerville FED[34] | 1,500[35] | Tr. 2352:4-22 |

85. Multiplying these capacity values by the number of treatment areas, the total capacity for the service area defined by MUHA is 338,300, calculated as follows:

| Facility | Capacity | Spaces | Total |
|---|---|---|---|
| Trident Medical Center | 1,850 | 48[36] | 88,800 |
| Summerville Medical Center | 2,200 | 46 | 101,200 |
| Roper Northwoods FED | 2,500 | 15[37] | 37,500 |
| Trident Moncks Corner FED | 2,200 | 8 | 17,600 |

[30] Ms. Eccleston testified as to 1,850 emergency room visits per bed. Ms. Valentine, the chief executive officer for Summerville Medical Center, testified that Trident Medical Center is seeing about 2,500 patients per emergency room bed. (Tr. 985:14-25). The Court placed more credibility on the testimony of Ms. Eccleston who is directly involved in the daily operations and oversight of emergency services.

[31] Ms. Eccleston testified as to 2,200 emergency room visits per bed. Ms. Valentine similarly testified that Summerville Medical Center is seeing about 2,500 patients per emergency room bed. (Tr. 889:4-14). The Court placed more credibility on the testimony of Ms. Eccleston who is directly involved in the daily operations and oversight of emergency services.

[32] At the time of the hearing, Roper Berkeley Hospital was under construction and scheduled to open in October 2019. (Tr. 279:22-24: 701:16-19; 825:2-6; 954:16-18).

[33] The Court used a capacity number of 1,500 visits per bed in the approved but not completely constructed or utilized facilities. Testimony was rendered by Mr. Sullivan that 1,500 was a number that was routinely used for planning purposes. (Tr. 2352:4-22). Also, there is no historical data for these specific facilities. While the Court could utilize higher capacity numbers as demonstrated by similar facilities in the proposed service area, the Court declines to do so to demonstrate that even erring on the conservative side, there is still additional capacity in the area.

[34] At the time of the hearing, ground was scheduled to soon be broken for the construction of Trident Summerville FED, and it was expected to be open within a year. (Tr. 1238:20-:1239:3).

[35] *Id.*

[36] At the hearing and in its proposed order, MUHA indicated that it believed that Trident had only 36 emergency department beds. Ms. Eccleston on behalf of Trident testified to that same number. (Tr. 993:22-994:4; 2129:1-59; 2132:24-2133:3; 2134:13-18). Mr. Sullivan, however, was provided with a copy of the floor plan of Trident's existing emergency department treatment areas and arrived at a figure of 48 indicating that both MUHA and Ms. Eccleston were incorrect. (Tr. 2353:2-2354:17); (Trident Ex. 103).

[37] This includes five additional beds that will be opening in April of 2022. (Tr. 485:23-486:1).

| | | | |
|---|---|---|---|
| Trident Centre Pointe FED | 2,200 | 12 | 26,400 |
| Roper Moncks Corner FED | 2,500 | 12 | 30,000 |
| Roper St. Francis Berkeley Hospital | 1,500 | 15 | 22,500 |
| Trident Summerville FED | 1,500 | 12 | 18,000 |
| Total | | 168 | 342,000 |

86. Roper St. Francis and MUHA's experts testified that in 2018, the current providers of emergency services in MUHA's self-defined service area had an actual utilization of between 220,000 and 225,000 visits. (Roper St. Francis Ex. 6-008); (MUSC Ex. 60-30). Based on the testimony presented, actual utilization of emergency services for the above facilities was 34% (225,000 ÷ 342,000 = .66) below the existing capacity for emergency services in the proposed service area.

87. Using these facilities, there is capacity in the service area to treat an additional 117,000 (342,000 – 225,000 = 117,000) patients without adding another FED or hospital-based emergency room.

88. Standard 6 of the 2015 Plan uses the word, "existing," as in "The applicant must demonstrate need for this service by documenting where the potential patients for this proposed service will come from and why they are not being adequately served by existing services in the area"[38] (emphasis added). Even if the Court were to exclude (1) Roper St. Francis Berkeley Hospital (which was scheduled to open in October of 2019),[39] (2) Trident's Summerville FED (which was approved simultaneously with MUHA's FED and was not appealed and scheduled to open within a year of the contested case hearing on MUHA's FED), and (3) Roper Northwoods FED's five additional beds that will be online in April 2022, from its capacity calculations on the basis that they were not "existing" and operational as of the conclusion of the contested case hearing, there would still be sufficient capacity in the service area to treat an additional 64,900 (289,900 – 225,000 = 64,900) patients without adding another FED or hospital-based emergency room. As an aside, there was also no evidence regarding excessive wait times at the facilities in MUHA's proposed service area. *See also* (Tr. 2244:3-2246:1).

[38] Standard 6 has been omitted from the 2017-2018 Plan, and the following language which still includes the word, "existing," was added: "The applicant must demonstrate need for this service by documenting capacity constraints within existing emergency departments in the service area and/or a travel time of greater than 15 minutes to an existing emergency department in the service area."
[39] (Tr. 465:14-18).

89. Although Ms. Murdock testified that she independently assessed capacity and utilization of emergency department services in the proposed service area, she was unaware of the number of treatment spaces in several of the existing FEDs, including Trident Centre Pointe FED. (Tr. 1455:13-1457:6). Without knowing the capacity of the emergency departments and FEDs in the proposed service area, I find that the Department's assessment of utilization of emergency services could not have been complete or reliable.

90. Roper St. Francis and Trident have additional capacity to provide emergency services in their presently operating emergency department locations to patients in the tri-county service area of Berkeley, Charleston, and Dorchester counties. (Tr. 467:5-11; 486:2-4; 1000:17-22).

91. Capacity cannot be evaluated in a vacuum, and the Court must consider not only the number of beds available for emergency visits but also, how population growth and growth in emergency room visits may affect capacity. Roper St. Francis' health care planner and former chief executive officer did not disagree that the tri-county area and particularly Berkeley County was rapidly growing and was the third fastest growing county in the state. (Tr. 401:22-402:3; 767:23-768:10). *See also*, (Tr. 1978:7-9; 2118:1324); (MUSC Ex. 36). The Department testified that the utilization of emergency services had been "exploding" over the last five years in the area in which the proposed FED was to be located but provided no supporting data as to whether such growth would continue. (Tr. 1348:1-11).

92. In response to Roper St. Francis and Trident's demonstration of existing additional capacity in the proposed service area, and in support of its proposed FED, MUHA presented extensive testimony regarding the population growth (including patient origin growth) and emergency department growth in the proposed service area (particularly in Berkeley County, the county in which MUHA's FED was proposed to be located). (Tr. 401:22-402:3; 1978:7-9; 2115:15-2121:5); (MUSC Ex. 30, 31, 32, 34, 35, 36, 37). The other parties did not dispute that there was population growth. Tr. 767:23-768:10; 2359:6-15). While the population and number of emergency room visits have grown in the tri-county area (and particularly in Berkeley County), statistical information alone can be misleading and does not support a need for an additional FED in the proposed service area given the existing capacity.

93. As an example, MUHA noted that there was a 23.1% (or 75,974 visits) increase in emergency room visits in the tri-county area from 2012 which exceeds the statewide average. (MUSC Ex. 37). This information does not necessarily lend support for an additional FED in the

proposed service area. While the Court does not dispute population and emergency room visit growth in the tri-county area, the trend in the growth of emergency department visits indicates that it slowed in 2016, and that it actually declined in 2017. (Tr. 2359:16-2361:16): (MUSC Ex. 37). There is no indication that there is going to be a consistent dramatic increase in emergency department visits going forward. (Tr. 2361:1-11). Moreover, there are additional facilities that will soon be coming online such as Roper St. Francis Berkeley Hospital and Trident Summerville FED.

94. MUHA stated that one of the reasons it was seeking the FED in the proposed service area was to alleviate constraints in its own emergency department. (Joint Ex. 001-022). MUHA's application projected growth in its emergency department visits. (Joint Ex. 001-0127). At the hearing, however, MUHA acknowledged that the total emergency department visits to MUSC from the tri-county area had slightly declined in 2016, and then again in 2017 and 2018. (Tr. 1467:10-21).[40] MUHA reported growth in the number of Berkeley County residents traveling to MUSC's downtown emergency department from 2015-2018, but the vast majority of its patients were still coming from Charleston County even though the number of visits originating from Charleston County declined during the same time period. (Tr. 2107:25-2108:23); (MUSC Ex. 34). MUHA had a decline in the total number of emergency department visits. *Id.*

95. MUHA's market share of tri-county emergency department patients for Berkeley County has declined by 1.6 % and for Dorchester County by 2.2%. (Tr. 741:1-742:10): (Roper St. Francis Ex. 59-016). This undermines one of MUHA's argument that serves as the basis for its FED: that it wants to create better accessibility for its existing patients in the proposed service area (which again, is not a criterion for project review), as its market share in the proposed service area appears to be declining.

96. Finally, Ms. Platt testified that there was sufficient existing capacity for future growth by taking into account both existing and approved projects. (Tr. 727:20-729:25). To establish that there was sufficient capacity for future growth, Ms. Platt applied a rate of 1.7% of annual growth in emergency department visits in the proposed service area which was also the percentage of growth used by MUHA in its application. (Tr. 729:1-25); (Joint Ex. 001-026); (Roper St. Francis Ex. 59-008). Ms. Platt applied that to the service area emergency department

[40] In fact, MUHA acknowledged a slight decline in Trident's emergency department visits between 2016 and 2017. (Tr. 4167:24-1468:4).

patient volume continuing to 2024 which she believed would likely encompass the time at which MUHA's proposed FED would become operational. (Tr. 729:7-12). The Court has adopted a growth rate of 1.7% per year in service area emergency department patients.

97. While the Court has utilized different numbers than did Ms. Platt for purposes of service area emergency department capacity, the Court finds that based upon the following, there exists sufficient capacity for additional emergency department visits even with ongoing population growth in MUHA's proposed service area.

| | Service Area ED Patients | Service Area ED Capacity [41] | Percent of Capacity Utilization in Service Area |
|---|---|---|---|
| FY 2016 Actual | 204,226 | 289,900<br>342,000 | 70.4%<br>59.7% |
| FY 2017 Actual | 200,701 | 289,900<br>342,000 | 69.2%<br>58.6% |
| FY 2018 Projected | 204,113 | 289,900<br>342,000 | 70.4%<br>59.7% |
| FY 2019 Projected | 207,583 | 289,900<br>342,000 | 71.6%<br>60.7% |
| FY 2020 Projected | 211,112 | 289,900<br>342,000 | 72.8%<br>61.7% |
| FY 2021 Projected | 214,701 | 289,900<br>342,000 | 74.1%<br>62.6% |
| FY 2022 Projected | 218,351 | 289,900<br>342,000 | 75.3%<br>63.8% |
| FY 2023 Projected | 222,063 | 289,900<br>342,000 | 76.6%<br>64.9% |
| FY 2024 Projected | 225,838 | 289,900<br>342,000 | 77.9%<br>66% |

98. While MUHA stated that the exploding population growth in the proposed service area provided a basis for its need of the FED, this contradicts MUHA's position that it would only (or even primarily) be serving or redirecting patients who are already being treated by MUSC at its downtown emergency departments. *See* (Tr. 1977: 12-23; 2161:19-22). If MUHA was only

[41] 289,900 represents the capacity of emergency room beds in the proposed service area that were operational at the conclusion of the contested case hearing. 342,000 includes the additional capacity for facilities approved as of the conclusion of the hearing and that would be coming online including Roper St. Francis Berkeley Hospital (which was scheduled to open in October of 2019), Trident Summerville FED (which was approved simultaneously with MUHA's FED and was not appealed), and Roper Northwoods FED's five additional beds that will be online in April 2022.

seeking to redirect its own patients to the new FED for its stated purposes of providing better access for its existing patients and alleviating capacity constraints at its downtown emergency departments, the growth in population and emergency department visits in Berkeley County would seem irrelevant.

99. Based on the foregoing, the Court finds that there is sufficient capacity in MUHA's proposed service area not only to meet the existing need but also, the projected growth without the need for MUHA's proposed FED.

**H. <u>2015 Plan's Relative Importance of Project Review Criteria</u>**

100. The 2015 Plan sets forth the following project review criteria as being the most important:

1. Compliance with the Need Outlined in this Section of the Plan;
2. Community Need Documentation;
3. Distribution (Accessibility);
4. Resource Availability; and
5. Financial Feasibility

The 2015 plan also provides that the "benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating [CON] applications for this service."

- <u>Compliance with Need Outlined in the Relevant Section of the 2015 Plan and Community Need Documentation</u>

101. The requirement for Community Need Documentation is addressed both in the 2015 Plan's Standards (*i.e.* Standard 6) and project review criterion 802.2. The Community Need Documentation criterion has five subparts although criterion 2(d)[42] does not apply. Community Need Documentation requires in part that the target population be clearly identified and that the projections of anticipated population changes be reasonable and based upon accepted demographic or statistical methodologies clearly presented in the application. S.C. Code Ann. Regs. 61-15 § 802.2(c) (Supp. 2019). A "proposed project should provide services that meet an identified (documented) need of the target population. The assumptions and methods used to determine the level of need should be specified in the application and based on a reasonable approach as judged by the reviewing body." *Id*.

[42] "In the case of a reduction, relocation, or elimination of a facility or service, the applicant should 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."

102. MUHA stated that the proposed FED "will enhance access and convenience, promote quality of care and increase patient satisfaction," but does not address an identified (documented) need of the target population as required by project review criterion 802.2(c). (Joint Ex. 001-028). I find that the need asserted by MUHA in the CON Application to "attempt to address the continued growth and space constraints" at its existing emergency departments downtown is not the community need required to satisfy Standard 6 or project review criterion 802.2. (Joint Ex. 001-021).

103. At trial, MUHA explained that "seeing our patients where they want to be seen and when they want to be seen is the most important thing." (Tr. 1816:15-17). MUHA further explained that what it would "like to offer – is the alternative that if [patients who choose MUSC for primary care] are seeking emergency room care in the North Charleston, Summerville area that we have something that is in network that can be offered to them." (Tr. 1915:18-25). Neither patient choice nor convenience is included in the Plan or encompassed by project review criterion 802.2. (Tr. 1507:2-12; 2276:8-2278:10; 2290:9-12; 2307:10-14).

104. While MUHA identified the target population, MUHA's methodology and the assumptions (including those relating to patient shift) used to support the proposed FED are unreasonable and flawed. As an example, MUHA utilized billing codes (rather than ESI levels) for purposes of shift projections, and failed to provide any information as to why its patients in the proposed service area were already driving past several other providers to seek treatment at MUSC on the peninsula.

105. As discussed above in more detail, Roper St. Francis and Trident have proven by a preponderance of the evidence that: (1) there is no community need for MUHA's proposed FED as there is no lack of access given the capacity in the proposed service area even with continued population growth; and (2) MUHA's methodology and assumptions including those relating to patient shift used to support the proposed FED are unreasonable and flawed as discussed herein.

- Distribution (Accessibility)

106. The Distribution (Accessibility) project review criterion addresses both duplication of services and the need to locate services in medically underserved areas. S.C. Code Ann. Regs. 61-15 § 802.3(a) and (b) (Supp. 2019). MUHA's presentation to the Department's staff at the project review meeting specifically addressing the Distribution (Accessibility) project review criterion, stated "the proposed project is solely based on MUSC's existing ED patient base and space constraints at the hospital-based ED." (Joint Ex. 001-534). Ms. Murdock acknowledged at

the hearing that MUHA was not proposing to serve a medically underserved group; "[t]hey were proposing to serve the patients that they were already serving." (Tr. 1482:4-11; 2161:19-22).

107. As to duplication of services, evidence at the contested case hearing was that the location of MUHA's proposed FED is less than 10 miles of multiple providers of emergency services, including Trident Medical Center and Summerville Medical Center. (Roper St. Francis Ex. 59-006). Neither of these were mentioned in MUHA's original CON application, and while they were mentioned in information submitted during or after project review, the information contained "very general conclusory statements about other providers and that there [would] be no effect or adverse effect on other providers." (Tr. 1463:10-1464:2; 2279:15-2280:17). While not operational at the time of trial, the proposed FED is only five miles from Roper St. Francis Berkeley Hospital, and less than one mile from Trident's Summerville FED, the latter of which was simultaneously approved by the Department along with MUHA's application for a FED. (Tr. 863:20-25; 1142:6-25); (Roper St. Francis Ex. 59-006). The existing and approved capacity for emergency services within 20 miles of MUHA's proposed FED location is approximately 342,000 visits per year in 168 treatment spaces, which does not include Berkeley Medical Center or MUHA's Berkeley Hospital. Trident's health planning expert testified "it would be hard to envision a part of the state of South Carolina where there would be less need for a freestanding emergency department than where the Medical University is proposing to put theirs," and that there is an abundance of access to emergency services for residents in the service area without the need of an additional FED. (Tr. 732:20-733:9; 1142:1-6). I find that MUHA's CON application does not comply with project review criterion 802.3 because it is both unnecessarily duplicative and is admittedly intended to serve patients who are already served by MUSC and thus, those patients cannot be considered to be medically underserved. To allow such unnecessary duplication would be contrary to the purpose of the CON Act in promoting cost containment.

108. While MUSC provides services to low income patients as well as those receiving Medicare[43] and Medicaid and represented that it would do so at its FED, there was no evidence that other facilities in the proposed service area do not treat similarly situated patients. In fact, EMTALA mandates that any patient (indigent, medically underserved and otherwise) who presents at an emergency department requiring treatment must be treated. (Tr. 1070:12-1071;2; 1071:23-1072:10; 1483:2-6; 2369:9-16). This includes any FED that would serve as an extension

[43] Not all Medicare patients are medically underserved. (Tr. 2369:17-2370:3).

of MUSC. (Tr. 1279:24-1280-6; 1358:3-12; 1483:7-12; Tr. 2384:8-16). Thus, the medically underserved, indigent, and others already have access to the same emergency services through the providers in MUHA's proposed service area. (Tr. 732:24-733:9: 1206:9-1207:2; 1483:2-12). There is nothing about MUHA's FED that will have any material impact, if any, on the medically underserved population. *Id*.

109. The Court also notes that while Mr. Levitt testified that it was irrelevant because it is not a criterion utilized by the Department, the site on which MUHA's proposed FED is located is not within a medically underserved area (MUA) as defined by the United States Department of Health and Human Services, although a zip code next to the proposed site is. (Tr. 1203:9-1204:10; 2154:25-2155:7; Tr. 2280:19-2281:2).

- Resource Availability

110. Resource availability[44] is set forth in the 2015 Plan as being one of the five criteria considered the most important in evaluating CON applications for FEDs yet the Department elected not to include it in the deemed complete letter of July 10, 2017, or address it in its decision granting a CON to MUHA for the FED. (Tr. 707:1-14); (Joint Ex. 001—551; -545); (Roper St. Francis Ex. 55-023).

111. Ms. Murdock testified that she did not include Resource Availability because it did not correspond to an actual project review criterion listed in Regulation 61-15, and that the closest criterion to "Resource Availability" set forth in the 2015 Plan was the "Staff Resources" criterion. (Tr. 1335:4-19; 1335:25-1336:3; 1336:17-1337:4; 1434:16-22);[45] *See* S.C. Regs. 61-15 § 802.20 (Supp. 2019). Additionally, Ms. Murdock stated that she did not include it among the priority criteria for MUHA or Summerville Medical Center's proposed FEDs because there was nothing particularly concerning or unique about MUHA's staffing plans. (Tr. 1337:5-1338:3).

112. While there is no specific criteria titled, "resource availability," several other project review criteria address resource availability including project review criterion 3(h), 20, 21, and 23(b). S.C. Code Ann. Regs. 61-15 § 802 (Supp. 2019). In 2015, the Department identified the same project review criteria set forth in the 2015 Plan in review of a CON application for a FED in Horry County, and defined "Resource Availability" to include project review criterion

[44] The 2017-2018 State Health Plan substitutes "Staff Resources" for "Resource Availability." (Roper St. Francis Ex. 57-026).

[45] Ms. Murdock testified that the Department interprets Regulation 304 as giving Department staff the authority to identify project review criteria for a project that may or may not include all of the project review criteria identified in the Plan for that particular facility or service. (Tr. 1426:1-11; 1431:17-21; 1433:5-1434:5).

20(a), 20(b), 20(c), 21(a), 22, 23(a), 23(b) and 24. (Roper St Francis Ex. 62-001; -002). Section 802.23 of Regulation 61-15 which is captioned, "The Adverse Effects on Other Facilities" provides in part that, "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 Ann. Regs. 61-15 § 802.23(b) (Supp. 2019).

113. Concerns about the project's impact on staffing and staffing shortages were raised by Roper St. Francis during the Department's staff review. (Tr. 1536:25-1537:5); (Joint Ex. 001-490); (Trident Ex. 020-003). While Ms. Murdock's notes from the project review meeting document that Roper St. Francis brought up "staffing problems" during the presentation, she testified that she did not conduct any research or do any analysis on staffing specifically, as she was "already aware of the – the general concern nationwide regarding nursing shortages." (Tr. 1537:10-15; 1537:25-1538:5).

114. At the hearing, both Roper St. Francis and Trident's nursing experts testified extensively as to nursing shortages both in South Carolina and throughout the United States. (Tr. 499:20-21; 514:11-18; 885:6-12; 885:25-886:11; 942:16-24; 1045:13-15). Concern was expressed about the competition for experienced and qualified clinical staff and how additional facilities exacerbate the difficulty. (Tr. 885:1-886:7; 2284:22-2285:25).

115. Contrary evidence was presented that despite a national nursing shortage, the addition of a FED such as the one proposed by MUHA would not significantly impact the nurse staffing needs of other facilities in the area. (Tr. 1305:11-14; 1617:10-14; 1617:22-1618:4). Neither Roper St. Francis nor Trident offered evidence quantifying the effect MUHA's proposed FED would have on nursing staff. (Tr. 545:3-6). Moreover, despite claims of a nursing shortage, Trident has not ceased its emergency department expansions in the tri-county area. (Tr. 943:19-944:4; 1109:1-9; 1298:4-12). Trident's expert healthcare planner testified that with regard to the current Summerville FED, Trident would "ultimately be able to staff it." (Tr. 1305:9-14). Similarly, Summerville Medical Center's chief operating officer testified that although some nurses were being targeted for recruitment by other facilities, she could not confirm any actual losses, particularly with regard to emergency department nurses. (Tr. 953:24-954:13). Roper St. Francis' director of emergency services only knew of two or three current vacancies at Roper Northwoods FED. (Tr. 545:10-21). MUHA's expert testified that Roper St. Francis and Trident's CON applications reported no staffing issues for their proposed projects. (Tr. 2199:6-2200:6).

Lastly, the Department's CON director testified that a reasonable staffing plan by MUHA should not exacerbate any nursing shortage. (Tr. 1617:19-1618:4).

116. Based upon all of the testimony presented at the hearing on the issue, Roper St. Francis and Trident have not demonstrated by a preponderance of the evidence that MUHA's project will have any significant effect on existing providers' staff or staffing costs.

- Financial Feasibility

117. "Financial Feasibility" is set forth in the 2015 Plan as being one of the five criteria and is included in the criteria for project review in Section 802.15 of Regulation 61-15. (Tr. 601:5-20; (Joint Ex. 001—551; -545); (Roper St. Francis Ex. 55-023). The pro forma budget for MUHA's FED is set forth in the CON application. (Tr. 2033:18-20); (Joint Ex. 001-0087). It projects annual net operating revenue for the FED's first four years of operation as ranging from $8.27 – $8.71 million. (Tr. 2157:4-5); (Joint Ex.001-0087). Net income is projected at over $2.7 million each year. (Tr. 2157:5-8); (Joint Ex. 001-087). All projections on the pro forma in the application remain the same with the exception of capital costs in that rent will be replaced by depreciation. (Tr. 2033:20-2034:9). The cost reductions as a result of the changes to the project including the deletion of the CDU unit and helipad[46] will result in decreased costs and improved net income. (Tr. 2034:2-12; 2157:2-2158:9). I find the pro forma projections and the assumptions on which they are based to be reasonable and based upon accepted accounting procedures. *See* (Joint Ex. 0001-084 through -088). The project remains financially feasible. *See* (Tr. 2156:12-2160:1).

- Equally Weighing the Benefits of Improved Accessibility with the Adverse Effects of Duplication in Evaluating [CON] Applications for this Service

118. MUHA stated that the primary motivation behind the FED project is to improve access for its own patients (those residing in the north area) "to get to a more convenient site." (Tr. 1711:23-1712:3; 1977:14-23); (MUSC Ex. 60-3). Improved access for a facility's own patient base is not a criterion included in the CON Act, the 2015 Plan, or the relevant Departmental regulations which this Court may consider in determining whether to approve a project.

[46] One of the criticisms contained in paragraphs 26-28 of Trident's Petition for Administrative Review and Contested Case Hearing filed on December 14, 2017 was the cost associated with the construction of a helipad and operation of a helicopter making the project inconsistent with the CON Act and project review criteria governing cost containment and financial feasibility.

119. Roper St. Francis and Trident have shown by a preponderance of the evidence that the proposed FED will not improve access to emergency department services as the proposed service area has sufficient availability of comparable emergency department services.

120. The Court finds that while MUHA's FED would not adversely affect staff resources at other facilities, the construction of another FED in the proposed service area when there is additional capacity in existing facilities would result in a waste of health care dollars and an unnecessary duplication of services.

121. Roper St. Francis and Trident have shown by a preponderance of the evidence that MUHA's FED does not comply with the 2015 Plan as there is no community need even with the increasing population growth, and the project is unnecessarily duplicative of existing services, and it is not located in a medically underserved area. Even if this Court were to apply the criteria set forth in the Department's letter of July 10, 2017, or the 2016-2017 Plan, MUHA would still not meet the requirements for approval of its application.

## I. Criteria Utilized by the Department in Evaluating the Project

122. Despite the 2015 Plan having set forth five criteria as being the most important for purposes of evaluating CON applications for FEDs as required by Section 44-7-180(B)(4), the Department advised MUHA of the following four review criteria by letter dated July 10, 2017, that would be used in reviewing its project:

1. Community Need Documentation
2. Distribution (Accessibility);
3. Medically Underserved Groups; and
4. Financial Feasibility.

(Joint Ex. 001-545). The Court's factual findings as to these criteria are the same as discussed above including, "Medically Underserved Groups." "Medically Underserved Groups" was addressed above under the heading of "Distribution (Accessibility)" which included a discussion of both duplication of services and the need to locate services in medically underserved areas. S.C. Code Ann. Regs. 61-15 § 802.3(a) and (b) (Supp. 2019).

## 2017-2018 STATE HEALTH PLAN[47]

### J. 2017-2018 State Health Plan

1. Need and Capacity Constraints

123. The 2017-2018 Plan includes the following in its need projections and standards section: "The applicant must demonstrate need for this service by documenting capacity constraints within existing emergency departments in the service area and/or a travel time of greater than 15 minutes to an existing emergency department in the service area." (Roper St. Francis Ex. 56-026). As discussed herein, Roper St. Francis and Trident have demonstrated by a preponderance of the evidence that there is no need for another FED in the proposed service area. While MUSC's downtown emergency department is constrained, it is not a criterion that the Court may consider.

2. Travel Time

124. Roper St. Francis and Trident presented testimony and evidence establishing by a preponderance of the evidence that the patients proposed to be served by MUHA's FED already reside within fifteen minutes travel time of an existing emergency department including Trident Medical Center and Summerville Medical Center, both of which are hospital based. (Tr. 725:8-726:1; 731:22-732:19); (Roper St. Francis Ex. 7-005). This is consistent with the statement under the 2017-2018 Plan's project review criteria which provides that the majority of South Carolina residents should have access to emergency medical services within fifteen (15) minutes' travel time. (Roper St. Francis Ex. 56-026).

125. While not critical to this determination, additional facilities (including Roper St. Francis-Berkeley Hospital, Trident's Summerville FED, and MUSC's Berkeley Hospital) have been approved and (one of which was under construction at the time of trial and was expected to be online in October 2019) will provide even more availability and capacity within the window of a fifteen-minute drive time. (Tr. 2255:3-2257:10); **(**Roper St. Francis Ex. 7-004; 7-005; 63-014). *See also*, (Roper St. Francis Ex. 63-015).

### K. 2017-2018 Plan's Relative Importance of Project Review Criteria

126. The project review criteria considered the most important in evaluating CONs for FEDs no longer include "Compliance with the Need Outlined in this Section of the Plan,"

[47] The Court exercises its discretion to consider the 2017-2018 State Health Plan in reviewing the proposed project. *See* S.C. Code Ann. § 44-7-225 (2018). Neither party asked the Court to consider the 2019 Plan and the Court declines to do so.

"Resource Availability," or "Financial Feasibility," and instead identify "Medically Underserved Groups," "Record of the Applicant," and "Staff Resources." The 2017-2018 Plan's criteria are as follows:

1. Community Need Documentation;
2. Distribution (Accessibility);
3. Medically Underserved Groups;
4. Record of the Applicant; and
5. Staff Resources.

(Roper St. Francis Ex. 56-026).

127. The 2015 Plan provided that "The benefits of improved accessibility will be equally weighed with the adverse effect of duplication in evaluating [CON] applications for this service," while the 2017-2018 Plan provided that "The benefits of improved accessibility will outweigh the adverse effects of duplication in evaluating applications for [freestanding emergency department services]. (emphasis added)." (Roper St. Francis Ex. 55-023; 56-026). The 2017-2018 Plan also added that "Access to emergency medical services should be available within fifteen (15) minutes travel time for the majority of residents of the State. (Roper St. Francis Ex. 56-026).

128. The Court need not revisit "Community Need Documentation," "Distribution (Accessibility)," "Medically Underserved Groups," or "Staff Resources."[48] The Court's findings of fact relative to these "most important criteria" are set forth above. (Roper St. Francis Ex. 56-026). MUHA meets the applicable project review criterion titled, "Record of the Applicant" as outlined by Section 802.13 of Regulation 61-15, and no evidence was presented to the contrary. S.C. Regs. 61-15 § 802.13 (Supp. 2019).

129. Based upon the findings of fact set forth above, the Court finds that MUHA's project does not provide increased accessibility and even if it did, it would be outweighed by the unnecessary duplication.

**L. Intuitive Health**

130. In the fall of 2017, MUHA began communicating with Intuitive Health, a company located in Texas that operates and manages emergency department services. (Tr. 1728:2-23). Over a 12-14-month period, representatives of MUHA and Intuitive Health exchanged information and participated in several telephone calls. (Tr. 1728:-13; 1732:11-15). MUHA officials made a

[48] As to "Staff Resources," the hearing testimony was that "Resource Availability" criterion in the 2015 Plan was equivalent to the Staff Resources" criterion in the 2017-2018 Plan. *See* (Tr. 1335:25-1336:3; 1336:17-1337:4; 2283:1-10); Roper St Francis Ex. 62-001; -002).

site visit to an Intuitive Health facility in the fall of 2018. (Tr. 1728:18-22; 1731:11-1732:15). During these communications, the topics of discussion included potential sites, size, and layout of MUHA's Berkeley County FED; use of a CDU and helipad; and a "hybrid," urgent care model used by Intuitive. (Tr. 1730:1-15). Intuitive provided MUHA with a "joint venture package" of proposals and information related to the Berkeley County FED. (Trident Ex. 68). This package included site information, a market analysis, a pro forma budget, staffing recommendations, a billing methodology, and a proposed joint venture legal structure between MUSC and Intuitive. *Id*.; (Tr. 1730:16-1731:7). MUHA eventually rejected Intuitive Health's proposal for a joint venture or any form of business venture. (Tr. 1732:16-21; 1737:15-18). MUHA also rejected Intuitive Health's proposed staffing plan, pro forma budget, and market analysis, which was based on a smaller service area. (Tr. 1443:5-22). Instead, MUHA decided to rely on the staffing plan, pro forma budget, and service area set forth in its application. (Tr. 1743:13-1744:5; 1744:20-1745:7). In late 2018 or early 2019, MUHA informed Intuitive Health that the two would not be working together on the Berkeley County FED. (Tr. 1734:14 – 1735:8); (Intuitive Health Rule 30(b)(6), *SCRCP* Depo. Tr. 78:8-13).

131. In February 2019, Dr. Cawley submitted an affidavit in support of MUHA's Memorandum in Opposition to Trident's Motion for Summary Judgment that was filed on February 19, 2019. (MUSC's Memo. in Opp. to Trident Motion for Summary Judgment, Ex. A.). In his February affidavit, Dr. Cawley stated that MUSC would consider retaining Intuitive or another company to provide management services for the Berkeley County FED. *Id*. ¶ 10. At the July trial, however, Dr. Cawley testified that MUSC had not entered into a management agreement with anyone, had no plans to do so, and that any decision about a management agreement would be his to make. (Tr. 1738:8-23). He further testified that MUSC would not enter into any management agreement under which the management company could determine elements of the nature and quality of medical services, select the physicians who would provide services, or change its charity care policies. (Tr. 1738:24 – 1739:12).

132. In his affidavit on February 19, 2019, Dr. Cawley stated MUSC intended to provide urgent care services in the FED. MUSC's Memorandum in Opposition to Trident's Motion for Summary Judgment, Ex. A ¶ 8:

> Another change to the Project that MUSC intends to make is to provide urgent care services (which are not subject to CON requirements) in the same building as the FED. Many people who come to an Emergency Department do not need emergency services, only urgent care services. Rather than providing such patients with

> unneeded emergency-level services, MUSC will instead provide them with urgent care services. When urgent care services are provided, payors will be billed for urgent care services, rather than for the more expensive emergency services.

*Id*. This paragraph describes the Intuitive Health "hybrid" model. (Tr. 1739:24–1740:1). In June, however, the Department notified MUHA that the Department's licensing and certification divisions might have concerns about providing urgent care in the FED. (Tr. 1576:21-1577:1; 1578:1-6; 1580:6-1582:3). As a result, MUHA reverted to the original proposal set forth in the application, that only emergent services would be provided in the FED. (Tr. 1741:7-21; 1744:6-10). On July 2, 2019, the day before Dr. Hall's deposition, Dr. Cawley sent him an email, which MUHA forwarded to Petitioners, clarifying that the Berkeley County FED would use the traditional FED model, as described in the CON application, and would not provide urgent care services. (Tr. 204:19-205:14; 1741:3-21); (Trident Ex. 76).

133. Dr. Cawley testified that MUHA benefitted from the discussions with Intuitive Health by learning about and adopting some best practices in FED operations and management. (Tr. 1746:1-4). However, Intuitive Health has not made any changes to MUHA's project and MUHA only adopted suggestions after conducting its own review and analysis. (Tr. 1742:4-23). Intuitive will not be a joint venture party with MUHA in this project, will not have any ownership interest in the project, and will not provide capital or financing for the project. (Tr. 1737:15-24).

134. The Court finds that while MUHA consulted[49] with Intuitive Health (an entity that has no experience in developing or operating a FED or one affiliated with an academic medical center similar to MUSC) as to the proposed FED, MUHA rejected most of Intuitive Health's proposals including the latter's proposed service area, and proposal for a joint venture. Intuitive Health will not be participating in MUHA's proposed FED. It is somewhat disconcerting that MUHA engaged in discussions with a third party as late as it did that could have *potentially* resulted in significant modifications that affected the manner in which the project complied with the Act, the Plan, and the project review criteria. However, as discussed herein, the project remained substantially the same. While these communications may have altered the manner in which the parties elected to proceed with discovery, the Court places little weight on documents and testimony relating to Intuitive Health including its representative's deposition.

[49] It appears that most of the communications occurred after MUHA's application had been submitted and after the project was approved by the Department.

**M. MUHA's Communication with the Department**

135. MUHA and the Department staff communicated several times about the Berkeley County FED application after the contested case was filed. MUHA first contacted the Department about potential changes to the FED project in February 2018. (Tr. 1534:2-4); (Roper St. Francis Ex. 22). *See also*, (Tr. 1534:4-11). In December 2018, MUHA's attorney and expert health care planner along with other MUHA representatives met with the Department to discuss possible changes to the project and the Department's position. (Tr. 1991:22-1992:25; 1993:17-1994:10). Roper St. Francis and Trident were not apprised of the communications or the meeting. (Tr. 1534:19-21).

136. During the meetings, MUHA asked the Department whether it would consider the potential project changes in location, size, and cost to be substantial and were told that such changes would not generally be considered substantial.[50] (Tr. 1993:20-1994:15).

137. The Department's practice is to encourage communication between interested parties and Department staff regarding CON applications. (Tr. 1392:2-6). When considering changes to a CON project during the pendency of contested case litigation, Mr. Levitt testified that his practice has been to advise clients to notify the Department. (Tr. 1990:23-1991:7).

138. On Monday, July 29, 2019, the sixth day of trial, and in response to questioning by counsel for Roper St. Francis, Ms. Murdock stated that she had communicated with MUHA since her deposition. (Tr. 1544:20-23). When asked about the purpose of the communication, the Department's attorney objected on the basis that the Department and MUSC had entered into an oral joint defense agreement and answering questions about their communication would violate the attorney-client privilege. (Tr. 1545:25-1546:5-10). The Court asked the parties to brief the issue as to the propriety of the agreement and adjourned for the day. (Tr. 1547:8-16). On July 30, 2019, the Court reconvened at which time the Department's attorney stated that MUHA and the Department's interests were aligned and that they had a common interest in preparing Ms. Murdock for her testimony; MUHA concurred. (Tr. 1548:17-1549:2; 1150:1-5; 1551:15-19). Upon further questioning by the Court as to the propriety of the agreement, the Department offered to allow Ms. Murdock to answer questions subject only to the privilege that existed between the Department's attorney and Ms. Murdock. (Tr. 1550:22-1551:11). Questioning resumed. (Tr. 1560:5-10).

[50] Mr. Levitt was uncertain whether elimination of the CDU and helipad was discussed. (Tr. at 1994:3-7).

139. Ms. Murdock testified that a few days before trial, one of MUHA's attorneys met with the Department's CON director and one of its attorneys. (Tr. 1560:17-1561:7). During the twenty minute or less meeting, Ms. Murdock was asked what she thought about the FED project and some of the proposed changes including the relocation and possibly whether the helipad and CDU were significant. (Tr. 1561:1-19; 1562:16-20; 1563:1-3).

140. Ms. Murdock then testified to a final meeting between MUHA and the Department that took place on July 26, 2019, after several days of trial testimony but before Ms. Murdock took the stand. (Tr. 1565:10-14). The meeting took place in the offices of MUHA's attorneys and lasted no more than 30 minutes. (Tr. 1566:1-8; 1565:12-13). Those attending were MUHA's two hearing attorneys, the Department's hearing attorney, and Ms. Murdock. (Tr. 1565:15-16). Mr. Levitt was also there at the beginning of the meeting but stayed less than five minutes. (Tr. at 1566:17-20). The stated purpose of the meeting was to discuss the trial testimony that had already been rendered including Ms. Murdock's interpretation of Roper St. Francis and Tridents' experts' testimony. (Tr. 1566:18-24; 1569:19-1570:1). She was also asked what she thought about the case moving forward.[51] *Id*. Per Ms. Murdock's testimony, none of the attorneys made any suggestions or advised her about her testimony. (Tr. 1567:11-15). Ms. Murdock did not review any documents during the meeting. (Tr. 1569:14-16). Ms. Murdock testified that nothing that was said during the meeting caused her to change her testimony.[52] (Tr. 1567:11-19).

## V. CONCLUSIONS OF LAW

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

### A. Legal Overview

1. The Administrative Law Court has jurisdiction over contested cases arising from Department final agency decisions, including CON decisions. S.C. Code Ann. §§ 1-23-600; § 44-1-60(F); 44-7-210(D) (2018 and 2019 Supp.). A contested case challenging a Department CON decision is tried de novo before the Administrative Law Court. *Marlboro Park Hosp., supra*. A

[51] When Ms. Murdock was first questioned on cross examination about the meeting, the Department's counsel objected on grounds the meeting was subject to an oral joint defense agreement but withdrew the objection subject to Department not waiving the attorney-client privilege with respect to communications solely between the Department's in-house counsel and Department staff. *Id*. at 1545:25-1546:5; at 1551:4-11.

[52] At trial, Roper argued that, although Ms. Murdock's trial testimony was the "same as it was at her deposition," it was "not consistent to the information we were provided at the deposition." (Tr. at 1590:3-8). Roper submitted designated portions of Ms. Murdock's deposition transcript to support its position, but they do not show any material inconsistencies between her deposition and trial testimonies.

*de novo* contested case hearing is one where the "whole case is tried as if no trial whatsoever had been had in the first instance." *Id.* (internal citation omitted). The Court makes both factual findings and conclusions of law in contested cases challenging Department CON decisions. *Spartanburg Reg. Med. Center v. Oncology and Hematology Assocs.*, 387 S.C. 79, 98, 690 S.E.2d 783, 788 (2010); *Brown v S.C. Dep't of Health & Envtl. Control*, 248 S.C. 507, 512, 560 S.E.2d 410, 413 (2002); S.C. Code Ann.§ 1-23-600(B) (Supp. 2019).

2. The CON Act regulates the establishment of health care facilities and services in South Carolina. *See* S.C. Code Ann. § 44-7-120 (2018). "The purpose of [the CON Act] is to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State." *Id*.

3. Parties are required to obtain CONs from the Department before establishing certain health care facilities and services. S.C. Code Ann. § 44-7-160 (2018). Freestanding emergency medical services are health services subject to standards or criteria in the South Carolina State Health Plan. S.C. Regs. Ann. § 65-15 § 103(14) (Supp. 2019).

4. To obtain a CON, a party must submit a CON application to the Department for approval on the form established by regulation. *See* S.C. Code Ann. § 44-7-200(A) (2018). "The application must address all applicable standards and requirements set forth in departmental regulations, Project Review Criteria of the Department, and the South Carolina Health Plan." *Id*. The Department determines whether to approve or deny the CON application by evaluating the proposed project's compliance with the State Health Plan and applicable project review criteria. "The [D]epartment may not issue a Certificate of Need unless an application complies with the South Carolina Health Plan, Project Review Criteria, and other regulations." S.C. Code Ann. § 44-7-210 (B) (2018).

5. While the Department and a later reviewing court must consider the Plan in place at the time of the application, both retain discretion to consider a later-adopted Plan when evaluating an application. *See* S.C. Code Ann. § 44-7-225 (2018).

6. Project review criteria are adopted as regulations, and "[t]he project review criteria promulgated in regulation must be used in reviewing all projects under the Certificate of Need process." S.C. Code Ann. § 44-7-190 (2018). From among the thirty-three project review criteria listed in the Department's regulations the Department chooses the most important and advises the

applicant in writing of the "relative importance of the project review criteria" that will be used to evaluate the application. S.C. Regs. Ann. 61-15 §§ 304(1) and 801 (Supp. 2019).

7. A proposed project may be approved despite failing to satisfy every project review criterion, but the Department has no discretion to approve a proposed project that is inconsistent with the Plan. *See* S.C. Regs. Ann. 61-15 § 801(3) (Supp. 2019).

8. Affected persons may request that the Department's Board review a Department staff decision approving or denying a CON application and, thereafter, may challenge the final Department decision by filing a contested case. S.C. Code Ann. § 44-1-60(G) (2018 &); S.C. Code Ann. § 44-7-210 (2010).

9. At the contested case hearing before this Court, the issues to be considered are limited to those presented to or considered by the Department 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 Department staff may be considered by this court. *Marlboro Park Hosp.,* 358 S.C. at 578-79, 595 S.E.2d at 854.

**B. Burden of Proof**

10. A petitioner challenging the Department's approval of a CON application bears the burden of proving, by a preponderance of the evidence, that the CON application does not satisfy the relevant CON standards and project review criteria. *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) (citations omitted). Here, Roper St. Francis and Trident bear the burden of proof by establishing by a preponderance of the evidence that a CON should be denied.

**C. Evidence**

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

12. Under Rule 702 of the South Carolina Rules of Evidence, "[i]f scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience,

training, or education, may testify thereto in the form of an opinion or otherwise." An expert is granted wide latitude in determining the basis of his opinion, and where an expert's testimony is based upon facts sufficient to form an opinion, the trier of fact must weigh its probative value. *Small v. Pioneer Mach., Inc.,* 329 S.C. 448, 470, 494 S.E.2d 835, 846 (Ct. App. 1997).

13. 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 §* 966 (2020). 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, 222, 417 S.E.2d 586, 589 (1992).

14. As the fact-finder, the Court "must make sufficiently detailed findings supporting the denial [or grant] of a permit application." *Marlboro Park Hosp.*, 358 S.C. at 578, 595 S.E.2d at 854. During the contested case hearing, the ALC can "weigh the evidence and assess each witness's testimony and credibility prior to ruling on whether [the] changes [are] substantial enough to constitute a new project." *MRI at Belfair*, 394 at 577, 716 S.E.2d 116 (citing *Spartanburg Reg'l Med. Ctr. v. Oncology & Hematology Assoc. of S.C.* 387 S.C. 79, 89, 690 S.E.2d 783, 788 (2010)).

**D. <u>Changes to the Project</u>**

15. Roper St. Francis and Trident contend that MUHA's project modifications subsequent to the Department's review are substantial such that it constitutes an entirely new project. The Court disagrees.

16. "The Certificate of Need, if issued, is valid only for the project described in the application including location, beds and services to be offered, physical plant, capital or operating costs, or other factors as set forth in the application, except as may be modified in accordance with these regulations ..." S.C. Code Ann. Regs. 61-15 § 311 (2018). Consequently, "If an applicant amends or alters his project after receipt of a Certificate of Need, the Department will decide whether or not the amendment is substantial and thereby constitutes a new project." S.C. Code Ann. Regs. 61-15 § 605 (Supp. 2018); *see also*, Black's Law Dictionary, *Substantial* (11th ed.

2019) (defining substantial as "[i]mportant, essential, and material; of real worth and importance.").

17. If an applicant makes changes to a project during the contested case proceedings, the Court may weigh the evidence and testimony on the alleged changes made to the project before determining, "whether these changes were substantial enough to constitute a new project under [S]ection 605." *See MRI at Belfair, LLC v. S.C. Dep't of Health and Envtl. Control*, 394 S.C. 567, 577-588, 716 S.E.2d 111, 116 (Ct. App. 2011) (*citing Spartanburg Reg. Med. Ctr*., 387 S.C. 79, 89, 690 S.E.2d 783, 788 (2010).

18. Review of this issue requires a comparison of the amended project to the original project proposed in the CON application to determine whether the amendment is substantial. *See MRI at Belfair, LLC*, 394 S.C. at 573-574, 716 S.E.2d at 114; *see also Providence Hosp. v. S.C. Dep't of Health and Envtl. Control & Palmetto Richland Mem'l Hosp*., 2002 WL 31423801 *2 (S.C.Admin.Law.Judge.Div. September 11, 2002).[53] In making that determination, the court may consider whether the amendments to the project substantially change the project's compliance with the relevant project review criteria. *See MRI at Belfair*, LLC, 394 S.C. at 574, 716 S.E.2d at 114. Accordingly, if MUHA's amended project meets the "same project review criteria it originally met *in substantially the same way*," this Court may find that the changes were not "substantial" under Section 605 of the CON Act. *See id*. (emphasis in original).

19. Due to the *de novo* nature of a contested case hearing, the Court was permitted to take new evidence, including expert testimony, on core issues presented to or considered by the Department during the review process, which it did in the instant case. Accordingly, Roper St. Francis and Trident spent considerable time during the hearing highlighting each change made to MUHA's project since the initial determination.

20. Conversely, MUHA presented ample evidence suggesting that the changes did not substantially impact the manner in which the project complies with any of the project review criteria. MUHA's new site is less than a mile away from its original proposed site and located in the same county, city, and zip code. Its target population, population and emergency department visit projections, need and utilization projections, methodologies, and assumptions, and pro forma budget statement remain the same as they were during the Department's staff review. (Tr. 2149:17-23; 2153:16-2154:12; 2156:16-21). There is no evidence MUHA's historical

[53] This case may also be found at Docket No. 02-ALJ-07-0155-CC.

commitment to serving medically underserved groups has changed although the project is not located in a medically underserved area. *See* (Tr. 2150:9-17; 2155:24-2156:8). There is no evidence MUHA's project changes will impact the market share or staffing of existing providers any more than the approved project. (Tr. 2161:3-2162:3; 2167:1-11). Based on these and other facts, Mr. Levitt testified persuasively that the project changes would not substantially affect compliance with any criteria. (Tr. 2149:17-24; 2150:9-17; 2153:16-2154:12; 2155:24-2156:8; 2156:16-21; 2161:3 – 2162:3; 2167:1-11). Petitioners have offered no compelling argument as to how the amendments to MUHA's project substantially change its compliance with any of the project review criteria.

21. The *Belfair* Court analyzed other factors in addition to the project review criteria. First, the Court noted that the change in location for the MRI at issue was not substantial because the change "would not reduce the standard of care of emergency room patients." *MRI at Belfair, LLC*, 394 S.C. at 575, 578, 716 S.E.2d at 115-17 ("the change in location of the MRI project … and the overall layout of the implemented MRI project did not substantially change the project from a clinical, operational, or patient safety perspective"). The location of MUHA's project was changed to improve accessibility and will have no impact on the project from a clinical, operational, or patient safety perspective; no evidence was produced to the contrary. Second, the *Belfair* Court specifically held that a decrease in project costs, such as in MUHA's project, is permissible and not a substantial change since it would not negatively affect compliance with cost containment or financial feasibility criteria. *Id.* at 578, 716 S.E.2d at 116. Third, the *Belfair* Court accepted the ALC's determination that the physical layout changes to the amended project were not relevant because they did not affect patient safety. *Id*. at 575, 716 S.E.2d. 115. Here, changes to the size and floor plan of the FED will have no impact on patient safety. Fourth, just as in *Belfair*, "the scope of the services is the same under both the original and amended project." *Id*. at 578, 716 S.E.2d. 116.

22. After weighing all of the evidence, I find that while MUHA made a number of changes to the project, the changes are not substantial so as to require a new application. The changes do not materially change the way in which the project complies with the project review criteria.

**E. <u>The Department May Not Reorder Review Criteria Set in State Plan</u>**

23. The project review criteria in the Department's letter are not identical to the priority project review criteria for freestanding emergency services found in either the 2015 Plan or the

2017-2018 Plan. The Department believes that pursuant to Section 44-7-180(B)(4), it has the discretion to not utilize all of the criteria deemed most important (as outlined in the Plans) in evaluating a proposed FED, as well as reorder the criteria. (Tr. 1389:17-22; 1418:14-1419-4; 1426:12-24; 1427:5; 1429:2-1430:23; 1431:4-22; 1622:9; 1624:2-11). The Court disagrees.

> The cardinal rule of statutory construction is to ascertain and effectuate the intent of the legislature. *Charleston County Sch. Dist. v. State Budget and Control Bd.*, 313 S.C. 1, 437 S.E.2d 6 (1993). Under the plain meaning rule, it is not the court's place to change the meaning of a clear and unambiguous statute. *In re Vincent J.*, 333 S.C. 233, 509 S.E.2d 261 (1998) (citations omitted). 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. *Id.* at 233, 509 S.E.2d at 262 (citing *Paschal v. State Election Comm'n*, 317 S.C. 434, 454 S.E.2d 890 (1995)). "What a legislature says in the text of a statute is considered the best evidence of the legislative intent or will. Therefore, the courts are bound to give effect to the expressed intent of the legislature." Norman J. Singer, *Sutherland Statutory Construction* § 46.03 at 94 (5th ed. 1992) …

*Hodges v. Rainey*, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000).

> Statutes dealing with the same subject matter must be reconciled, if possible, so as to render both operative. *Id.* "It is presumed that the Legislature is familiar with prior legislation, and that if it intends to repeal existing laws it would ... expressly do so; hence, if by any fair or liberal construction two acts may be made to harmonize, no court is justified in deciding that the later repealed the first." *Justice v. Pantry*, 330 S.C. 37, 43–44, 496 S.E.2d 871, 874 (Ct. App. 1998) (*quoting State v. Hood*, 181 S.C. 488, 491, 188 S.E. 134, 136 (1936)).

*Id*. at 88-89, 533 S.E.2d at 583.

> This Court will not construe a statute in a way which leads to an absurd result or renders it meaningless. *See Lancaster Cnty. Bar Ass'n v. S.C. Comm'n on Indigent Defense*, 380 S.C. 219, 670 S.E.2d 371 (2008) (in construing a statute, this Court will reject an interpretation which leads to an absurd result that could not have been intended by the General Assembly); *Gordon v. Phillips Utils., Inc.*, 362 S.C. 403, 608 S.E.2d 425 (2005) (it is presumed that the General Assembly intended to accomplish something by its choice of words and would not do a futile thing); *Denene, Inc. v. City of Charleston*, 352 S.C. 208, 574 S.E.2d 196 (2002) (this Court must presume the General Assembly did not intend a futile act, but rather intended its statutes to accomplish something); *Hinton v. S.C. Dep't of Probation, Parole and Pardon Servs.*, 357 S.C. 327, 592 S.E.2d 335 (Ct.App.2004) (the Court should seek a construction that gives effect to every word of a statute rather than adopting an interpretation that renders a portion meaningless).

*Florence Cnty. Democratic Party v. Florence Cnty. Republican Party*, 398 S.C. 124, 128, 727 S.E.2d 418, 420 (2012).

24. The Court generally defers to an administrative agency's interpretation of an applicable statute or its own regulation but will reject the agency's interpretation if it is arbitrary, capricious, or manifestly contrary to the statute, regulation, or law. *See Sierra Club v. S.C. Dept. of Health & Envtl. Control*, 426 S.C. 236, 256, 826 S.E.2d 595, 606 (2019).

25. As required by Section 44-7-180(B)(4), the criteria set forth in the Plan have been determined to be the most important, and a CON may not be issued absent compliance with the Plan. The Department does not have discretion to choose whether to include the most important criteria listed in the Plan when considering an application for a FED, although it may add additional criteria listed in Section 802 and reorder those. *See* S.C. Code Ann. § 44-7-210(B) (2018) ("The Department may not issue a Certificate of Need unless an application complies with the South Carolina Health Plan, Project Review Criteria, and other regulations."). *See also*, S.C. Code Regs. § 802.1 (Supp. 2019) ("The proposal shall not be approved unless it is compliance with the South Carolina Health Plan."). To hold otherwise, would render the criteria set forth in the applicable Plan meaningless, and render its enactment futile.

26. I find that the Department erred in failing to include "Resource Availability" in the Department's deemed complete letter as one of the most important review criteria as mandated by the 2015 Plan. Likewise, the Department should have evaluated the proposed project's impact on staffing resources and included it in its letter approving the project. Nevertheless, upon consideration of all the testimony presented at the hearing on the issue, Roper St. Francis and Trident have not demonstrated that MUHA's project will have any significant effect on existing providers' staff or staffing costs.

27. The Department also does not have discretion to choose whether to include compliance with the Plan as a project review criterion. (Tr. 1334:20-22).

**F. MUHA's Proposed FED Does Not Comply with the CON Act, the 2015 or 2016-2017 Plans, or the Project Review Criteria Chosen by the Department**

1. MUHA's Proposed FED does Not Comply with Standard 6 of the 2015 Plan

28. Roper St. Francis and Trident demonstrated by a preponderance of the evidence and I conclude as a matter of law that MUHA's FED does not comply with Standard 6 of the 2015 Plan.

29. Roper St. Francis and Trident demonstrated that MUHA failed to sufficiently establish the origin of its potential patients for its proposed FED. MUHA has shown that an unknown number of patients[54] travel past other existing providers of emergency services to receive care at MUSC's emergency department at its hospital in Charleston, but MUHA could not adequately describe why this was occurring. Without basis, insight, or information to support its assumption, MUHA posits that the majority of those patients will self-redirect to its freestanding emergency room if given the opportunity simply because it is more convenient.

30. Additionally, MUHA's shift projections are flawed. MUHA utilized billing codes versus acuity levels and did not take acuity into account in making its projections. Also, MUHA's representation that it assumed no (or even little) market shift and intended only (or even primarily) a shift of its existing patients,[55] is unrealistic.

31. The Court is unconvinced that patients from the tri-county and beyond, who presently obtain services at MUHA's downtown Level I trauma center, which includes a robust specialty practice, will necessarily seek services at MUHA's FED (and be satisfied with telemedicine). MUHA assumed a percentage would shift but presented no information regarding why the patients from its proposed zip codes will transition to a satellite FED other than it was more convenient.[56]

32. Roper St. Francis and Trident have also proven by a preponderance of the evidence and I conclude as a matter of law that there is sufficient existing capacity in MUHA's proposed service area not only to meet the current need but also for projected population growth without the need for an additional FED. There is no evidence that patients who seek treatment at MUHA's downtown campus but who are originating from locations within the tri-county area, are not able to be adequately served by existing providers. These existing facilities have medical personnel that are competent and qualified and have demonstrated efficient operation.

33. The capacity constraints of MUSC's emergency department is not a factor included in any of the Plans.

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[54] The testimony established that over 20,000 visits were made from the proposed service area to MUSC's emergency department. MUHA was not able to demonstrate whether this was 20,000 individuals, since some individuals may present for more than one visit. Patients and visits were used interchangeably by MUHA's expert. (Tr. 2076:19-25).

[55] "We are seeking to treat our patients at a location closer to their residence. We're relying on only our patients. We're not assuming a market share shift and therefore it won't have any impact on existing providers." (Tr. 2161:17-22).

[56] "It is a guess." (Tr. 1181:3).

2. MUHA's Proposed FED Does not Satisfy Relevant Project Review Criteria Under the 2015 or 2016-2017 Plan, or Those Selected by the Department

34. The 2015 Plan lists the following project review criteria as the most important in evaluating CON applications for freestanding emergency department services: (1) Compliance with the Need Outlined in [the freestanding Emergency Services] Section of the Plan; (2) Community Need Documentation; (3) Distribution (Accessibility); (4) Resource Availability;[57] and (5) Financial Feasibility.

35. The 2016-2017 Plan altered this list slightly, ranking the following criteria as the most important in evaluating an application for a FED: (1) Community Need Documentation; (2) Distribution (Accessibility); (3) Medically Underserved Groups; (4) Record of the Applicant; and, (5) Staff Resources.

- Community Need

36. The proposed FED does not comply with the "Community Need Documentation" criterion. S.C. Code Ann. Regs. 61-15 § 802.2 (Supp. 2019). Through fact and expert testimony, Roper St. Francis and Trident have proven, by a preponderance of the evidence, that there is adequate emergency department capacity in MUHA's defined service area to meet the needs of the proposed population in that service area. MUHA incorrectly focused on the population it currently serves in the community and suggested that a portion of that population would patronize its new FED in Berkeley County simply because they would choose a shorter travel time. However, MUHA could not reasonably explain why these same patients were not choosing a shorter travel time already, as the targeted patients are currently bypassing existing hospital-based and other FEDs in favor of MUSC's downtown location. Without an understanding of why its patients are seeking emergency services downtown at MUSC's tertiary/quaternary level hospital, MUHA cannot reasonably expect those same patients to redirect to another lower acuity emergency facility simply because it is located in closer proximity to where they live. This is especially the case when there are already lower acuity emergency options in the area with far better emergency department service metrics.

37. Even though they were not operational at the time of the contested case hearing, Roper St. Francis Berkeley Hospital which was scheduled to open in October 2019 and Trident

[57] Curiously, "Resource Availability" was listed in the 2015 State Health Plan but does not appear in the CON Act or in the controlling regulations. *See* S.C. Code Ann. Regs. 61-15 § 802. The Department considered "resource availability" in the State Plan to refer to "staff resources," although the Court need not make this determination to reach a decision.

Summerville's FED (which is located less than one mile from MUHA's proposed project) which was scheduled to open within a year of this contested case hearing, will provide even more capacity thereby reducing the need for an additional FED in this location.

- Distribution (Accessibility)

38. The proposed FED does not comply with the "Distribution (Accessibility)" criterion. S.C. Code Ann. Regs. 61-15 § 802.2 (Supp. 2019). "Duplication and modernization of services must be justified," and "[u]nnecessary duplication of services and unnecessary modernization of services will not be approved." S.C. Code Ann. Regs. 61-15 § 802.3(a) (Supp. 2019). No modernization is involved.

39. Increased accessibility and convenience to MUHA's existing patients who reside in the service area and are currently seeking treatment at MUSC in downtown Charleston, are not relevant to the Court's inquiry. These factors do not appear in the CON Act, the regulations, or Plans.

40. Roper St. Francis and Trident have proven by a preponderance of the evidence that MUHA's proposed FED would result in unnecessary duplication because residents in MUHA's defined service area, including the medically underserved, currently have easy access to both freestanding and hospital-based emergency room services within a fifteen-minute drive time. MUHA's FED would not increase access or otherwise improve it.

41. Roper St. Francis and Trident have also proven by a preponderance of the evidence that MUHA's FED is an unnecessary duplication of services given that there are no capacity constraints in the proposed service area for emergency department services now or in the near future. While the decision in this matter does not rest upon the following, the Court notes that additional facilities are scheduled to open in October 2019 (Roper St. Francis Berkeley Hospital) and within the year (Trident Summerville FED), the latter of which is less than one mile from MUHA's project.

42. While MUHA has established that it has efficiency challenges in its own emergency department as a result of several factors (e.g., design, boarding as a result of an insufficient number of admission beds) which have led to capacity constraints at its facility on the peninsula, neither the Plan nor regulations consider facility-specific needs in evaluating applications for FEDs.

- Medically Underserved Groups

43. Roper St. Francis and Trident have proven by a preponderance of the evidence that MUHA's proposed project does not comply with project review criterion 802.3 because it is both

unnecessarily duplicative and is admittedly intended to serve patients who are already served by MUSC.

44. I find as a matter of law that the medically underserved, indigent, and others who reside in the proposed service area already have access to the same emergency services through the providers in MUHA's proposed service area. There is no evidence of excessive wait times at existing facilities in the proposed service area and EMTALA ensures public access to emergency services irrespective of the ability to pay. MUHA's proposed FED is not within a MUA. There is nothing about MUHA's FED that will have any material impact, if any, on the medically underserved population.

- Resource Availability/Staff Resources

45. The 2015 Plan used the term, "Resource Availability" but there was no specific project review criteria heading titled, "Resource Availability." Even though, the Department cannot exclude and fail to consider it because the 2015 Plan lists it as among the most important review criteria in evaluating an FED.[58]

46. The 2017-2018 Plan substituted "Resource Availability" for "Staff Resources," and lists "Staff Resources" as among the most important criteria in evaluating an application for a FED. There are project review criteria that are specific to resource availability. See S.C. Code Ann. Regs. 61-15 § 802.20 (Supp. 2019).

47. The Court finds as a matter of law that Section 304 does not give the Department the discretion to exclude (substitute, or reorder) any of the criteria set forth in a Plan, or to change the weight of the project review criteria set forth in the Plan. S.C. Code Ann. Regs. 61-15 § 304 (Supp. 2019).

48. Consistent with the Department's and other testimony, the Court concludes that "Resource Availability" generally refers to staffing plans.

49. While a nursing shortage exists in South Carolina, under either the 2015 Plan or the 2017-2018 Plan, the greater weight of the evidence is that Roper St. Francis and Trident have not demonstrated that MUHA's project will have any significant adverse effect on existing providers' staff or staffing costs; especially considering that Petitioners continue to add emergency department services requiring additional nursing staff.

[58] Roper St. Francis established by a preponderance of the evidence that historically, the Department has used the following project review criteria to evaluate resource availability: Subsections 20(a), 20(b), 20(c), 21(a), 22, 23(a), 23(b) and 24 of Section 802 of Regulation 61-15. Other criteria are also relevant to "Resource Availability" including 3(h) and 23(b).

- Financial Feasibility

50. The "Financial Feasibility" criterion provides: "The applicant must have projected both the immediate and long-term financial feasibility of the proposal. Such projection should be reasonable and based upon accepted accounting procedures." S.C. Code Ann. Reg. 61-15 § 802.15 (Supp. 2019). MUHA's pro forma budget projects both the immediate and long-term financial feasibility of the FED, and even increased feasibility with the changes made to the project. The pro forma's projections are reasonable and based on accepted accounting procedures, and Roper St. Francis and Trident have failed to establish otherwise by a preponderance of the evidence. For these reasons, MUHA complies with this criterion.

- Record of the Applicant

51. MUHA's record is one of successful operation and adequate management experience. S.C. Code Ann. Regs. 61-15 § 802.13(a) (Supp. 2019). No evidence was produced to the contrary. While Roper St. Francis and Trident elicited testimony that suggested that MUHA may have difficulty funding the proposed project, the Court concludes as a matter of law that they failed to meet their burden of proof. I conclude as a matter of law that MUHA has a demonstrated ability to obtain necessary capital financing. S.C. Code Ann. Regs. 61-15 § 802.13(b) (Supp. 2019).

3. MUHA's Proposed FED Does Not Satisfy the Drive Time and Access Standards in the 2017-2018 Plan that Replaced Standard 6 in the 2015 Plan

52. Standard 6 of the 2015 State Health Plan was not included in the 2017-2018 South Carolina Health Plan that became effective three days after MUSC's CON Application was filed. A new requirement, not numbered but appearing at the end of the list of Standards, was added, providing:

> The applicant must demonstrate need for this service by documenting capacity constraints within existing emergency departments in the service area and/or a travel time of greater than 15 minutes to an existing emergency department in the service area.

(Roper St. Francis Ex. 56-026).

53. This standard does not address instances where a particular patient chooses to travel more than 15 minutes to see a particular or preferred provider. The purpose of this provision is not to ensure that **a specific** provider will be easily accessible, but rather to ensure that **a** provider is easily accessible.

54. Roper St. Francis and Trident have demonstrated by a preponderance of the evidence that there are no capacity constraints in existing emergency departments. Their emergency departments that were operational at the time of the hearing have additional capacity to provide emergency services and are not experiencing capacity constraints. While not critical to this determination, additional facilities that were scheduled to come online upon the conclusion of the hearing will provide additional capacity.

55. Additionally, Roper St. Francis and Trident have established by a preponderance of the evidence that patients in MUHA's proposed service area do not experience a "travel time of greater than 15 minutes to an existing emergency department in the service area." Ms. Platt demonstrated that all of the patients proposed to be served by MUHA already reside within fifteen minutes of an existing emergency services provider. (Roper St. Francis Ex. 63-014).

56. The Court did not base its decision upon the following but notes that while the standard speaks in terms of time, there are four existing and one approved FED within twenty miles of MUHA's proposed location. (Roper St. Francis Ex. 63-005).

4. The Balancing Test Under the 2015 and 2017-2018 Plans

57. Both the 2015 and the 2017-2018 Plans require the Department to weigh the benefits of improved accessibility and the adverse effects of duplication. The 2015 Plan which this Court is required to consider, provides that the benefits of improved accessibility "will be equally weighed" with the adverse effects of duplication for the service. The 2017-2018 Plan mandates that "the benefits of improved accessibility will outweigh the adverse effects of duplication" with accessibility having been determined to be the fifteen-minute travel time standard set forth in the Plan.

58. The persons in the proposed service area will not experience improved accessibility as result of the FED. As a result, MUHA has identified certain persons who live in the proposed service area and who have received emergency services at its main campus in the past. There is no evidence that those individuals lack access to emergency medical services, or that they lack access to emergency medical services within a fifteen-minute travel time.

59. The persons projected to shift from MUSC's downtown campus emergency department to MUHA's proposed FED in Berkeley County already have robust emergency service options within a fifteen-minute travel time window.

60. It is uncontroverted that MUHA has efficiency challenges in its own emergency departments at MUSC. However, neither the regulations nor the Plans consider facility-specific needs when evaluating applications to add freestanding FED services.

61. The Court has already concluded that the proposed project would not adversely affect other facilities as to staffing. *See* S.C. Code Ann. Regs. 61-15 § 802.23 (Supp. 2019). No evidence was presented that the FED would adversely affect the occupancy or use rates of the existing facilities in the proposed service area. *Id.*

62. As the proposed project would not result in increased accessibility and there are no adverse effects in terms of staffing, the Court cannot engage in a meaningful balancing test as specifically set forth in the 2015 and 2017-2018 Plans. "Adverse Effects" is not defined in the CON Act. *See* S.C. Code Ann. § 44-7-130 (2018 and 2019 Supp.)

63. If one expanded the meaning of "adverse effects" beyond the parameters of Section 802.23 of Regulation 61-15 to an ordinary and every day meaning, wasted health care dollars that would be expended if an unnecessary duplicative facility was approved would qualify as an adverse effect. Accordingly, the adverse effects of an unnecessary duplication resulting in wasted health care dollars would handily outweigh improved accessibility as there is none.

64. Irrespective of the balancing test, the project fails to comply with other significant project criteria contained in the Plans, the regulations, and the CON Act, and therefore the CON application must be denied.

5. <u>MUHA's Proposed FED Does Not Comply with the CON Act</u>

65. The purpose of the CON Act is to "promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities." S.C. Code Ann. § 44-7-120 (2018).

66. Even though a project does not have to satisfy every criterion to be approved, no project may be approved unless it is consistent with the State Health Plan. S.C. Code Ann. Regs. § 801.3 (Supp. 2019).

67. MUHA's FED violates the purposes of the CON Act. It is unnecessarily duplicative of facilities and services that exist in the proposed service area for which additional capacity exists. The proposed project does not promote cost containment and will not best serve the public need.

## G. MUHA'S Communication with the Department[59]

68. At trial, Roper St. Francis' counsel argued that the mid-trial meeting between the Department and MUHA influenced Ms. Murdock's testimony in a way that "cannot be undone." (Tr. 1588:25-1591:15). The South Carolina Administrative Procedures Act prohibits "members or employees of an agency **assigned to render a decision or to make findings of fact and conclusions of law in a contested case**" from communicating "directly or indirectly, in connection with any issue of fact, with any person or party, nor, in connection with any issue of law, with any party or his representative, except upon notice and opportunity for all parties to participate." S.C. Code Ann. § 1-23-360 (2005) (emphasis added).

69. While Section 1-23-360 does not appear to specifically prohibit the communications between the Department and MUHA, the Court is troubled by the surreptitious oral[60] joint defense agreement into which the Department and MUHA entered at the conclusion of the first week of trial for the purposes of securing Ms. Murdock's thoughts on testimony rendered by witnesses who previously testified and to prepare her for her hearing testimony. It violates the spirit of Section 1-23-360 and smacks of unfairness.

70. The Court considered the credibility of and assigned such weight to Ms. Murdock's testimony in light of the circumstances that preceded her testimony. Thus, there has been no resulting prejudice.

## H. The Parties' Discovery Motions

71. Throughout the pendency of this matter, the parties engaged in a very active motion practice including Roper St. Francis' filing of discovery motions against MUHA alleging various

[59] The Court need not decide the issue as pertains to the joint defense agreement as the Department agreed to waive whatever privilege existed. The Court finds, however, that the Department and MUHA do not share a "common and singular public-private interest"[59] in this matter and is unpersuaded by their arguments to the contrary including that there is public interest in the CON being approved.[59] *See Hunton & Williams v. U.S. Dept. of Justice*, 590 F.3d 272, 281 (4th Cir. 2010). As noted by Roper St. Francis, all parties to this case have a shared interest in insuring that the purposes of the CON Act are accomplished. (Tr. 1556:2-4). While both have an interest in the approval of the CON application, their underlying interests and motivations are not the same. *Hunton v. Williams*, 590 F.3d at 281. (In evaluating agency participation in a common defense agreement, the court inquired into "whether a singular public-private interest is present).

[60] The Court is aware that joint defense agreements need not be in writing to be enforced although a written agreement is the most effective method of establishing the existence of one. *See, e.g., United States v. Gonzales*, 669 F.3d 974, 979 (9th Cir. 2012) ("[I]t is clear that no written agreement is required, and that a JDA may be implied from conduct and situation, such as attorneys exchanging confidential communications from clients who are or potentially may be codefendants or have common interests in litigation."); *Minebea Co., Ltd. v. Papst*, 228 F.R.D. 13, 16 (D.D.C. 2005) ("Obviously, a written agreement is the most effective method of establishing the existence of a joint defense agreement, although an oral agreement whose existence, terms and scope are proved by the party asserting it, may be enforceable as well.").

discovery abuses including that MUHA withheld and failed to timely produce relevant information pertaining to changes to the proposed FED. Other motions (for summary judgment, to compel, to quash, and for a protective order) were filed prior to the contested case hearing and ruled upon. The outstanding motion pertains to a discovery motion filed on July 16, 2019; Roper St. Francis filed it against MUHA alleging in part that MUHA violated this Court's order of April 11, 2019.

72. On January 28, 2019, Roper St. Francis filed a discovery motion stating that MUHA's discovery answers and responses were materially deficient. Roper St. Francis stated that MUHA untimely supplemented its discovery and "withheld and failed to produce highly relevant and probative information regarding the Project for an unreasonable period of time" thereby prejudicing Roper St. Francis. Roper St. Francis stated that the documents withheld and/or produced late related to MUHA's plans for changes to the project. Roper St. Francis requested that the Court order MUHA to fully and immediately supplement its discovery. On February 7, 2019, Trident filed its "Response in Support and Consent to CareAlliance's Motion for Discovery Order." On February 19, 2018, MUHA submitted a memorandum opposing the motion.

73. After a hearing on Roper St. Francis' discovery motion, the Court issued an order on April 11, 2019 requiring all parties to immediately supplement their discovery answers and responses and continue to timely do so. The Court declined to assess costs or issue sanctions against MUHA[61] but reserved the right to revisit matters raised in Roper St. Francis' motion should any discovery violation be committed by MUHA or any other party during the remainder of the case.

74. On July 16, 2019 and days before the commencement of the contested hearing on July 22, 2019, Roper St. Francis filed another discovery motion against MUHA alleging that MUHA violated the Court's order of April 11, 2019. In particular, it was alleged that MUHA: (1) failed to fully and timely supplement its answers and responses primarily pertaining to project changes; and (2) deliberately withheld responsive, discoverable information as evidenced by documents subpoenaed from third parties including Intuitive Health, LLC,[62] Health Facilities

[61] In its order, the Court noted the delay in the parties' commencement and participation of discovery. While Roper St. Francis and Trident filed a request for a contested case hearing in December 2017, the party seeking relief served no written discovery in this case until August 30, 2018. As of February 27, 2019, no party had taken any depositions which resulted in a postponement of the contested case hearing.

[62] On January 7, 2019, Roper St. Francis issued a subpoena to third party Equity, LLC, with a compliance date of January 25, 2019. When the documents were not forthcoming, Roper St. Francis filed a motion on June 17, 2019 (almost five months after the compliance date and approximately four weeks before the commencement of the hearing) to enforce the subpoena. One June 27, 2019, MUHA filed a motion to quash the subpoena. On July 5, Roper St.

Planning Partners, LLC, and Equity, LLC. Roper St. Francis requested an order sanctioning MUHA to include the entry of an adverse disposition against MUHA. Roper St. Francis requested that it be awarded costs and fees associated with the filing of this motion and its motion of April 11, 2019. Alternatively, Roper St. Francis requested a continuance of the contested case hearing. Trident orally joined in Roper St. Francis' motion. (Tr. 12:23). On July 19, 2019, MUHA filed its response to Roper St. Francis' discovery motion asking that the motion be denied.

75. On July 22, 2019, the first day of the contested case hearing, the Court heard from both parties on Roper St. Francis' motion. (Tr. 7:5-49:4). The Court stated that the motion would be considered as she heard testimony, and that she would render a determination later. (Tr. 49:5-13).

76. On October 24, 2019, MUHA filed a supplemental memorandum in response to Roper St. Francis' motion for discovery. On November 1, 2019, Roper St. Francis filed a reply to MUHA's supplemental memorandum reiterating MUHA's alleged discovery abuses including the failure to comply with discovery rules, the failure to produce requested data, and misplaced reliance upon the "anticipation of litigation" as exception to document production.

77. After having carefully reviewed and considered all materials pertaining to Roper St. Francis' discovery motion of July 16, 2019 (including materials received from MUHA), and after listening to all of the testimony in the contested case, the Court denies Roper St. Francis' motion.

Francis filed a response to MUHA's motion stating MUHA had no standing to object to Roper St. Francis' subpoena to Equity, LLC, and that its motion was untimely. On July 8, 2019, the Court issued an order finding that MUHA had no standing to object to Equity LLC's production and ordered that the documents be produced by July 16, 2019.

## ORDER

After careful review of the evidence presented in this matter and based upon the findings of fact and conclusions of law stated above, **IT IS HEREBY ORDERED** that the South Carolina Department of Health and Environmental Control's decision is **REVERSED** and the Medical University Hospital Authority, d/b/a MUSC Health Services' application to establish a freestanding emergency department in Berkeley County is **DENIED**.

**IT IS FURTHER ORDERED** that the discovery motion filed by CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital is **DENIED**.

**AND IT IS SO ORDERED.**

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**SHIRLEY C. ROBINSON**
Administrative Law Judge

May 28, 2020
Columbia, South Carolina

**CERTIFICATE OF SERVICE**

I, Ti'a Smith, 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).



Ti'a Smith
Judicial Law Clerk

May 28, 2020
Columbia, South Carolina

**STATE OF SOUTH CAROLINA**
**ADMINISTRATIVE LAW COURT**

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| Trident Medical Center, LLC, d/b/a Trident Medical Center and Summerville Medical Center,<br><br>Petitioners,<br><br>vs.<br><br>South Carolina Department of Health and Environmental Control and Medical University Hospital Authority, d/b/a MUSC Health Emergency Services,<br><br>Respondents. | Docket No.: 17-ALJ-07-0441-CC<br>(consolidated)<br><br>**AMENDED ORDER DENYING SUMMARY JUDGMENT (Standard 2 of South Carolina Health Plan) & ORDER DENYING MOTION FOR RECONSIDERATION** |
| CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital,<br>Petitioners,<br><br>vs.<br><br>South Carolina Department of Health and Environmental Control and Medical University Hospital Authority, d/b/a MUSC Health Emergency Services,<br><br>Respondents. | Docket No.: 17-ALJ-07-0444-CC |

**APPEARANCES:** David B. Summer, Jr., Esquire
Amy S. Flanary-Smith, Esquire
For Petitioner Trident Medical Center, LLC, d/b/a Trident Medical Center and Summerville Medical Center

Jennifer J. Hollingsworth, Esquire
For Petitioner CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital

FILED
MAY 24 2019
SC ADMIN. LAW COURT

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

Daniel J. Westbrook, Esquire
For Respondent Medical University Hospital Authority, d/b/a MUSC Health Emergency Services

## STATEMENT OF THE CASE

This consolidated matter is before the Administrative Law Court (ALC or Court) pursuant to requests for contested case hearings filed by Petitioner Trident Medical Center, d/b/a Trident Medical Center and Summerville Medical Center (collectively referred to as "Trident") and Petitioner CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital (collectively referred to as "Roper St. Francis"). Roper St. Francis and Trident challenge the decision of the South Carolina Department of Health and Environmental Control (Department) approving Respondent Medical University Hospital Authority, d/b/a MUSC Health Emergency Services (MUSC)'s Certificate of Need (CON) application for freestanding emergency room department (FSED) in Berkeley County.

On February 8, 2019, Roper St. Francis filed a motion requesting that it be granted summary judgment on the basis that the Department erred as a matter of law in granting MUSC's CON application as the application failed to comply with Standard 2 of the South Carolina Health Plan (Plan). On April 11, 2019, the Court issued an Order Denying Roper St. Francis' Motion for Summary Judgment. On April 22, 2019, Roper St. Francis filed a Motion for Reconsideration. Upon review of the parties' submissions and the applicable law, the Court issues this Amended Order. All matters raised in the Motion for Reconsideration have been reviewed and considered, and to the extent they are not addressed in this Amended Order, are denied.

## BACKGROUND

On June 6, 2017, MUSC submitted a CON application for the construction of a 15,300 square foot FSED at a cost of $13,584.161. Roper St. Francis timely notified the Department of its status as an affected person, and its opposition to MUSC's project; Trident similarly opposed MUSC's project. On August 24, 2017, the Department held a project review meeting and all

parties to this action participated. On September 25, 2017, the Department issued a decision approving MUSC's application. The Department's letter to MUSC stated that MUSC had "presented substantial evidence that the Project complies with the relevant project review criteria and with the *South Carolina State Health Plan*, enacted August 13, 2015 ..."

On October 6, 2017, Roper St. Francis filed a written request for the Department's Board to conduct a final review of the staff decision approving MUSC's CON. On November 15, 2017, the Department declined to conduct a final review conference thereby rendering its staff decision approving MUSC's project as a final agency decision. *See* S.C. Code Ann. § 44-1-60(F) (2018). On December 15, 2017, Roper St. Francis filed a Request for a Contested Case Hearing asking the Court to reverse the Department's decision to approve MUSC's CON application for an FSED. In its Request, Roper St. Francis asserted that the Department's decision approving MUSC's application was not in compliance with the State Certification of Need and Health Facility Licensure Act (CON and Licensure Act), the Plan, or CON regulations. On May 4, 2018, MUSC's motion to lift the automatic stay was denied.

On February 8, 2019, Roper St. Francis filed a motion requesting that it be granted summary judgment on the basis that the Department erred as a matter of law in granting MUSC's CON application as the application failed to comply with Standard 2 of the South Carolina Health Plan (Plan). A hearing was held on February 27, 2019. On April 11, 2019, this Court issued an Order Denying Roper St. Francis' Motion for Summary Judgment. On April 22, 2019, Roper St. Francis filed a Motion for Reconsideration. On May 2, 2019, MUSC and DHEC submitted memoranda opposing the Motion for Reconsideration. On May 6, 2019, Roper St. Francis filed a Reply in Further Support of Motion for Reconsideration.

## STANDARD OF REVIEW

The granting of summary judgment is proper when there is no genuine issue of material fact such that the moving party must prevail as a matter of law. *Rule 56(c), SCRCP*. "The purpose of summary judgment is to expedite disposition of cases which do not require the services of a fact finder." *George v. Fabri*, 345 S.C. 440, 452, 548 S.E.2d 868, 874 (2001). "In determining whether summary judgment is proper, the court must construe all ambiguities, conclusions, and inferences arising from the evidence against the moving party. *Byers v. Westinghouse Elec. Corp.*, 310 S.C. 5, 7, 425 S.E.2d 23, 24 (1992). Because it is a drastic remedy, summary judgment should be cautiously invoked to ensure that a litigant is not improperly deprived of a trial on disputed factual

issues. *Baughman v. American Tel. and Tel. Co.*, 306 S.C. 101, 410 S.E.2d 537 (1991). However, "when plain, palpable, and indisputable facts exist on which reasonable minds cannot differ, summary judgment should be granted." *Bayle v. S.C. Dep't of Transp.*, 344 S.C. 115, 120, 542 S.E.2d 736, 738 (Ct. App. 2001).

The question of statutory interpretation, however, is one of law for a court to decide. *CFRE, LLC v. Greenville Cnty. Assessor*, 395 S.C. 67, 73, 716 S.E.2d 877, 881 (2011). Similarly, so is the interpretation of a regulation. *S.C. Dep't of Revenue v. Blue Moon of Newberry*, 397 S.C. 256, 260, 725 S.E.2d 483, 483 (2012). "When the Court is faced with a purely legal issue for which there are no factual issues to resolve, summary judgment is appropriate. *See Bell v. Progressive Direct Ins. Co.*, 407 S.C. 565, 575-576, 757 S.E.2d 399, 404 (2014).

## DISCUSSION

A. The Issue and the Parties' Positions

The CON and Licensure Act requires that a CON be obtained by a person or health care facility before undertaking "the offering of a health service by or on behalf of a health care facility which has not been offered by the facility in the preceding twelve months and for which specific standards or criteria are prescribed in the South Carolina Health Plan." S.C. Code Ann. § 44-7-160(5) (2018). The CON and Licensure Act dictates that "[t]he department may not issue a Certificate of Need unless an application complies with the South Carolina Health Plan, Project Review Criteria, and other regulations." S.C. Code Ann. § 44-7-210(B) (2018). The CON regulations also provide:

> The Department may not issue a Certificate of Need unless an application is in compliance with the South Carolina Health Plan as described in this regulation, project review criteria, and other regulations which must be identified by the Department. The Department may refuse to issue a Certificate of Need even if an application is in compliance with the South Carolina Health Plan but is inconsistent with project review criteria or departmental regulations.

S.C. Code Ann. Regs. 61-15 § 307(1). The CON and Licensure Act further provides that, "The department, the Administrative Law Court, and the Court of Appeals shall consider the South Carolina Health Plan in place at the time the application was filed and may consider the current South Carolina Health Plan when making its decision." S.C. Code Ann. § 44-7-225 (2018).

MUSC's CON application to construct an FSED was filed on June 6, 2017, when the *2015 South Carolina Health Plan* (2015 Plan) was still in place. The standards for outpatient facilities

which includes FSEDs are found in Chapter XI of the 2015 Plan.[1] The 2015 Plan contains six standards that must be satisfied to establish an FSED. The first standard provides that a CON is required to establish an FSED or "off-campus emergency service." Standard 2 provides:

> 2. All off-campus emergency services must be an extension of an existing hospital's emergency service in the same county, unless the applicant is proposing to establish a freestanding emergency service in a county that does not have a **licensed hospital**. The hospital must have a license that is in good standing and must be in operation to support the off-campus emergency services.

(Emphasis added).

Roper St. Francis contends that MUSC's application does not comply with Standard 2 as MUSC does not have an existing hospital emergency service in Berkeley County but rather, in Charleston County. While Standard 2 contains an exception, Roper St. Francis argues that MUSC's application for an FSED does not fall within the exception because Berkeley County already contains a "licensed hospital." Roper St. Francis points to DHEC's prior issuance of CONs for acute care hospitals in Berkeley County on January 6, 2016: Roper St. Francis Hospital - Berkeley which is owned by Roper St. Francis, and Berkeley Medical Center which is owned by Trident.

The parties dispute the meaning of "licensed hospital" as contained in Standard 2. The term, "licensed hospital" is neither defined in the standards for FSEDs, nor in the glossary of terms of the 2015 Plan. Roper St. Francis (joined by Trident) maintains that a "license" as used in Standard 2 is defined by the Administrative Procedures Act (APA) and the South Carolina Administrative Law Judge Division Act (SCALJD): "'License' includes the whole or part of any agency permit, franchise, certificate, approval, registration, charter, or similar form of permission required by law, but does not include a license required solely for revenue purposes.'" S.C. Code Ann. §§ 1-23-310(4) (2018); -505(4) (Supp. 2018). Roper St. Francis argues that under this definition, two licensed hospitals exist in Berkeley County, although neither have completed construction nor obtained licenses to operate or provide services.

Contrarily, MUSC maintains that a "licensed hospital" means a "license" as defined by

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[1] The *2017-2018 South Carolina Health Plan* (2017-2018 Plan) was enacted on June 9, 2017, three days after the CON application was filed in this case and was in effect as of the date of the Department's decision. While there were several modifications contained in the 2017-2018 Plan as applies to FSEDs, the standard at issue in this motion is the same in both the 2015 Plan and the 2017-2018 Plan.

Section 101 of Regulation 61-16, and that hospital must be in operation to be considered a licensed hospital for purposes of Standard 2. S.C. Code Regs. 61-16 § 101 ("For the purpose of these Standards[2] [a license is defined as a] certificate issued by the Department to the licensee that authorizes the operation of a hospital of institutional general infirmary."). Using this definition, no licensed hospital exists in Berkeley County. *See* S.C. Code Ann. § 44-7-260(A)(1) (2018) (prohibiting the establishment of a hospital without first obtaining a license "in the manner provided by this article and regulations promulgated by the department."

The Department submitted a memorandum opposing Roper St. Francis and Trident's Motion for Summary Judgment setting forth its interpretation of "licensed hospital" in Standard 2 as a hospital that not only has a CON but also, is licensed to operate as provided in Regulation 61-16, *Minimum Standards for Licensing Hospital and General Institutional Infirmaries*. At the hearing on the Motion for Summary Judgment, the Department's general counsel, a legal representative of the Department as well as an officer of the court, further clarified the Department's interpretation that a "licensed hospital" in Standard 2 is a hospital that not only has a CON but also, is licensed to operate as provided in Regulation 61-16, *Minimum Standards for Licensing Hospital and General Institutional Infirmaries*.

As an initial matter, the question presented by Roper St. Francis' Motion for Summary Judgment in which Trident joined, was posited as being a legal one requiring no resolution of factual issues. It filed its Motion for Summary Judgment prior to deposing any potential witnesses and in so filing, represented to the Court that its motion was "ripe for summary judgment," involved "undisputed material facts and a question of law," and "a purely legal issue for which there are no factual issues to resolve." Until now, Roper St. Francis' position was that the Court should rule on the meaning of "license" in Standard 2 as a matter of law. After the Court ruled as a matter of law that "license" in Standard 2 required that a facility be licensed to operate (which was contrary to the interpretation postulated by Roper St. Francis and Trident), Roper St. Francis now contends in part that further development of the record is necessary to resolve the legal issue.[3] The Court disagrees as the interpretation of statutes and regulations involve questions of law. *CFRE, LLC, supra; Blue Moon of Newberry, supra.*

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[2] "Standards" as used in Section 101 of Regulation 61-16 refers to the "Minimum Standards for Licensing Hospitals and Institutional General Infirmaries."

[3] On Page 12 of its Motion for Reconsideration, Roper St. Francis captioned its heading, "D. Reconsideration is Necessary for Further Development of the Record."

B. Deference to the Department's Interpretation[4]

Our supreme court recently expounded on the application of statutes and regulations administered by an administrative agency. *Trident Med. Cntr. v. S.C. Dep't of Health & Envtl. Control*, 412 S.C. 341, 772 S.E.2d 177 (Ct. App. 2015). In *Kiawah Development Partners, II v. South Carolina Department of Health & Environmental Control (Kiawah II)*, the court stated:

> Interpreting and applying statutes and regulations administered by an agency is a two-step process. First, a court must determine whether the language of a statute or regulation directly speaks to the issue. If so, the court must utilize the clear meaning of the statute or regulation. If the statute or regulation is silent or ambiguous with respect to the specific issue, the court then must give deference to the agency's interpretation of the statute or regulation, assuming the interpretation is worthy of deference.

411 S.C. 16, 766 S.E.2d 707 (2014) (citations and internal quotation marks omitted).

The Supreme Court in *Kiawah II* further stated, "We defer to an agency interpretation unless it is 'arbitrary, capricious, or manifestly contrary to the statute.'" *Id.* at 34–35, 766 S.E.2d at 718 (*quoting Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 844, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984)). After tracing the history of South Carolina's deference doctrine, the Supreme Court concluded, "[W]e give deference to agencies both because they have been entrusted with administering their statutes and regulations and because they have unique skill and expertise in administering those statutes and regulations." *Id.* at 34, 766 S.E.2d at 718.

Standard 2 does not specifically address the meaning of "license," as used in the standard. Since the standard is both silent and ambiguous as to whether the applicable definition of "license" is set forth in the APA or Regulation 61-16, the Court "must give deference" to the Department's

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[4] In the original order denying the Motion for Summary Judgment, the Court based its decision in part on its deference to the Department's interpretation. In Roper St. Francis' Motion for Reconsideration, it maintained that the Court erred in doing so as the Department submitted no "affidavits, deposition testimony or other evidence of this 'interpretation.'" Roper St. Francis continued by arguing that the Supreme Court "has repeatedly held that statements of fact appearing only in argument of counsel will not be considered." Roper St. Francis stated that the Court should not consider an interpretation that was set forth in the Department's memorandum opposing the granting of summary judgment, and by its general counsel at the hearing as they were unsupported by the record. The Court finds that the record for the Motion for Summary Judgment contains sufficient evidence of the Department's interpretation as discussed herein.

Interestingly, Roper St. Francis' "Proposed Order Granting Summary Judgment," included an extensive discussion as to the reasons the Court should reject the Department's interpretation of "licensed hospital" but made no mention of the record being "completely devoid" of evidentiary support for the interpretation as it did in its Motion for Reconsideration. It also did not raise at the hearing or in its proposed order that the Department's counsel's representation of the Department's interpretation of "licensed hospital" was an improper consideration for the Court.

interpretation, "assuming the interpretation is worthy of deference." *Id.* at 32-33, 766 S.E.2d at 717. Moreover, the construction assigned to a statute by those charged with the duty of exercising it, is always entitled to the most respectful consideration, and ought not to be overruled without cogent reasons. *Id.* at 33, 766 S.E.2d at 718 (*quoting Read Phosphate Co. v. S.C. Tax Comm'n*, 169 S.C. 314, 330, 168 S.E.2d 707, 728 (1933)).

Even without considering the argument raised by the Department in its memorandum opposing summary judgment or through its general counsel at the hearing, it is apparent that the Department interprets "licensed hospital" in Standard 2 as a hospital that not only has a CON but also, is licensed to operate as provided in Regulation 61-16, *Minimum Standards for Licensing Hospital and General Institutional Infirmaries*. This is convincingly evidenced by the Department's letter of September 25, 2007 to MUSC granting a CON for an FSED in Berkeley County. The letter is signed by the Director of the CON Program and the Bureau Chief of Healthcare Planning and Construction and was submitted by Roper St. Francis as an exhibit to its Motion for Summary Judgment. Despite having previously issued two CONs to Roper St. Francis and Trident for acute care hospitals in Berkeley County on January 6, 2016, the Department's letter of September 25, 2017 quoted Standard 2 and then unequivocally stated, "MUSC is located in Charleston County and seeks to establish the Project in Berkeley County. **Berkeley County currently does not have a licensed hospital**." (Emphasis added). The Department's interpretation is supported by the CON and Licensure Act. See S.C. Code Ann. § 44-7-110 *et seq.*, and the health care facility licensing regulation it authorizes, Regulation 61-16. Its interpretation not only best supports the purposes of the CON and Licensure Act but also, is worthy of deference. In addition, it does not contradict the plain meaning of the statute or regulation.[5]

C. The Court's Independent Analysis and Interpretation

Irrespective of the Court's deference to the Department, the Court still has the authority to interpret the meaning of "license" as used in Standard 2 since the standard is silent and ambiguous

[5] Originally in support of its argument that the court should not defer to the Department but rather, rely upon the plain meaning of Standard 2, Roper St. Francis cited *South Carolina Department of Revenue v. Blue Moon of Newberry, Inc.*, 397 S.C. 256, 725 S.E.2d 480 (2012) and *Trident Medical Center v. South Carolina Department of Health and Environmental Control*, 412 S.C. 341, 772 S.E.2d 177 (2015). Unlike the meaning of "licensed hospital" in Standard 2 in the present case, the meaning of terms in *Blue Moon* and *Trident Medical Center* was plain. Neither *Blue Moon* nor *Trident* involved a disputed term with two inconsistent legal definitions and are inapplicable to the present case.

as to whether the applicable definition of "license" is set forth in the APA or Regulation 61-16. The issue of interpretation of a statute or regulation involves a question of law. *Barton v. Higgs*, 381 S.C. 367, 674 S.E.2d 145 (2009); *State v. Sweat*, 379 S.C. 367, 379 S.E.2d 645 (Ct. App. 2008). The cardinal rule of statutory interpretation is to ascertain and effectuate the intent of the legislature." *Sloan v. Hardee*, 371 S.C. 495, 498, 640 S.E.2d 457, 459 (2007). In doing so, the words found in the statute must be given their "plain and ordinary meaning without resort to subtle or forced construction to limit or expand the statute's operation." *Id.* at 499, 640 S.E.2d at 459. Thus, if the words are unambiguous, we must apply their literal meaning. *Id.* at 498, 640 S.E.2d at 459.

"[T]he statute must be read as a whole and sections which are part of the same general statutory law must be construed together and each one given effect." *S.C. State Ports Auth. v. Jasper County*, 368 S.C. 388, 398, 629 S.E.2d 624, 629 (2006). A court must read the statute as a whole and in a manner consonant and in harmony with its general purpose. *State v. Sweat*, 379 at 375, 665 at 649 (Ct. App. 2008), *aff'd*, 386 S.C. 339, 688 S.E.2d 569 (2010). In that vein, we must read the statute so "that no word, clause, sentence, provision or part shall be rendered surplusage, or superfluous," *id.* at 377, 665 S.E.2d at 651, for "[t]he General Assembly obviously intended [the statute] to have some efficacy, or the legislature would not have enacted it into law" *id.* at 382, 665 S.E.2d at 654. Regulations are construed using the same canons of construction as statutes. *S.C. Ambulatory Surgery Ctr. Ass'n v. S.C. Workers' Comp. Comm'n*, 389 S.C. 380, 389, 699 S.E.2d 146, 151 (2010).

Here, the General Assembly expressly declared that the purpose of the CON and Licensure Act "is to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State." S.C. Code Ann. § 44-7-120 (2018). This purpose is reiterated in the CON regulations at Section 101. *See* S.C. Code Ann. Regs. 61-15 § 101. In order "to achieve [the] purposes" of the CON and Licensure Act, the Act requires the Department both prepare and publish a State Health Plan, and administer "the licensure of facilities rendering medical, nursing, and other health care." S.C. Code Ann. § 44-7-120 (2018). Thus, two of the Act's essential components, both of which have been designated as necessary to achieve the Act's purposes include the State Health Plan and the operational licensure of health care facilities to render healthcare services.

The CON and Licensure Act defines a "free standing emergency service" in pertinent part as "an extension of an existing hospital emergency department," which hospital "**shall have a valid license and be in operation** to support the off-campus emergency service." S.C. Code Ann. 44-7-130(25) (2018) (Emphasis added). In reading and interpreting Standard 2 of the 2015 Plan in a manner that is harmonious with the statutory definition of "freestanding emergency service," this Court finds that a "licensed hospital" is not simply one that has received a CON; it must also be one that has a valid license and is in operation. The CON and Licensure Act requires that a person or entity obtain both a CON and a license to operate prior to establishing and operating a new hospital. *See* S.C. Code Ann. §§ 44-7-130(10) (2002) (defining "health care facility" to include hospitals); 44-7-160(1) (2018) (requiring a person to obtain a CON prior to establishing a new health care facility); 44-7-260(A)(1) (2018) (prohibiting a hospital from operating prior to obtaining a license from the Department in a manner set forth in the CON and Licensure Act and any regulations promulgated thereto); *see also* S.C. Code Ann. Regs. 61-16 § 201 (Supp. 2018) (setting forth the regulatory requirements for obtaining a license from the Department to operate and maintain a hospital**).**

C. Collateral Estoppel Does Not Apply in This Case[6]

Roper St. Francis argues that MUSC is collaterally estopped to raise the meaning of "license" based on an opinion recently issued by The Honorable Milton G. Kimpson relating to the Department's grant of a CON extension to Berkeley Medical Center. *See Med. Univ. Hosp. Auth. v. S.C. Dep't of Health & Envtl. Control and Trident Med. Ctr., LLC, d/b/a Berkeley Med. Ctr.*, 2019 WL 183991 (S.C.Admin.Law.Judge.Div. Jan. 4, 2019). That matter involved Trident's proposed Berkeley County hospital. The Department issued a CON to Trident in 2016 for the construction of Berkeley Medical Center, an acute care facility, thereby triggering a twelve-month timetable for Trident to implement the project. *See* S.C. Code Ann. § 44-7-230(D) (2018). After receiving a nine-month extension of the implementation deadline, Trident requested and obtained a second extension.

On May 9, 2018, MUSC filed a request for a contested case hearing with the ALC challenging the Department's decision to grant Berkeley Medical Center's second request for an extension of its CON. At issue was whether the Department's extension decision was a "license," as defined by the APA in Section 1-23-505(4) of the South Carolina Code, that could give rise to

[6] No party requested reconsideration of the Court's ruling on this issue.

a contested case. Judge Kimpson ruled that a Department's extension decision was a license under the APA which could give rise to a contested case. The present case involves a different issue: the meaning of "licensed hospital" as contained in Standard 2. As the meaning of the "licensed hospital" requirement in Standard 2 was not previously raised to or addressed by Judge Kimpson, collateral estoppel is inapplicable.

**ORDER**

Based on the foregoing,

**IT IS HEREBY ORDERED** that Petitioner CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital's Motion for Summary Judgment, is **DENIED**.

**IT IS FURTHER ORDERED** that all matters raised in Petitioner CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital's Motion for Reconsideration have been reviewed and considered, and to the extent they are not addressed in this Amended Order, are **DENIED**.

**AND IT IS SO ORDERED**.

SHIRLEY C. ROBINSON
Administrative Law Judge

May 24, 2019
Columbia, South Carolina

CERTIFICATE OF SERVICE
This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, in the United States mail, postage paid, or in the interagency Mail Service addressed to the party(ies) or their attorney(s).
This 24 day of May, 2019
By: Judicial Law Clerk

**STATE OF SOUTH CAROLINA**
**ADMINISTRATIVE LAW COURT**

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| CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital,<br><br>Petitioners,<br><br>vs.<br><br>South Carolina Department of Health and Environmental Control and Trident Medical Center, LLC, d/b/a Summerville Medical Center,<br><br>Respondents. | ) Docket No.: | 17-ALJ-07-0433-CC<br><br>**ORDER DENYING MOTION TO LIFT AUTOMATIC STAY** |
| Trident Medical Center, LLC, d/b/a Trident Medical Center and Summerville Medical Center,<br><br>Petitioners,<br><br>vs.<br><br>South Carolina Department of Health and Environmental Control and Medical University Hospital Authority, d/b/a MUSC Health Emergency Services,<br><br>Respondents. | ) Docket No.: | 17-ALJ-07-0441-CC |
| CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital,<br><br>Petitioners,<br><br>vs.<br><br>South Carolina Department of Health and Environmental Control and Medical University | ) Docket No.: | 17-ALJ-07-0444-CC |

FILED
MAY 04 2018
SC ADMIN. LAW COURT

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| Hospital Authority, d/b/a MUSC Health Emergency Services, | ) |
| Respondents. | ) |

## STATEMENT OF THE CASE

These matters are before the South Carolina Administrative Law Court pursuant to three separate Requests for Contested Case Hearings, all of which challenge the South Carolina Department of Health and Environmental Control's ("DHEC") concurrent approval of two distinct Certificate of Need ("CON") applications. During the pendency of these contested cases, Respondent, Medical University Hospital Authority, d/b/a MUSC Health Emergency Services ("MUSC"), filed a Motion to Lift the Automatic Stay ("Motion") imposed under S.C. Code Ann. § 1-23-600(H)(2). Petitioners, Trident Medical Center, LLC, d/b/a Trident Medical Center and Summerville Medical Center ("Trident"), and CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital, and Roper St. Francis Berkeley Hospital ("Roper"), oppose MUSC's Motion. After careful consideration, the Court denies MUSC's Motion.

## BACKGROUND

On April 12, 2017, Trident submitted a CON application to build a free-standing emergency department ("FED") in Berkeley County. On June 6, 2017, MUSC also requested a CON to build a FED in Berkeley County. On July 6, 2017, Trident notified DHEC of its opposition to MUSC's CON application. MUSC did not oppose Trident's application. Soon thereafter, Roper timely notified DHEC of its opposition to both MUSC's and Trident's CON applications. On September 25, 2017, DHEC simultaneously approved both CON applications. In its determination letter, DHEC made a finding that MUSC did not qualify as a "competing applicant" pursuant to S.C. Code Ann. § 44-7-130 (5), nor did the opposition to both applications provide sufficient evidence requiring DHEC's denial. Trident timely requested a Final Review Conference of the staff determination approving MUSC's CON application. Roper also requested a Final Review Conference of both MUSC's and Trident's CON application approvals. On November 15, 2017, the DHEC Board declined review.

On December 7, 2017, Roper filed a Request for Contested Case Hearing to dispute Trident's CON approval. A subsequent Request for Contested Case Hearing challenging MUSC's

CON was filed by Trident on December 14, 2017. A third contested case followed on December 15, 2017, in which Roper contests MUSC's CON. On March 14, 2018, MUSC filed the Motion that is currently before the Court. On April 13, 2018, after all parties submitted their responsive briefs, this Court heard oral arguments on the Motion.

**DISCUSSION**

Upon a party's request for a contested case hearing of an agency decision, a stay of the matter is automatically imposed. S.C. Code Ann. § 1-23-600(H)(2). A party may move the Administrative Law Court to lift the automatic stay if certain statutory elements are demonstrated. *See* § 1-23-600(H)(4), *amended by* § 1-23-600(H)(4)(a). In December of 2017, the time in which MUSC became subject to the automatic stay, the applicable statutory elements were found in § 1-23-600(H)(4), which stated, in pertinent part, "the court shall lift the stay for good cause shown or if no irreparable harm will occur, then the stay shall be lifted." ("Former Statute"). However, on March 12, 2018, two days prior to MUSC's Motion, the statute was amended to read as follows:

> The court shall lift the stay unless the party that requested a contested case hearing proves: (i) the likelihood of irreparable harm if the stay is lifted, (ii) the substantial likelihood that the party requesting the contested case will succeed on the merits of the case, (iii) the balance of equities weigh in favor of continuing the stay, and (iv) continuing the stay serves the public interest.

§ 1-23-600(H)(4)(a) ("Amendment" or "Current Statute"). Due to the Amendment's timing, this Court is tasked with determining which statutory version to utilize in evaluating the merits of MUSC's Motion. MUSC urges the Court to apply the Current Statute since the Amendment was in effect at the time of filing. Trident and Roper, on the other hand, maintain that the Former Statute, which was the law at the time the stay was imposed, denotes the applicable standard.

While there is no precedential authority directly on point, "[i]n South Carolina, the law in effect at the time the cause of action accrued controls the parties' legal relationships and rights." *Stephens v. Draffin,* 327 S.C. 1, 5, 488 S.E.2d 307, 309 (1997)(holding that the rule of law in effect when the claims accrued controls despite being abrogated during the pendency of the lawsuit); *see Tiley v. Pacesetter Corp.,* 355 S.C. 361, 371, 585 S.E.2d 292, 297 (2003); *S.C. Nat'l Bank v. S.C. Tax Comm'n,* 297 S.C. 279, 281, 376 S.E.2d 512, 513 (1989). In the case *sub judice*, the Former Statute was in place on December 14, 2018, the day in which MUSC's stay was statutorily imposed. Consequently, and in consideration that South Carolina courts ordinarily utilize the law in place when suit is filed, I find that the Former Statute is applicable to MUSC's Motion

Having determined that the Current Version of § 1-23-600(H)(4)(a) is not applicable to MUSC's Motion by virtue of prospective treatment, the question of its retroactive effect remains. Our Supreme Court has stated that statutory enactments are presumed to be prospective unless retroactive application is stated or clearly intended. *Neel v. Shealy*, 261 S.C. 266, 273, 199 S.E.2d 542, 545 (1973); *Hyder v. Jones*, 271 S.C. 85, 88, 245 S.E.2d 123, 125 (1978)("No statute will be applied retroactively unless that result is so clearly compelled as to leave no room for reasonable doubt. . . ."). This presumption, however, does not apply to statutes that are remedial or procedural in nature, as they are generally held to apply retrospectively. *S.C. Dept. of Revenue v. Rosemary Coin Machines, Inc.*, 339 S.C. 25, 28, 528 S.E.2d 416, 418 (2000)(citing *Merchants Mut. Ins. Co. v. S.C. Second Injury Fund,* 277 S.C. 604, 291 S.E.2d 667 (1982)).

The Current Statute lacks not only clear language necessitating retrospective application, but also any indication of legislative intent. Thusly, the question becomes whether the Amendment is remedial or procedural in nature. A statute is remedial if "it creates new remedies for existing rights or enlarges the rights of persons under disability." *Edwards v. State Law Enf't Div.*, 395 S.C. 571, 580, 720 S.E.2d 462, 466 (2011) (citing *Smith v. Eagle Constr. Co.,* 282 S.C. 140, 143, 318 S.E.2d 8, 9 (1984)). Remedial legislation, by its nature, is that which is procedural. *See Bartley v. Bartley Logging Co.,* 293 S.C. 88, 92, 359 S.E.2d 55, 56-57 (1987). In this respect, a law is procedural if it designates a mode of procedure for a court to follow or "'prescribes a method of enforcing rights.'" *Edwards,* 395 S.C. at 580, 720 S.E.2d at 466-67 (citing Black's Law Dictionary, 1083 (1979)).

In reviewing the Amendment, there are obvious procedural components, as the method of lifting the stay is proscribed therein. Yet, the Amendment's remedial nature is minimal. The Amendment does not modify, limit, or enlarge the substantive right to an automatic stay or the remedy to lift the stay. Moreover, the Amendment provides for considerable substantive changes by way of shifting the burden of persuasion and the burden of production. *See* 395 S.C. at 579, 720 S.E.2d at 466 (quoting 82 C.J.S. Statutes § 585 (2009))("[W]here a statute . . . creates new obligations [or] imposes a new duty. . . it will be construed as prospective only.").

When presented with a law that is comprised of mixed procedural and substantive components, as is the statute at bar, I am persuaded to follow the rationale espoused by the Court of Appeals in *Southeastern Site Prep, LLC v. Atlantic Coast Builders and Contractors,* 394 S.C. 97, 106, 713 S.E.2d 650 (Ct. App. 2011). In that case, an amendment to Rule 11 of the South

Carolina Rules of Civil Procedure modified the standard for imposing sanctions from a frivolity standard to a reasonable attorney standard. *Id.* at 105, 654. The Court of Appeals held that the amendment was to be applied prospectively as it "impose[d] new obligations by effectively changing the standard for imposing sanctions to a 'reasonable attorney' standard." *Id.* at 107, 655. Similarly, the Amendment to § 1-23-600(H)(4) changed the substantive standard for lifting an automatic stay. In doing so, the Amendment imposed new obligations upon the parties, thereby rendering retrospective application inappropriate. Nonetheless, as is detailed *infra*, this Court is of the opinion that MUSC's Motion must be denied regardless of whether the Current or Former Statute is utilized.

## I. Good Cause

The Former Statute states that a showing of good cause presents sufficient grounds for lifting the stay. S.C. Code Ann. § 1-23-600(H)(4). As the moving party asserting the affirmative on the issue, MUSC has the burden of demonstrating good cause. *See Leventis v. S.C. Dep't of Health and Envtl. Control,* 340 S.C. 118, 132, 530 S.E.2d 643, 651 (Ct. App. 200). Good cause "requires some showing more than 'any cause,' as otherwise the word 'good' is rendered meaningless." *Heath Hill Petitioners v. S.C. Dept. of Health & Envtl. Control*, Docket No. 08-ALJ-07-0183-CC (S.C. Admin. Law Judge Div. 2008). Furthermore, "courts have found that 'good cause' requires more than personal circumstances or facts that are common to the population in general." *Id.*

MUSC submits to this Court that the grave and immediate need for emergency services in Berkeley County and the surrounding areas presents sufficient cause to lift the stay. In support of its position, MUSC provided the Court with documentation that the applicable service area is experiencing strong population growth. MUSC also provided internal data reflecting that its emergency services have grown approximately five percent from 2014 to 2016. MUSC suggests that this data illustrates an unmet demand for emergency services in the area.

While MUSC has adequately shown that population growth has affected its existing emergency services, it has failed to supply evidence that existing emergency services are inadequate in meeting patient needs. Moreover, MUSC has not demonstrated that moving forward with its project will alleviate the purported needs while this contested case is pending. Instead, it appears that MUSC is merely eager to enter the market in Berkeley County. Such cause is customary to most other parties whose CONs are stayed pending resolution by the courts. For this

reason, I conclude that MUSC has failed to demonstrate good cause for lifting the automatic stay under the prior version of S.C. Code Ann. § 1-23-600(H)(4).

## II. Irreparable Harm

An assessment of irreparable harm, or lack thereof, is needed to evaluate MUSC's Motion under either the Former or Current Statute. While the Former Statute requires a showing of a lack of irreparable harm, the new statute requires a showing of the likelihood of irreparable harm. Again, under either approach, MUSC's Motion fails.

Irreparable harm has yet to be defined by our highest Courts.[1] Nonetheless, this Court recognizes that "[g]enerally, 'irreparable injury is suffered when monetary damages are difficult to ascertain [with any accuracy] or are inadequate.'" *Hodges v. Abraham*, 253 F.Supp.2d 846, 864 (D.S.C. 2002) (citing *Multi–Channel TV Cable Co. v. Charlottesville Quality Cable Operating Co.*, 22 F.3d 546, 551 (4th Cir. 1994)); *see Z-Man Fishing Prods., Inc. v. Renosky*, 790 F.Supp.2d 418, 433 (D.S.C. 2011) (citing *Bushnell, Inc. v. Brunton Co.*, 673 F.Supp.2d 1241, 1262-63 (D. Kan. 2009))(finding that the loss of market share may represent irreparable harm).

Trident and Roper have both shown a likelihood of irreparable harm in the form of loss of market share and loss of revenue which, at this stage in the litigation, are difficult to quantify. Both parties have established that MUSC's current market share for emergency services within the service area is relatively small. Consequently, to be sustainable, MUSC will have to redirect market share from Trident and Roper. Trident's health planning expert, Daniel Sullivan, opined that such redirection of market share by a competitor "can result in substantial economic losses, equating to millions of dollars in revenue, and those losses can have devastating impacts on the health care provider and may affect the long-term viability of the health care provider." In addition, Mr. Sullivan explained that once a patient is treated by a provider, the patient will typically stay within that provider's health system. As a result, a likelihood exists that Trident's and Roper's decreased market share may extend beyond just emergency services. Therefore, I find that both Trident and Roper have made a prima facie showing that irreparable economic harm is likely if the stay is lifted. Having found a likelihood of irreparable harm, I also conclude that

[1] This Court rejects MUSC's proposition that a complete loss of business is required to demonstrate irreparable harm. In *Peek v. Spartanburg Regional Healthcare Systems*, the case on which MUSC relies, the Court of Appeals held that "[t]he complete loss of a professional practice *can be an irreparable harm*." 367 S.C. 450, 455, 626 S.E.2d 34, 37 (Ct. App. 2005) (emphasis added). This case merely illustrates one example of irreparable harm, not an exclusive requirement.

MUSC has not satisfied the Former Statutory standard in showing that no irreparable harm will occur.

**III. Likelihood of Success on the Merits**

As to the likelihood of success on the merits, the Current Statute requires Trident and Roper to provide a prima facie showing that they may succeed in reversing DHEC's CON approvals. *See Compton v. S.C. Dept. of Corrections*, 392 S.C. 361, 367, 709 S.E.2d 639, 642 (2011). There is no need to address each alleged deficiency of MUSC's CON application. Rather, this Court finds that Roper and Trident have sufficiently met their burdens. Both Roper and Trident have alleged with particularity, *inter alia,* that there is a lack of need for *two* additional FSEDs in the service area; and, that the approvability of MUSC's CON Application was evaluated by DHEC without mention of the Roper St. Francis Berkeley Hospital. Accordingly, Petitioners have met the threshold burden of demonstrating a prima facie showing of entitlement to relief.

**IV. Balance of Equities**

In balancing equities, the Court weighs the benefit of lifting the stay against any resulting inconvenience and damage. *See Johnson v. Williams,* 238 S.C.623, 639, 121 S.E.2d 223, 231 (1961). As already discussed, this Court is dubious of MUSC's proposition that emergency services are so greatly needed in the service area that it must proceed with the project at once. Accordingly, the potential damage that Trident and Roper may incur outweighs any meager benefits of lifting the stay prior to a decision on the merits. Thusly, I find that fairness requires maintenance of the status quo pending resolution of these matters.

**V. Public Interest**

The last factor this Court must evaluate also favors keeping the automatic stay in place. MUSC estimates that its total project cost will be $13,584,161. A portion of these costs will be supplied by taxpayer dollars. It is most certainly in the public's interest to avoid substantial, unrecoverable expenditures tied to taxpayer funding. *See MRI at Belfair, LLC v. S.C. Dept. of Health & Envtl. Control*, Docket No. 16-ALJ-07-0158-CC (S.C. Admin. Law Judge Div. 2016)(finding that wasted health care dollars amounts to public harm). Despite MUSC's contention that it will convert the planned FED into an office building if the CON is ultimately denied, this Court is not persuaded that those funds can be adequately recouped. Moreover, the expenditure of public funds on a project that may never be utilized in the manner conceived is

contrary to the goals and purposes of the CON Act. *See* S.C. Code Ann. § 44-7-120. Therefore, it is in the public's interest for the stay to remain in place pending a decision on the merits.

**CONCLUSION**

For the reasons set forth herein, the Court finds that MUSC is not entitled to a lifting of the automatic stay.

**ORDER**

**IT IS HEREBY ORDERED** that the Motions to Lift the Automatic Stay as filed by MUSC in Docket No. 17-ALJ-07-0441-CC and in Docket No. 17-ALJ-07-0444-CC are **DENIED**.

**IT IS FURTHER ORDERED** that Roper's Motion to Strike MUSC's Reply is **DENIED**.

**AND IT IS SO ORDERED.**

SHIRLEY C. ROBINSON
Administrative Law Judge

May 4, 2018
Columbia, South Carolina

CERTIFICATE OF SERVICE

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

This 4 day of May, 2018

By: _____
Judicial Law Clerk

**STATE OF SOUTH CAROLINA**
**ADMINISTRATIVE LAW COURT**

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|---|---|
| Trident Medical Center, LLC, d/b/a Trident Medical Center and Summerville Medical Center,<br><br>Petitioners,<br><br>vs.<br><br>South Carolina Department of Health and Environmental Control and Medical University Hospital Authority, d/b/a MUSC Health Emergency Services,<br><br>Respondents. | Docket No.: 17-ALJ-07-0441-CC<br>(consolidated)<br><br>**ORDER**<br>**DENYING SUMMARY JUDGMENT**<br>**(Standard 2 of South Carolina Health Plan)** |
| CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital,<br>Petitioners,<br><br>vs.<br><br>South Carolina Department of Health and Environmental Control and Medical University Hospital Authority, d/b/a MUSC Health Emergency Services,<br><br>Respondents. | Docket No.: 17-ALJ-07-0444-CC |

**APPEARANCES:** David B. Summer, Jr., Esquire
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Jennifer J. Hollingsworth, Esquire
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FILED
APR 11 2019
SC ADMIN. LAW COURT

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

Daniel J. Westbrook, Esquire
For Respondent Medical University Hospital Authority, d/b/a MUSC Health Emergency Services

## STATEMENT OF THE CASE

This consolidated matter is before the Administrative Law Court (ALC or Court) pursuant to requests for contested case hearings filed by Petitioner Trident Medical Center, d/b/a Trident Medical Center and Summerville Medical Center (collectively referred to as "Trident") and Petitioner CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital (collectively referred to as "Roper St. Francis"). Roper St. Francis and Trident challenge the decision of the South Carolina Department of Health and Environmental Control (Department) approving Respondent Medical University Hospital Authority, d/b/a MUSC Health Emergency Services (MUSC)'s Certificate of Need (CON) application for freestanding emergency room department (FSED) in Berkeley County.

On February 8, 2019, Roper St. Francis filed a motion requesting that it be granted summary judgment on the basis that the Department erred as a matter of law in granting MUSC's CON application as the application failed to comply with Standard 2 of the South Carolina Health Plan (Plan). A hearing was held on February 27, 2019. After listening to extensive oral arguments, and reviewing the parties' submissions and applicable law, Roper St. Francis' Motion for Summary Judgment is denied.

## BACKGROUND

On June 6, 2017, MUSC submitted a CON application for the construction of a 15,300 square foot FSED at a cost of $13,584.161. Roper St. Francis timely notified the Department of its status as an affected person, and its opposition to MUSC's project; Trident similarly opposed MUSC's project. On August 24, 2017, the Department held a project review meeting and all parties to this action participated. On September 25, 2017, the Department issued a decision approving MUSC's application. The Department's letter to MUSC stated that MUSC had

"presented substantial evidence that the Project complies with the relevant project review criteria and with the *South Carolina State Health Plan*, enacted August 13, 2015 …"

On October 6, 2017, Roper St. Francis filed a written request for the Department's Board to conduct a final review of the staff decision approving MUSC's CON. On November 15, 2017, the Department declined to conduct a final review conference thereby rendering its staff decision approving MUSC's project as a final agency decision. *See* S.C. Code Ann. § 44-1-60(F) (2018). On December 15, 2017, Roper St. Francis filed a Request for a Contested Case Hearing asking the Court to reverse the Department's decision to approve MUSC's CON application for an FSED. In its Request, Roper St. Francis asserted that the Department's decision approving MUSC's application was not in compliance with the State Certification of Need and Health Facility Licensure Act (CON and Licensure Act), the Plan, or CON regulations. On May 4, 2018, MUSC's motion to lift the automatic stay was denied.

On February 8, 2019, Roper St. Francis filed a motion requesting that it be granted summary judgment in the underlying contested case on the basis that the Department erred as a matter of law in granting MUSC's CON application as the application failed to comply with Standard 2 of the Plan. On February 19, 2019, Trident filed a memorandum in support of and joining in Roper St. Francis' Motion for Summary Judgment. On February 19, 2019, both MUSC and the Department filed memoranda opposing Roper St. Francis' motion.

## STANDARD OF REVIEW

The granting of summary judgment is proper when there is no genuine issue of material fact such that the moving party must prevail as a matter of law. *Rule 56(c), SCRCP*. "The purpose of summary judgment is to expedite disposition of cases which do not require the services of a fact finder." *George v. Fabri*, 345 S.C. 440, 452, 548 S.E.2d 868, 874 (2001). "In determining whether summary judgment is proper, the court must construe all ambiguities, conclusions, and inferences arising from the evidence against the moving party. *Byers v. Westinghouse Elec. Corp.*, 310 S.C. 5, 7, 425 S.E.2d 23, 24 (1992). Because it is a drastic remedy, summary judgment should be cautiously invoked to ensure that a litigant is not improperly deprived of a trial on disputed factual issues. *Baughman v. American Tel. and Tel. Co.*, 306 S.C. 101, 410 S.E.2d 537 (1991). However, "when plain, palpable, and indisputable facts exist on which reasonable minds cannot differ, summary judgment should be granted." *Bayle v. S.C. Dep't of Transp.*, 344 S.C. 115, 120, 542 S.E.2d 736, 738 (Ct. App. 2001).

The question of statutory interpretation, however, is one of law for the court to decide. *CFRE, LLC v. Greenville Cnty. Assessor,* 395 S.C. 67, 73, 716 S.E.2d 877, 881 (2011). Similarly, so is the interpretation of a regulation. *S.C. Dep't of Revenue v. Blue Moon of Newberry*, 397 S.C. 256, 260, 725 S.E.2d 483, 483 (2012). "When the Court is faced with a purely legal issue for which there are no factual issues to resolve, summary judgment is appropriate. *See Bell v. Progressive Direct Ins. Co.*, 407 S.C. 565, 575-576, 757 S.E.2d 399, 404 (2014).

**DISCUSSION**

A. The Issue and the Parties' Positions

The CON and Licensure Act requires that a CON be obtained by a person or health care facility before undertaking "the offering of a health service by or on behalf of a health care facility which has not been offered by the facility in the preceding twelve months and for which specific standards or criteria are prescribed in the South Carolina Health Plan." S.C. Code Ann. § 44-7-160(5) (2018). The CON and Licensure Act dictates that "[t]he department may not issue a Certificate of Need unless an application complies with the South Carolina Health Plan, Project Review Criteria, and other regulations." S.C. Code Ann. § 44-7-210(B) (2018). The CON regulations also provide:

> The Department may not issue a Certificate of Need unless an application is in compliance with the South Carolina Health Plan as described in this regulation, project review criteria, and other regulations which must be identified by the Department. The Department may refuse to issue a Certificate of Need even if an application is in compliance with the South Carolina Health Plan but is inconsistent with project review criteria or departmental regulations.

S.C. Code Ann. Regs. 61-15 § 307(1). The CON and Licensure Act further provides that, "The department, the Administrative Law Court, and the Court of Appeals shall consider the South Carolina Health Plan in place at the time the application was filed and may consider the current South Carolina Health Plan when making its decision." S.C. Code Ann. § 44-7-225 (2018).

MUSC's CON application to construct an FSED was filed on June 6, 2017, when the *2015 South Carolina Health Plan* (2015 Plan) was still in place. The standards for outpatient facilities which includes FSEDs are found in Chapter XI of the 2015 Plan.[1] The 2015 Plan contains six

[1] The *2017-2018 South Carolina Health Plan* (2017-2018 Plan) was enacted on June 9, 2017, three days after the CON application was filed in this case and was in effect as of the date of the Department's decision. While there were several modifications contained in the 2017-2018 Plan as applies to FSEDs, the standard at issue in this motion is the same in both the 2015 Plan and the 2017-2018 Plan.

standards that must be satisfied to establish an FSED. The first standard provides that a CON is required to establish an FSED or "off-campus emergency service." Standard 2 provides:

> 2. All off-campus emergency services must be an extension of an existing hospital's emergency service in the same county, unless the applicant is proposing to establish a freestanding emergency service in a county that does not have a **licensed hospital**. The hospital must have a license that is in good standing and must be in operation to support the off-campus emergency services.

(Emphasis added).

Roper St. Francis contends that MUSC's application does not comply with Standard 2 as MUSC does not have an existing hospital emergency service in Berkeley County but rather, in Charleston County. While Standard 2 contains an exception, Roper St. Francis argues that MUSC's application for an FSED does not fall within the exception because Berkeley County already contains a "licensed hospital." Roper St. Francis points to DHEC's prior approval on January 6, 2016 of two applications for CONs for acute care hospitals in Berkeley County: Roper St. Francis Hospital - Berkeley which is owned by Roper St. Francis, and Berkeley Medical Center which is owned by Trident.

Roper St. Francis and MUSC dispute the meaning of "licensed hospital" as contained in Standard 2. The term, "licensed hospital" is neither defined in the standards for FSEDs, nor in the glossary of terms of the 2015 Plan. Roper St. Francis maintains that a "license" as used in Standard 2 is defined by the Administrative Procedures Act (APA) and the South Carolina Administrative Law Judge Division Act (SCALJD): "'License' includes the whole or part of any agency permit, franchise, certificate, approval, registration, charter, or similar form of permission required by law, but does not include a license required solely for revenue purposes.'" S.C. Code Ann. §§ 1-23-310(4) (2018); -505(4) (Supp. 2018). Roper St. Francis argues that under this definition, two licensed hospitals exist in Berkeley County, although neither have completed construction nor obtained licenses to operate or provide services.

Contrarily, MUSC maintains that a "licensed hospital" means a "license" as defined by Section 101 of Regulation 61-16, and that hospital must be in operation to be considered a licensed hospital for purposes of Standard 2. S.C. Code Regs. 61-16 § 101 ("For the purpose of these

Standards[2] [a license is defined as a] certificate issued by the Department to the licensee that authorizes the operation of a hospital of institutional general infirmary."). Using this definition, no licensed hospital exists in Berkeley County. *See* S.C. Code Ann. § 44-7-260(A)(1) (2018) (prohibiting the establishment of a hospital without first obtaining a license "in the manner provided by this article and regulations promulgated by the department." MUSC's interpretation is consistent with that of the Department and this Court. The Department maintains that even now, there is still no licensed hospital in Berkeley County.

B. Deference to the Department's Interpretation and the Court's Concurrence

Our supreme court has recently expounded on the application of statutes and regulations administered by an administrative agency. *Trident Med. Cntr. v. S.C. Dep't of Health & Envtl. Control*, 412 S.C. 341, 772 S.E.2d 177 (Ct. App. 2015). In *Kiawah Development Partners, II v. South Carolina Department of Health & Environmental Control (Kiawah II)*, the court stated:

> Interpreting and applying statutes and regulations administered by an agency is a two-step process. First, a court must determine whether the language of a statute or regulation directly speaks to the issue. If so, the court must utilize the clear meaning of the statute or regulation. If the statute or regulation is silent or ambiguous with respect to the specific issue, the court then must give deference to the agency's interpretation of the statute or regulation, assuming the interpretation is worthy of deference.

411 S.C. 16, 766 S.E.2d 707 (2014) (citations and internal quotation marks omitted).

The Supreme Court in *Kiawah II* further stated, "We defer to an agency interpretation unless it is 'arbitrary, capricious, or manifestly contrary to the statute.'" *Id.* at 34–35, 766 S.E.2d at 718 (*quoting Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 844, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984)). After tracing the history of South Carolina's deference doctrine, the Supreme Court concluded, "[W]e give deference to agencies both because they have been entrusted with administering their statutes and regulations and because they have unique skill and expertise in administering those statutes and regulations." *Id.* at 34, 766 S.E.2d at 718.

Standard 2 does not specifically address the meaning of "license," as used in the standard. Since the standard is both silent and ambiguous as to whether the applicable definition of "license" is set forth in the APA or Regulation 61-16, the Court "must give deference" to the Department's

[2] "Standards" as used in Section 101 of Regulation 61-16 refers to the "Minimum Standards for Licensing Hospitals and Institutional General Infirmaries."

interpretation, "assuming the interpretation is worthy of deference." *Id.* at 32-33, 766 S.E.2d at 717. Moreover, the construction assigned to a statute by those charged with the duty of exercising it, is always entitled to the most respectful consideration, and ought not to be overruled without cogent reasons. *Id.* at 33, 766 S.E.2d at 718 (*quoting Read Phosphate Co. v. S.C. Tax Comm'n*, 169 S.C. 314, 330, 168 S.E.2d 707, 728 (1933)).

The Department interprets "licensed hospital" in Standard 2 as a hospital that not only has a CON but also, is licensed to operate as provided in Regulation 61-16, *Minimum Standards for Licensing Hospital and General Institutional Infirmaries*. Its interpretation is supported by the CON and Licensure Act. S.C. Code Ann. § 44-7-110 *et seq.*, and the health care facility licensing regulation it authorizes, Regulation 61-16. The Court concurs with the Department's interpretation as it not only best supports the purposes of the CON and Licensure Act but also, is worthy of deference.

The General Assembly expressly declared that the purpose of the CON and Licensure Act "is to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State." S.C. Code Ann. § 44-7-120 (2018). This purpose is reiterated in the CON regulations at Section 101. *See* S.C. Code Ann. Regs. 61-15 § 101. In order "to achieve [the] purposes" of the CON and Licensure Act, the Act requires the Department both prepare and publish a State Health Plan, and administer "the licensure of facilities rendering medical, nursing, and other health care." S.C. Code Ann. § 44-7-120 (2018). Thus, two of the Act's essential components, both of which have been designated as necessary to achieve the Act's purposes include the State Health Plan and the operational licensure of health care facilities to render healthcare services.

The CON and Licensure Act defines a "free standing emergency service" in pertinent part as "an extension of an existing hospital emergency department," which hospital "**shall have a valid license and be in operation** to support the off-campus emergency service." S.C. Code Ann. 44-7-130(25) (2018) (Emphasis added). In reading and interpreting Standard 2 of the 2015 Plan in a manner that is harmonious with the statutory definition of "freestanding emergency service," the Department interprets, and this Court agrees that a "licensed hospital" is not simply one that has received a CON; it must also be one that has a valid license and is in operation. As noted by the Department, the CON and Licensure Act requires that a person or entity obtain both a CON

and a license prior to establishing and operating a new hospital. *See* S.C. Code Ann. §§ 44-7-130(10) (2002) (defining "health care facility" to include hospitals); 44-7-160(1) (2018) (requiring a person to obtain a CON prior to establishing a new health care facility); 44-7-260(A)(1) (2018) (prohibiting a hospital from operating prior to obtaining a license from the Department in a manner set forth in the CON and Licensure Act and any regulations promulgated thereto); *see also* S.C. Code Ann. Regs. 61-16 § 201 (Supp. 2018) (setting forth the regulatory requirements for obtaining a license from the Department to operate and maintain a hospital**).** If both were not required, there would be nothing to prevent health care providers from securing CONs (with no intent of completing the projects) for the sole purpose of frustrating potentially competing health care providers from securing CONs to provide services in the same area. This would thwart the intent of the CON and Licensure Act and Plan by frustrating the fulfillment of a documented community need.

In support of its argument that the Court should not defer to the Department but rather, rely upon the plain meaning of Standard 2, Roper St. Francis cites *South Carolina Department of Revenue v. Blue Moon of Newberry, Inc.*, 397 S.C. 256, 725 S.E.2d 480 (2012) and *Trident Medical Center v. South Carolina Department of Health and Environmental Control*, 412 S.C. 341, 772 S.E.2d 177 (2015). Unlike the meaning of "licensed hospital" in Standard 2 in the present case, the meaning of terms in *Blue Moon* and *Trident Medical Center* was plain. Neither *Blue Moon* nor *Trident* involved a disputed term with two inconsistent legal definitions and are inapplicable to the present case.

Finally, Roper St. Francis maintains that because the last three State Health Plans listed either Berkeley Medical Center and/or Roper – Berkeley Hospital in their inventories, the Plan considers a "license" in the general context of those CON application approved facilities even though they remain unopened and not operational. The Department, MUSC, and the Court disagree. The Department's website contains a list of all licensed health care facilities in the state by county. No licensed hospital is listed in Berkeley County.

While the Court's opinion is not based upon the following, the Court finds it curious that Trident, who filed a memorandum in support of and joining in Roper St. Francis' motion for summary judgment, fairly recently maintained a position in another matter that is: (1) inconsistent with its position in this matter; and (2) consistent with the Department and MUSC's position in this matter. On April 12, 2017, Trident submitted its own application for a FSED. Trident's

application asserted its compliance with Standard 2 on the following grounds. "The [Trident] FSED will operate as an extension of [Summerville Medical Center] and will be located in Berkeley County where there is no licensed hospital." Trident asserted this same position at a project review meeting on August 24, 2017, in a power point slide captioned, "The Project Is Consistent with the 2015 SC Health Plan," that noted that the FSED will be located in Berkeley County "where there is no licensed hospital." Trident's expert health care planner has likewise maintained different positions in the matters.

C. Collateral Estoppel Does Not Apply in This Case

Roper St. Francis argues that MUSC is collaterally estopped to raise the meaning of "license" based on an opinion recently issued by The Honorable Milton G. Kimpson relating to the Department's grant of a CON extension to Berkeley Medical Center. *See Med. Univ. Hosp. Auth. v. S.C. Dep't of Health & Envtl. Control and Trident Med. Ctr., LLC, d/b/a Berkeley Med. Ctr.*, 2019 WL 183991 (S.C.Admin.Law.Judge.Div. Jan. 4, 2019). That matter involved Trident's proposed Berkeley County hospital. The Department issued a CON to Trident in 2016 for the construction of Berkeley Medical Center, an acute care facility, thereby triggering a twelve-month timetable for Trident to implement the project. *See* S.C. Code Ann. § 44-7-230(D) (2018). After receiving a nine-month extension of the implementation deadline, Trident requested and obtained a second extension.

On May 9, 2018, MUSC filed a request for a contested case hearing with the ALC challenging the Department's decision to grant Berkeley Medical Center's second request for an extension of its CON. At issue was whether the Department's extension decision was a "license," as defined by the APA in Section 1-23-505(4) of the South Carolina Code, that could give rise to a contested case. Judge Kimpson ruled that a Department's extension decision was a license under the APA which could give rise to a contested case. The present case involves a different issue: the meaning of "licensed hospital" as contained in Standard 2. As the meaning of the "licensed hospital" requirement in Standard 2 was not previously raised to or addressed by Judge Kimpson, collateral estoppel is inapplicable.

## ORDER

**Based on the foregoing,**

**IT IS HEREBY ORDERED** that Petitioner CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper

Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital's Motion for Summary Judgment, is **DENIED**.

**AND IT IS SO ORDERED**.

**SHIRLEY C. ROBINSON**
Administrative Law Judge

April 11, 2019
Columbia, South Carolina

CERTIFICATE OF SERVICE

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

This 11 day of April 2019

By: _____
Judicial Law Clerk

**STATE OF SOUTH CAROLINA**
**ADMINISTRATIVE LAW COURT**

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| Trident Medical Center, LLC, d/b/a Trident Medical Center and Summerville Medical Center,<br><br>Petitioners,<br><br>vs.<br><br>South Carolina Department of Health and Environmental Control and Medical University Hospital Authority, d/b/a MUSC Health Emergency Services,<br><br>Respondents. | Docket No.: 17-ALJ-07-0441-CC<br>(consolidated)<br><br>**ORDER**<br>**DENYING SUMMARY JUDGMENT** |
| CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital,<br>Petitioners,<br><br>vs.<br><br>South Carolina Department of Health and Environmental Control and Medical University Hospital Authority, d/b/a MUSC Health Emergency Services,<br><br>Respondents. | Docket No.: 17-ALJ-07-0444-CC |

**APPEARANCES:** David B. Summer, Jr., Esquire
Amy S. Flanary-Smith, Esquire
For Petitioner Trident Medical Center, LLC, d/b/a Trident Medical Center and Summerville Medical Center,

Jennifer J. Hollingsworth, Esquire
For Petitioner CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital.

FILED
APR 11 2019
SC ADMIN. LAW COURT

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

Daniel J. Westbrook, Esquire
For Respondent Medical University Hospital Authority, d/b/a MUSC Health Emergency Services

## STATEMENT OF THE CASE

This consolidated matter is before the Administrative Law Court (ALC or Court) pursuant to requests for contested case hearings filed by Petitioner Trident Medical Center, d/b/a Trident Medical Center and Summerville Medical Center (collectively referred to as "Trident") and Petitioner CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital (collectively referred to as "Roper St. Francis"). Trident and Roper St. Francis challenge the decision of the South Carolina Department of Health and Environmental Control (Department) granting a Certificate of Need (CON) to Respondent Medical University Hospital Authority, d/b/a MUSC Health Emergency Services (MUSC) for a freestanding emergency department (FSED) in Berkeley County.

During discovery, MUSC produced documentation indicating that it had made changes to the project described in its CON application as approved by the Department. On February 8, 2019, Trident filed a motion requesting that it be granted summary judgment in the underlying contested case on the basis that MUSC's changes to the project were so substantial as to constitute an entirely new project. A hearing was held on February 27, 2019. After listening to extensive oral arguments, and reviewing the parties' submissions and the applicable law, Trident's Motion for Summary Judgment is denied.

## BACKGROUND

On April 12, 2017, Trident submitted a CON application for the construction of a 12,200 square feet freestanding emergency department (FSED) in Berkeley County at a cost of $13,079,900. On June 6, 2017, MUSC also submitted a CON application for the construction of a 15,300 square feet FSED at a cost of $13,584.161. Roper St. Francis timely notified the Department of its status as an affected person, and its opposition to MUSC's project; Trident similarly opposed MUSC's project. Pursuant to Regulation 61-15 § 802 of the South Carolina

Code of Regulations, and by letter dated July 10, 2017, the Department advised MUSC that the specific project review criteria that would be utilized in reviewing its project included: (1) Community Need Documentation; (2) Distribution (Accessibility); (3) Medically Underserved Groups; and (4) Financial Feasibility. On August 24, 2017, the Department held a project review meeting and all parties to this action participated. On September 25, 2017, the Department issued decisions concluding that MUSC and Trident's CON applications for FSEDs were not competing; the Department approved both applications. The Department's letter to MUSC stated that MUSC had "presented substantial evidence that the Project complies with the relevant project review criteria and with the *South Carolina State Health Plan*, enacted August 13, 2015 …"

On October 6, 2017, Roper St. Francis filed a written request for the Department's Board to conduct a final review of the staff decision approving MUSC's CON. On October 10, 2017, Trident likewise asked the Department to conduct a final review. On November 15, 2017, the Department declined to conduct a final review conference thereby rendering it staff decision approving MUSC's project as a final agency decision. *See* S.C. Code Ann. § 44-1-60(F) (2018).

On December 14, 2017, Trident filed a Petition for Administrative Review and Request for a Contested Case Hearing. In its Petition, Trident argued that MUSC's application and its own application for FSEDs were competing, and that the Department incorrectly found otherwise. Trident posited that the Department was required to grant the application that most fully complied with the requirements, goals, and purposes of the CON Act, the State Health Plan (Plan), and the established project review criteria, and that Trident's application most fully complied. On December 15, 2017, Roper St. Francis also filed a Request for a Contested Case Hearing asking the Court to reverse the Department's decision to approve MUSC's CON for an FSED. On April 18, 2018, the Court issued an order consolidating these cases.[1] On May 4, 2018, MUSC's motion to lift the automatic stay was denied.

On June 6, 2018, the parties agreed to a Consent Scheduling Order which set a trial date of November 26, 2018. On November 7, 2018 and per request of the parties, the Court issued an

[1] This statement is somewhat of an oversimplification of what occurred. There was also a third related case filed under Docket No. 17-ALJ-07-0433-CC in which Roper St. Francis filed a Request for a Contested Case Hearing challenging the Department's approval of Trident's CON application for a FSED. MUSC's Motion to Intervene in that case was denied but its request to consolidate all three cases including Docket Nos. 17-ALJ-07-0441-CC and 17-ALJ-07-0444-CC, was granted by Order of this Court on April 18, 2018. The case filed by Roper St. Francis under Docket No. 17-ALJ-074-0433-CC contesting the Department's approval of Trident's CON application for a FSED was dismissed by consent of Roper St. Francis, Trident and the Department.

Amended Consent Scheduling Order providing that discovery be completed by February 8, 2019 and calendaring the trial to commence on March 18, 2019.[2]

On January 10, 2019, MUSC supplemented its discovery responses to Roper St. Francis disclosing changes to its project for which the Department had previously approved the issuance of CON on September 25, 2017. On February 8, 2019, Trident filed a motion requesting that it be granted summary judgment in the underlying contested case on the basis that MUSC's changes to the project were so significant as to constitute an entirely new project. Specifically, Trident requested a finding that MUSC abandoned the project previously approved by the Department, and that MUSC be required to file a CON application for the alleged new project. On February 20, 2019, Roper St. Francis filed a memorandum in support of and joining in Trident's Motion for Summary Judgment. On February 19, 2019, both MUSC and the Department filed memoranda opposing the granting of summary judgment.

## STANDARD OF REVIEW

The granting of summary judgment is proper when there is no genuine issue of material fact such that the moving party must prevail as a matter of law. *Rule 56(c), SCRCP*. Summary judgment is not appropriate where further inquiry into the facts of the case is desirable to clarify the application of the law. *Carolina Chloride, Inc. v. S.C. Dep't of Transp.*, 391 S.C. 429, 435-436, 706 S.E.2d 501, 504 (2011). "The purpose of summary judgment is to expedite disposition of cases which do not require the services of a fact finder." *George v. Fabri*, 345 S.C. 440, 452, 548 S.E.2d 868, 874 (2001). "In determining whether summary judgment is proper, the court must construe all ambiguities, conclusions, and inferences arising from the evidence against the moving party. *Byers v. Westinghouse Elec. Corp.*, 310 S.C. 5, 7, 425 S.E.2d 23, 24 (1992).

Because it is a drastic remedy, summary judgment should be cautiously invoked to ensure that a litigant is not improperly deprived of a trial on disputed factual issues. *Baughman v. American Tel. and Tel. Co.*, 306 S.C. 101, 410 S.E.2d 537 (1991). However, "when plain, palpable, and indisputable facts exist on which reasonable minds cannot differ, summary judgment should be granted." *Bayle v. S.C. Dep't of Transp.*, 344 S.C. 115, 120, 542 S.E.2d 736, 738 (Ct. App. 2001).

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[2] Since the hearing on this motion on February 27, 2019, the Court has been awaiting receipt of a second amended proposed scheduling order from the parties as pertains to discovery and other matters, although a three-week trial date has been scheduled to commence on July 22, 2019.

## DISCUSSION

Trident contends that MUSC's changes to its project constitute a substantial and material change such that the CON application approved by the Department has been abandoned and MUSC must complete a new application. Trident maintains that MUSC's supplemental discovery production of January 10, 2019 evidences that MUSC has made significant changes to its project as approved by the Department including that it has moved the location of the project, and has changed the size, scope and cost of the project. Trident contends that it appears that MUSC has eliminated its Clinical Decision Unit and helipad,[3] and has also possibly changed "participation/management/ownership"[4] of the project. In support of its motion, Trident submitted the affidavit of Daniel J. Sullivan, MHA, Trident's expert healthcare planner. Roper St. Francis concurs with Trident and submitted the supporting affidavit of Kathryn M.T. Platt, MBA, Roper St. Francis' expert healthcare planner.

MUSC concedes that changes have been made to its project including that (1) the FSED will move less than one mile from its original site which will result in increased access; (2) the FSED will be smaller and have fewer exam rooms, and will not have a Clinical Decision Unit or helipad which will reduce costs; and (3) urgent care services which are not subject to CON requirements will be provided in the FSED. MUSC submits that it may contract with a company to provide management services for the FSED. MUSC disagrees with Trident and Roper St. Francis' position that the changes to its project are material and submits that the issue is a factual one that cannot be ruled upon at the summary judgment stage. MUSC maintains that no factual record has been developed that would allow the Court to rule as a matter of law, that the approved project has changed to such a degree as to require the Court to remand the matter.

The Department maintains that while it has been served with copies of the documents produced during the contested case, no updates to or amendments of MUSC's CON application have been filed with the Department so as to trigger a review by the Department. The Department concurs with MUSC position that whether an amendment to an application or a project is

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[3] The Court notes that in Trident's Petition for Administrative Review and Request for a Contested Case Hearing, Trident questioned the financial feasibility of MUSC's project because of undisclosed capital and maintenance costs for the operation of a helicopter. Trident also raised the issue that a Clinical Decision Unit was not a new service delivery model as Trident already provided this and for MUSC to do so would result in duplicative services.

[4] Affidavit of Daniel J. Sullivan, MHA, Paragraph 5 (February 8, 2019). *See also* Affidavit of Kathryn M. T. Platt, MBA, Paragraph 7, (February 19, 2019).

substantial is a fact-intensive inquiry, and that genuine issues of material fact exist regarding any changes MUSC may be planning to make to its project.

While MUSC has clearly made alterations to a number of aspects of its project, changes are both expected and allowed if they are not substantial.[5] The issue of whether a change is substantial is a factual question and in rendering such conclusion, the Court must weigh many facts and factors. MUSC urges the Court to adopt the analysis set forth in *MRI at Belfair, LLC v. S.C. Dep't of Health and Envtl. Control*, Docket No. 07-ALJ-07-0389-CC (November 24, 2009), *aff'd* 394 S.C. 567, 716 S.E.2d 111 (Ct. App. 2011); and *Providence Hospital v. S.C. Dep't Health & Envtl. Control*, 2002 WL 31423801 at 13 (S.C.Admin.Law.Judge.Div. September 11, 2002).[6]

At this time, the Court cannot say that there are not material facts in issue as to whether the changes identified by MUSC constitute substantial ones. This is evidenced by the parties' submissions including their supporting affidavits, and oral arguments. Not only do the parties dispute whether the changes constitute substantial ones, but also, they disagree as to the extent of changes being made.[7] The record is likewise insufficient to determine whether changes to MUSC's project will affect compliance with the established project review criteria as only MUSC's expert addressed this in his affidavit. Affidavit of David S. Levitt, MHA (February 18, 2019). Accordingly, the Court is unwilling to grant summary judgment on those matters or to remand the issue.

Moreover, the Court conducts a *de novo* hearing in CON cases. *Brown v. S.C. Dep't of Health & Envtl. Control*, 348 S.C. 507, 560 S.E.2d 410 (2002). While this Court may not consider new or different issues, the parties are permitted to submit new or additional facts for consideration at the contested case hearing which were not part of the administrative record at the time of the Department's review. *Marlboro Park Hosp. v. S.C. Dep't of Health & Envtl. Control*, 358 S.C. 573, 595 S.E.2d 851 (2004).

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[5] While not controlling, the Court references the following by way of example: *Carolina Regional Cancer Center, LLC v. S.C. Dep't of Health and Envtl. Control*, 2015 WL 2159497 *19 (S.C.Admin.Law.Judge.Div. June 10, 2015) (concluding that a transfer of ownership interest in that case was not a substantial change); *id.* n. 20 (noting that even had a management agreement been executed, it would not have been a substantial change).

[6] At this time, the Court does not opine as to whether the factors enunciated in *MRI at Belfair, LLC* and *Providence* are conclusive and/or exclusive in ascertaining if a change (alone or in concert) is substantial.

[7] While MUSC did not supplement discovery and advise of changes until January 10, 2019, these contested cases were filed in December 2017 and very little discovery has been conducted by any party. As of the date of the motions hearing in this matter on February 27, 2019, no depositions had been taken.

## ORDER

**Based on the foregoing,**

**IT IS HEREBY ORDERED** that Petitioner Trident Medical Center, LLC, d/b/a Trident Medical Center and Summerville Medical Center's Motion for Summary Judgment, is **DENIED**.

**IT IS HEREBY FURTHER ORDERED** that the parties shall submit a proposed Second Amended Scheduling Order to the Court no later five days after the date of this Order.

**AND IT IS SO ORDERED**.

Shirley C. Robinson

**SHIRLEY C. ROBINSON**
Administrative Law Judge

April 11, 2019
Columbia, South Carolina

CERTIFICATE OF SERVICE

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

This 11 day of April, 2019

By: _____
Judicial Law Clerk

**STATE OF SOUTH CAROLINA**
**ADMINISTRATIVE LAW COURT**

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| CareAlliance Health Services d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital, and Roper St. Francis Berkeley Hospital,<br><br>Petitioners,<br><br>vs.<br><br>South Carolina Department of Health and Environmental Control, and Medical University Hospital Authority d/b/a MUSC Health Emergency Services,<br><br>Respondents. | Docket No.: 17-ALJ-___-____-___<br><br>**REQUEST FOR CONTESTED CASE HEARING** |

Pursuant to South Carolina Code Sections 44-1-60 and 44-7-210 and Rule 11 of the South Carolina Rules of Procedure for the Administrative Law Court, the Petitioners, CareAlliance Health Services d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital, and Roper St. Francis Berkeley Hospital (collectively from time to time "Roper St. Francis"), by and through its undersigned attorneys, respectfully requests a contested case hearing and reversal of the September 25, 2017 decision of the Respondent South Carolina Department Health & Environmental Control ("DHEC" or the "Department") to grant the Medical University Hospital Authority d/b/a MUSC Health Emergency Services ("MUSC"), a Certificate of Need ("CON") for the construction of a freestanding emergency department in Berkeley County at a total project cost of $13,584,161.00 (the "Project").

In support of this Request, Roper St. Francis would show as follows:

1. The Court has jurisdiction over this matter under S.C. Const. Art. I, § 22; S.C. Code Ann. § 1-23-320; § 1-23-600(B); § 44-1-60(F) and § 44-7-210(D); 24A S.C. Code Ann. Regs. 61-15; and Rule 11 RPALC.

2. Roper St. Francis is an existing provider of medical services in the service area proposed to be served by MUSC's project.

3. Roper St. Francis is an "affected person" pursuant to S.C. Regulation 61-15 § 103(1) and has standing to assert its claims in this case.

4. By letter dated September 25, 2017, Department staff approved MUSC's request for CON for the Project (attached hereto as **Exhibit A**).

5. On October 6, 2017, Roper St. Francis filed its request for a final review conference with the Department Board pursuant to S.C. Code Ann. § 44-7-60(F) on the Department's decision to approve the Project (attached as **Exhibit B**).

6. By letter dated November 15, 2017, the Department Board informed Roper St. Francis of its decision not to conduct a Final Review Conference of the Department Staff's decision to approve MUSC's Project (attached hereto as **Exhibit C**).

7. Roper St. Francis hereby files its Request for Contested Case Hearing with this Court. Reserving its right to raise any and all issue presented to the Department below and specifically incorporating all issues raised or addressed in its previous filings in this matter, Roper St. Francis seeks reversal of the Department's September 25, 2017 decision to approve MUSC's CON application on numerous grounds, including but not limited to:

a. The Application is not in compliance with the *South Carolina Health Plan* enacted August 13, 2015 and the Regulations contained in 24A S.C. Code Ann. Regs. 61-15, as

more specifically identified in the following correspondence from Roper St. Francis to the Department:

(1) Letter of July 21, 2017 from Platt HMC, Inc. to Maggie Murdock, DHEC (see attached **Exhibit D**).

(2) Letter of July 31, 2017 from Roper St. Francis to Maggie Murdock, DHEC (attached as **Exhibit E**).

(2) Power Point for August 24, 2017 DHEC Project Review Meeting, Roper St. Francis (see attached **Exhibit F**).

b. The Department's improper standard of review and burden shifting as evidenced by the Decision letter requires reversal of the decision.

c. The Department's decision exceeds its statutory authority and is erroneous.

d. The Department's decision was affected by error of law.

e. The Department's decision was clearly erroneous in view of the reliable, probative and substantial evidence on the whole record.

f. The Department's decision was arbitrary and capricious.

g. Roper St. Francis reserves the right to amend or supplement this Request.

**WHEREFORE**, Roper St. Francis seeks the following relief:

a. Reversing the Department's decision to approve MUSC's CON Application; and

b. Finding the Department's decision to be arbitrary, capricious, and affected by other error of law or fact; and

b. Denying MUSC's CON Application.

Respectfully submitted,

James G. Long, III
Jennifer J. Hollingsworth
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1230 Main Street, Suite 700 (29201)
Post Office Drawer 2426
Columbia, South Carolina 29202
803.771.8900

Attorneys for Petitioners,
CareAlliance Health Services d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital, and Roper St. Francis Berkeley Hospital

December 15, 2017
Columbia, South Carolina

# EXHIBIT A

dhec
Healthy People. Healthy Communities.

September 25, 2017

**VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED**

Patrick J. Cawley, MD
Medical University Hospital Authority
169 Ashley Avenue
Charleston, SC 29425

**Decision Granting Certificate of Need for:**
**Re:** Medical University Hospital Authority d/b/a MUSC Health Emergency Services
**Project:** Construction of a 15,300 sf Freestanding Emergency Department (FSED) in Berkeley County at a total project cost of $13,584,161.
**Matter No.** 2459

Dear Dr. Crawley:

The South Carolina Department of Health and Environmental Control (Department) has reviewed the application of Medical University Hospital Authority d/b/a MUSC Health Emergency Services (MUSC) to receive a Certificate of Need (CON) for the construction of a 15,300 sf Freestanding Emergency Department (FSED) in Berkeley County at a total project cost of $13,584,161 (Project). After consideration of the entire administrative record of this matter, the Department concludes MUSC has presented substantial evidence that the Project complies with the relevant project review criteria and with the *South Carolina Health Plan*, enacted August 13, 2015 (*Plan*). Accordingly, it is the decision of the Department that a Certificate of Need be issued for this Project. This decision is based on the following findings:

Pursuant to Regulation 61-15, Section 103(6), the following application is potentially competing with the above-referenced matter:

2440 - Summerville Medical Center, LLC d/b/a Summerville Freestanding ED (SMC); construction of a freestanding emergency department in Berkeley County at a total project cost of $13,079,900.

The Department concludes that the instant application and SMC's application do not meet the definition of "[c]ompeting applicants" pursuant to Regulation 61-15, Section 103.6. SMC and CareAlliance Health Services d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon-Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital, and Roper-St. Francis – Berkeley Hospital (collectively "Roper") are Affected Persons in this matter, pursuant to Regulation 61-15, Section 103.1, and both SMC and Roper oppose the Project. After considering documents and arguments submitted by the Affected Persons in opposition to the Project, including comments made at a project review meeting conducted by the Department in this matter on August 24, 2017, the Department finds that the opposition has not provided evidence sufficient to require denial of a CON for the Project.

**Compliance with the Need Outlined in the South Carolina State Health Plan**

1. *A Certificate of Need is required to establish a freestanding emergency service (also referred to as an off-campus emergency service).*

2. *All off-campus emergency services must be an extension of an existing hospital's emergency service in the same county, unless the applicant is proposing to establish a freestanding emergency service in a county that does not have a licensed hospital. The hospital must have a license that is in good standing and must be in operation to support the off-campus emergency services.*

3. *Regulation 61-16 will be used to survey off-campus emergency services, specifically including 24 hour/7 day per week physician coverage on site.*

4. *An off-campus emergency service must have written agreements with Emergency Medical Services providers and surrounding hospitals regarding serious medical problems, which the off-campus emergency service cannot handle.*

5. *The physical structure must meet Section 12-6 of the Life Safety Code, New Ambulatory Health Care Centers, and must specifically have an approved sprinkler system.*

6. *The applicant must demonstrate need for this service by documenting where the potential patients for this proposed service will come from and why they are not being adequately served by the existing services in the area.*

MUSC is located in Charleston County and seeks to establish the Project in Berkeley County. Berkeley County currently does not have a licensed hospital. MUSC has a license that is in good standing and is in operation to support the Project. MUSC has documented its compliance with the relevant Plan standards, including documentation showing where the

potential patients for the proposed Project will come from and why they are not being adequately served by the existing services in the area.

The Department finds that MUSC has sufficiently complied with 3 S.C. Code Reg. 61-15, Section 802.1.

**Community Need Documentation**

MUSC clearly identified its target population and, using population statistics consistent with those generated by the State Demographer, MUSC made reasonable projections of anticipated population changes, with assumptions and methodologies clearly outlined in the application. MUSC has sufficiently demonstrated that the proposed Project will meet an identified need and that the projected utilization of the Project is sufficient to justify its implementation.

The Department finds that MUSC has sufficiently complied with 3 S.C. Code Reg. 61-15, Section 802.2.

**Distribution (Accessibility)**

The Department finds that the Project will not result in unnecessary duplication or modernization of services based on MUSC's documentation regarding both need and accessibility. MUSC states that patients have access to MUSC by self-referral and by internal and external physician referral; that referrals derive from private physician practices, public clinics and other hospitals; and that access to the facility also comes from physicians affiliated with certain healthcare organizations listed by MUSC in its application. MUSC states that there are no limitations placed on admissions to the Project. MUSC states that any patient in need of services presenting to the facility has access to available services, and that all patients in need of ED services are accepted by MUSC regardless of age, race, religion, national origin, or ability to pay. MUSC provided its Patient Rights and Responsibilities policy, its charity care and financial assistance policies, and its historical and projected amount of indigent care to demonstrate that it has established provisions to insure that individuals in need of treatment as determined by a physician have access to the Project, regardless of ability to pay.

The Department finds that MUSC has sufficiently complied with 3 S.C. Code Reg. 61-15, Section 802.3.

**Medically Underserved Groups**

MUSC addressed the contribution of the Project in meeting the health needs of members of medically underserved groups, particularly uninsured, low-income, and indigent patients. The Department considered MUSC's historical and projected indigent care in comparison

with the percentage of population in the Project's service area which is medically underserved, and the extent to which the medically underserved populations are expected to use the Project if approved. The Department further considered MUSC's documented performance in meeting its obligation under applicable regulations requiring provision of uncompensated care, its indigent care plan, community service, and access by minorities and handicapped persons to programs receiving federal financial assistance. Finally, the Department considered the extent to which Medicare, Medicaid, and medically indigent patients are served by MUSC.

The Department finds that MUSC has sufficiently complied with 3 S.C. Code Reg. 61-15, Section 802.31.

**Financial Feasibility**

MUSC reasonably projected both the immediate and long-term financial feasibility of the Project using projected income statements that are based upon accepted accounting procedures. MUSC provided a letter from John Cooper, an accountant, stating that the information contained in the proforma was prepared by Hospital Finance, and certifying that all of the assumptions, calculations, and information contained in the projections were prepared accurately to the best of his knowledge.

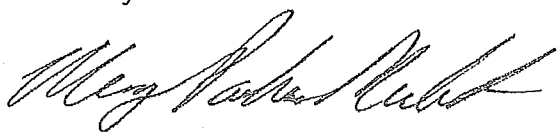
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The Department has determined that the requirements of 3 S.C. Code Reg. 61-15, Section 501 are not applicable to the Project.

The issuance of a Certificate of Need does not constitute approval for any proposed construction, licensing, or certification changes. You should contact the following individuals for information concerning these related issues: Bureau of Radiological Health, Mr. Aaron Gantt, (803) 545-4400; Division of Health Facilities Construction, Mr. William McCallum, (803) 545-4211; Division of Health Licensing, Ms. Gwendolyn Thompson, (803) 545-4370; and Bureau of Certification, Ms. MaryJo Roué, (803) 545-4293.

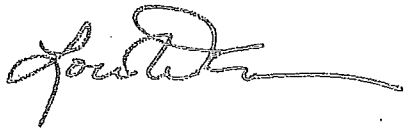
A copy of the Guide to Board Review is enclosed for your convenience.

Written By:



Maggie Parham Murdock
Director
Certificate of Need Program

Reviewed By:



Louis Eubank
Chief, Bureau of Healthcare
Planning and Construction

cc: Ralph W. Barbier, Esquire (via Certified Mail)
William R. Thomas, Esquire (via Certified Mail)
Matt Hasbrouck (via email)
Lisa Valentine (via email)
Daniel J. Westbrook, Esquire (via email)
Daniel Sullivan (via email)
Kathryn M.T. Platt (via email)
David Levitt (via email)

Enclosure: Guide to Board Review.

# South Carolina Board of Health and Environmental Control

## Guide to Board Review

## Pursuant to S.C. Code Ann. § 44-1-60

The decision of the South Carolina Department of Health and Environmental Control (Department) becomes the final agency decision fifteen (15) calendar days after notice of the decision has been mailed to the applicant, permittee, licensee and affected persons who have requested in writing to be notified, unless a written request for final review accompanied by a filing fee in the amount of $100 is filed with Department by the applicant, permittee, licensee or affected person.

Applicants, permittees, licensees, and affected parties are encouraged to engage in mediation or settlement discussions during the final review process.

If the Board declines in writing to schedule a final review conference, the Department's decision becomes the final agency decision and an applicant, permittee, licensee, or affected person may request a contested case hearing before the Administrative Law Court within thirty (30) calendar days after notice is mailed that the Board declined to hold a final review conference. In matters pertaining to decisions under the South Carolina Mining Act, appeals should be made to the South Carolina Mining Council.

### I. Filing of Request for Final Review

1. A written Request for Final Review (RFR) and the required filing fee of one hundred dollars ($100) must be received by Clerk of the Board within fifteen (15) calendar days after notice of the staff decision has been mailed to the applicant, permittee, licensee, or affected persons. If the 15th day occurs on a weekend or State holiday, the RFR must be received by the Clerk on the next working day. RFRs will not be accepted after 5:00 p.m.
2. RFRs shall be in writing and should include, at a minimum, the following information:
   - The grounds for amending, modifying, or rescinding the staff decision;
   - a statement of any significant issues or factors the Board should consider in deciding how to handle the matter;
   - the relief requested;
   - a copy of the decision for which review is requested; and
   - mailing address, email address, if applicable, and phone number(s) at which the requestor can be contacted.
3. RFRs should be filed in person or by mail at the following address:
   South Carolina Board of Health and Environmental Control
   Attention: Clerk of the Board
   2600 Bull Street
   Columbia, South Carolina 29201
   Alternatively, RFR's may be filed with the Clerk by facsimile (803-898-3393) or by electronic mail (boardclerk@dhec.sc.gov).
4. The filing fee may be paid by cash, check or credit card and must be received by the 15th day.
5. If there is any perceived discrepancy in compliance with this RFR filing procedure, the Clerk should consult with the Chairman or, if the Chairman is unavailable, the Vice-Chairman. The Chairman or the Vice-Chairman will determine whether the RFR is timely and properly filed and direct the Clerk to (1) process the RFR for consideration by the Board or (2) return the RFR and filing fee to the requestor with a cover letter explaining why the RFR was not timely or properly filed. Processing an RFR for consideration by the Board shall not be interpreted as a waiver of any claim or defense by the agency in subsequent proceedings concerning the RFR.
6. If the RFR will be processed for Board consideration, the Clerk will send an Acknowledgement of RFR to the Requestor and the applicant, permittee, or licensee, if other than the Requestor. All personal and financial identifying information will be redacted from the RFR and accompanying documentation before the RFR is released to the Board, Department staff or the public.
7. If an RFR pertains to an emergency order, the Clerk will, upon receipt, immediately provide a copy of the RFR to all Board members. The Chairman, or in his or her absence, the Vice-Chairman shall based on the circumstances, decide whether to refer the RFR to the RFR Committee for expedited review or to decline in writing to schedule a Final Review Conference. If the Chairman or Vice-Chairman determines review by the RFR Committee is appropriate, the Clerk will forward a copy of the RFR to Department staff and Office of General Counsel. A Department response and RFR Committee review will be provided on an expedited schedule defined by the Chairman or Vice-Chairman.
8. The Clerk will email the RFR to staff and Office of General Counsel and request a Department Response within eight (8) working days. Upon receipt of the Department Response, the Clerk will forward the RFR and Department Response to all Board members for review, and all Board members will confirm receipt of the RFR to the Clerk by email. If a Board member does not confirm receipt of the RFR within a twenty-four (24) hour period, the Clerk will contact the Board member and confirm receipt. If a Board member believes the RFR should be considered by the RFR Committee, he or she will

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*NOTE: If the time periods described above end on a weekend or State holiday, the time is automatically extended to 5:00 p.m. on the next business day.*

9. If the RFR is to be considered by the RFR Committee, the Clerk will notify the Presiding Member of the RFR Committee and the Chairman that further review is requested by the Board. RFR Committee meetings are open to the public and will be public noticed at least 24 hours in advance.
10. Following RFR Committee or Board consideration of the RFR, if it is determined no Conference will be held, the Clerk will send a letter by certified mail to the Requestor, with copy by regular mail to the applicant, permittee, or licensee, if not the Requestor, stating the Board will not hold a Conference. Contested case guidance will be included within the letter.

## II. Final Review Conference Scheduling

1. If a Conference will be held, the Clerk will send a letter by certified mail to the Requestor, with copy by regular mail to the applicant, permittee, or licensee, if not the Requestor, informing the Requestor of the determination.
2. The Clerk will request Department staff provide the Administrative Record.
3. The Clerk will send Notice of Final Review Conference to the parties at least ten (10) days before the Conference. The Conference will be publically noticed and should:
   - include the place, date and time of the Conference;
   - state the presentation times allowed in the Conference;
   - state evidence may be presented at the Conference;
   - if the conference will be held by committee, include a copy of the Chairman's order appointing the committee; and
   - inform the Requestor of his or her right to request a transcript of the proceedings of the Conference prepared at Requestor's expense.
4. If a party requests a transcript of the proceedings of the Conference and agrees to pay all related costs in writing, including costs for the transcript, the Clerk will schedule a court reporter for the Conference.

## III. Final Review Conference and Decision

1. The order of presentation in the Conference will, subject to the presiding officer's discretion, be as follows:
   - Department staff will provide an overview of the staff decision and the applicable law to include [10 minutes]:
     - Type of decision (permit, enforcement, etc.) and description of the program.
     - Parties
     - Description of facility/site
     - Applicable statutes and regulations
     - Decision and materials relied upon in the administrative record to support the staff decision.
   - Requestor(s) will state the reasons for protesting the staff decision and may provide evidence to support amending, modifying, or rescinding the staff decision. [15 minutes] *NOTE: The burden of proof is on the Requestor(s)*
   - Rebuttal by Department staff [15 minutes]
   - Rebuttal by Requestor(s) [10 minutes]
     Note: Times noted in brackets are for information only and are superseded by times stated in the Notice of Final Review Conference or by the presiding officer.
2. Parties may present evidence during the conference; however, the rules of evidence do not apply.
3. At any time during the conference, the officers conducting the Conference may request additional information and may question the Requestor, the staff, and anyone else providing information at the Conference.
4. The presiding officer, in his or her sole discretion, may allow additional time for presentations and may impose time limits on the Conference.
5. All Conferences are open to the public.
6. The officers may deliberate in closed session.
7. The officers may announce the decision at the conclusion of the Conference or it may be reserved for consideration.
8. The Clerk will mail the written final agency decision (FAD) to parties within 30 days after the Conference. The written decision must explain the basis for the decision and inform the parties of their right to request a contested case hearing before the Administrative Law Court or in matters pertaining to decisions under the South Carolina Mining Act, to request a hearing before the South Carolina Mining Council.. The FAD will be sent by certified mail, return receipt requested.
9. Communications may also be sent by electronic mail, in addition to the forms stated herein, when electronic mail addresses are provided to the Clerk.

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

# EXHIBIT B

NEXSEN | PRUET

RECEIVED
OCT 06 2017
SC Department of
Health & Environmental Control

**Ralph W. Barbier**
Member
Admitted in SC

October 6, 2017

**VIA HAND DELIVERY AND EMAIL**

Ms. Lisa Lucas Longshore
Clerk of the Board
South Carolina Department of Health and Environmental Control
2600 Bull Street
Columbia, SC 29201

Re: Request for Final Review of the Department's decision, dated September 25, 2017, to award a Certificate of Need to Medical University Hospital Authority d/b/a MUSC Health Emergency Services for the construction of a 15,300 sf Freestanding Emergency Department (FSED) in Berkeley County at a total project cost of $13,584,161
Matter No. 2459

Charleston
Charlotte
**Columbia**
Greensboro
Greenville
Hilton Head
Myrtle Beach

Dear Ms. Longshore:

Pursuant to S.C. Code Ann. § 44-1-60(E) and (F); the South Carolina Certification of Need and Health Facility Licensure Act, S.C. Code Ann. § 44-7-110 *et seq.* (the "CON Act"); and S.C. Code Ann. Regs. 61-15, CareAlliance Health Services d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc. and Roper St. Francis Berkeley Hospital (collectively from time to time "Roper St. Francis") hereby submits this Request for Final Review of the South Carolina Department of Health and Environmental Control ("Department") staff's decision, dated September 25, 2017, to approve a CON to Medical University Hospital Authority d/b/a MUSC Health Emergency Services ("MUSC") for the above referenced project. The decision is attached hereto as Exhibit A.

The grounds for this request are that the application is inconsistent with the applicable CON laws and the South Carolina Health Plan. Further, the DHEC Staff should have denied this CON application for reasons set forth forth in the previous correspondence to the DHEC Staff attached hereto as Exhibit B. Furthermore, the DHEC Staff applied the incorrect standard of review/burden of proof on this application.

1230 Main Street
Suite 700 (29201)
PO Drawer 2426
Columbia, SC 29202
www.nexsenpruet.com

**T** 803.540.2004
**F** 803.727.1404
**E** RBarbier@nexsenpruet.com
Nexsen Pruet, LLC
**Attorneys and Counselors at Law**

Roper St. Francis requests that the Department Board grant a Final Review Conference and reverse the Department Staff's approval of this application.

Please find enclosed our Firm's check in the amount of $100 in payment of the filing fee for this Request.

Thank you for your consideration.

Very truly yours,

Ralph W. Barbier

cc: Louis Eubank (via email w/encs.)
Maggie Murdock (via email w/encs.)
Dan Westbrook (attorney for MUSC) (via email w/encs.)

# EXHIBIT A

dhec
Healthy People. Healthy Communities.

September 25, 2017

**VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED**
Patrick J. Cawley, MD
Medical University Hospital Authority
169 Ashley Avenue
Charleston, SC 29425

**Decision Granting Certificate of Need for:**
**Re:** Medical University Hospital Authority d/b/a MUSC Health Emergency Services
**Project:** Construction of a 15,300 sf Freestanding Emergency Department (FSED) in Berkeley County at a total project cost of $13,584,161.
**Matter No.** 2459

Dear Dr. Crawley:

The South Carolina Department of Health and Environmental Control (Department) has reviewed the application of Medical University Hospital Authority d/b/a MUSC Health Emergency Services (MUSC) to receive a Certificate of Need (CON) for the construction of a 15,300 sf Freestanding Emergency Department (FSED) in Berkeley County at a total project cost of $13,584,161 (Project). After consideration of the entire administrative record of this matter, the Department concludes MUSC has presented substantial evidence that the Project complies with the relevant project review criteria and with the *South Carolina Health Plan*, enacted August 13, 2015 (*Plan*). Accordingly, it is the decision of the Department that a Certificate of Need be issued for this Project. This decision is based on the following findings:

Pursuant to Regulation 61-15, Section 103(6), the following application is potentially competing with the above-referenced matter:

2440 - Summerville Medical Center, LLC d/b/a Summerville Freestanding ED (SMC); construction of a freestanding emergency department in Berkeley County at a total project cost of $13,079,900.

The Department concludes that the instant application and SMC's application do not meet the definition of "[c]ompeting applicants" pursuant to Regulation 61-15, Section 103.6. SMC and CareAlliance Health Services d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon-Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital, and Roper-St. Francis – Berkeley Hospital (collectively "Roper") are Affected Persons in this matter, pursuant to Regulation 61-15, Section 103.1, and both SMC and Roper oppose the Project. After considering documents and arguments submitted by the Affected Persons in opposition to the Project, including comments made at a project review meeting conducted by the Department in this matter on August 24, 2017, the Department finds that the opposition has not provided evidence sufficient to require denial of a CON for the Project.

**Compliance with the Need Outlined in the South Carolina State Health Plan**

1. *A Certificate of Need is required to establish a freestanding emergency service (also referred to as an off-campus emergency service).*

2. *All off-campus emergency services must be an extension of an existing hospital's emergency service in the same county, unless the applicant is proposing to establish a freestanding emergency service in a county that does not have a licensed hospital. The hospital must have a license that is in good standing and must be in operation to support the off-campus emergency services.*

3. *Regulation 61-16 will be used to survey off-campus emergency services, specifically including 24 hour/7 day per week physician coverage on site.*

4. *An off-campus emergency service must have written agreements with Emergency Medical Services providers and surrounding hospitals regarding serious medical problems, which the off-campus emergency service cannot handle.*

5. *The physical structure must meet Section 12-6 of the Life Safety Code, New Ambulatory Health Care Centers, and must specifically have an approved sprinkler system.*

6. *The applicant must demonstrate need for this service by documenting where the potential patients for this proposed service will come from and why they are not being adequately served by the existing services in the area.*

MUSC is located in Charleston County and seeks to establish the Project in Berkeley County. Berkeley County currently does not have a licensed hospital. MUSC has a license that is in good standing and is in operation to support the Project. MUSC has documented its compliance with the relevant Plan standards, including documentation showing where the

potential patients for the proposed Project will come from and why they are not being adequately served by the existing services in the area.

The Department finds that MUSC has sufficiently complied with 3 S.C. Code Reg. 61-15, Section 802.1.

**Community Need Documentation**

MUSC clearly identified its target population and, using population statistics consistent with those generated by the State Demographer, MUSC made reasonable projections of anticipated population changes, with assumptions and methodologies clearly outlined in the application. MUSC has sufficiently demonstrated that the proposed Project will meet an identified need and that the projected utilization of the Project is sufficient to justify its implementation.

The Department finds that MUSC has sufficiently complied with 3 S.C. Code Reg. 61-15, Section 802.2.

**Distribution (Accessibility)**

The Department finds that the Project will not result in unnecessary duplication or modernization of services based on MUSC's documentation regarding both need and accessibility. MUSC states that patients have access to MUSC by self-referral and by internal and external physician referral; that referrals derive from private physician practices, public clinics and other hospitals; and that access to the facility also comes from physicians affiliated with certain healthcare organizations listed by MUSC in its application. MUSC states that there are no limitations placed on admissions to the Project. MUSC states that any patient in need of services presenting to the facility has access to available services, and that all patients in need of ED services are accepted by MUSC regardless of age, race, religion, national origin, or ability to pay. MUSC provided its Patient Rights and Responsibilities policy, its charity care and financial assistance policies, and its historical and projected amount of indigent care to demonstrate that it has established provisions to insure that individuals in need of treatment as determined by a physician have access to the Project, regardless of ability to pay.

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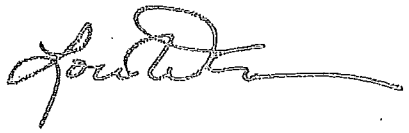
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Written By:



Maggie Parham Murdock
Director
Certificate of Need Program

Reviewed By:



Louis Eubank
Chief, Bureau of Healthcare
Planning and Construction

cc: Ralph W. Barbier, Esquire (via Certified Mail)
William R. Thomas, Esquire (via Certified Mail)
Matt Hasbrouck (via email)
Lisa Valentine (via email)
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Enclosure: Guide to Board Review.

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   - Rebuttal by Department staff [15 minutes]
   - Rebuttal by Requestor(s) [10 minutes]

   Note: Times noted in brackets are for information only and are superseded by times stated in the Notice of Final Review Conference or by the presiding officer.
2. Parties may present evidence during the conference; however, the rules of evidence do not apply.
3. At any time during the conference, the officers conducting the Conference may request additional information and may question the Requestor, the staff, and anyone else providing information at the Conference.
4. The presiding officer, in his or her sole discretion, may allow additional time for presentations and may impose time limits on the Conference.
5. All Conferences are open to the public.
6. The officers may deliberate in closed session.
7. The officers may announce the decision at the conclusion of the Conference or it may be reserved for consideration.
8. The Clerk will mail the written final agency decision (FAD) to parties within 30 days after the Conference. The written decision must explain the basis for the decision and inform the parties of their right to request a contested case hearing before the Administrative Law Court or in matters pertaining to decisions under the South Carolina Mining Act, to request a hearing before the South Carolina Mining Council.. The FAD will be sent by certified mail, return receipt requested.
9. Communications may also be sent by electronic mail, in addition to the forms stated herein, when electronic mail addresses are provided to the Clerk.

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

# EXHIBIT B

*Platt HMC, Inc.*
*Health Management Consulting*

881 Piedmont Avenue, Atlanta, Georgia 30309
Phone: 404-728-1974 • Fax: 404-728-1975

July 21, 2017

Maggie Murdock, Director
Certificate of Need Program
SC Department of Health and Environmental Control
2600 Bull Street
Columbia, SC 29201

Re: Medical University Hospital Authority d/b/a MUSC Health Emergency Services
Construction of a 15,300 sf Freestanding Emergency Department (FSED) in Berkeley County at a total project cost of $13,584,161
Matter No: 2459

Dear Ms. Murdock:

On behalf of our client, Care Alliance Health Services d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours St. Francis Xavier Hospital, Inc., Roper Mt. Pleasant Hospital, Inc. and Roper St. Francis - Berkeley Hospital, Inc. (collectively from time to time "Roper St. Francis"), an "affected person" for the above-referenced matter, we submit the following written opposition. Medical University Hospital Authority d/b/a MUSC Health Emergency Services ("MUSC") proposes to develop a new off-campus emergency service or freestanding emergency department ("FSED") to serve an area that already has multiple existing and approved emergency department ("ED") providers, additions, and expansions underway. The proposed project will not enhance geographic access to an underserved population and it will not promote cost containment. This analysis will show that the proposed service area is already well-served and that the application does not meet an identified need or conform to the project review criteria deemed to be most important by the Department.

*Background*

In its application, MUSC proposes to develop a new FSED to be located in Summerville, Berkeley County approximately 23.87 miles from its existing hospital located in downtown Charleston, Charleston County. MUSC does not operate a hospital in Berkeley County.

There are two approved hospitals in Berkeley County that will have significant ED capacity including Roper St. Francis Hospital - Berkeley ("RSFH - Berkeley") and Berkeley Medical Center, an affiliate of Trident Medical Center. As will be described, there are numerous other existing hospital and FSEDs in the vicinity of the proposed MUSC FSED with abundant capacity.

As will be presented in detail, the MUSC FSED cannot be approved because it fails to meet the following criteria and State Health Plan Standards:

- The proposed project cannot meet Standards 2 and 6 of the State Health Plan.
- The proposed project cannot identify a community need based on the abundance of existing and approved ED capacity in the Tri-County and specifically Berkeley County.
- MUSC has not adequately defined its service area and the proposed population it intends to serve.
- The location of the proposed FSED does not meet a community need, improve access, or promote cost containment

*The Project Fails to Meet State Health Plan Standards for Freestanding Hospital Services and Most Important Project Review Criteria*

At a minimum, MUSC fails to meet Standards 2 and 6 of the Freestanding Hospital Services Section of the South Carolina Health Plan (SHP) under which this project is being reviewed. Specifically, Standard 2 states,

> ***"All off-campus emergency services must be an extension of an existing hospital's emergency service in the same county, unless the applicant is proposing to establish a freestanding emergency service in a county that does not have a licensed hospital. The hospital must have a license that is in good standing and must be in operation to support the off-campus emergency services."***

To address this Standard, the Applicant states, "The Freestanding ED will be licensed under and operated as a department of MUSC, functioning as an extension of MUSC's existing hospital-based ED. MUSC has a license in good standing and is prepared to support the freestanding ED (Application, p.24)." MUSC Medical Center is located in Charleston County and not in Berkeley County where the proposed FSED will be located. Under Standard 2, MUSC is permitted to establish a FSED in Charleston County, the hospital's same county.

MUSC can only establish an FSED in a "county that does not have a licensed hospital". This standard was established to recognize that an FSED can expand access in a county without a hospital. As the Department is aware, two hospitals are approved and underway in Berkeley County. Therefore, MUSC's proposed project does not meet this State Health Plan Standard.

Further, the intent of this Standard is to establish freestanding providers of ED services that have the most proximal geographic access to hospital-based services in the event that a patient needs a higher level of care. MUSC Medical Center, located 23.8 miles from the proposed site, is among the least proximal hospital-based providers in the Tri-County area from the proposed facility location.

In addition, Standard 6 states,

> **"The applicant must demonstrate need for this service by documenting where the potential patients for this proposed service will come from and why they are not being adequately served by the existing services in the area."**

MUSC does not meet either aspect of this Standard. As will be described in detail below, the Applicant identifies a vague service area for this project. It anticipates serving all of Berkeley and Dorchester Counties at different, but unidentified levels and anticipates serving some of Charleston County, but does not identify which areas of Charleston County it will and will not serve . In addition, MUSC fails to show why the service area is not being adequately served by the existing providers in the area. As discussed in detail below, the application fails to identify any current barriers to access and why this project is needed.

The Department identifies the most important criteria for this project to be community need, distribution (accessibility), medically underserved groups, and financial feasibility. Based on these criteria, the Department appears to be evaluating this application on increased accessibility to an underserved community. As will be described, there is abundant access to ED services for the primary service area identified by the Applicant. In fact, the ZIP code in which the Applicant proposes to locate is receiving ED services at rates well above the county, Tri-County area, State and national averages. The service area does not appear to be medically underserved in terms of accessing ED services. From a geographic perspective, MUSC proposes to locate another ED provider in the center of three existing/approved hospital-based EDs. MUSC has not demonstrated that this area is experiencing extended wait times, extended travel time, or access issues in and to the current EDs.

*There is an Abundance of Existing and Approved ED Capacity to Serve the Tri-County Area*

There are numerous existing and approved providers of ED services in the Tri-County area to meet the needs of the service area defined by the applicant. While the project is proposed to be located at the border of Berkeley and Dorchester Counties, it is necessary to consider all ED providers in the Tri-County area in this analysis given the Applicant's vague definition of the Tri-County services area (page 19) and description of patients it intends to serve.

**Exhibit 1** below shows all existing and approved providers of ED services in Berkeley, Charleston, and Dorchester Counties. **Exhibit 2** provides a map of the location of each of these providers. There are currently eight hospital-based providers and four freestanding providers of ED services in the Applicant's service area. Four of the Twelve existing and approved providers are located in Berkeley County.

## Exhibit 1

## Inventory of Existing and Approved ED Providers

| Facility | Affiliation | Type | Status | Location |
|---|---|---|---|---|
| Bon Secours St. Francis | Roper St. Francis | Hospital | Existing | Charleston/ West Ashley |
| Roper Hospital | Roper St. Francis | Hospital | Existing | Charleston/ Peninsula |
| Mount Pleasant Hospital | Roper St. Francis | Hospital | Existing | Charleston/ Mt. Pleasant |
| MUSC Medical Center | MUSC | Hospital | Existing | Charleston/ Peninsula |
| Trident Medical Center | Trident | Hospital | Existing and Approved for Expansion | Charleston/ North Charleston |
| Summerville Medical Center | Trident | Hospital | Existing | Dorchester County |
| RSFH - Berkeley | Roper St. Francis | Hospital | Approved | Berkeley County |
| Berkeley Medical Center | Trident | Hospital | Approved | Berkeley County |
| Roper Hospital Diagnostics and ER - Northwoods | Roper St. Francis | Freestanding | Existing and Approved for Relocation/ Expansion | Charleston/ North Charleston |
| Roper Hospital Diagnostics and ER - Berkeley | Roper St. Francis | Freestanding | Existing | Berkeley County/ Moncks Corner |
| Moncks Corner Medical Center | Trident | Freestanding | Existing | Berkeley County/ Moncks Corner |
| Centre Point Emergency | Trident | Freestanding | Existing | Charleston/ North Charleston |

## Exhibit 2
## Tri-County Emergency Department Providers

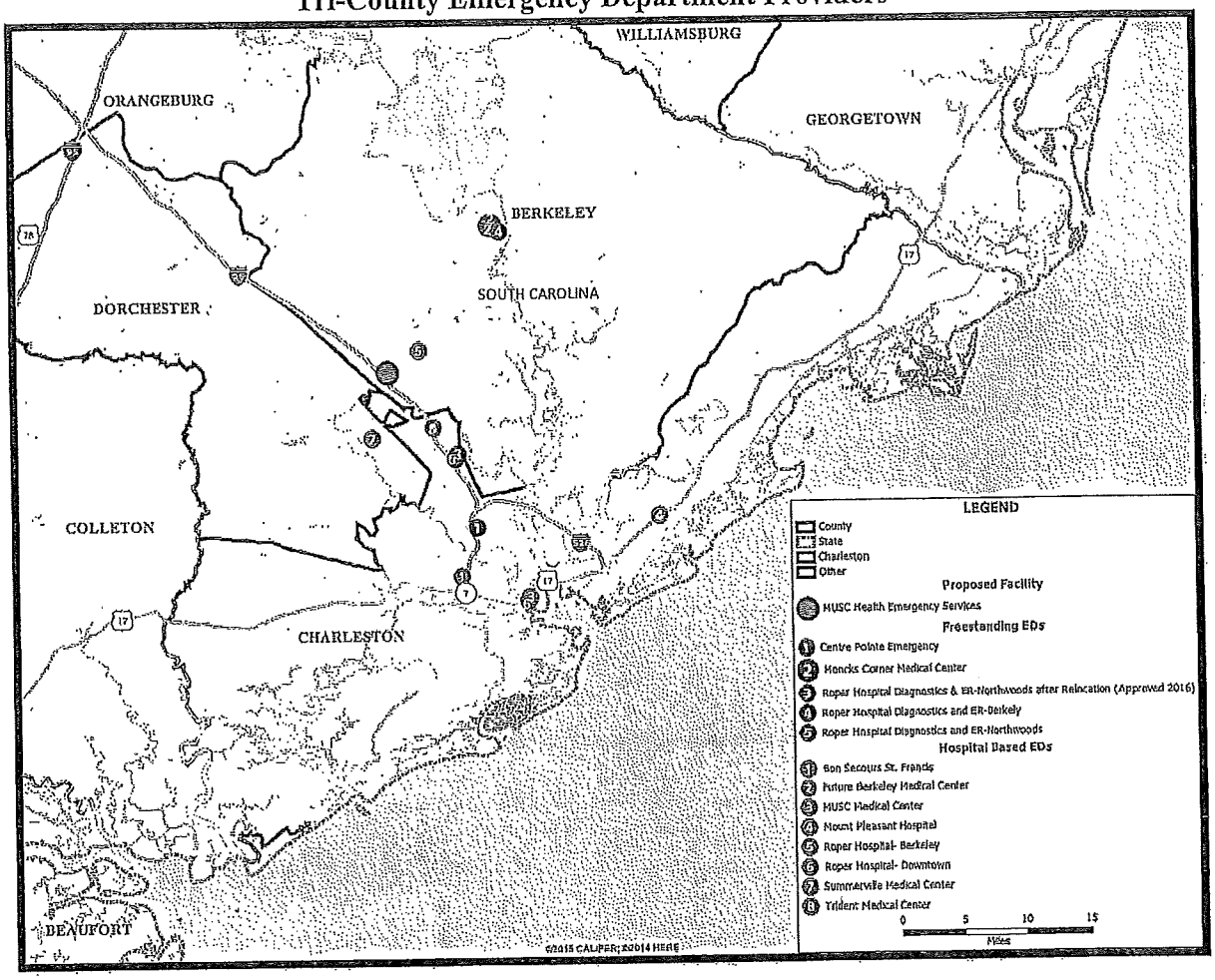


**Exhibit 3** shows the time and distance to all existing providers of ED services from MUSC's proposed location. There are currently three providers of ED services within a 7.5 mile driving distance of the MUSC FSED and an additional five providers within a 20-mile driving distance of the proposed facility.

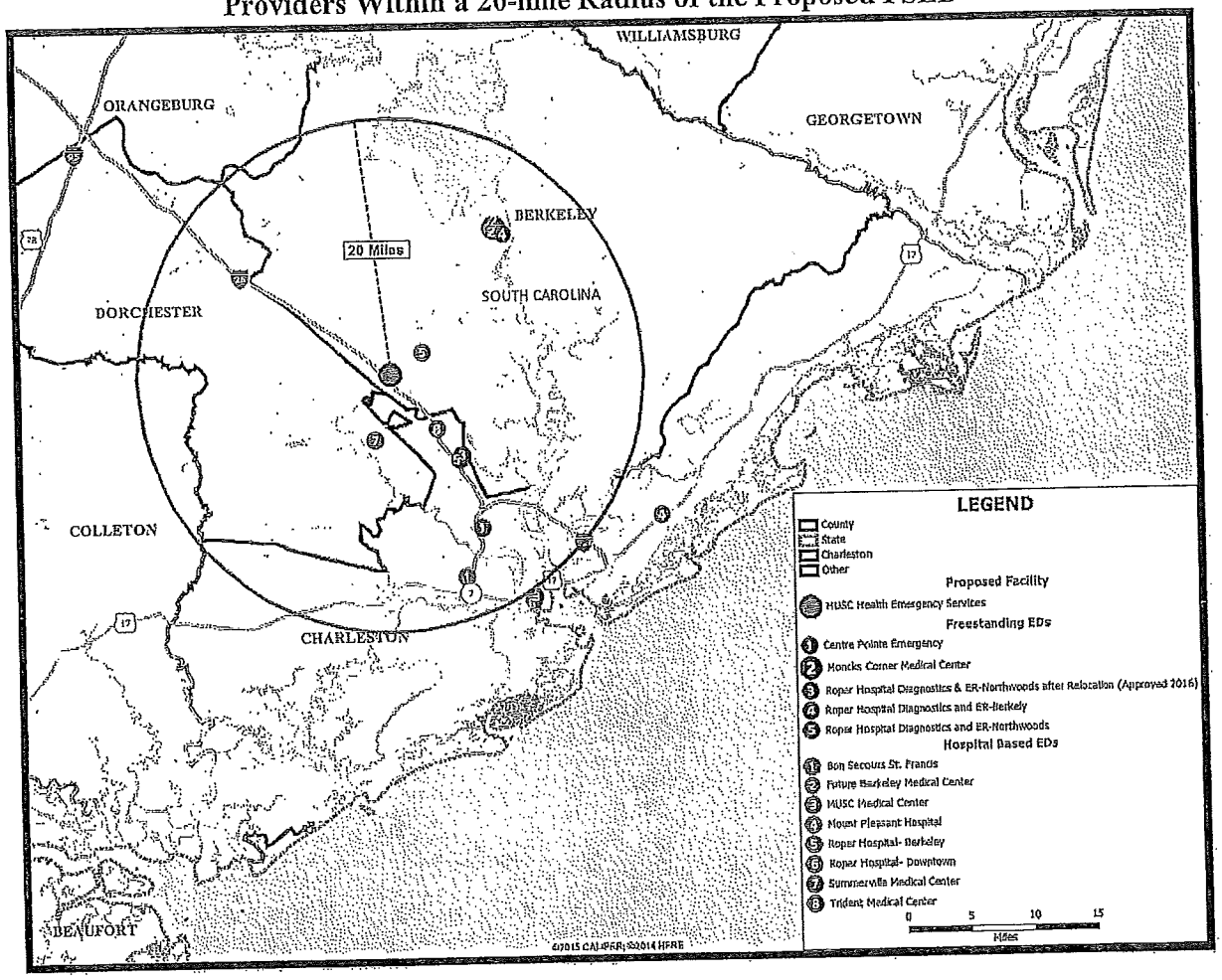
**Exhibit 3**
**Drive Time Analysis**

| **Distance from Proposed MUSC Health Emergency Services to:** | | |
|---|---|---|
| **Facility** | **Distance (miles)** | **Time (minutes)** |
| Roper St. Francis- Berkeley | 3.9 | 8 |
| Trident Medical Center | 7.5 | 11 |
| Summerville Medical Center | 7.5 | 18 |
| Roper Hospital Diagnostics & ER- Northwoods (Existing) | 11 | 15 |
| Roper Hospital Diagnostics & ER- Northwoods (Relocated) | 12 | 17 |
| Moncks Corner Medical Center | 15.4 | 22 |
| Berkeley Medical Center | 15.4 | 22 |
| Centre Pointe Emergency | 16.2 | 18 |
| Roper Hospital Diagnostics & ER- Berkeley | 16.4 | 26 |
| Bon Secours St. Francis | 20.9 | 25 |
| MUSC Medical Center | 23.8 | 31 |
| Roper Hospital- Downtown | 24.1 | 28 |
| Mount Pleasant Hospital | 33.4 | 40 |

*Source: Google Maps 2017*

**Exhibit 4** illustrates further the number of ED providers that are already proximal to the site for the proposed project. As the crow flies, there are nine existing and approved providers within 20 miles of the proposed site. **Exhibit 4** also shows that the proposed site for this project is in the center of three existing providers of ED services. The location in and of itself does not demonstrate a geographic need.

**Exhibit 4**
**Providers Within a 20-mile Radius of the Proposed FSED**




There is also significant additional ED capacity approved, but not yet operational, that will serve the proposed service area. First, Roper St. Francis Hospital - Berkeley, which will have a full-service, 24-hour Emergency Department, is slated for completion in 2019, just after the proposed FSED is slated to open. RSFH - Berkeley is located less than four miles from the proposed project and will serve patients originating from the identified service area.

In addition, Trident Medical Center was issued a CON in 2016 to expand its existing hospital-based Emergency Department. Construction for this expansion began in January 2017 and is currently underway. Trident Medical Center is located 7.5 miles from the proposed facility. Based on timelines provided to the Department, it appears that the Trident Medical Center ED

expansion, the RSFH - Berkeley ED, and the proposed project are all scheduled to come online within an approximate one-year period.

Finally, Roper Hospital Diagnostics and ER – Northwoods was approved by the Department to relocate in late 2016. As part of this relocation, Roper will add five additional patient bays that will come online three years from the date of the initial licensure of the relocated facility. Roper Hospital Diagnostics and ER – Northwoods is located twelve miles from the proposed site for MUSC's FSED.

**Exhibit 5** summarizes the significant amount of approved new ED capacity within 20 miles of MUSC's proposed location along with MUSC's planned capacity. There will be capacity to provide 123,000 additional ED visits established based on CON applications that have already been approved. If MUSC's application is approved, there will be an additional 36,000 visit capacity in addition for a total new capacity of 159,000 visits. This amount of new ED capacity is simply unnecessary and MUSC has not provided any facts or analysis to show more capacity is needed or that there is any unmet need. It should also be noted that MUSC projects to provide approximately 17,000 visits in the new FSED with a proposed capacity of 32,000. MUSC's projections do not support its own facility.

**Exhibit 5**

**Incremental Approved and Proposed ED Capacity**

| Provider | Bays | Visit Capacity per Bay | Total Visit Capacity |
|---|---|---|---|
| Trident Medical Center (Expansion) | 8 | 3,000 | 24,000 |
| Roper Hospital Diagnostics and ER - Northwoods (Expansion) | 5 | 3,000 | 15,000 |
| Roper St. Francis Hospital - Berkeley | 15 | 3,000 | 45,000 |
| Berkeley Medical Center | 13 | 3,000 | 39,000 |
| Proposed MUSC FSED* | 12 | 3,000 | 36,000 |
| **Total NEW Capacity within 20 Mile Radius** | 53 | 3,000 | 159,000 |

*Assumes capacity of 3,000 based on approximately 8 visits per day*
** CON #. Does not include two mental health rooms.*
***MUSC application Attachment B. In addition to 12 treatment bays, MUSC proposes 5 CDU/Observation rooms, 5 triage bays a resuscitation area larger than two treatment bays.*

Given that the Trident Medical Center ED expansion and the RSFH - Berkeley ED are slated to come online within a year of the initiation of the proposed facility and that Roper Hospital Diagnostics and ER – Northwoods will expand in the coming years, it is premature to add more ED capacity in the same overlapping service area until the providers which have already been approved are operational and the system impact on the existing ED providers can be determined.

*The Applicant's Proposal Does Not Adequately Identify the Service Area or the Population that it Anticipates Serving with the Proposed Project*

The Applicant identifies the service area to be Berkeley, Charleston, and Dorchester Counties on page 19 of the application based on its historical patient origin for MUSC Medical Center's existing ED. However, on page 23 of the application, MUSC clarifies that the patient origin is based by ZIP code, "mainly ZIP codes in Berkeley and Dorchester Counties plus a small number of ZIP codes in Charleston County." The Applicant never identifies the specific ZIP codes it anticipates serving and those from which it will shift patients, in part, from the MUSC ED to the FSED. Further, MUSC never identifies the percent shift it anticipates for each specific ZIP code. The most specific information provided by the applicant relative to its methodology for projecting utilization is listed on page 23. It states:

> *"Berkeley County resident redirection by ZIP Code ranged from 25% to 75%. Dorchester County resident redirection by ZIP Code ranged from 25% to 75%. Charleston County redirection by ZIP Code ranged from 0% to 60%."*

MUSC goes on to present the projected utilization without quantitatively identifying its assumed shift by ZIP or county. Based on this information, it is impossible to assess what level of redirection the Applicant anticipates for each ZIP and for which areas of Charleston County the Applicant anticipates no shift at all. As a result, it is not possible to assess the Applicant's analysis or methodology for reasonableness and accuracy.

The applicant claims to entirely shift patients within the system from MUSC to the FSED, though MUSC is located 23.87 miles or a 30-minute drive-time away from the proposed facility. While not specifically quantified in the application, it appears that much of the shift comes from Berkeley and Dorchester Counties. Based on data provided by the Applicant, only 12.1 percent of its existing ED patients originate from Berkeley County and only 9.4 percent of ED patients originate from Dorchester County. This is likely because the MUSC ED is not proximal to these locations. As a result, the proposed site does not result in a natural extension of its existing ED as intended by the State Health Plan.

There are a number of other hospital-based providers in the area, including Roper St. Francis Hospital – Berkeley, that are much more convenient to the proposed site. It is a more natural extension of services for these providers to operate a FSED to serve residents of Berkeley and Dorchester Counties than MUSC which only offers hospital-based services on the peninsula of Charleston. In fact, the intent of the State Health Plan is to require that an FSED operate as and extension of a hospital ED in the same county, unless proposed in a county without a hospital. It is a well-known fact, that RSFH - Berkeley is approved and under development in Berkeley County. MUSC is applying under the caveat that Roper St. Francis Hospital – Berkeley, while underway, is not yet operational.

MUSC repeatedly emphasizes the differentiating factors for this project throughout the application, alluding to enhanced service offerings at the proposed facility due to its linkage with

the specialists that come with an academic medical center and a Level 1 trauma center[1]. MUSC is indeed an academic medical center and a Level 1 Trauma center with access to the highest level of specialist in the state. However, to access this level of care, if needed, a patient must be transferred to the hospital downtown. The cadre of specialists that come with an academic medical center will not be readily available at the proposed FSED. Should a patient present to the FSED needing this level of care, they will have to be transported 23.8 miles away to the hospital downtown. The differentiating factors presented in the application may differentiate the Applicant's hospital-based ED from other ED providers, but they do not apply to the proposed FSED. In fact, access to life-saving specialist may be delayed while a patient stops at the proposed FSED prior to transfer to MUSC more than 30 minutes away.

*The Location of the Proposed Freestanding ED Does Not Meet a Community Need, Improve Access, or Promote Cost Containment*

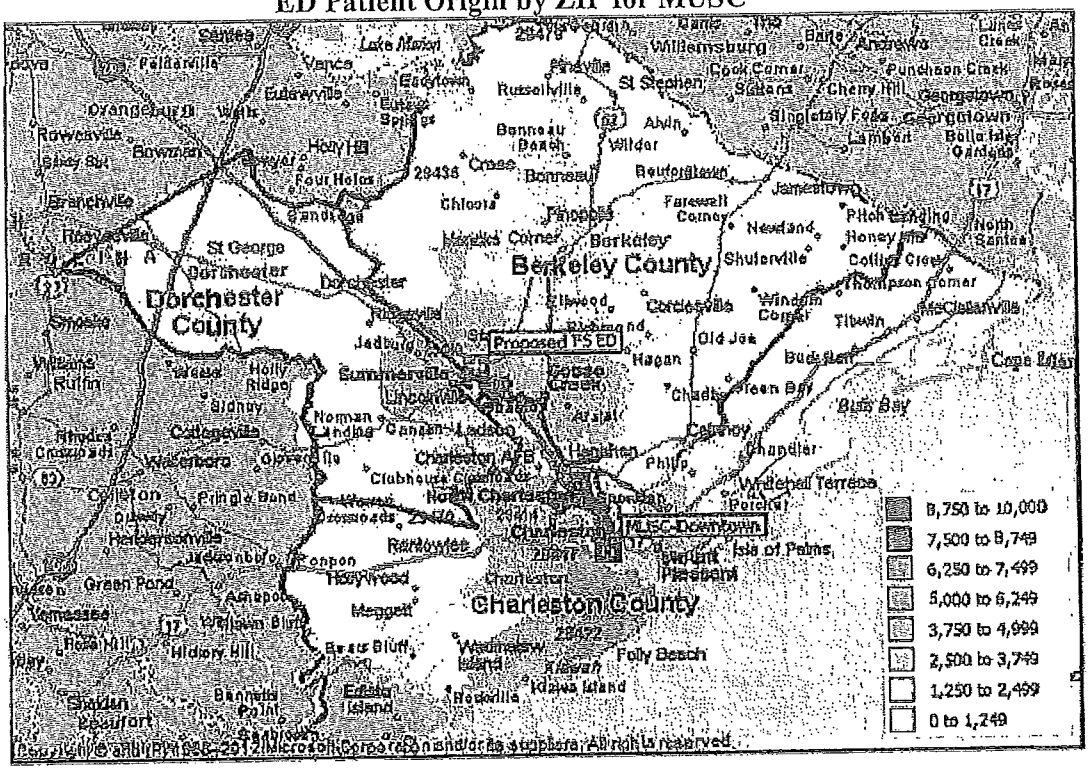
MUSC repeatedly cites improving access to ED services for its existing patient base while relieving capacity constraints at the downtown hospital as the impetus for this project.[2] However, the Applicant fails to document both of these claims.

First, MUSC never quantifies or describes any capacity constraints, wait times, or other issues experienced at the downtown hospital. It only quantifies the number of visits and a 5.2 percent growth in visits in the past three years (Application, p. 22). No other documentation or letters are provided to quantify capacity constraints for MUSC and document its present level of utilization in relation to capacity. Current average wait times are also not quantified or discussed within the application.

More importantly, the Applicant states that this project will shift its own patients to a more accessible location in order to alleviate the capacity constraints experienced at the hospital. However, this is not a logical assumption given the current patient origin presented in the application for this project. Exhibit 8 to the MUSC instant application shows the levels of patient origin throughout the Tri-County area and is included below as **Exhibit 6**.

[1] See Application pages 5, 17, 18, 25, and 27.
[2] See Application pages 6, 7, 10, 19, 25, 27, 33

**Exhibit 6**
**ED Patient Origin by ZIP for MUSC**




Most areas of Berkeley and Dorchester County are white, indicating patient volumes of 0-1,249. Even the areas directly surrounding the proposed facility have lower levels of patient origin. The fact that patients in these areas of low patient volume are currently bypassing other freestanding providers and community hospitals to seek care at MUSC indicates that the patients originating from ZIP codes surrounding and proximal to the proposed site are likely higher acuity patients seeking specialized care at a high level, hospital-based provider. This suggests that many of these patients would still bypass MUSC's proposed freestanding ED to seek care at the hospital-based emergency room, even if they had the option of the proposed FSED.

Further, as discussed and analyzed in detail above, the proposed project does not meet a geographic need. It is proposed to be situated between three ED providers and located in a county that currently has two other freestanding emergency departments. There are many other areas in the Tri-county area that have less geographic accessibility to ED services that are more proximal to MUSC's existing patient base if accessibility to its existing patients is genuinely the impetus for this project.

In addition, patients who reside within the ZIP code in which the proposed facility is to be located are accessing ED services at a rate well above the area and the state. As shown in **Exhibit 7** below, residents of ZIP Code 29483 experienced 72.4 visits per 100 population during the period for April 2015 - March 2016. In contrast, the Tri-County average and the State average are 41.6 and 43.3 visits per 100 population, respectively. This comparison indicates that a significant part of MUSC's proposed service area is already accessing ED services at a rate

well above others in the county, Tri-County area, and the state. It also suggests that there are sufficient ED providers available to this area, especially considering the expansions and additional providers that will come online in the next three years.

**Exhibit 7**
**Tri-County Area**
**Comparison of ED Visits per 100 Population**
**CY 2015**

| County | 2015 Visits per 100 Population |
|---|---|
| 29483 Summerville, SC* | 72.4 |
| Charleston County | 44.3 |
| Dorchester County | 42.1 |
| Berkeley County | 38.5 |
| Tri-County Average | 41.6 |
| State Average | 43.3 |

*Rate is for the time period 4/1/2015 -3/31/2016
*Sources: Data Request - Revenue and Fiscal Affairs Office, Application for Matter No. 2459, p27*

Overall, MUSC has not demonstrated that the proposed project is needed or will have any positive effect on the patient experience. The Applicant has not mentioned or demonstrated that there are currently capacity constraints among the existing providers in the area or that there are excessive wait times at the current ED providers. Moreover, MUSC has failed to demonstrate any capacity constraints or delays at its own hospital-based ED. In addition, MUSC has not demonstrated that there will be any cost savings to the patient or enhanced patient experience by using the proposed freestanding ED over one of the existing and approved EDs in the Tri-County area. The Applicant affirms in the application that the proposed FSED will operate as a hospital department and will utilize the same charge schedule of MUSC Medical Center. As a result, use of the freestanding ED will not result in any cost-efficiencies for the patient.

It should also be noted that in its financial projections, MUSC presents budgets for 2020-2023, while it states that the proposed project will come online in the second half of 2018.

In conclusion, the Applicant fails to demonstrate need for this project in terms of geographic and medical accessibility or any benefit to the patient in terms of cost or time savings, and as a result this project should not be approved based on, but not limited to, the reasons outlined above.

If you have any questions regarding these comments, please feel free to contact me.

Sincerely,

Kathryn M.T. Platt

Kathryn M.T. Platt
President

NEXSEN|PRUET

**Ralph W. Barbier**
Member
Admitted in SC

July 31, 2017

**VIA EMAIL AND U.S. MAIL**

murdocmp@dhec.sc.gov

Maggie P. Murdock, Esq.
Director, Certificate of Need Program
South Carolina Dept. of Health & Environmental Control
301 Gervais Street
Columbia, SC

Re: Medical University Hospital Authority d/b/a MUSC Emergency Services Construction of a 15,300 square foot Freestanding Emergency Department ("FSED") in Berkeley County at a total project cost of $13,584,161
Matter No: 2459

Charleston
Charlotte
**Columbia**
Greensboro
Greenville
Hilton Head
Myrtle Beach
Raleigh

Dear Ms. Murdock:

On behalf of our client CareAlliance Health Services d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital and Roper St. Francis - Berkeley Hospital, Inc. (collectively from time to time "Roper St. Francis"), please accept this letter as additional information in opposition to the referenced Certificate of Need application.

Under South Carolina law, "***The Department may not issue a Certificate of Need unless an application complies with the South Carolina Health Plan, project review criteria, and other regulations.***" *S.C. Code Ann. § 44-7-210(B)* (emphasis added). The South Carolina Health Plan under which the referenced Certificate of Need application is being reviewed clearly states that "***All off campus emergency services must be an extension of an existing hospital's emergency service in the same county ...***" *South Carolina Health Plan, Enacted August 13, 2015, Chapter XI, pg. IX-4 Standard 2.* The applicant MUSC does not have an existing hospital in Berkeley County, and therefore fails the first requirement under Standard 2. The only exception to this Standard is if the county in which the applicant proposes to locate a freestanding ED does not have a licensed hospital. As the Department is aware, both Roper St. Francis and Trident Medical Center were issued certificates of need and are currently in the process of

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**Attorneys and Counselors at Law**

constructing two 50-bed acute care hospitals in Berkeley County. Accordingly, as a matter of law, MUSC's application must be denied. It would lead to an absurd result if the exception to Standard 2 were interpreted to allow MUSC to open a freestanding ED at the same time that Roper St. Francis and Trident Medical Center are constructing two hospitals in Berkeley County. This would certainly run contrary to the intent of Standard 2 and violate South Carolina Code 44-7-21(B).

In interpreting standards in the South Carolina Health Plan, the South Carolina Court of Appeals has applied the common law rules of statutory construction:

> "A statute as a whole must receive practical, reasonable, and fair interpretation consonant with the purpose, design, and policy of lawmakers," and "the language of the statute must be read in a sense that harmonizes with its subject matter and accords with its general purpose."(citation and internal quotation marks omitted)); *id.* At 128-29, 750 S.F.2d at 63 (holding that words in a statute must be construed in context and that the court "may not, in order ****186** to give effect to particular words, virtually destroy the meaning of the entire context; that is, give the particular words a significance which would be clearly repugnant to the statute, looked at as a whole, and destructive to its obvious intent(citation and internal quotation marks omitted))."

Trident Medical Center v. South Carolina Dept. of Health and Environmental Control, 772 S.E.2d 177 (S.C. Ct. App. 2015) (citing Cf. Spark v. Palmetto Hardwood, Inc. 750 S.E.2d 61, 63 (S.C. 2013).

The South Carolina Supreme Court has further held:

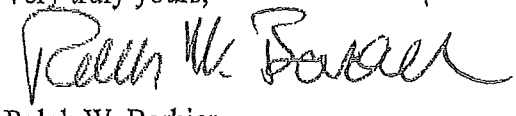
> "However, regardless of how plain the ordinary meaning of the words in a **statute**, courts will reject that meaning when to accept it would lead to a result so plainly absurd that it could not have been intended by the General Assembly."

Duke Energy Corp. v. South Carolina Dept. of Revenue, 772 S.E.2d 177 (S.C. 2015).

Roper St. Francis respectfully requests that the Department notify MUSC that this application fails Standard 2, and therefore, no further review of the application is required, and the application is denied as a matter of law.

Thank you for your consideration.

Very truly yours,



Ralph W. Barbier

cc: Shannon Cantwell
Kathy Platt

ROA 0149

# Comments in Response to Applications for Freestanding Emergency Departments in Berkeley County

ROPER ST. FRANCIS

**Roper St. Francis Healthcare**

**Matter Nos. 2440 and 2459**

**August 24, 2017**

# Overview

- There is abundant existing and approved access to ED services in the proposed service areas. As a result, there is no community need for these projects.
- MUSC Emergency Health Services fails to meet Standard 2 of the SHP and cannot be approved. In addition, it does not conform to other Standards and relevant Project Review Criteria.
- Summerville FSED fails to meet SHP Standards and Project Review Criteria as its application fails to show improved access to services and community need.

ROPER ST. FRANCIS

# There is No Community Need for Either of the Proposed Projects

- There is abundant access to emergency services in Berkeley County and for residents of the proposed service areas.
- Multiple providers have been granted expansions to existing projects and two new hospital based providers of ED services will come online in Berkeley County in the next two years
- Neither application quantifies or demonstrates any access or wait issues with current providers of ED services in the proposed service areas or within their own EDs.

ROPER ST. FRANCIS

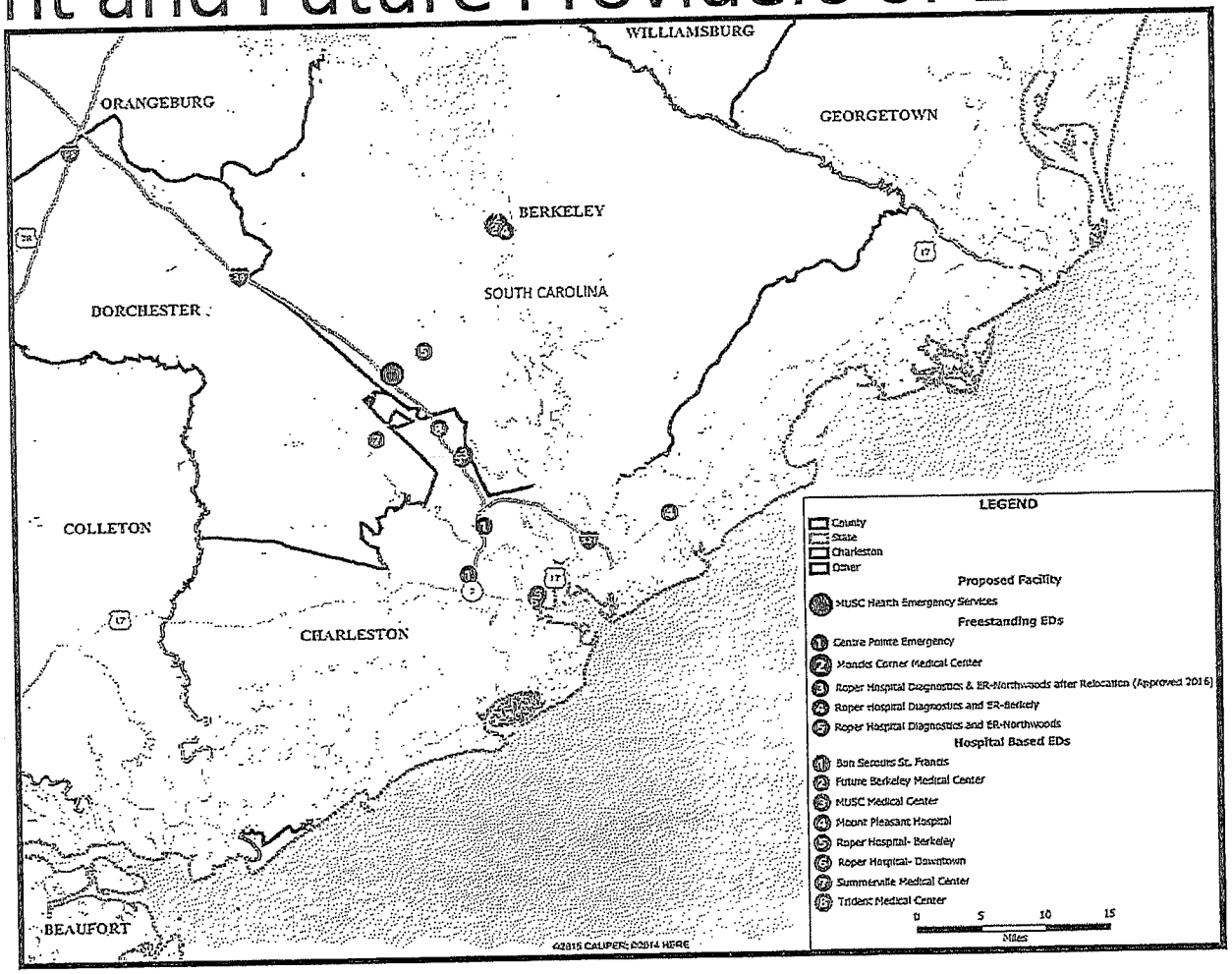
# Current and Future Providers of ED Services in the Tri-County Area

| Facility | Affiliation | Type | Status | Location |
|---|---|---|---|---|
| Bon Secours St. Francis | Roper St. Francis | Hospital | Existing | Charleston/ West Ashley |
| Roper Hospital | Roper St. Francis | Hospital | Existing | Charleston/ Peninsula |
| Mount Pleasant Hospital | Roper St. Francis | Hospital | Existing | Charleston/ Mt. Pleasant |
| MUSC Medical Center | MUSC | Hospital | Existing | Charleston/ Peninsula |
| Trident Medical Center | Trident | Hospital | Existing and Approved for Expansion | Charleston/ North Charleston |
| Summerville Medical Center | Trident | Hospital | Existing | Dorchester County |
| RSFH – Berkeley | Roper St. Francis | Hospital | Approved | Berkeley County |
| Berkeley Medical Center | Trident | Hospital | Approved | Berkeley County |
| Roper Hospital Diagnostics and ER - Northwoods | Roper St. Francis | Freestanding | Existing and Approved for Relocation/ Expansion | Charleston/ North Charleston |
| Roper Hospital Diagnostics and ER - Berkeley | Roper St. Francis | Freestanding | Existing | Berkeley County/ Moncks Corner |
| Moncks Corner Medical Center | Trident | Freestanding | Existing | Berkeley County/ Moncks Corner |
| Centre Point Emergency | Trident | Freestanding | Existing | Charleston/ North Charleston |

ROPER ST. FRANCIS

ROA 0153

# Current and Future Providers of ED Services




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# Both Proposed Facilities are Within 15 Miles of Six Existing Providers

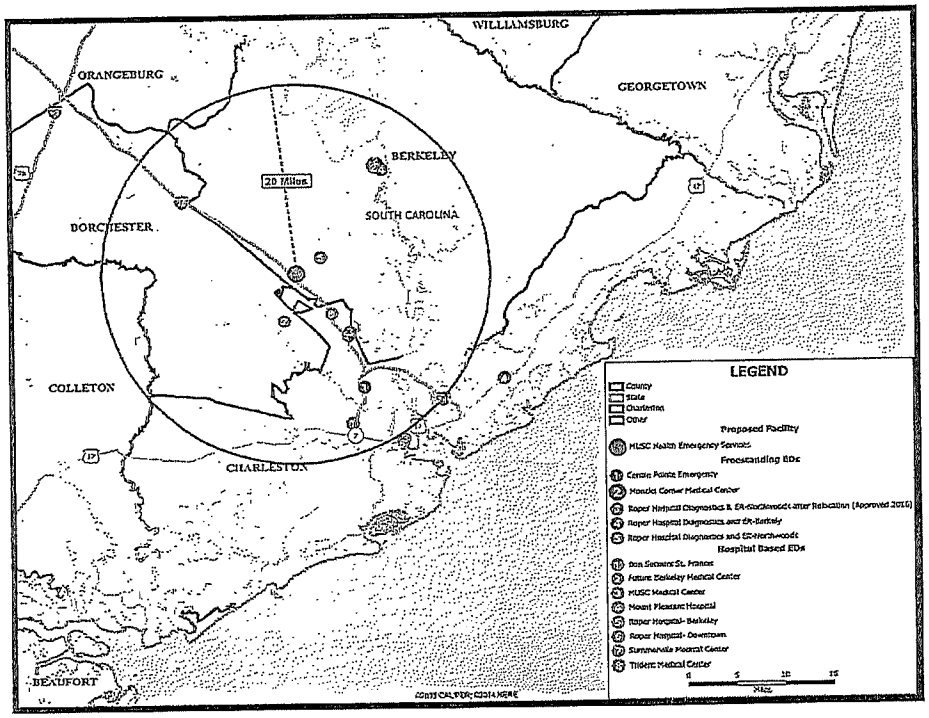
| | Proposed MUSC Health Emergency Department to: | | Proposed SMC ED to: | |
|---|---|---|---|---|
| Facility | Distance (miles) | Time (minutes) | Distance (miles) | Time (minutes) |
| Roper St. Francis- Berkeley | 3.9 | 8 | 3.4 | 7 |
| Trident Medical Center | 7.5 | 11 | 7.8 | 11 |
| Summerville Medical Center | 7.5 | 18 | 10.1 | 19 |
| Roper Hospital Diagnostics & ER- Northwoods (Existing) | 11 | 15 | 11.3 | 16 |
| Roper Hospital Diagnostics & ER- Northwoods (Relocated) | 12 | 17 | 12.3 | 17 |
| Moncks Corner Medical Center and Berkeley Medical Center | 15.4 | 22 | 15.2 | 22 |
| Centre Pointe Emergency | 16.2 | 18 | 16.2 | 20 |
| Roper Hospital Diagnostics & ER- Berkeley | 16.4 | 26 | 15.9 | 25 |
| Bon Secours St. Francis | 20.9 | 25 | 21 | 27 |
| MUSC Medical Center | 23.8 | 31 | 24.1 | 31 |
| Roper Hospital- Downtown | 24.1 | 28 | 24.1 | 31 |
| Mount Pleasant Hospital | 33.4 | 40 | 33.5 | 44 |

*Source: googlemaps.com 2017*

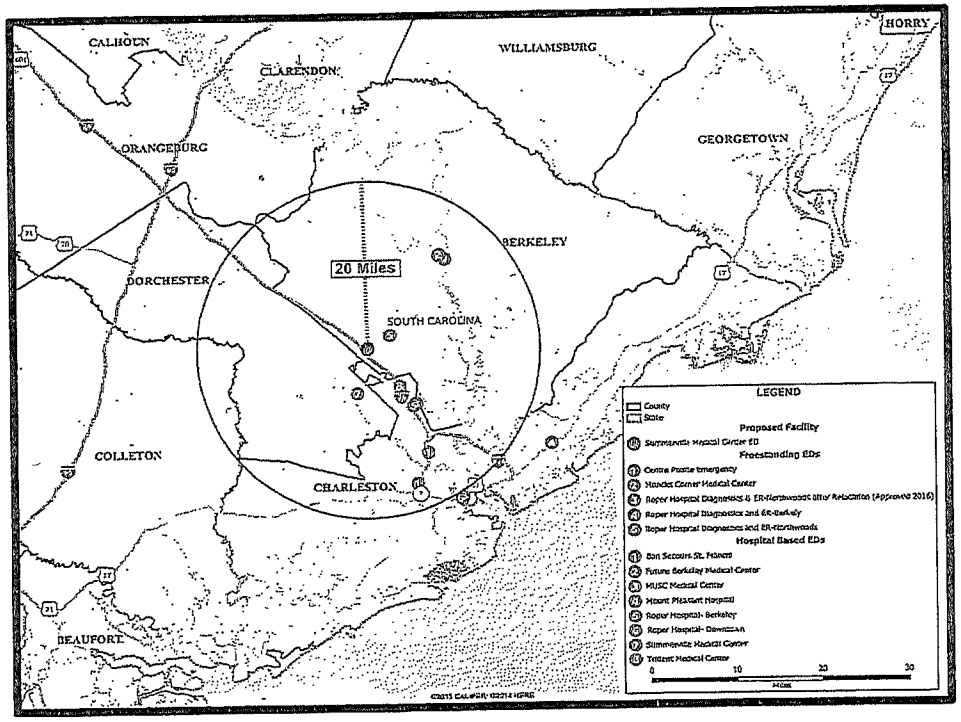
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# 20-mile Radius Maps

## MUSC Health Emergency Services




## Summerville Freestanding ED




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# Existing and Proposed Berkeley County ED Providers

- Existing and Approved Providers (4 Total)
  - Monks Corner Medical Center (Freestanding)
  - Roper Hospital Diagnostics and ER – Berkeley (Freestanding)
  - Berkeley Medical Center (Approved - Hospital Based)
  - Roper St. Francis – Berkeley (Approved – Hospital Based)

- Proposed Providers (2 Under Review)
  - MUSC Health Emergency Services
  - Summerville Freestanding ED

**If approved, there would be 6 ED providers in Berkeley County.**

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# Existing and Proposed ED Capacity in Berkeley County

| Provider | Bays | Visit Capacity per Bay | Total Visit Capacity |
|---|---|---|---|
| Monks Corner Medical Center | 8 | 3,000 | 24,000 |
| Roper Hospital Diagnostics and ER - Berkeley | 13 | 3,000 | 39,000 |
| Roper St. Francis Hospital - Berkeley | 15 | 3,000 | 45,000 |
| Berkeley Medical Center | 13 | 3,000 | 39,000 |
| Total Existing and Approved Capacity | 49 | 3,000 | 147,000 |
| Proposed MUSC FSED | 12 | 3,000 | 36,000 |
| Proposed Summerville FSED | 10 | 3,000 | 30,000 |
| Total Capacity after Proposed Projects | 71 | 3,000 | 213,000 |

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# Multiple ED Expansions are Underway in the Proposed Service Areas

| Provider | Bays | Visit Capacity per Bay | Total Visit Capacity | Distance from MUSC EHS | Distance from SFSED |
|---|---|---|---|---|---|
| Trident Medical Center (Expansion)* | 8 | 3,000 | 24,000 | 7.5 | 7.8 |
| Roper Hospital Diagnostics and ER - Northwoods (Expansion) | 5 | 3,000 | 15,000 | 12 | 12.3 |
| Roper St. Francis Hospital - Berkeley | 15 | 3,000 | 45,000 | 3.9 | 3.4 |
| Berkeley Medical Center | 13 | 3,000 | 39,000 | 15.4 | 15.2 |
| Proposed MUSC FSED | 12 | 3,000 | 36,000 | | |
| Proposed SFSED | 10 | 3,000 | 30,000 | | |
| Total NEW Capacity within 20 Mile Radius if both projects are approved | 63 | 3,000 | 189,000 | | |

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ROA 0159

# Introduction

John Walters, M.D.

Chairman

Roper St. Francis Emergency Services

ROPER ST. FRANCIS

ROA 0160

# MUSC Does Not Meet the SHP Standards for FSED and Does not Meet Other Relevant Project Review Criteria

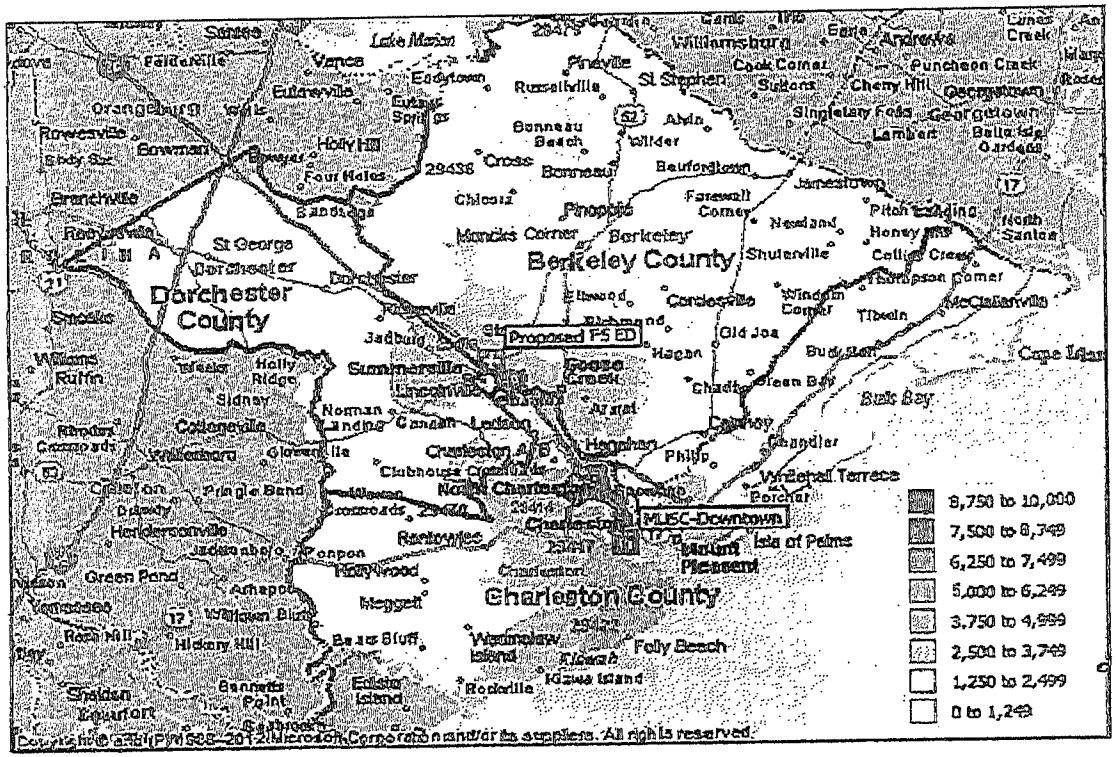
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*"All off-campus emergency services must be an extension of an existing hospital's emergency service in the same county, unless the applicant is proposing to establish a freestanding emergency service in a county that does not have a licensed hospital. The hospital must have a license that is in good standing and must be in operation to support the off-campus emergency services." – Standard 2, 2017-2018 SC Health Plan*

- MUSC Does not Operate a Hospital in Berkeley County
- Berkeley County has two approved hospitals which are currently underway with development and construction.
- The proposed FSED does not represent an extension of the downtown Hospital's existing emergency service.
- As a result, MUSC does not meet Standard 2.

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# Existing Patient Origin Demonstrates that the Proposed Project is not an Extension of the Downtown Hospital




- There are numerous existing providers between these counties and MUSC.
- In all likelihood, patients traveling from distant locations are bypassing these other providers to seek a higher level of care in truly emergent situations.
- It is unlikely, these patients would still bypass the proposed FSED to seek care at the hospital.

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*"The applicant must demonstrate need for this service by documenting where the potential patients for this proposed service will come from and why they are not being adequately served by the existing services in the area." – Standard 6, 2017-2018 SC Health Plan*

- MUSC fails to identify the service area.
  - *"Berkeley County resident redirection by ZIP Code ranged from 25% to 75%. Dorchester County resident redirection by ZIP Code ranged from 25% to 75%. Charleston County redirection by ZIP Code ranged from 0% to 60%." – p23 Application, Matter No. 2459*
- MUSC fails to demonstrate that any service area residents are not being adequately served by the existing EDs in the service area.
- Instead, MUSC states that the proposed facility will its alleviate its own capacity constraints downtown. However, it does not quantitatively or anecdotally support these statements.

# Relevant Project Review Criteria for MUSC Health Emergency Services

## The Proposed Freestanding ED Does Not Meet a Community Need, Improve Access, or Promote Cost Containment

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# Community Need

- MUSC cites improving access to ED services for its existing patient base while relieving capacity constraints at the downtown hospital as the impetus for this project.
- First, MUSC never quantifies or describes any capacity constraints, wait times, or other issues experienced at the downtown hospital.
- It only quantifies the number of visits and a 5.2 percent growth in visits in the past three years (Application for Matter No. 2459, p. 22).
- No other documentation or letters are provided to quantify capacity constraints for MUSC and document its present level of utilization in relation to capacity. Current average wait times are also not quantified or discussed within the application.

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# Improved Access

- MUSC states that this project will shift its own patients to a more accessible location in order to alleviate the capacity constraints experienced at the hospital.
  - Not a logical assumption given the current patient origin presented by the Applicant.
- The proposed project does not meet a geographic need.
  - It is proposed to be situated between three ED providers and located in a county that currently has two other freestanding emergency departments in addition to two hospital-based EDs that are currently underway
- Patients who reside within the ZIP code in which the proposed facility is to be located are accessing ED services at a rate well above the area and the state.

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# Comparison of ED Visits per 100 Population

| County | 2015 Visits per 100 Population |
|---|---|
| 29483 Summerville, SC* | 72.4 |
| Charleston County | 44.3 |
| Dorchester County | 42.1 |
| Berkeley County | 38.5 |
| Tri-County Average | 41.6 |
| State Average | 43.3 |

*Sources: Data Request - Revenue and Fiscal Affairs Office, Application for Matter No. 2459, p27*
**Data is for 4/1/20105-3/31/2016*

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# In Summary

- MUSC fails to meet Standard 2 and should be denied on this factor alone.
- In addition...
  - MUSC has not demonstrated that the proposed project is needed or will have any positive effect on the patient experience.
  - MUSC has not mentioned or demonstrated that there are currently capacity constraints among the existing providers in the area or that there are excessive wait times at the current ED providers.
  - MUSC has failed to demonstrate any capacity constraints or delays at its own hospital-based ED.
  - MUSC has not demonstrated that there will be any cost savings to the patient or enhanced patient experience by using the proposed freestanding ED over one of the existing and approved EDs in the Tri-County area.

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# Trident's Summerville Freestanding Emergency Department Does Not Meet the SHP Standards for FSED and Does not Meet Other Relevant Project Review Criteria

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# SFED's Application Conflicts with Its Written Arguments Submitted in Opposition of Roper Hospital Diagnostics and ER – Northwoods CON Application (Matter No. 2344) to Relocate

- In 2016, Roper St. Francis applied to relocate its existing 10-bay FSED in North Charleston and simultaneously add five additional bays as part of the relocation to alleviate capacity issues.
- Trident Health System opposed this application.
- In an opposition letter dated November 2, 2016, Trident makes a number of statements that conflict with the introduction of the proposed application for SFED.
- The letter suggests that additional capacity is not needed due to approvals and initiation of services at:
  - Centre Pointe Emergency
  - Trident Medical Center
  - Roper St. Francis – Berkeley Hospital

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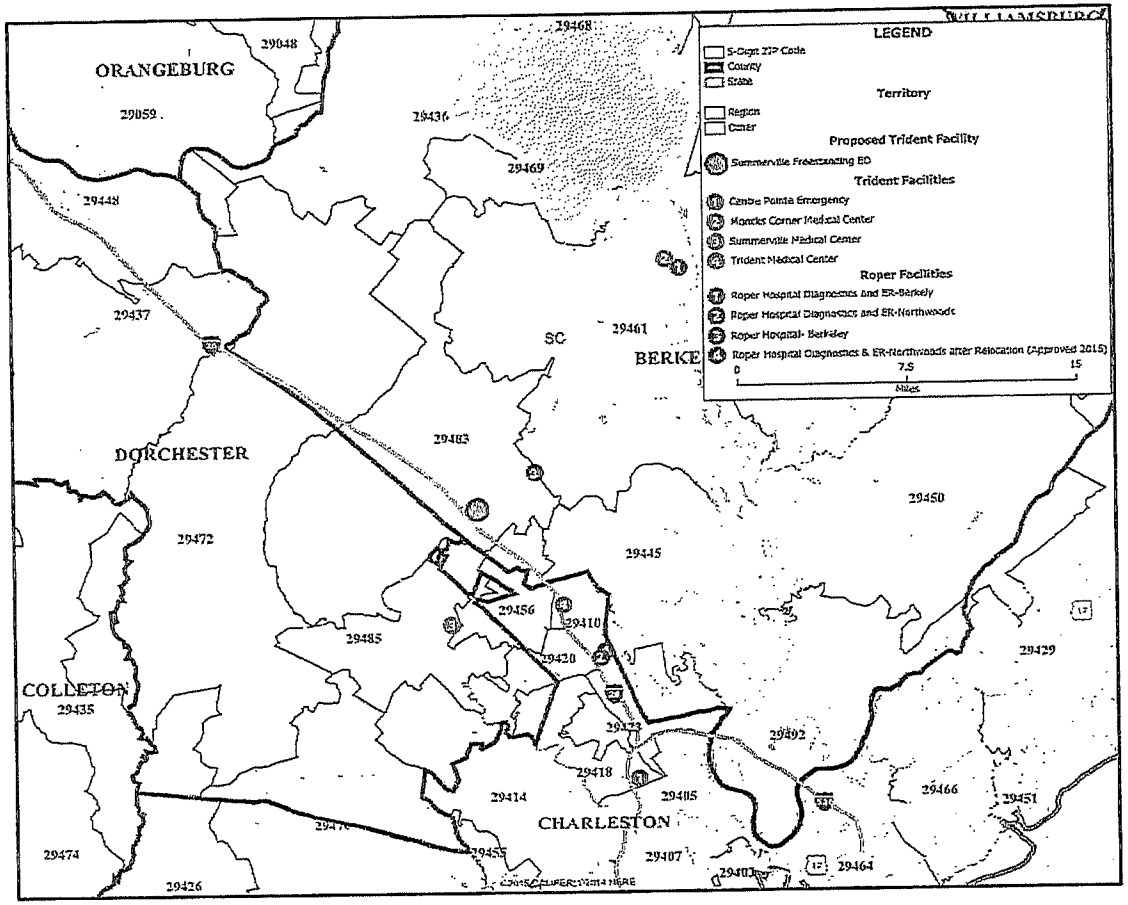
# Trident's Basis for Northwoods Opposition

Trident is not challenging Roper-Northwoods need to address the flooding issues it has experienced in the past two years. Trident's principal concern with the proposal is with the proposed increase in capacity at a time when significant new emergency department capacity is becoming available to serve much of the service area that Roper-Northwoods has historically served. *- Dan Sullivan, November 2, 2016 Letter of Opposition, p.1*

**Trident identifies this "new emergency capacity" to be Centre Pointe Emergency, Trident Medical Center expansion, and Roper St. Francis Hospital – Berkeley.**

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# SFED's Primary Service Area Consists of Four ZIP Codes




- 29483, 29456, 29485, 29472
- Service area is significantly smaller than other Trident System EDs
  - Centre Point Emergency – 9 ZIPS
  - Trident Medical Center - 14 ZIPS
  - Application does not fully identify PSA of Summerville Medical Center

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# SFED is Proximal to the Expanded Capacity It Identifies in Northwoods Opposition and has Significant Overlap in Service Area

| Facility | Distance from SFED (miles) | Distance from SFED (minutes) | Description of Overlap with SFED Service Area |
|---|---|---|---|
| Centre Pointe Emergency | 16.2 | 20 | One of four primary service area ZIP Codes |
| Trident Medical Center | 7.8 | 11 | Three out of four ZIP Codes are in the primary service area for TMC; these four ZIP codes made up 30% of TMC ED volume in 2015 and 2016. |
| Roper St. Francis Hospital - Berkeley | 3.9 | 7 | SFED will be located in the ZIP code immediately adjacent to RSFH-Berkeley; large overlap of service area ZIP Codes |

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# Statements Made by Trident Regarding the Northwoods application in its November 2, 2016 Letter of Opposition

- *"Centre Point Emergency's service area overlaps substantially with Roper-Northwood's service area.... While the level of dependence on individual ZIP Codes varies between the two facilities, they are drawing emergency patients from substantially the same population base."*

- *"Trident Medical Center was approved in 2015 for an expansion of its Emergency Department based on its historical volume growth and its development of a Level II trauma program.... As with Centre Pointe, Trident Medical Center's primary service area for emergency patients reflects significant overlap with that of Roper-Northwoods."*

- *"A final concern is the additional Emergency Department capacity that will be created with the opening of Roper-Berkeley Hospital.... A portion of Roper-Northwoods primary service area includes the area proximate to the new hospital in Berkeley County."*

- *ALL OF THESE STATEMENTS ALSO APPLY TO THE PROPOSED SUMMERVILLE FREESTANDING ED*

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# Resolution of Northwoods Opposition

- Roper St. Francis entered into a settlement with Trident and the Department that allows the relocation of Northwoods, but precludes the five additional patient bays from coming online for three years after the initial licensure of the facility to give previously approved capacity additions the opportunity to be implemented prior to Northwoods' addition.
- Trident has now applied to increase capacity to serve many of the same areas it opposed in the Northwoods application.

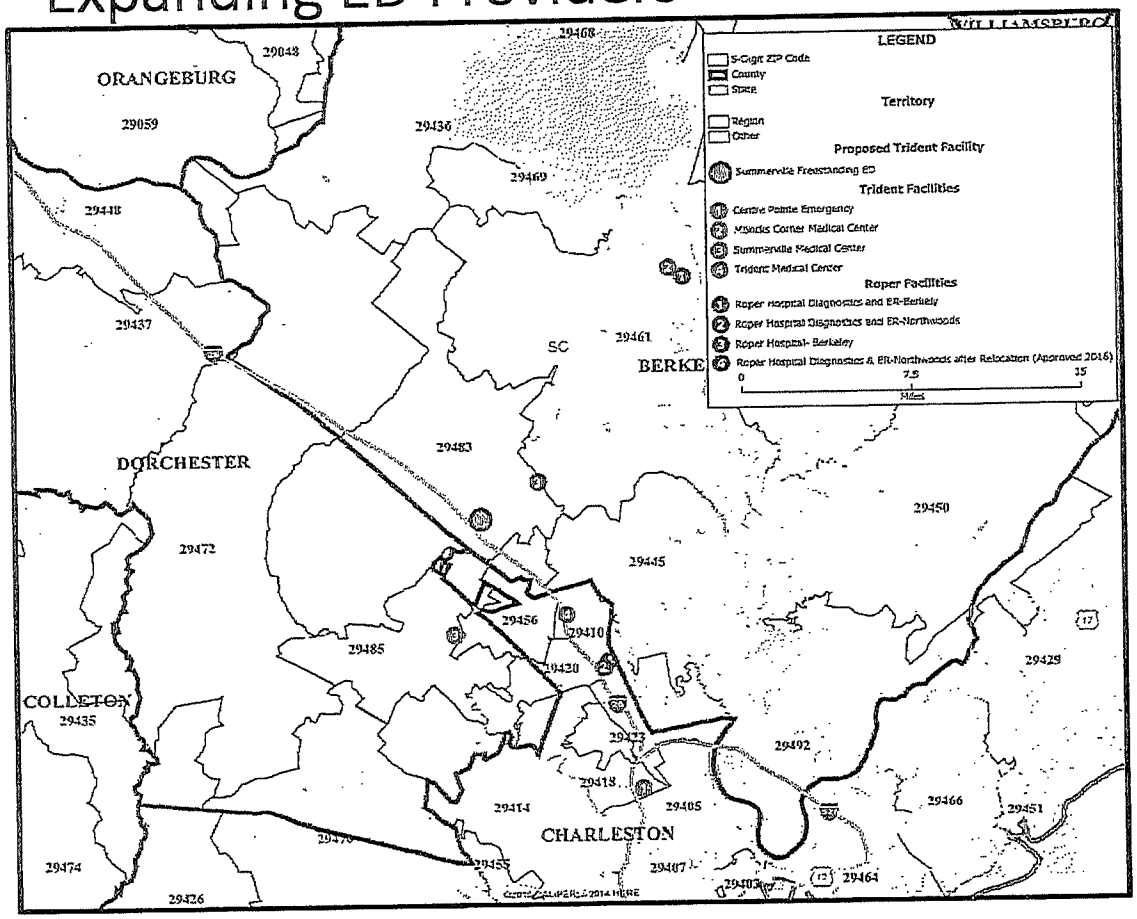
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# Even Without Considering Trident's Previous Opposition to Northwoods, This Project Does Not Meet a Community Need or Provide Increased Access to ED Services

- SFED is proximal to a number of existing and approved providers.
- Use rates provided by the applicant indicate that the proposed service area counties have abundant access to ED services and utilize ED providers well above the Tri-County and state average.
- Summerville's goals for this project would be better accomplished with an urgent care center than with a FSED.

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# SFED is Proximal to Numerous Existing, Approved, and Expanding ED Providers




- 3 Closest Providers
  - Roper St. Francis Hospital Berkeley ED – will come online in 2018-2019
  - Trident Medical Center – Expansion of ED currently underway
  - Summerville Medical Center

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# The PSA ZIP Codes Access ED Service at a Rate Above the Tri-County and State Average

**ED Visits per 100 Population for Proposed Service ZIP Codes 4/1/2015 -3/31/2016**

| ZIP Code | 2015 Visits per 100 Population |
|---|---|
| 29456 Ladson, SC | 52.8 |
| 29472 Ridgeville, SC | 49.7 |
| 29483 Summerville, SC | 72.4 |
| 29485 Summerville, SC | 43.3 |
| Total/Average | 55.8 |

*Source: Exhibit 9 (Application p27)*

**ED Visits per 100 Population for the Tri-County Area and the State CY 2015**

| County | 2015 Visits per 100 Population |
|---|---|
| Charleston (C) | 44.3 |
| Dorchester (D) | 42.1 |
| Berkeley (B) | 38.5 |
| Tri-County Average | 41.6 |
| State Average | 43.3 |

*Source: Data Request - Revenue and Fiscal Affairs Office*

ROPER ST. FRANCIS

# Comparison of SFED Primary Service Area ZIPs to Associated County Rates

| ZIP Code | 2015 Visits per 100 Population | Counties Overlapped by ZIP | 2015 Average ED Use Rate of Counties Overlapped by ZIP |
|---|---|---|---|
| 29456 Ladson, SC | 52.8 | B, C, D | 41.6 |
| 29472 Ridgeville, SC | 49.68 | B, D | 40.3 |
| 29483 Summerville, SC | 72.4 | B, D | 40.3 |
| 29485 Summerville, SC | 43.31 | B,C,D | 41.6 |
| Total | 55.8 | | 41.6 |

*Source: Exhibit 9 (p27), Instant Application for SFED, Data Request - Revenue and Fiscal Affairs Office*

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# Trident Cites the Treatment of Patients of Lower Acuity as the Impetus for this Project

- ***"Current trends indicate that emergency departments are being used more frequently by individuals without insurance whose needs are not emergent. Freestanding emergency departments offer the ability to treat most of the problems experienced by patients presenting to hospital EDs. By serving these less acutely ill patients in a freestanding environment, hospital EDs will have greater capacity to serve patients with true emergent needs (SFED Application, p. 33)."***

- Figures on the previous slides indicate that patients from the proposed service area are likely seeking primary or urgent care in existing EDs.
- SFED does not describe or quantify any existing capacity issues at Summerville Medical Center or any other Trident ED.
- If the intent of the applicant is to alleviate non-emergent cases from hospital-based EDs, a more appropriate option is to develop an urgent care center that would address non-emergent issues at a fraction of the cost of services delivered at a free-standing ED.

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# SFED Does not Meet SHP Standards 2 and 6

- ***"All off-campus emergency services must be an extension of an existing hospital's emergency service in the same county, unless the applicant is proposing to establish a freestanding emergency service in a county that does not have a licensed hospital. The hospital must have a license that is in good standing and must be in operation to support the off-campus emergency services." – Standard 2, 2017-2018 SC Health Plan***
  - Two hospitals are under construction in Berkeley County, one of which is Trident's own facility, Berkeley Medical Center, though this facility is not mentioned in the application.
- ***"The applicant must demonstrate need for this service by documenting where the potential patients for this proposed service will come from and why they are not being adequately served by the existing services in the area." – Standard 6, 2017-2018 SC Health Plan***
  - The Applicant identifies a very distinct service area for this project, but fails to show why it is not being adequately served by the existing services in the area.
  - SFED fails to identify any current barriers to access and actually quantitatively demonstrates that the identified service area has increased access to ED services compared with the individual counties in which it overlaps, the Tri-County area, and the State overall.

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# Conclusion

- There is not a geographic or medical community need for the proposed projects.
- Neither project increases access to ED services.
- Both projects fail to meet several State Health Plan standards for Freestanding ED services.
- MUSC Health Emergency Services' proposed location and existing patient origin does not represent an extension of an existing hospital-based provider.
- Summerville Freestanding ED will provide more costly urgent and primary care through a freestanding ED without any cost benefit to the patient.
- As Dr. Walters stated, existing and approved providers are at risk for staffing shortages if too much ED capacity is brought online at the same time.
- Both CON applications should be denied.

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# EXHIBIT C

dhec
Healthy People. Healthy Communities.

Board:
Allen Amsler, *Chairman*
Ann B. Kirol, DDS, *Vice Chair*
L. Clarence Batts, Jr., *Secretary*
R. Kenyon Wells
Charles M. Joye II, P.E.
David W. Gillespie, MD

November 15, 2017

**Electronic Mail and U.S. Certified Mail Delivery 9214 8969 0099 9790 1410 1585 86**
Ralph W. Barbier, III (rbarbier@nexsenpruet.com
Nexsen Pruet
Post Office Drawer 2426
Columbia, SC 29202

**Electronic Mail and U.S. Certified Mail Delivery 9214 8969 0099 9790 1410 1587 15**
William R. Thomas (willthomas@parkerpoe.com)
Parker Poe Adams & Bernstein, LLP
Post Office Box 1509
Columbia, SC 29202

**Electronic Mail and U.S. Mail Delivery**
Daniel J. Westbrook (dan.westbrook@nelsonmullins.com)
Nelson Mullins Riley & Scarborough, LLP
Post Office Box 11070
Columbia, SC 29211

**Electronic Mail Delivery**
Ashley C. Biggers (biggerca@dhec.sc.gov)
SCDHEC – Office of General Counsel
2600 Bull Street
Columbia, SC 29201

RE: **Docket No. 17-RFR-34, MUSC Health Emergency Services**
Approval of Certificate of Need for the construction of a freestanding emergency department in Berkeley County.

Dear Counsel of Record:

The South Carolina Board of Health and Environmental Control will not conduct a Final Review Conference on the above-referenced matter.

**CONTESTED CASE GUIDANCE**

S.C. Code Section 44-1-60 provides that if the Board declines in writing to schedule a final review conference, the staff decision becomes the final agency decision, and an applicant, permittee, licensee, or affected person may request a contested case hearing before the Administrative Law Court (ALC) within thirty calendar days after notice is mailed to the applicant, permittee, licensee, and affected person that the Board declined to hold a final review conference.

A request for a contested case hearing before the Administrative Law Court must be filed within the time allowed and in accordance with the Rules of the ALC, including payment of the ALC's filing fee, at the following address:

Clerk's Office
South Carolina Administrative Law Court
Edgar A. Brown Building
1205 Pendleton St., Suite 224
Columbia, SC 29201

The ALC's Notice of Request for Contested Case Hearing form and the Rules of the ALC can be found at the ALC's website: http://www.scalc.net. Further information on filing a request for a contested case hearing before the ALC may be obtained by calling the Clerk's Office at the Administrative Law Court (803-734-0550).

If a party files a request for a contested case hearing with the ALC, the party must serve a copy of the request on DHEC and any other parties at the same time the request is filed with the ALC. A copy of the request for a contested case hearing must be delivered or mailed to DHEC at the address at the top of this memorandum.

Sincerely,

Lisa Lucas Longshore

Lisa Lucas Longshore
Clerk
S.C. Board of Health and Environmental Control

The above information on filing a request for a contested case hearing before the Administrative Law Court is provided as a courtesy; parties before the ALC are responsible for complying with all applicable requirements of the Court.

# EXHIBIT D

*Platt HMC, Inc.*
***Health Management Consulting***
881 Piedmont Avenue, Atlanta, Georgia 30309
Phone: 404-728-1974 • Fax: 404-728-1975

July 21, 2017

Maggie Murdock, Director
Certificate of Need Program
SC Department of Health and Environmental Control
2600 Bull Street
Columbia, SC 29201

Re: Medical University Hospital Authority d/b/a MUSC Health Emergency Services
Construction of a 15,300 sf Freestanding Emergency Department (FSED) in Berkeley County at a total project cost of $13,584,161
Matter No: 2459

Dear Ms. Murdock:

On behalf of our client, Care Alliance Health Services d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours St. Francis Xavier Hospital, Inc., Roper Mt. Pleasant Hospital, Inc. and Roper St. Francis - Berkeley Hospital, Inc. (collectively from time to time "Roper St. Francis"), an "affected person" for the above-referenced matter, we submit the following written opposition. Medical University Hospital Authority d/b/a MUSC Health Emergency Services ("MUSC") proposes to develop a new off-campus emergency service or freestanding emergency department ("FSED") to serve an area that already has multiple existing and approved emergency department ("ED") providers, additions, and expansions underway. The proposed project will not enhance geographic access to an underserved population and it will not promote cost containment. This analysis will show that the proposed service area is already well-served and that the application does not meet an identified need or conform to the project review criteria deemed to be most important by the Department.

*Background*

In its application, MUSC proposes to develop a new FSED to be located in Summerville, Berkeley County approximately 23.87 miles from its existing hospital located in downtown Charleston, Charleston County. MUSC does not operate a hospital in Berkeley County.

There are two approved hospitals in Berkeley County that will have significant ED capacity including Roper St. Francis Hospital - Berkeley ("RSFH - Berkeley") and Berkeley Medical Center, an affiliate of Trident Medical Center. As will be described, there are numerous other existing hospital and FSEDs in the vicinity of the proposed MUSC FSED with abundant capacity.

As will be presented in detail, the MUSC FSED cannot be approved because it fails to meet the following criteria and State Health Plan Standards:

- The proposed project cannot meet Standards 2 and 6 of the State Health Plan.
- The proposed project cannot identify a community need based on the abundance of existing and approved ED capacity in the Tri-County and specifically Berkeley County.
- MUSC has not adequately defined its service area and the proposed population it intends to serve.
- The location of the proposed FSED does not meet a community need, improve access, or promote cost containment

*The Project Fails to Meet State Health Plan Standards for Freestanding Hospital Services and Most Important Project Review Criteria*

At a minimum, MUSC fails to meet Standards 2 and 6 of the Freestanding Hospital Services Section of the South Carolina Health Plan (SHP) under which this project is being reviewed. Specifically, Standard 2 states,

> ***"All off-campus emergency services must be an extension of an existing hospital's emergency service in the same county, unless the applicant is proposing to establish a freestanding emergency service in a county that does not have a licensed hospital. The hospital must have a license that is in good standing and must be in operation to support the off-campus emergency services."***

To address this Standard, the Applicant states, "The Freestanding ED will be licensed under and operated as a department of MUSC, functioning as an extension of MUSC's existing hospital-based ED. MUSC has a license in good standing and is prepared to support the freestanding ED (Application, p.24)." MUSC Medical Center is located in Charleston County and not in Berkeley County where the proposed FSED will be located. Under Standard 2, MUSC is permitted to establish a FSED in Charleston County, the hospital's same county.

MUSC can only establish an FSED in a "county that does not have a licensed hospital". This standard was established to recognize that an FSED can expand access in a county without a hospital. As the Department is aware, two hospitals are approved and underway in Berkeley County. Therefore, MUSC's proposed project does not meet this State Health Plan Standard.

Further, the intent of this Standard is to establish freestanding providers of ED services that have the most proximal geographic access to hospital-based services in the event that a patient needs a higher level of care. MUSC Medical Center, located 23.8 miles from the proposed site, is among the least proximal hospital-based providers in the Tri-County area from the proposed facility location.

In addition, Standard 6 states,

> **"The applicant must demonstrate need for this service by documenting where the potential patients for this proposed service will come from and why they are not being adequately served by the existing services in the area."**

MUSC does not meet either aspect of this Standard. As will be described in detail below, the Applicant identifies a vague service area for this project. It anticipates serving all of Berkeley and Dorchester Counties at different, but unidentified levels and anticipates serving some of Charleston County, but does not identify which areas of Charleston County it will and will not serve . In addition, MUSC fails to show why the service area is not being adequately served by the existing providers in the area. As discussed in detail below, the application fails to identify any current barriers to access and why this project is needed.

The Department identifies the most important criteria for this project to be community need, distribution (accessibility), medically underserved groups, and financial feasibility. Based on these criteria, the Department appears to be evaluating this application on increased accessibility to an underserved community. As will be described, there is abundant access to ED services for the primary service area identified by the Applicant. In fact, the ZIP code in which the Applicant proposes to locate is receiving ED services at rates well above the county, Tri-County area, State and national averages. The service area does not appear to be medically underserved in terms of accessing ED services. From a geographic perspective, MUSC proposes to locate another ED provider in the center of three existing/approved hospital-based EDs. MUSC has not demonstrated that this area is experiencing extended wait times, extended travel time, or access issues in and to the current EDs.

*There is an Abundance of Existing and Approved ED Capacity to Serve the Tri-County Area*

There are numerous existing and approved providers of ED services in the Tri-County area to meet the needs of the service area defined by the applicant. While the project is proposed to be located at the border of Berkeley and Dorchester Counties, it is necessary to consider all ED providers in the Tri-County area in this analysis given the Applicant's vague definition of the Tri-County services area (page 19) and description of patients it intends to serve.

**Exhibit 1** below shows all existing and approved providers of ED services in Berkeley, Charleston, and Dorchester Counties. **Exhibit 2** provides a map of the location of each of these providers. There are currently eight hospital-based providers and four freestanding providers of ED services in the Applicant's service area. Four of the Twelve existing and approved providers are located in Berkeley County.

## Exhibit 1

## Inventory of Existing and Approved ED Providers

| Facility | Affiliation | Type | Status | Location |
|---|---|---|---|---|
| Bon Secours St. Francis | Roper St. Francis | Hospital | Existing | Charleston/ West Ashley |
| Roper Hospital | Roper St. Francis | Hospital | Existing | Charleston/ Peninsula |
| Mount Pleasant Hospital | Roper St. Francis | Hospital | Existing | Charleston/ Mt. Pleasant |
| MUSC Medical Center | MUSC | Hospital | Existing | Charleston/ Peninsula |
| Trident Medical Center | Trident | Hospital | Existing and Approved for Expansion | Charleston/ North Charleston |
| Summerville Medical Center | Trident | Hospital | Existing | Dorchester County |
| RSFH - Berkeley | Roper St. Francis | Hospital | Approved | Berkeley County |
| Berkeley Medical Center | Trident | Hospital | Approved | Berkeley County |
| Roper Hospital Diagnostics and ER - Northwoods | Roper St. Francis | Freestanding | Existing and Approved for Relocation/ Expansion | Charleston/ North Charleston |
| Roper Hospital Diagnostics and ER - Berkeley | Roper St. Francis | Freestanding | Existing | Berkeley County/ Moncks Corner |
| Moncks Corner Medical Center | Trident | Freestanding | Existing | Berkeley County/ Moncks Corner |
| Centre Point Emergency | Trident | Freestanding | Existing | Charleston/ North Charleston |

## Exhibit 2
## Tri-County Emergency Department Providers

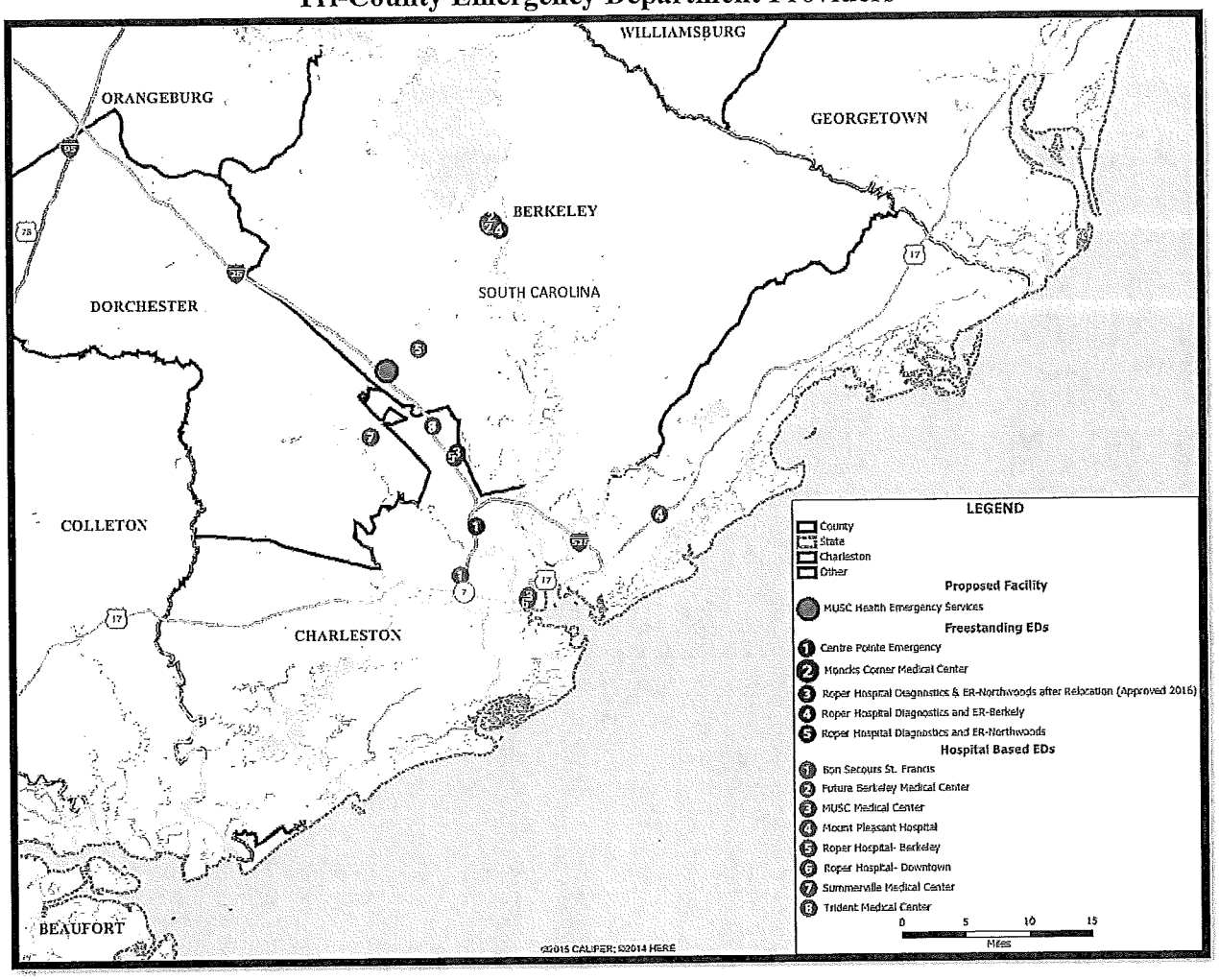


**Exhibit 3** shows the time and distance to all existing providers of ED services from MUSC's proposed location. There are currently three providers of ED services within a 7.5 mile driving distance of the MUSC FSED and an additional five providers within a 20-mile driving distance of the proposed facility.

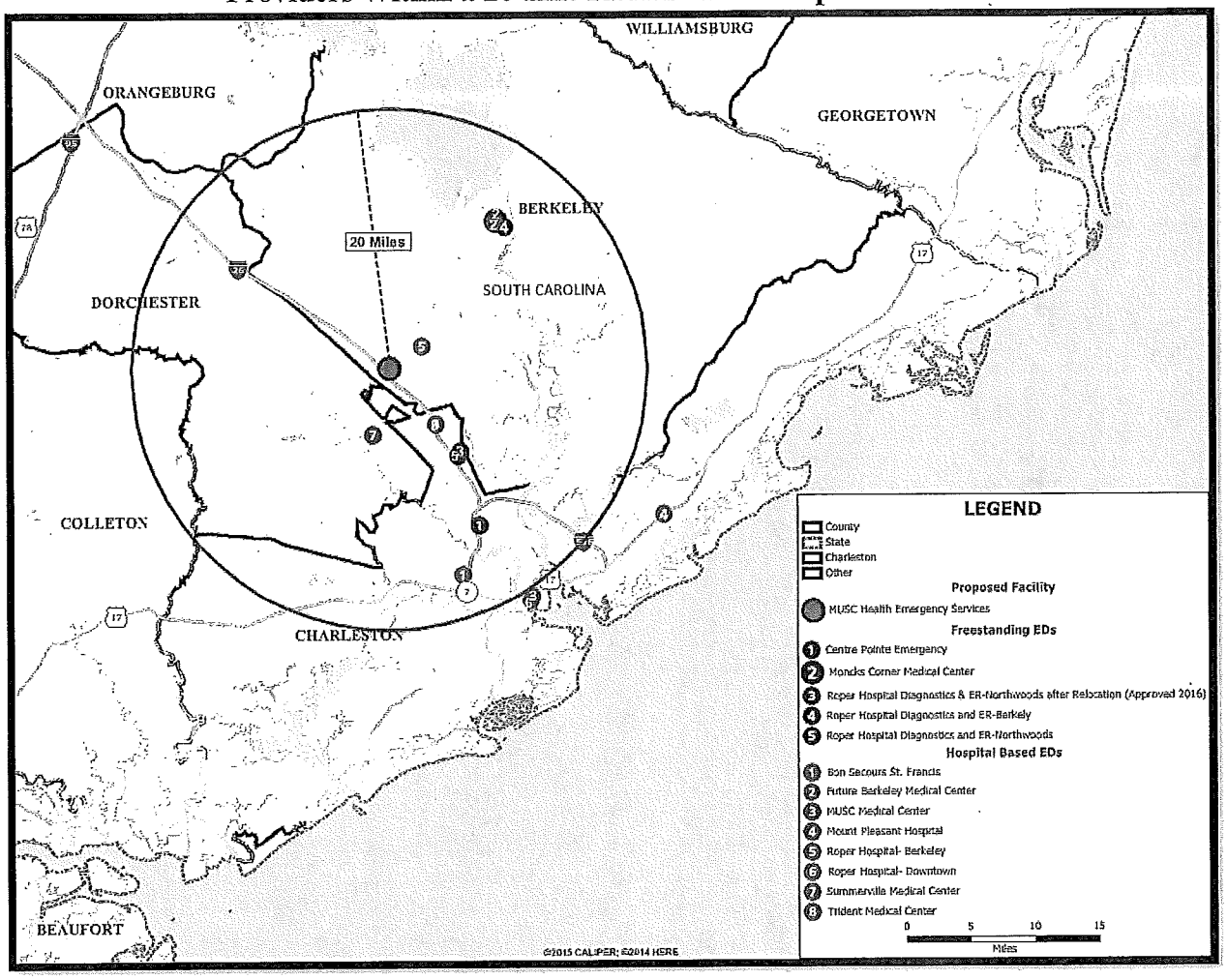
**Exhibit 3**
**Drive Time Analysis**

| **Distance from Proposed MUSC Health Emergency Services to:** | | |
|---|---|---|
| **Facility** | **Distance (miles)** | **Time (minutes)** |
| Roper St. Francis- Berkeley | 3.9 | 8 |
| Trident Medical Center | 7.5 | 11 |
| Summerville Medical Center | 7.5 | 18 |
| Roper Hospital Diagnostics & ER- Northwoods (Existing) | 11 | 15 |
| Roper Hospital Diagnostics & ER- Northwoods (Relocated) | 12 | 17 |
| Moncks Corner Medical Center | 15.4 | 22 |
| Berkeley Medical Center | 15.4 | 22 |
| Centre Pointe Emergency | 16.2 | 18 |
| Roper Hospital Diagnostics & ER- Berkeley | 16.4 | 26 |
| Bon Secours St. Francis | 20.9 | 25 |
| MUSC Medical Center | 23.8 | 31 |
| Roper Hospital- Downtown | 24.1 | 28 |
| Mount Pleasant Hospital | 33.4 | 40 |

*Source: Google Maps 2017*

**Exhibit 4** illustrates further the number of ED providers that are already proximal to the site for the proposed project. As the crow flies, there are nine existing and approved providers within 20 miles of the proposed site. **Exhibit 4** also shows that the proposed site for this project is in the center of three existing providers of ED services. The location in and of itself does not demonstrate a geographic need.

**Exhibit 4**
**Providers Within a 20-mile Radius of the Proposed FSED**




There is also significant additional ED capacity approved, but not yet operational, that will serve the proposed service area. First, Roper St. Francis Hospital - Berkeley, which will have a full-service, 24-hour Emergency Department, is slated for completion in 2019, just after the proposed FSED is slated to open. RSFH - Berkeley is located less than four miles from the proposed project and will serve patients originating from the identified service area.

In addition, Trident Medical Center was issued a CON in 2016 to expand its existing hospital-based Emergency Department. Construction for this expansion began in January 2017 and is currently underway. Trident Medical Center is located 7.5 miles from the proposed facility. Based on timelines provided to the Department, it appears that the Trident Medical Center ED

expansion, the RSFH - Berkeley ED, and the proposed project are all scheduled to come online within an approximate one-year period.

Finally, Roper Hospital Diagnostics and ER – Northwoods was approved by the Department to relocate in late 2016. As part of this relocation, Roper will add five additional patient bays that will come online three years from the date of the initial licensure of the relocated facility. Roper Hospital Diagnostics and ER – Northwoods is located twelve miles from the proposed site for MUSC's FSED.

**Exhibit 5** summarizes the significant amount of approved new ED capacity within 20 miles of MUSC's proposed location along with MUSC's planned capacity. There will be capacity to provide 123,000 additional ED visits established based on CON applications that have already been approved. If MUSC's application is approved, there will be an additional 36,000 visit capacity in addition for a total new capacity of 159,000 visits. This amount of new ED capacity is simply unnecessary and MUSC has not provided any facts or analysis to show more capacity is needed or that there is any unmet need. It should also be noted that MUSC projects to provide approximately 17,000 visits in the new FSED with a proposed capacity of 32,000. MUSC's projections do not support its own facility.

**Exhibit 5**
**Incremental Approved and Proposed ED Capacity**

| Provider | Bays | Visit Capacity per Bay | Total Visit Capacity |
|---|---|---|---|
| Trident Medical Center (Expansion) | 8 | 3,000 | 24,000 |
| Roper Hospital Diagnostics and ER - Northwoods (Expansion) | 5 | 3,000 | 15,000 |
| Roper St. Francis Hospital - Berkeley | 15 | 3,000 | 45,000 |
| Berkeley Medical Center | 13 | 3,000 | 39,000 |
| Proposed MUSC FSED* | 12 | 3,000 | 36,000 |
| **Total NEW Capacity within 20 Mile Radius** | 53 | 3,000 | 159,000 |

*Assumes capacity of 3,000 based on approximately 8 visits per day*
** CON #. Does not include two mental health rooms.*
***MUSC application Attachment B. In addition to 12 treatment bays, MUSC proposes 5 CDU/Observation rooms, 5 triage bays a resuscitation area larger than two treatment bays.*

Given that the Trident Medical Center ED expansion and the RSFH - Berkeley ED are slated to come online within a year of the initiation of the proposed facility and that Roper Hospital Diagnostics and ER – Northwoods will expand in the coming years, it is premature to add more ED capacity in the same overlapping service area until the providers which have already been approved are operational and the system impact on the existing ED providers can be determined.

*The Applicant's Proposal Does Not Adequately Identify the Service Area or the Population that it Anticipates Serving with the Proposed Project*

The Applicant identifies the service area to be Berkeley, Charleston, and Dorchester Counties on page 19 of the application based on its historical patient origin for MUSC Medical Center's existing ED. However, on page 23 of the application, MUSC clarifies that the patient origin is based by ZIP code, "mainly ZIP codes in Berkeley and Dorchester Counties plus a small number of ZIP codes in Charleston County." The Applicant never identifies the specific ZIP codes it anticipates serving and those from which it will shift patients, in part, from the MUSC ED to the FSED. Further, MUSC never identifies the percent shift it anticipates for each specific ZIP code. The most specific information provided by the applicant relative to its methodology for projecting utilization is listed on page 23. It states:

> *"Berkeley County resident redirection by ZIP Code ranged from 25% to 75%. Dorchester County resident redirection by ZIP Code ranged from 25% to 75%. Charleston County redirection by ZIP Code ranged from 0% to 60%."*

MUSC goes on to present the projected utilization without quantitatively identifying its assumed shift by ZIP or county. Based on this information, it is impossible to assess what level of redirection the Applicant anticipates for each ZIP and for which areas of Charleston County the Applicant anticipates no shift at all. As a result, it is not possible to assess the Applicant's analysis or methodology for reasonableness and accuracy.

The applicant claims to entirely shift patients within the system from MUSC to the FSED, though MUSC is located 23.87 miles or a 30-minute drive-time away from the proposed facility. While not specifically quantified in the application, it appears that much of the shift comes from Berkeley and Dorchester Counties. Based on data provided by the Applicant, only 12.1 percent of its existing ED patients originate from Berkeley County and only 9.4 percent of ED patients originate from Dorchester County. This is likely because the MUSC ED is not proximal to these locations. As a result, the proposed site does not result in a natural extension of its existing ED as intended by the State Health Plan.

There are a number of other hospital-based providers in the area, including Roper St. Francis Hospital – Berkeley, that are much more convenient to the proposed site. It is a more natural extension of services for these providers to operate a FSED to serve residents of Berkeley and Dorchester Counties than MUSC which only offers hospital-based services on the peninsula of Charleston. In fact, the intent of the State Health Plan is to require that an FSED operate as and extension of a hospital ED in the same county, unless proposed in a county without a hospital. It is a well-known fact, that RSFH - Berkeley is approved and under development in Berkeley County. MUSC is applying under the caveat that Roper St. Francis Hospital – Berkeley, while underway, is not yet operational.

MUSC repeatedly emphasizes the differentiating factors for this project throughout the application, alluding to enhanced service offerings at the proposed facility due to its linkage with

the specialists that come with an academic medical center and a Level 1 trauma center[1]. MUSC is indeed an academic medical center and a Level 1 Trauma center with access to the highest level of specialist in the state. However, to access this level of care, if needed, a patient must be transferred to the hospital downtown. The cadre of specialists that come with an academic medical center will not be readily available at the proposed FSED. Should a patient present to the FSED needing this level of care, they will have to be transported 23.8 miles away to the hospital downtown. The differentiating factors presented in the application may differentiate the Applicant's hospital-based ED from other ED providers, but they do not apply to the proposed FSED. In fact, access to life-saving specialist may be delayed while a patient stops at the proposed FSED prior to transfer to MUSC more than 30 minutes away.

*The Location of the Proposed Freestanding ED Does Not Meet a Community Need, Improve Access, or Promote Cost Containment*

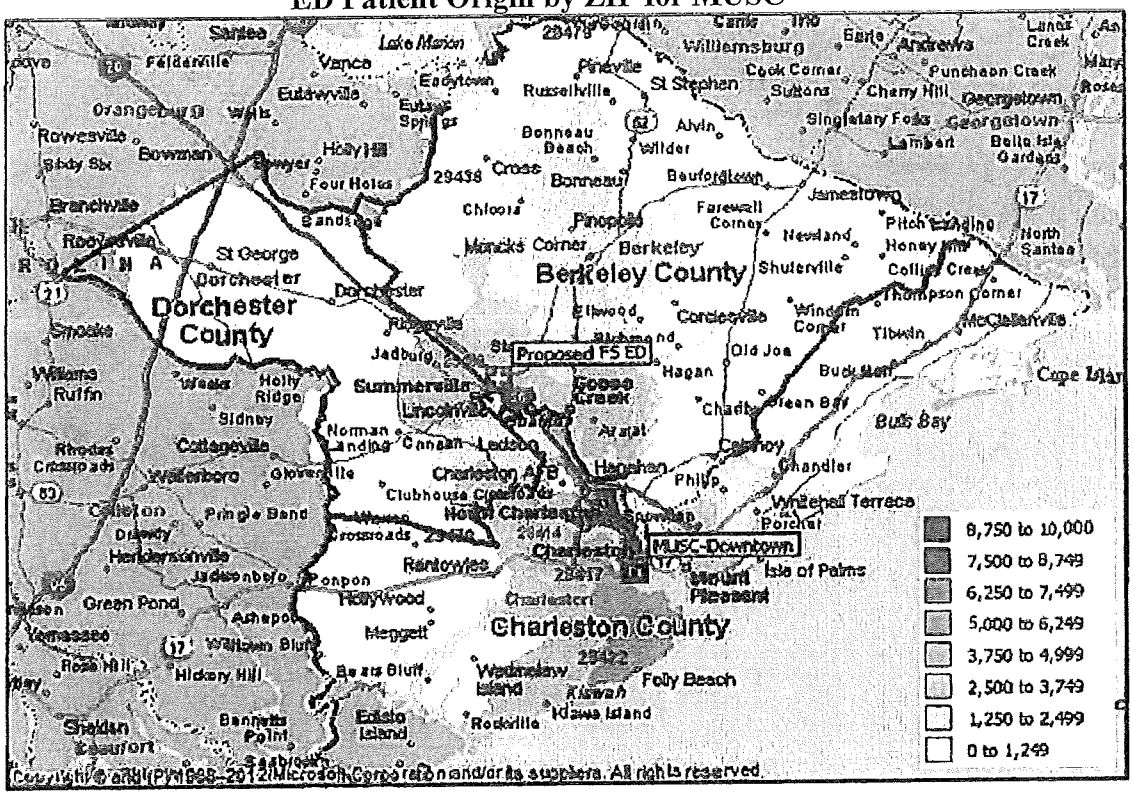
MUSC repeatedly cites improving access to ED services for its existing patient base while relieving capacity constraints at the downtown hospital as the impetus for this project.[2] However, the Applicant fails to document both of these claims.

First, MUSC never quantifies or describes any capacity constraints, wait times, or other issues experienced at the downtown hospital. It only quantifies the number of visits and a 5.2 percent growth in visits in the past three years (Application, p. 22). No other documentation or letters are provided to quantify capacity constraints for MUSC and document its present level of utilization in relation to capacity. Current average wait times are also not quantified or discussed within the application.

More importantly, the Applicant states that this project will shift its own patients to a more accessible location in order to alleviate the capacity constraints experienced at the hospital. However, this is not a logical assumption given the current patient origin presented in the application for this project. Exhibit 8 to the MUSC instant application shows the levels of patient origin throughout the Tri-County area and is included below as **Exhibit 6**.

[1] See Application pages 5, 17, 18, 25, and 27.
[2] See Application pages 6, 7, 10, 19, 25, 27, 33

**Exhibit 6**
**ED Patient Origin by ZIP for MUSC**




Most areas of Berkeley and Dorchester County are white, indicating patient volumes of 0-1,249. Even the areas directly surrounding the proposed facility have lower levels of patient origin. The fact that patients in these areas of low patient volume are currently bypassing other freestanding providers and community hospitals to seek care at MUSC indicates that the patients originating from ZIP codes surrounding and proximal to the proposed site are likely higher acuity patients seeking specialized care at a high level, hospital-based provider. This suggests that many of these patients would still bypass MUSC's proposed freestanding ED to seek care at the hospital-based emergency room, even if they had the option of the proposed FSED.

Further, as discussed and analyzed in detail above, the proposed project does not meet a geographic need. It is proposed to be situated between three ED providers and located in a county that currently has two other freestanding emergency departments. There are many other areas in the Tri-county area that have less geographic accessibility to ED services that are more proximal to MUSC's existing patient base if accessibility to its existing patients is genuinely the impetus for this project.

In addition, patients who reside within the ZIP code in which the proposed facility is to be located are accessing ED services at a rate well above the area and the state. As shown in **Exhibit 7** below, residents of ZIP Code 29483 experienced 72.4 visits per 100 population during the period for April 2015 - March 2016. In contrast, the Tri-County average and the State average are 41.6 and 43.3 visits per 100 population, respectively. This comparison indicates that a significant part of MUSC's proposed service area is already accessing ED services at a rate

well above others in the county, Tri-County area, and the state. It also suggests that there are sufficient ED providers available to this area, especially considering the expansions and additional providers that will come online in the next three years.

**Exhibit 7**
**Tri-County Area**
**Comparison of ED Visits per 100 Population**
**CY 2015**

| County | 2015 Visits per 100 Population |
|---|---|
| 29483 Summerville, SC* | 72.4 |
| Charleston County | 44.3 |
| Dorchester County | 42.1 |
| Berkeley County | 38.5 |
| Tri-County Average | 41.6 |
| State Average | 43.3 |

*Rate is for the time period 4/1/2015 -3/31/2016
*Sources: Data Request - Revenue and Fiscal Affairs Office, Application for Matter No. 2459, p27*

Overall, MUSC has not demonstrated that the proposed project is needed or will have any positive effect on the patient experience. The Applicant has not mentioned or demonstrated that there are currently capacity constraints among the existing providers in the area or that there are excessive wait times at the current ED providers. Moreover, MUSC has failed to demonstrate any capacity constraints or delays at its own hospital-based ED. In addition, MUSC has not demonstrated that there will be any cost savings to the patient or enhanced patient experience by using the proposed freestanding ED over one of the existing and approved EDs in the Tri-County area. The Applicant affirms in the application that the proposed FSED will operate as a hospital department and will utilize the same charge schedule of MUSC Medical Center. As a result, use of the freestanding ED will not result in any cost-efficiencies for the patient.

It should also be noted that in its financial projections, MUSC presents budgets for 2020-2023, while it states that the proposed project will come online in the second half of 2018.

In conclusion, the Applicant fails to demonstrate need for this project in terms of geographic and medical accessibility or any benefit to the patient in terms of cost or time savings, and as a result this project should not be approved based on, but not limited to, the reasons outlined above.

If you have any questions regarding these comments, please feel free to contact me.

Sincerely,

Kathryn M.T. Platt
President

# EXHIBIT E

NEXSEN|PRUET

**Ralph W. Barbier**
Member
Admitted in SC

July 31, 2017

**VIA EMAIL AND U.S. MAIL**

murdocmp@dhec.sc.gov

Maggie P. Murdock, Esq.
Director, Certificate of Need Program
South Carolina Dept. of Health & Environmental Control
301 Gervais Street
Columbia, SC

Re: Medical University Hospital Authority d/b/a MUSC Emergency Services Construction of a 15,300 square foot Freestanding Emergency Department ("FSED") in Berkeley County at a total project cost of $13,584,161
Matter No: 2459

Charleston
Charlotte
**Columbia**
Greensboro
Greenville
Hilton Head
Myrtle Beach
Raleigh

Dear Ms. Murdock:

On behalf of our client CareAlliance Health Services d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital and Roper St. Francis - Berkeley Hospital, Inc. (collectively from time to time "Roper St. Francis"), please accept this letter as additional information in opposition to the referenced Certificate of Need application.

Under South Carolina law, "***The Department may not issue a Certificate of Need unless an application complies with the South Carolina Health Plan, project review criteria, and other regulations.***" *S.C. Code Ann. § 44-7-210(B)* (emphasis added). The South Carolina Health Plan under which the referenced Certificate of Need application is being reviewed clearly states that "***All off campus emergency services must be an extension of an existing hospital's emergency service in the same county ...***" *South Carolina Health Plan, Enacted August 13, 2015, Chapter XI, pg. IX-4 Standard 2.*. The applicant MUSC does not have an existing hospital in Berkeley County, and therefore fails the first requirement under Standard 2. The only exception to this Standard is if the county in which the applicant proposes to locate a freestanding ED does not have a licensed hospital. As the Department is aware, both Roper St. Francis and Trident Medical Center were issued certificates of need and are currently in the process of

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Nexsen Pruet, LLC
**Attorneys and Counselors at Law**

constructing two 50-bed acute care hospitals in Berkeley County. Accordingly, as a matter of law, MUSC's application must be denied. It would lead to an absurd result if the exception to Standard 2 were interpreted to allow MUSC to open a freestanding ED at the same time that Roper St. Francis and Trident Medical Center are constructing two hospitals in Berkeley County. This would certainly run contrary to the intent of Standard 2 and violate South Carolina Code 44-7-21(B).

In interpreting standards in the South Carolina Health Plan, the South Carolina Court of Appeals has applied the common law rules of statutory construction:

> "A statute as a whole must receive practical, reasonable, and fair interpretation consonant with the purpose, design, and policy of lawmakers," and "the language of the statute must be read in a sense that harmonizes with its subject matter and accords with its general purpose."(citation and internal quotation marks omitted)); *id.* At 128-29, 750 S.F.2d at 63 (holding that words in a statute must be construed in context and that the court "may not, in order ****186** to give effect to particular words, virtually destroy the meaning of the entire context; that is, give the particular words a significance which would be clearly repugnant to the statute, looked at as a whole, and destructive to its obvious intent(citation and internal quotation marks omitted))."

Trident Medical Center v. South Carolina Dept. of Health and Environmental Control, 772 S.E.2d 177 (S.C. Ct. App. 2015) (citing Cf. Spark v. Palmetto Hardwood, Inc. 750 S.E.2d 61, 63 (S.C. 2013).

The South Carolina Supreme Court has further held:

> "However, regardless of how plain the ordinary meaning of the words in a **statute**, courts will reject that meaning when to accept it would lead to a result so plainly absurd that it could not have been intended by the General Assembly."

Duke Energy Corp. v. South Carolina Dept. of Revenue, 772 S.E.2d 177 (S.C. 2015).

Roper St. Francis respectfully requests that the Department notify MUSC that this application fails Standard 2, and therefore, no further review of the application is required, and the application is denied as a matter of law.

Thank you for your consideration.

Very truly yours,

Ralph W. Barbier

cc: Shannon Cantwell
Kathy Platt

# EXHIBIT F

# Comments in Response to Applications for Freestanding Emergency Departments in Berkeley County

ROPER ST. FRANCIS

**Roper St. Francis Healthcare**

**Matter Nos. 2440 and 2459**

**August 24, 2017**

# Overview

- There is abundant existing and approved access to ED services in the proposed service areas. As a result, there is no community need for these projects.
- MUSC Emergency Health Services fails to meet Standard 2 of the SHP and cannot be approved. In addition, it does not conform to other Standards and relevant Project Review Criteria.
- Summerville FSED fails to meet SHP Standards and Project Review Criteria as its application fails to show improved access to services and community need.

ROPER ST. FRANCIS

# There is No Community Need for Either of the Proposed Projects

- There is abundant access to emergency services in Berkeley County and for residents of the proposed service areas.
- Multiple providers have been granted expansions to existing projects and two new hospital based providers of ED services will come online in Berkeley County in the next two years
- Neither application quantifies or demonstrates any access or wait issues with current providers of ED services in the proposed service areas or within their own EDs.

ROPER ST. FRANCIS

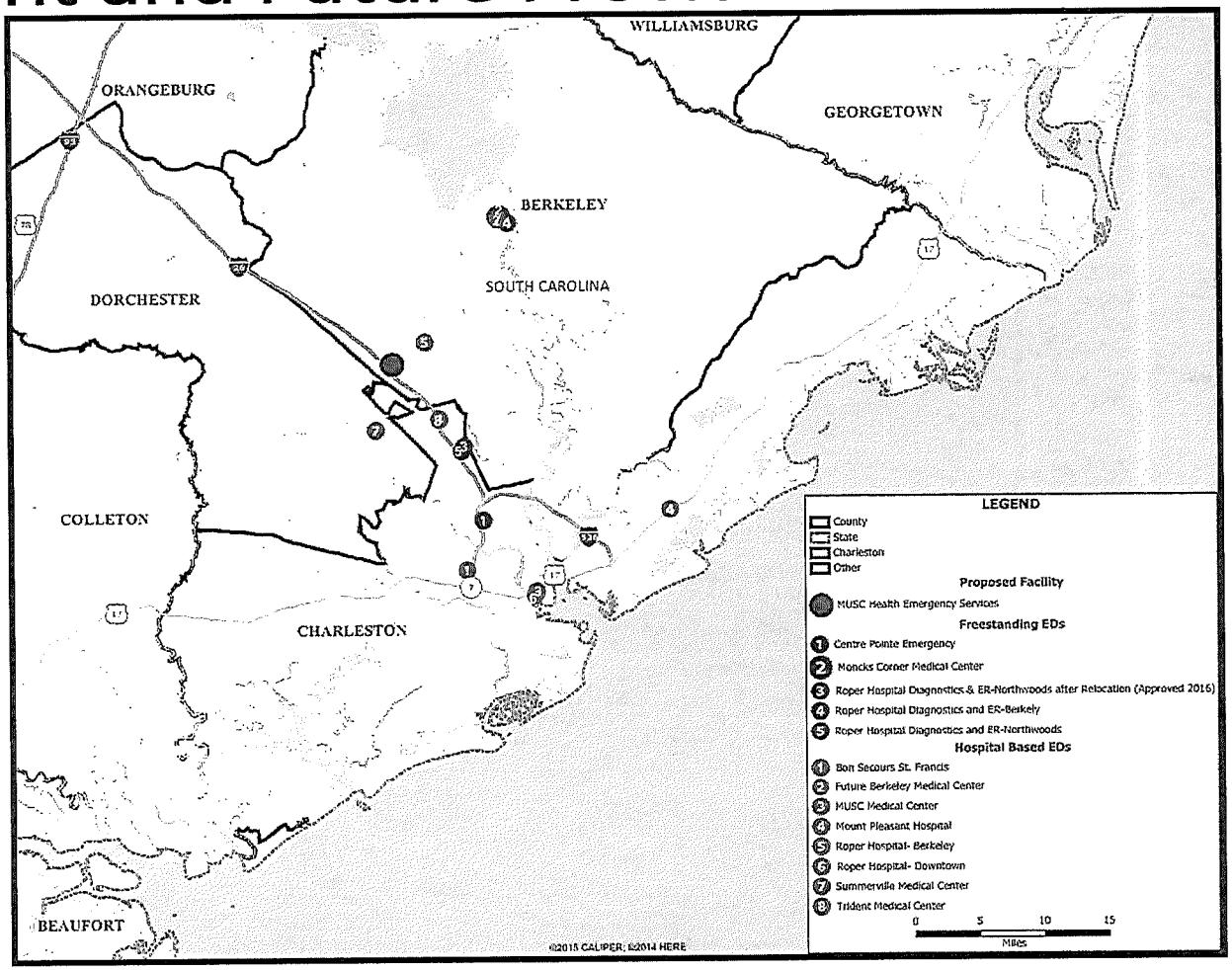
# Current and Future Providers of ED Services in the Tri-County Area

| Facility | Affiliation | Type | Status | Location |
|---|---|---|---|---|
| Bon Secours St. Francis | Roper St. Francis | Hospital | Existing | Charleston/ West Ashley |
| Roper Hospital | Roper St. Francis | Hospital | Existing | Charleston/ Peninsula |
| Mount Pleasant Hospital | Roper St. Francis | Hospital | Existing | Charleston/ Mt. Pleasant |
| MUSC Medical Center | MUSC | Hospital | Existing | Charleston/ Peninsula |
| Trident Medical Center | Trident | Hospital | Existing and Approved for Expansion | Charleston/ North Charleston |
| Summerville Medical Center | Trident | Hospital | Existing | Dorchester County |
| RSFH – Berkeley | Roper St. Francis | Hospital | Approved | Berkeley County |
| Berkeley Medical Center | Trident | Hospital | Approved | Berkeley County |
| Roper Hospital Diagnostics and ER - Northwoods | Roper St. Francis | Freestanding | Existing and Approved for Relocation/ Expansion | Charleston/ North Charleston |
| Roper Hospital Diagnostics and ER - Berkeley | Roper St. Francis | Freestanding | Existing | Berkeley County/ Moncks Corner |
| Moncks Corner Medical Center | Trident | Freestanding | Existing | Berkeley County/ Moncks Corner |
| Centre Point Emergency | Trident | Freestanding | Existing | Charleston/ North Charleston |

ROPER ST. FRANCIS

BOA 0207

# Current and Future Providers of ED Services




ROPER ST. FRANCIS

# Both Proposed Facilities are Within 15 Miles of Six Existing Providers

| | Proposed MUSC Health Emergency Department to: | | Proposed SMC ED to: | |
|---|---|---|---|---|
| Facility | Distance (miles) | Time (minutes) | Distance (miles) | Time (minutes) |
| Roper St. Francis- Berkeley | 3.9 | 8 | 3.4 | 7 |
| Trident Medical Center | 7.5 | 11 | 7.8 | 11 |
| Summerville Medical Center | 7.5 | 18 | 10.1 | 19 |
| Roper Hospital Diagnostics & ER- Northwoods (Existing) | 11 | 15 | 11.3 | 16 |
| Roper Hospital Diagnostics & ER- Northwoods (Relocated) | 12 | 17 | 12.3 | 17 |
| Moncks Corner Medical Center and Berkeley Medical Center | 15.4 | 22 | 15.2 | 22 |
| Centre Pointe Emergency | 16.2 | 18 | 16.2 | 20 |
| Roper Hospital Diagnostics & ER- Berkeley | 16.4 | 26 | 15.9 | 25 |
| Bon Secours St. Francis | 20.9 | 25 | 21 | 27 |
| MUSC Medical Center | 23.8 | 31 | 24.1 | 31 |
| Roper Hospital- Downtown | 24.1 | 28 | 24.1 | 31 |
| Mount Pleasant Hospital | 33.4 | 40 | 33.5 | 44 |

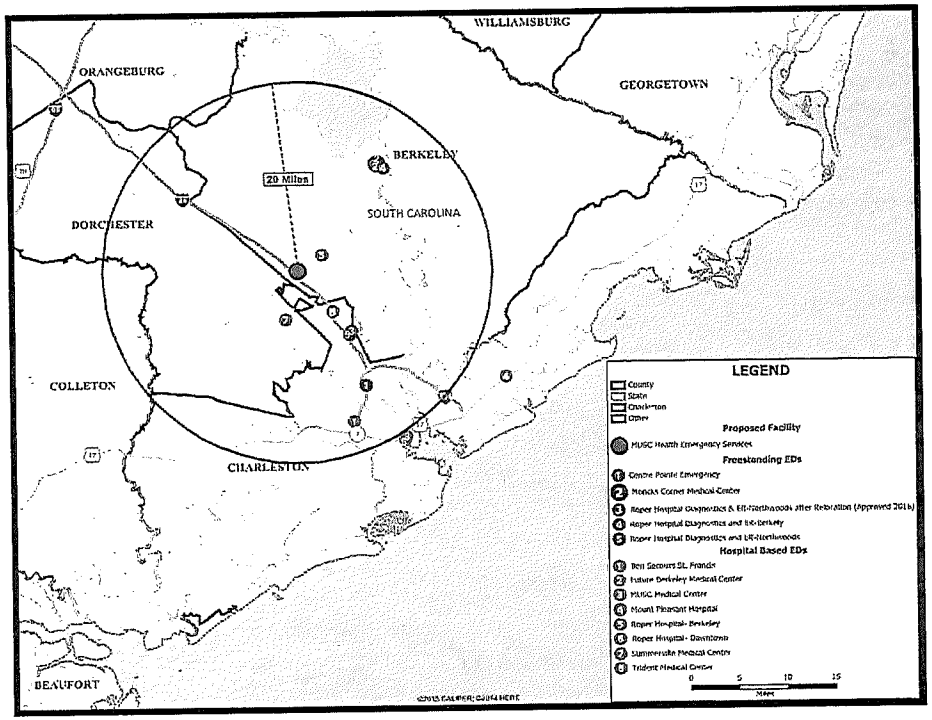
*Source: googlemaps.com 2017*

ROPER ST. FRANCIS

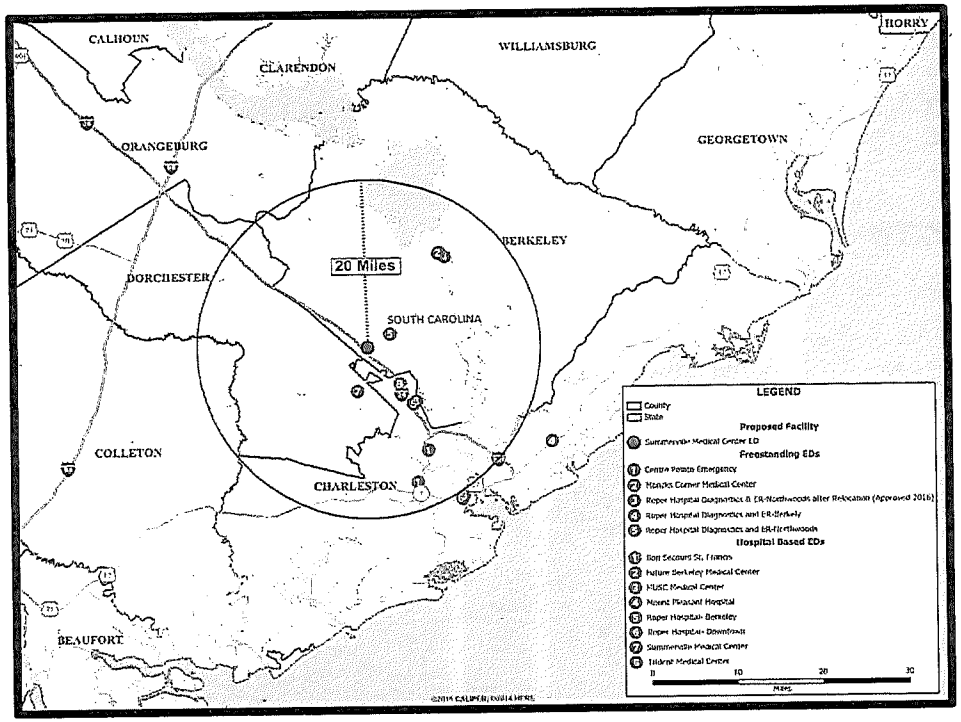
RCSA 0209

# 20-mile Radius Maps

## MUSC Health Emergency Services




## Summerville Freestanding ED




ROPER ST. FRANCIS

# Existing and Proposed Berkeley County ED Providers

- Existing and Approved Providers (4 Total)
  - Monks Corner Medical Center (Freestanding)
  - Roper Hospital Diagnostics and ER – Berkeley (Freestanding)
  - Berkeley Medical Center (Approved - Hospital Based)
  - Roper St. Francis – Berkeley (Approved – Hospital Based)

- Proposed Providers (2 Under Review)
  - MUSC Health Emergency Services
  - Summerville Freestanding ED

**If approved, there would be 6 ED providers in Berkeley County.**

ROPER ST. FRANCIS

# Existing and Proposed ED Capacity in Berkeley County

| Provider | Bays | Visit Capacity per Bay | Total Visit Capacity |
|---|---|---|---|
| Monks Corner Medical Center | 8 | 3,000 | 24,000 |
| Roper Hospital Diagnostics and ER - Berkeley | 13 | 3,000 | 39,000 |
| Roper St. Francis Hospital - Berkeley | 15 | 3,000 | 45,000 |
| Berkeley Medical Center | 13 | 3,000 | 39,000 |
| **Total Existing and Approved Capacity** | **49** | **3,000** | **147,000** |
| Proposed MUSC FSED | 12 | 3,000 | 36,000 |
| Proposed Summerville FSED | 10 | 3,000 | 30,000 |
| **Total Capacity after Proposed Projects** | **71** | **3,000** | **213,000** |

ROPER ST. FRANCIS

# Multiple ED Expansions are Underway in the Proposed Service Areas

| Provider | Bays | Visit Capacity per Bay | Total Visit Capacity | Distance from MUSC EHS | Distance from SFSED |
|---|---|---|---|---|---|
| Trident Medical Center (Expansion)* | 8 | 3,000 | 24,000 | 7.5 | 7.8 |
| Roper Hospital Diagnostics and ER - Northwoods (Expansion) | 5 | 3,000 | 15,000 | 12 | 12.3 |
| Roper St. Francis Hospital - Berkeley | 15 | 3,000 | 45,000 | 3.9 | 3.4 |
| Berkeley Medical Center | 13 | 3,000 | 39,000 | 15.4 | 15.2 |
| Proposed MUSC FSED | 12 | 3,000 | 36,000 | | |
| Proposed SFSED | 10 | 3,000 | 30,000 | | |
| Total NEW Capacity within 20 Mile Radius if both projects are approved | 63 | 3,000 | 189,000 | | |

ROPER ST. FRANCIS

# Introduction

John Walters, M.D.

Chairman

Roper St. Francis Emergency Services

ROPER ST. FRANCIS

ROA 0214

# MUSC Does Not Meet the SHP Standards for FSED and Does not Meet Other Relevant Project Review Criteria

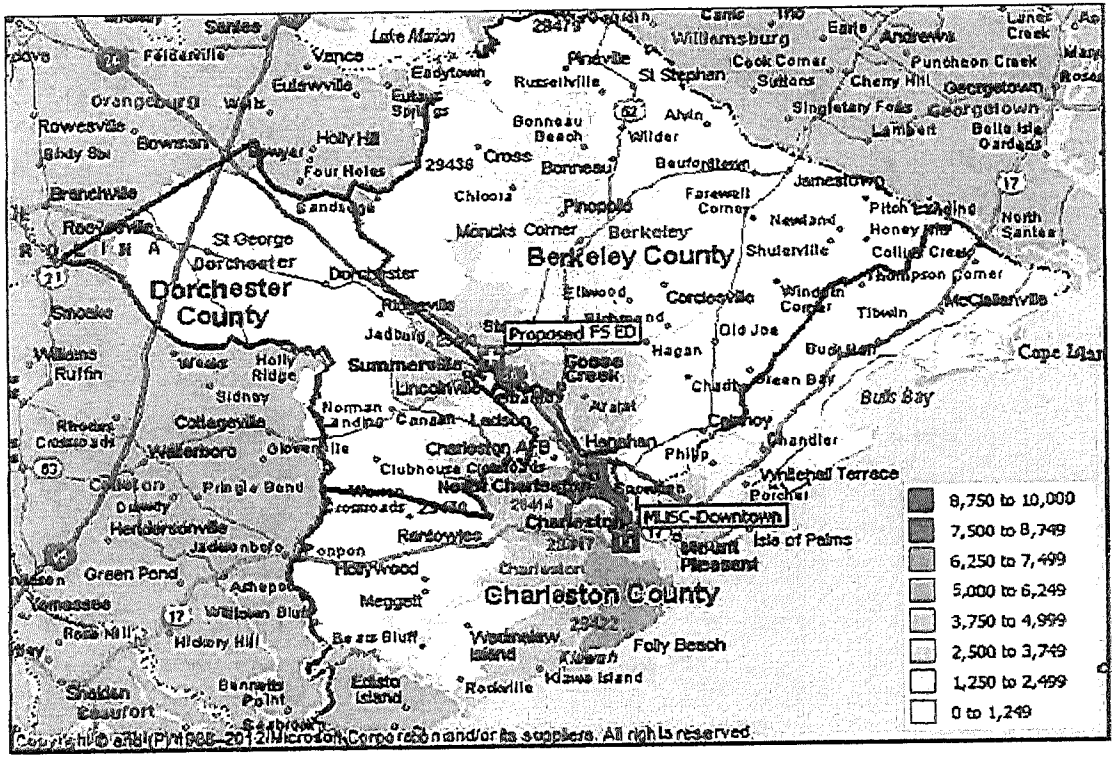
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*"All off-campus emergency services must be an extension of an existing hospital's emergency service in the same county, unless the applicant is proposing to establish a freestanding emergency service in a county that does not have a licensed hospital. The hospital must have a license that is in good standing and must be in operation to support the off-campus emergency services." – Standard 2, 2017-2018 SC Health Plan*

- MUSC Does not Operate a Hospital in Berkeley County
- Berkeley County has two approved hospitals which are currently underway with development and construction.
- The proposed FSED does not represent an extension of the downtown Hospital's existing emergency service.
- As a result, MUSC does not meet Standard 2.

ROPER ST. FRANCIS

# Existing Patient Origin Demonstrates that the Proposed Project is not an Extension of the Downtown Hospital




- There are numerous existing providers between these counties and MUSC.
- In all likelihood, patients traveling from distant locations are bypassing these other providers to seek a higher level of care in truly emergent situations.
- It is unlikely, these patients would still bypass the proposed FSED to seek care at the hospital.

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*"The applicant must demonstrate need for this service by documenting where the potential patients for this proposed service will come from and why they are not being adequately served by the existing services in the area." – Standard 6, 2017-2018 SC Health Plan*

- MUSC fails to identify the service area.
  - *"Berkeley County resident redirection by ZIP Code ranged from 25% to 75%. Dorchester County resident redirection by ZIP Code ranged from 25% to 75%. Charleston County redirection by ZIP Code ranged from 0% to 60%." – p23 Application, Matter No. 2459*
- MUSC fails to demonstrate that any service area residents are not being adequately served by the existing EDs in the service area.
- Instead, MUSC states that the proposed facility will its alleviate its own capacity constraints downtown. However, it does not quantitatively or anecdotally support these statements.

ROPER ST. FRANCIS

# Relevant Project Review Criteria for MUSC Health Emergency Services

## The Proposed Freestanding ED Does Not Meet a Community Need, Improve Access, or Promote Cost Containment

ROPER ST. FRANCIS

# Community Need

- MUSC cites improving access to ED services for its existing patient base while relieving capacity constraints at the downtown hospital as the impetus for this project.
- First, MUSC never quantifies or describes any capacity constraints, wait times, or other issues experienced at the downtown hospital.
- It only quantifies the number of visits and a 5.2 percent growth in visits in the past three years (Application for Matter No. 2459, p. 22).
- No other documentation or letters are provided to quantify capacity constraints for MUSC and document its present level of utilization in relation to capacity. Current average wait times are also not quantified or discussed within the application.

ROPER ST. FRANCIS

# Improved Access

- MUSC states that this project will shift its own patients to a more accessible location in order to alleviate the capacity constraints experienced at the hospital.
  - Not a logical assumption given the current patient origin presented by the Applicant.
- The proposed project does not meet a geographic need.
  - It is proposed to be situated between three ED providers and located in a county that currently has two other freestanding emergency departments in addition to two hospital-based EDs that are currently underway
- Patients who reside within the ZIP code in which the proposed facility is to be located are accessing ED services at a rate well above the area and the state.

ROPER ST. FRANCIS

# Comparison of ED Visits per 100 Population

| County | 2015 Visits per 100 Population |
|---|---|
| [illegible] | [illegible] |
| Charleston County | 44.3 |
| Dorchester County | 42.1 |
| Berkeley County | 38.5 |
| Tri-County Average | 41.6 |
| State Average | 43.3 |

*Sources: Data Request - Revenue and Fiscal Affairs Office, Application for Matter No. 2459, p27*
**Data is for 4/1/20105-3/31/2016*

ROPER ST. FRANCIS

# In Summary

- MUSC fails to meet Standard 2 and should be denied on this factor alone.
- In addition...
  - MUSC has not demonstrated that the proposed project is needed or will have any positive effect on the patient experience.
  - MUSC has not mentioned or demonstrated that there are currently capacity constraints among the existing providers in the area or that there are excessive wait times at the current ED providers.
  - MUSC has failed to demonstrate any capacity constraints or delays at its own hospital-based ED.
  - MUSC has not demonstrated that there will be any cost savings to the patient or enhanced patient experience by using the proposed freestanding ED over one of the existing and approved EDs in the Tri-County area.

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# Trident's Summerville Freestanding Emergency Department Does Not Meet the SHP Standards for FSED and Does not Meet Other Relevant Project Review Criteria

ROPER ST. FRANCIS

ROA 0224

# SFED's Application Conflicts with Its Written Arguments Submitted in Opposition of Roper Hospital Diagnostics and ER – Northwoods CON Application (Matter No. 2344) to Relocate

- In 2016, Roper St. Francis applied to relocate its existing 10-bay FSED in North Charleston and simultaneously add five additional bays as part of the relocation to alleviate capacity issues.
- Trident Health System opposed this application.
- In an opposition letter dated November 2, 2016, Trident makes a number of statements that conflict with the introduction of the proposed application for SFED.
- The letter suggests that additional capacity is not needed due to approvals and initiation of services at:
  - Centre Pointe Emergency
  - Trident Medical Center
  - Roper St. Francis – Berkeley Hospital

ROPER ST. FRANCIS

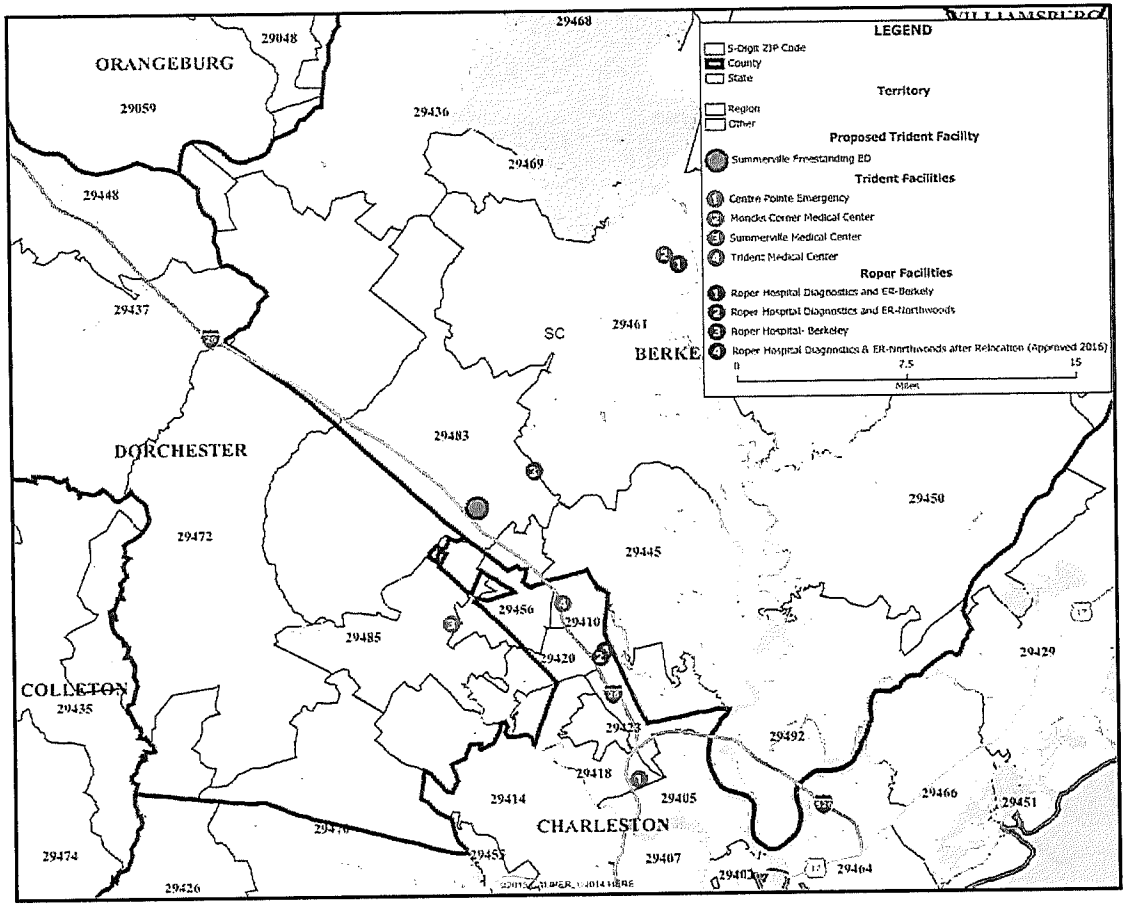
# Trident's Basis for Northwoods Opposition

Trident is not challenging Roper-Northwoods need to address the flooding issues it has experienced in the past two years. Trident's principal concern with the proposal is with the proposed increase in capacity at a time when significant new emergency department capacity is becoming available to serve much of the service area that Roper-Northwoods has historically served. *- Dan Sullivan, November 2, 2016 Letter of Opposition, p.1*

**Trident identifies this "new emergency capacity" to be Centre Pointe Emergency, Trident Medical Center expansion, and Roper St. Francis Hospital – Berkeley.**

ROPER ST. FRANCIS

# SFED's Primary Service Area Consists of Four ZIP Codes




- 29483, 29456, 29485, 29472
- Service area is significantly smaller than other Trident System EDs
  - Centre Point Emergency – 9 ZIPS
  - Trident Medical Center - 14 ZIPS
  - Application does not fully identify PSA of Summerville Medical Center

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# SFED is Proximal to the Expanded Capacity It Identifies in Northwoods Opposition and has Significant Overlap in Service Area

| Facility | Distance from SFED (miles) | Distance from SFED (minutes) | Description of Overlap with SFED Service Area |
|---|---|---|---|
| Centre Pointe Emergency | 16.2 | 20 | One of four primary service area ZIP Codes |
| Trident Medical Center | 7.8 | 11 | Three out of four ZIP Codes are in the primary service area for TMC; these four ZIP codes made up 30% of TMC ED volume in 2015 and 2016. |
| Roper St. Francis Hospital - Berkeley | 3.9 | 7 | SFED will be located in the ZIP code immediately adjacent to RSFH-Berkeley; large overlap of service area ZIP Codes |

ROPER ST. FRANCIS

# Statements Made by Trident Regarding the Northwoods application in its November 2, 2016 Letter of Opposition

- *"Centre Point Emergency's service area overlaps substantially with Roper-Northwood's service area.... While the level of dependence on individual ZIP Codes varies between the two facilities, they are drawing emergency patients from substantially the same population base."*

- *"Trident Medical Center was approved in 2015 for an expansion of its Emergency Department based on its historical volume growth and its development of a Level II trauma program.... As with Centre Pointe, Trident Medical Center's primary service area for emergency patients reflects significant overlap with that of Roper-Northwoods."*

- *"A final concern is the additional Emergency Department capacity that will be created with the opening of Roper-Berkeley Hospital.... A portion of Roper-Northwoods primary service area includes the area proximate to the new hospital in Berkeley County."*

- *ALL OF THESE STATEMENTS ALSO APPLY TO THE PROPOSED SUMMERVILLE FREESTANDING ED*

ROPER ST. FRANCIS

# Resolution of Northwoods Opposition

- Roper St. Francis entered into a settlement with Trident and the Department that allows the relocation of Northwoods, but precludes the five additional patient bays from coming online for three years after the initial licensure of the facility to give previously approved capacity additions the opportunity to be implemented prior to Northwoods' addition.
- Trident has now applied to increase capacity to serve many of the same areas it opposed in the Northwoods application.

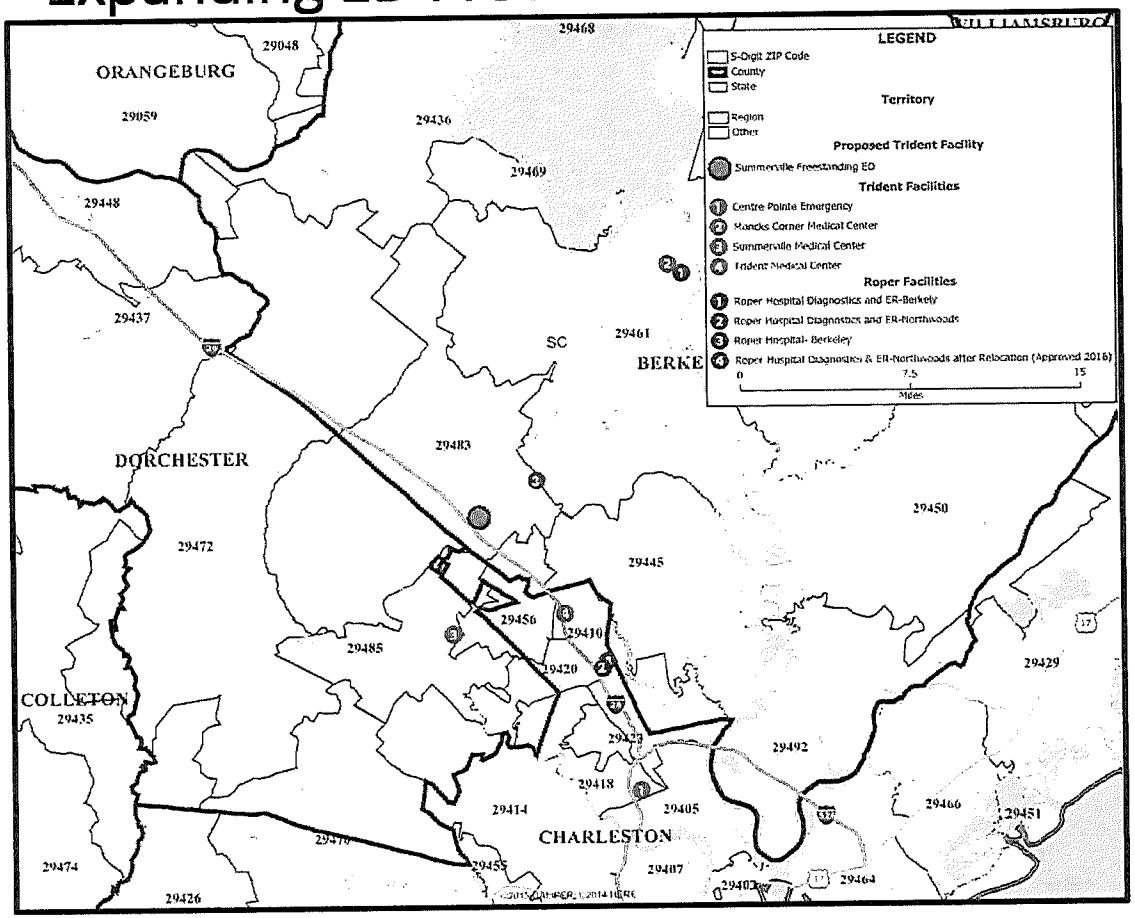
ROPER ST. FRANCIS

## Even Without Considering Trident's Previous Opposition to Northwoods, This Project Does Not Meet a Community Need or Provide Increased Access to ED Services

- SFED is proximal to a number of existing and approved providers.
- Use rates provided by the applicant indicate that the proposed service area counties have abundant access to ED services and utilize ED providers well above the Tri-County and state average.
- Summerville's goals for this project would be better accomplished with an urgent care center than with a FSED.

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# SFED is Proximal to Numerous Existing, Approved, and Expanding ED Providers




- 3 Closest Providers
  - Roper St. Francis Hospital Berkeley ED – will come online in 2018-2019
  - Trident Medical Center – Expansion of ED currently underway
  - Summerville Medical Center

ROPER ST. FRANCIS

RSA 0232

# The PSA ZIP Codes Access ED Service at a Rate Above the Tri-County and State Average

**ED Visits per 100 Population for Proposed Service ZIP Codes 4/1/2015 -3/31/2016**

| ZIP Code | 2015 Visits per 100 Population |
|---|---|
| 29456 Ladson, SC | 52.8 |
| 29472 Ridgeville, SC | 49.7 |
| 29483 Summerville, SC | 72.4 |
| 29485 Summerville, SC | 43.3 |
| Total/Average | 55.8 |

*Source: Exhibit 9 (Application p27)*

**ED Visits per 100 Population for the Tri-County Area and the State CY 2015**

| County | 2015 Visits per 100 Population |
|---|---|
| Charleston (C) | 44.3 |
| Dorchester (D) | 42.1 |
| Berkeley (B) | 38.5 |
| Tri-County Average | 41.6 |
| State Average | 43.3 |

*Source: Data Request - Revenue and Fiscal Affairs Office*

ROPER ST. FRANCIS

# Comparison of SFED Primary Service Area ZIPs to Associated County Rates

| ZIP Code | 2015 Visits per 100 Population | Counties Overlapped by ZIP | 2015 Average ED Use Rate of Counties Overlapped by ZIP |
|---|---|---|---|
| 29456 Ladson, SC | 52.8 | B, C, D | 41.6 |
| 29472 Ridgeville, SC | 49.68 | B, D | 40.3 |
| 29483 Summerville, SC | 72.4 | B, D | 40.3 |
| 29485 Summerville, SC | 43.31 | B,C,D | 41.6 |
| Total | 55.8 | | 41.6 |

*Source: Exhibit 9 (p27), Instant Application for SFED, Data Request - Revenue and Fiscal Affairs Office*

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# Trident Cites the Treatment of Patients of Lower Acuity as the Impetus for this Project

- ***"Current trends indicate that emergency departments are being used more frequently by individuals without insurance whose needs are not emergent. Freestanding emergency departments offer the ability to treat most of the problems experienced by patients presenting to hospital EDs. By serving these less acutely ill patients in a freestanding environment, hospital EDs will have greater capacity to serve patients with true emergent needs (SFED Application, p. 33)."***

- Figures on the previous slides indicate that patients from the proposed service area are likely seeking primary or urgent care in existing EDs.
- SFED does not describe or quantify any existing capacity issues at Summerville Medical Center or any other Trident ED.
- If the intent of the applicant is to alleviate non-emergent cases from hospital-based EDs, a more appropriate option is to develop an urgent care center that would address non-emergent issues at a fraction of the cost of services delivered at a free-standing ED.

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# SFED Does not Meet SHP Standards 2 and 6

- ***"All off-campus emergency services must be an extension of an existing hospital's emergency service in the same county, unless the applicant is proposing to establish a freestanding emergency service in a county that does not have a licensed hospital. The hospital must have a license that is in good standing and must be in operation to support the off-campus emergency services." – Standard 2, 2017-2018 SC Health Plan***
  - Two hospitals are under construction in Berkeley County, one of which is Trident's own facility, Berkeley Medical Center, though this facility is not mentioned in the application.
- ***"The applicant must demonstrate need for this service by documenting where the potential patients for this proposed service will come from and why they are not being adequately served by the existing services in the area." – Standard 6, 2017-2018 SC Health Plan***
  - The Applicant identifies a very distinct service area for this project, but fails to show why it is not being adequately served by the existing services in the area.
  - SFED fails to identify any current barriers to access and actually quantitatively demonstrates that the identified service area has increased access to ED services compared with the individual counties in which it overlaps, the Tri-County area, and the State overall.

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# Conclusion

- There is not a geographic or medical community need for the proposed projects.
- Neither project increases access to ED services.
- Both projects fail to meet several State Health Plan standards for Freestanding ED services.
- MUSC Health Emergency Services' proposed location and existing patient origin does not represent an extension of an existing hospital-based provider.
- Summerville Freestanding ED will provide more costly urgent and primary care through a freestanding ED without any cost benefit to the patient.
- As Dr. Walters stated, existing and approved providers are at risk for staffing shortages if too much ED capacity is brought online at the same time.
- Both CON applications should be denied.

ROPER ST. FRANCIS

CAUSE NO. 417-02948-2019

| | | |
|---|---|---|
| TRIDENT MEDICAL CENTER, LLC, D/B/A TRIDENT MEDICAL CENTER AND SUMMERVILLE MEDICAL CENTER, | § | IN THE DISTRICT COURT |
| Plaintiff, | § | |
| vs. | § | COLLIN COUNTY, TEXAS |
| SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL AND MEDICAL UNIVERSITY HOSPITAL AUTHORITY, D/B/A MUSC HEALTH EMERGENCY SERVICES, | § | |
| Defendants. | § | 417TH JUDICIAL DISTRICT |

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STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

| | | |
|---|---|---|
| Trident Medical Center, LLC, d/b/a Trident Medical Center and Summerville Medical Center, | § | |
| Petitioners, | § | |
| vs. | § | Docket No.: |
| | § | 17-ALJ-07-0441-CC |
| South Carolina Department of Health and Environmental Control and Medical University Hospital Authority, d/b/a MUSC Health Emergency Services, | § | |
| Respondents. | § | |

| | | |
|---|---|---|
| CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital, | § | |
| Petitioners, | § | |
| vs. | § | |
| South Carolina Department of Health and Environmental Control and Medical University Hospital Authority, d/b/a MUSC Health Emergency Services, | § | Docket No.: 17-ALJ-07-0444-CC |
| Respondents. | § | |

**********

ORAL DEPOSITION OF

THOMAS MATTHEW HERRMANN - 30(b)(6)

AS CORPORATE REPRESENTATIVE OF INTUITIVE HEALTH

JULY 18, 2019

CONFIDENTIAL - EXPERTS' AND ATTORNEYS' EYES ONLY

PURSUANT TO PROTECTIVE ORDER

**********

ORAL DEPOSITION OF THOMAS MATTHEW HERRMANN, produced as a witness at the instance of the Petitioner Trident Medical Center, LLC, d/b/a Trident Medical Center, and duly sworn, was taken in the above-styled and numbered cause on July 18, 2019, from 1:00 p.m. to 3:58 p.m., before Karen L. D. Schoeve, CSR, RDR, CRR, in and for the State of Texas, reported by computerized machine shorthand, at the law offices of Ferguson Braswell Fraser Kubasta, PC, 2500 Dallas Parkway, Suite 600, Plano, Texas, pursuant to the Texas Rules of Civil Procedure, the South Carolina Rules of Civil Procedure, and the provisions stated on the record or attached hereto.

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THE COURT REPORTER:

Karen L. D. Schoeve, CSR, CRR, RDR
Realtime Systems Administrator

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REPORTER'S NOTE 1: Please be advised that an UNCERTIFIED ROUGH DRAFT version of this transcript exists. If you are in possession of said rough draft, please replace it immediately with this CERTIFIED FINAL TRANSCRIPT.

REPORTER'S NOTE 2: Quotation marks are used for clarity and do not necessarily reflect a direct quote.

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| Exhibit 67 | Market Capture Analysis Bates stamped IH000336 - 338 Confidential Attorney/Expert Eyes Only | 62 |
| Exhibit 68 | CBRE, Demographic Brief for 1310 N Main Street, Summerville, SC Bates stamped IH000444 - 445 | 137 |
| Exhibit 69 | CBRE, Demographic Brief for Goose Creek Bates stamped IH000446 - 447 | 137 |
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P R O C E E D I N G S

(All deposition exhibits were premarked by Mr. Summer.)

THE COURT REPORTER: If counsel could please introduce themselves for the record, then I'll swear in the witness.

MR. SUMMER: I'm David Summer, here for the petitioner Trident Health System.

MR. SESSIONS: Anderson Sessions on behalf of petitioner Trident Health System.

MR. VOLNEY: John Volney for INtuitive Health.

MR. WESTBROOK: Dan Westbrook for respondent MUSC.

MS. HOLLINGSWORTH: Jennifer Hollingsworth is here with CareAlliance Health Services.

MS. GLOBER: Emily Glober with CareAlliance Health Services as well.

MS. BIGGERS: Ashley Biggers for South Carolina Department of Health and Environmental Control.

THOMAS MATTHEW HERRMANN,

having been first duly sworn to tell the truth, the whole truth, and nothing but the truth, so help him

God, testified as follows:

EXAMINATION

BY MR. SUMMER:

Q. All right. Mr. Herrmann, would you please state your full name for the record.

A. Thomas Matthew Herrmann.

Q. And tell me, what is your title with INtuitive?

A. CEO.

Q. Okay. Have you ever been deposed before?

A. No.

Q. Okay. I'm hoping that your counsel has explained the process to you.

This is what is known as a discovery deposition. Part of it may be used at the time of trial, but for our purposes here today, it's a discovery deposition.

I represent Trident Health System in a certificate of need proceeding in South Carolina regarding the establishment of a freestanding ED in Berkeley County, South Carolina, by MUSC.

So we are conducting this deposition today pursuant both to the Texas Rules and then, obviously, from a subpoena from the State of South Carolina which has been domesticated here in Texas.

The process works this way. I'll ask you questions. It's extremely important that you enunciate an audible answer. It's very easy when we get talking for an hour to say "uh-huh" or "huh-uh" and that does not translate well for either you or me on the record.

So the first rule I'd ask is that you answer audibly for whatever questions I may ask you.

Do you understand?

A. I do.

Q. Okay. The other issue is -- and I need to respect you in the same fashion -- is let me finish the question before you begin your answer because talking over makes it very difficult for the court reporter to get an accurate transcript.

Also, you're entitled to explain any answer that you give me. So if at any point in time you think I'm cutting you off, you're to say, "Excuse me, I've got more to say on that topic." Okay?

I think that from a standpoint of taking breaks and things of that nature, you know, you're in control of that part of this. If you need to take a break, if you need a few minutes, you want to get a glass of water, whatever, all you gotta do

is say, "May we please have a break," and we'll do so. Okay?

A. Understood.

Q. All right. Objections. I think that the South Carolina Rules and the Texas Rules are pretty similar. The bottom line is that the -- really, the objection that you may hear a lot of today may be, "Object to the form."

That's an objection that your counsel or any other counsel may make to a question that I ask. After that has been lodged, then you need to go ahead and answer the question.

So there may be times where your counsel will stop you or interrupt you because he needs to say something, so just pay close attention to, you know, whatever instructions you may get and the rare occasion may be -- because you may be instructed not to answer a question.

Again, I'll instruct you to listen to your counsel regarding any instructions of that nature. Okay?

A. Okay.

Q. All right.

MR. SUMMER: Gentlemen, am I missing anything under the Texas Rules you think I need to

throw out there.

MR. VOLNEY: We talked about designating the entire deposition as confidential, given that some of the -- a large portion of the documents we produced are marked confidential.

MR. SUMMER: I think it's probably -- when we look at the number of exhibits that we've got and that the vast majority of them are marked that way, unless I've got an objection from other counsel, I think that the easiest thing to do is to make the entire deposition subject to the Protective Order for Attorneys' and Experts' Eyes Only.

Obviously, at time of trial it gets utilized -- gets utilized for discovery purposes and because of the number of documents that are marked -- and I don't want that to -- for the record, I want to say that I'm not sure that every one of those designations is appropriate. But in light of the fact that we start trial on Monday, that's not a battle I've chosen to wage.

So I think the easiest thing for us to do is to designate the entire record, from this point forward, as Attorneys' and Experts' Eyes Only.

Any issues from counsel on the phone?

MR. WESTBROOK: No, not from me.

(No response from other telephonic counsel.)

MR. WESTBROOK: David, I just will comment -- and I'm sorry if there's nothing else to be done -- I'm still having a difficult time hearing you from time to time. I don't know if there's anything can be done about that, but . . .

MR. SUMMER: I'm gonna try and get as close to the microphone as I can. Okay, Dan?

MR. WESTBROOK: I understand. And I don't think it's a matter of volume so much as the static.

(Discussion off the record from 1:08 p.m. to 1:09 p.m.)

Q. (BY MR. SUMMER) Okay. I think we've gone through the process. The witness has been sworn.

This is a 30(b)(6) deposition, Mr. Herrmann, so you are here as a designated witness for your company.

Do you understand that notion?

A. I do.

Q. Okay. And because of that, it's extremely important that you be able to answer my questions today. So if at all possible, please bear with me. If I'm asking questions several times, I want to

make sure that we get the information that we need from a company perspective.

Why don't we start this process off.

I have seen several presentations or webinars or slide decks that had a really good background on your company. So I think I -- and some background on you.

So what I'd like to do is dispense with a lot of what we would do on the front end of a deposition so that we can get quickly into the documents and then let that information emerge from the documents as we go through them.

But I do think it would be helpful if you can tell me, when did you -- your company first either contact MUSC or have contact with MUSC?

A. Yeah. So we -- I don't know the exact date. And I talked to Kris Webster, who's the one who actually initiated contact with MUSC, and we don't have the exact date. I just know that it was the second -- roughly, the second half of 2017.

Q. So when you say "the second half," you mean sometime third quarter or later?

A. Correct.

Q. Okay. Of 2017?

A. Yeah. That is our best estimate.

Q. All right. And can you tell me who initiated the contact? Was it initiated by your company or by MUSC?

A. By our company, by Kris Webster.

Q. Okay. And how did you identify MUSC as a potential customer?

A. So we have a sales team, and we also have certain market demographics that we look at.

So if there's a community that's of a certain size that either, in that community, has what we consider to be potential for additional ER capacity -- ER and urgent care capacity, then that kind of makes our target list.

Then we look at the health systems within that area, and if it's somebody that we feel like might be open to partnering or could benefit by our strategy, meaning a way to ensure that they're capturing a greater market share and aren't being cut off from the market because of their position, then that makes it an even better opportunity for us.

And then we also want to make sure that in the state there's been some precedence where freestanding emergency departments have had a path forward moving through the state regulatory process.

And so South Carolina was one of those states.

HCA, Trident, they've opened quite a few freestanding emergency departments. We realized there was some kind of CON process. But even to this day, I don't fully understand it. But -- so we knew there was a path forward.

And so Kris, as part of her territory, was reaching out to probably several different healthcare systems. We felt like Charleston being the largest metro area in South Carolina was an ideal market for us to go after.

MUSC had a good reputation. She was able to get ahold of someone there and get a phone call going just to at least explain what it is that we do.

Q. Okay. Let's go ahead and let's start walking through these documents. I'll try to get more background as we go through, that way we won't be as duplicative.

A. Okay.

(Petitioner's Exhibit 1 referenced.)

Q. (BY MR. SUMMER) Let's start with what's been marked as Exhibit Number 1. That's a two-page document, and it has as its Subject line, "MUSC/Intuitive Health HOPD FSED and Urgent Care

Centers."

Remind me what -- I'm assuming that hospital is hospital based, but what does it stand for, the HOPD?

A. Hospital outpatient department.

Q. Got it. Okay.

What's the relevance of the HOPD designation in your business and what you do?

A. So there's only two states in the United -- out of all 50 where you're actually able to just open up a freestanding emergency department without being a hospital outpatient department. So that's Texas and Colorado.

So a lot of folks hear the word "freestanding emergency department" and they're not very familiar with different ways that you can structure those departments. And they think it's just something that can't be done in their state.

And so as a way to clarify, you need to clarify that this technically is licensed as a hospital outpatient department. They just happen to be offering emergency services in that hospital outpatient department.

Q. Got it. Okay.

This looks -- this is dated

October 30, 2017. And you are listed as one of the attendees.

Do you remember this call?

A. Not specifically. I mean, we had a handful of calls with them, so not -- I mean, no, not specifically.

Q. Okay.

A. This is early days, though, so this would have been kind of general information where we go through our background and who we are.

(Petitioner's Exhibit 2 referenced.)

Q. (BY MR. SUMMER) Okay. If you don't mind, turn over, then, to Exhibit Number 2.

A. (Complied.) Yep.

Q. And I think this is probably a good opportunity to discuss this.

This has a 2017 date on it.

A. Um-hum.

Q. We've done the best that we can do -- could do to get these in chronological order. And you'll see me taking some exhibits today out of order --

A. Sure.

Q. -- because I didn't get it right the first time. Hopefully, we will today as we go through it.

This was the earliest iteration of this document we could find, and from our standpoint, we assumed that this was a document that was shared, if not on the call, that we just looked at on Exhibit 1 sometime in 2017.

What is your knowledge about this document, Exhibit Number 2?

A. I probably created it.

And one thing to point out, too, just so that it doesn't trip us up later in the deposition, is we have this year designation on the presentation which is not always updated.

So, for instance, I'm sure that there's certain presentations that have gone out the door in 2018 that might have still had a 2017 listed on the footer. So I wouldn't take that as, you know, a guarantee other than it couldn't have happened before 2017. So . . .

Q. Got you. It's on there.

Okay. I'm assuming that this is a document that you shared with MUSC?

A. Yes.

Q. Okay. So let's talk about -- if you don't mind, let's just walk through this deck a little bit.

And tell me a little bit about your company's history, starting 2008.

A. Yep. Started in 2008 in Frisco, Texas, by three physicians. They created a new concept.

So in Texas, there was an incredible amount of competition with new freestanding emergency departments. Most of them were operating out-of-network, meaning they weren't contracting with payors.

And then most of them were charging every patient that walked in the door as an ER, which to their, you know, I guess defense, they are calling themselves an emergency department.

But when you put an emergency department in a retail type setting, it's very easy for patients to get confused as to what kind of service they're gonna get from that facility.

They understand when they go to the hospital and there's "ER" on the wall that it's an ER service, but what these physicians had identified while working at a couple of different freestanding emergency departments is that more than half the patients that were showing up there really didn't need ER level services, yet they're walking out with a 2- to $3,000 bill.

And so they felt like they could do it differently, and so they created their own location that was 100 percent in-network and it offered ER and urgent care in the same site.

So if a patient came in, they didn't really have to figure out whether they really should go to an ER or an urgent care anymore. They just come to our location, they get treated, and they get the right bill.

So it's much lower cost to the payor, lower cost to the patient, saves money for everybody, patients love it, high volume, and that's why the business has been so successful. It's one of the reasons.

Q. Okay. Talk to me a little bit more about this notion of a hybrid model.

A. I think I just described it. So it's the ER and urgent care together.

Q. Okay. And I guess my -- what I'm trying to understand is, how did you -- how do you segregate that for operations purposes, payment purposes? I'm just curious, how does that work on a day-to-day basis?

A. Same staff. It's one front door.

So really it's a billing function. So

we have an objective-based resource -- resource-based criteria that determines whether or not a patient would be billed as ER or urgent care.

So as an example, if you came into our facility, doctor writes their orders -- so you've been medically screened, and they say, you know, "He just needs stitches because he had a small laceration on his upper arm." You're gonna walk out with an urgent care bill.

Now, on the other hand, if you walked in and you said that you had abdominal pain and we couldn't quickly ident- -- the physician couldn't quickly identify what it is and they order some more complex tests like a CT scan, for instance, a CT is usually not available in an urgent care center. That would be designated as an emergency visit and ultimately billed as an ER visit.

Q. So basically what you're doing is you're triaging that acuity and making that decision on the front end of the visit? The back end of the visit?

A. After the medical screening exam.

Q. Okay. And that -- is medical screening exam basically the triage?

A. It's more than triage. It's --

Q. Okay.

A. Yeah, so it's a CMS term.

Q. Okay. Jump over and look at the next page, which is 452 of Exhibit Number 2.

And this is the INtuitive team.

A. (Complied.) Oh, yep.

Q. Talk to me about the folks that you have on your team.

How long have you been with the company?

A. I started in March of 2017.

Q. Okay. And where did you come from?

A. Immediately prior, I was with a company called Covalent Health where I was -- at the end of that stint there, was the CEO, so I think we had another -- we had several subbrands, and one of which was ProTransport-1.

Q. And what's your training, your educational background?

A. As far as education, bachelor's of science degree in cell molecular biology, and then I have an MBA with a health sector management concentration.

Q. Okay. Where'd you get your undergrad?

A. University of Washington.

Q. And where'd you get your graduate degree?

A. Duke.

Q. Okay. Talk to me about -- I'm looking at -- because the name is not spelled the same.

Is it Memorial Hermann Southwest?

A. Yeah, no relation.

Q. No relation?

A. No. Just many people stand up straight when I got in the elevator and they saw my badge.

Q. Okay. Talk to me -- the two people that I see the most in the e-mail traffic is Kris Webster and Azar -- is it Zaid?

A. Azar Zaidi.

Q. Zaidi.

A. Um-hum.

Q. Okay. Explain to me what Kris's duties are within the company.

A. She's our salesperson. So her role is to manage new potential customers. So she's kind of the quarterback of the process.

Q. Okay. And then what was Azar's?

A. He did a couple things but really his focus was real estate. So he was kind of our development real estate expert, so when we come into a new market, he worked at the local brokers to identify ideal locations.

He also -- if we did move down the

road with a customer, he would help select the developer who would then develop the property.

And then he also was responsible for inputting data into our pro forma and trying to make sure the data was accurate.

Q. Now, is Kris still with your company?

A. She is.

Q. Okay. And is Azar still with your company?

A. He is not.

Q. Okay. Do you know where he is now?

A. Yeah. I think it's called Lydian Dental.

Q. Okay. Is that here in Texas?

A. They -- I don't know if they're headquartered here. They have locations here. It's a multisite dental business. Actually, I think they might be -- they might be headquartered in Austin.

Q. Okay.

A. He still lives in the area.

Q. How big is your company's footprint?

A. Well, we are in -- as of today, we're in three states. We're gonna be expanding into another three next year so that's roughly the size, I guess.

Q. And what three states are you in right now?

A. Texas, New Mexico, and Indiana.

Q. Okay. And how many facilities total do you own or participate in?

A. So as of today, there are seven that are open. We have another one opening in October, another one opening in November, and then we have seven that are scheduled to open next year.

Q. All right. And then explain to me ownership and/or management structure. Are they all owned? Are they joint-ventured? What do they look like?

A. So this is an important distinction, I think, because I think there may be some misunderstanding. So when we partner with a healthcare system, we do not own the HOPD. So there's some prohibitions against outside entities joint-venturing a hospital.

So the department itself is always 100 percent owned by our hospital partner. What we do with our hospital partner is we will create a new management company, which we will jointly own.

So that management company is also responsible for capitalization of the facility. So we'll basically build that facility. Usually, we use a developer on a build-to-suit lease spaces so

that we work with a developer who actually buys the land, builds -- goes and gets funding, builds the facility, and then they lease it back to this management company that we created.

And then depending on our capital contribution -- because there is some capital contribution for major medical equipment, some working capital issues -- we proportionately own that management company.

That management company enters into a management services agreement with the hospital to manage that new HOPD within provider-based rule guidelines.

Q. Okay. Talk to me about the rest of your team while we're still on this page.

A. Sure.

Q. You've got a chief medical officer named Jay Woody; is that correct?

A. That's correct.

Q. Okay. How long has he been with the company?

A. Since the beginning. He's one of the three founding physicians.

Q. Okay. So he is ED trained?

A. Yes.

Q. Okay. And then who is Pat McColpin?

A. He's our chief financial officer.

Q. Okay. And how long has he been with the company?

A. He came in 2016, I think. I don't know for sure. It was before I got there. It was 2015 or '16.

Q. Okay. How many of these facilities that you currently have up and running are HOPD facilities?

A. One.

Q. Okay. So the rest of them are just freestanding EDs that are not --

A. Well, the other six that are here in Texas are all freestanding emergency departments.

Q. Not aligned with the hospital?

A. Correct. Yeah. The next one opens in October or November. All subsequent locations are in hospital outpatient departments.

Q. Okay.

A. That's our model going forward.

Q. Gotcha.

THE COURT REPORTER: Okay. Excuse me. I'm just gonna have to ask you to slow down a little bit here.

MR. SUMMER: Oh, sure.

THE COURT REPORTER: Okay. The speed is great, but we're just on top of each other, so just down a little bit, please.

MR. SUMMER: Okay.

Q. (BY MR. SUMMER) Go to the next page, 453.

A. (Complied.)

Q. Are any of these folks a part of the original founders?

A. No.

Q. Okay. Go to page 454, please.

A. (Complied.) Um-hum.

Q. What does the phrase -- what does "Legacy" mean? I see "Legacy" a lot on the documents.

A. Yeah. That's a good catch. This was an error, so that should have said "INtuitive." But like I said, there were some quality control issues early on. I hadn't been there very long.

Q. It's an after-the-fact artifact?

A. Yeah, yeah. So the local branding here in Texas is Legacy. So if you want to go to one of our centers, it's Legacy ER and Urgent Care.

We rebranded the company that then partnered with healthcare systems outside of Texas to INtuitive Health.

The reason being is Legacy had a very specific meaning here in the North Dallas area because the first location was built on Legacy Drive, and Legacy is an area of Legacy West, Legacy East, shopping area. People know what it is here.

Outside of Texas, if you say "Legacy," it sounds like, "Oh, that's the way -- the old way of doing things," which we're clearly not doing it the old way. We're doing it a completely new way, which is why healthcare systems are interested in partnering with us.

And so I felt like it was not consistent with our value proposition, so we rebranded the company to INtuitive Health.

Q. Go over, if you would, to page 456, please. "Patients have more choices than ever before to meet their health needs, but are often unsure where to go when care is needed."

If I'm reading this correctly, the two bottom lines above the Bain ER source have a percent going to urgent care center and then a percent going to ER.

A. Um-hum.

Q. So if we take "Cold and flu symptoms," for example --

A. Yep.

Q. -- your tracking of this survey is that 29 percent show up at the urgent care center versus 7 going to the ED.

Am I reading that right?

A. So these were responses. So this isn't actual data. These were 700 patients that were surveyed.

Q. And were these your patients?

A. No. These are -- so Bain -- an outside entity, Bain Consulting, conducted a survey.

Q. Okay.

A. And so they surveyed patients and they said, "Okay. For these eight common conditions, if you had a choice of going to ER, urgent care, Minute Clinic, primary care physician, or would not seek treatment, where would you go?"

And so then they answer, and the percentages down below are just showing what percentage of those patients said UC or ur- -- or ER.

Q. Okay. All right. That's very helpful. Thank you.

Let's go on over to page 457. I'm looking at Number 2, "Patient-centered care in

convenient retail locations."

How do you define a retail location as far as your business is concerned?

A. Where there's other retail businesses, grocery stores, Target, Walmart, quick service restaurants, Apple store. So retail.

Q. And so why do you look for retail locations, you know, as opposed to, I don't know, other accessible areas in a community? What's the benefit of being there?

A. So our -- you know, our model is built on that moment of ouch. We call it the moment of ouch, which is the patient all of a sudden, you know, hurts themselves playing a sport or they start feeling really sick.

Up until that point, they weren't thinking about us at all. And so we want to be in an area that they're seeing on a regular basis or on their commuting pattern or on -- you know, have you ever heard of the gallon of milk rule?

So, you know, where do you go, it's 8:00 at night and you need a gallon of milk? And there's only a certain distance somebody's gonna go, and they know where they're gonna go for that gallon of milk at that time.

That's where we want to be for the most households we can, because if they need some kind of thing right away, some health issue, they're gonna go to that place right then and there. And so that's why we center ourselves in those type of retail settings.

Q. People want to go in their neighborhood?

A. Exactly. Somewhere easy to get to.

Q. Okay. Jumping over to page 458. Explain to me what you're trying to depict here.

A. And so health systems, you know, they've got a diff- -- what we're positioning ourselves is an alternative front door to the healthcare system. And they have a lot of different options and a lot of times they have different sites of care.

So you've got -- they can build new primary care physician offices.

They can build more actual hospitals with ERs.

They can build freestanding emergency departments or urgent care centers.

Patients, though, when they look at those types of locations, are gonna evaluate those sites based on certain types of criteria like how easy is it to access;

how quick can I get in and out of that facility;

what kind of care can I get, I mean, what level of care?

You know, if I -- I'm not gonna go to my primary care physician if I have a broken leg. You know, you're gonna go somewhere else that has a higher acuity capability.

Am I going to get value for what I buy or am I going to get overcharged every time I walk in the door?

Is there follow-up capability?

Can I go back for additional care?

And so just trying to compare our combined ER/urgent care site versus some of the alternatives.

And, you know, sales materials, we're trying to highlight some of the good things about our model or things that we see as good about our model.

Q. I'm interested in this, in particular, looking at the acuity capabilities.

A. Um-hum.

Q. You're not suggesting that freestanding ERs have the same full-service acuity capability

that a hospital-based ER does, do you?

A. They should.

Q. Really?

A. Yeah.

Q. For all neuro, stroke, cardiac, everything?

A. Not all hospitals have neuro or stroke programs.

Not all hospitals have open heart programs at their facility.

Not all hospitals have a cath lab, but they still have emergency departments. So there's variation amongst hospitals themselves.

Q. Okay. That's fair.

So if we're comparing it to a small community hospital, that might be a fair comparison.

If we're comparing it to a tertiary care medical center, it might not be a fair comparison?

A. Probably. For instance, say trauma, you know, if you have a car accident, you're actually going to bypass most hospitals in the community, even some larger ones. You can go to a Level 1 trauma center.

But just to add on to that, think

about a stroke. So if our hospital partner has a STEMI or a stroke protocol, a rapid response protocol, it's implemented in our facility. So that protocol -- the timing. So let's say door to balloon time is your measurement for a STEMI protocol.

You want to make sure that that protocol starts in any emergency site of care. So if their ERs aren't -- their freestanding ERs aren't doing that, that's a disservice to the community.

Ours do, so we're part of that same rapid response protocol.

Q. Yeah, but bottom line, if you show up with a STEMI to a freestanding ER, I don't know if any freestanding ERS have got original cath labs in them.

A. So if you think about showing up to a STEMI, the door to balloon time, there's targets, so you want a 90-minute door to balloon time, as an example.

Even if you go to a hospital, they have to then trigger the cath lab crew and the OR folks to come on-site and get ready while the ER folks are trying to stabilize that patient and get them prepared.

That can be done sometimes faster, even with the transport, at a freestanding emergency department, depending on the distance from the hospital. And by the time that patient gets in the door, they hit the cath lab team. They hit the OR team.

So we've actually found that we have quicker responses than some of our hospital partners.

Q. Interesting.

Turn over to page 459, please. Talk to me about the benefits -- I think here you're just kind of going through why the hybrid works and who it works for.

Give me the -- you know, the 30-second elevator speech on that.

A. So for patients, you no longer have to choose -- you know, I have three kids. There's been multiple circumstances where one of my kids either, you know, hits his head during a sporting event or have a fever. It's like 7:00 at night, and I'm not sure if I need to go to the emergency department or just the urgent care center.

I know how expensive the ER's gonna be, so I go to the emergency depart- -- or the

urgent care center, which I did last -- couple months ago in Seattle because they didn't have a Legacy location there yet. We're gonna get one of those.

But I went and was seen, taken back. You know, took about an hour-and-a-half total. But while the PA, because there's no M.D. in the building, is taking care of my son, he says, "He's probably fine, but just to be safe, I recommend that you go to the emergency department because there's a couple additional tests they can run there."

So I just wasted, you know, an hour-and-a-half plus $200 at the urgent care center, plus I had to go have the terrible experience at the hospital ER, spend $2,000.

And so we fix that for patients. You don't have to pick anymore. Just come to our facility. You get the right service. You get the right care.

Q. Okay.

A. On the payor employer side, for payors, for every patient -- and there's been Milliman studies that have been done that have looked at the percentage of patients that show up at a hospital-based ER that could have been treated in a

lower acuity setting, and it's somewhere between the low end of 40 in the 10 metropolitan markets that we looked at to 60, and at the high end of 60 percent of those patients could have been treated in an urgent care setting or a lower acuity setting.

The average charges are a little over $2,000 for ED or ED avoidable ER visit. Ours is closer to 200 if you were an urgent care patient, so that's about 16- to $1,800 of savings for every one of those patients that we would have converted to urgent care, so a significant financial benefit to the payors.

And then on the health system side, you know, this is a new front door, a lot less expensive than opening up a new hospital. We're fully clinically integrated with our hospital partner using our electronic medical record.

If the patient needs an emergency -- or, excuse me, an admission and they don't have a different personal selection, they're gonna get admitted to our hospital partner, so there's that.

If they need a specialist referral, we'll do everything that's appropriate to keep them in network. Of course, the patient always has the choice.

And then we have incredibly high customer satisfaction scores, which we think benefits the reputation of the healthcare system.

Q. Okay. Tell me where your HOPD programs exist right now.

A. New Mexico and Indiana.

Q. Okay. And who are your partners in each of those states?

A. Presbyterian Health System in New Mexico --

Q. Yeah.

A. -- and Riverview Healthcare System in Indiana.

Q. And how long have you been in those two projects?

A. I think both -- so we started -- so it's a fairly long process by executing transaction documents, so we agreed to move forward and actually getting the building out of the ground and operational.

So I think both of those it was early -- first quarter of 2018.

Q. That you became operational?

A. That we became partners, and now they're just -- the first one just opened this year in June.

Q. And which one is that?

A. Presbyterian.

Q. Okay. Take me over to -- I'm just curious about page 463, the B2B Strategy.

What is that?

A. Business to business. So this is just -- for instance, let's say you're a large self-insured employer. I talked earlier about how we can reduce cost to payors.

If you're a self-insured employer, meaning you're actually taking financial risk for the direct costs of your health plan that you're offering your employees, then you benefit by any cost savings that you can get through the system.

And so we've been able to work with large self-insured employers and municipalities to get them to change plan design to make it more advantageous for their employees for covered lives to come to our site for care in order to save them money.

Q. Got it.

Let's look over on page 465. Just explain to me how these models work.

A. Sure. So in 2014, Medicare, CMS changed certain regulations as to which sites of care that

are operated by a hospital could be designated as a hospital outpatient department.

And the reason that that's important is there's a different reimbursement schedule for a hospital outpatient department than a non. Sounds like you're familiar.

So they changed the rule in 2014 where previously you could -- the hospital could open and license a department within 35 miles of their facility and it would get reimbursed the same way.

In 2014, they changed that for all new services, so they grandfathered existing, changed it for new services where now there's a 250-yard from the campus rule. So wherever that primary campus was, the furthest you can open an HOPD is 250 yards from that campus.

Now, that would really shrink the footprint that we could operate in for freestanding emergency departments if that was the case, but there is a -- in Section 603, there's a dedicated emergency department except- -- exemption, so if you operate a Type A emergency department also as a dedicated emergency department, you're not limited by the 250-yard rule. You can go the 35 miles.

Q. Okay.

A. So that's why we lay that out.

And then our model, then, is the hospital owns that HOPD. They write the attestation to Medicare to set it up.

But what we do is we help them identify the best location for the site, and then we would codevelop or create this new management company that would provide management services to help operate that HOPD within the constraints of provider-based rules.

And we would also be responsible for the build-out and developing the facility itself, and then we would sublease that facility to the hospital as well as provide those management services to the hospital.

Q. Basically, you take everything off the balance sheet?

A. Well, it still hits their balance sheet because if they've got a lease, you got to capitalize the long-term lease.

(Petitioner's Exhibit 3a referenced.)

Q. (BY MR. SUMMER) Okay. Let's go on next to Exhibit 3a.

A. (Complied.) Okay.

Q. I'm assuming that after seeing this

presentation, it must have worked because we got a data request in 3a.

A. Yes.

Q. Is that a fair assessment?

A. Yeah, that's -- move from this -- yeah, step A we got this -- or -- yeah. Step 1, we got step 2.

Q. Okay. So after you provided them with this slide deck, it -- I'm looking at Exhibit 3a --

A. Um-hum.

Q. -- and it says, Tuesday, December 19, 2017.

What we've got here -- and I apologize to you, but we took a lot of information from you and your company and tried to get it at least in strings or e-mail strings that seem to be related to each other.

A. Sure.

Q. And so what I'm looking at here seems to be -- if we go, you know, all the way to the very back, it starts with, for instance, over -- look on page 29.

You've got Kris Webster saying, "Elizabeth, Please see the attached executed document. Please send me the fully executed

document upon completion."

I'm not sure what that is. I'm assuming that that was the original NDA, because if you go to page 28, it's Kris Webster again saying, "Elizabeth, I hope you had a nice Thanksgiving holiday. I wanted to inquire about the NDA. If executed, please send me a copy."

So it appears to me you're, at this point in time in November of 2017, trying to get a nondisclosure agreement executed.

A. Correct. Yeah. So what we do is we request certain financial data so that we can produce a pro forma.

Q. Okay.

A. You know, it's a hypothetical pro forma. It's very early. But in order to do that, we do need certain financial information from the hospital, which is proprietary.

So, I mean, they even have certain types of disclosure agreements with the payors that they can't release their negotiated rates or share with anybody, but we need some of that basic information to put into a pro forma; so we always execute an NDA.

Q. Okay. And then if you look over on page

26 of this Exhibit 3a, this would say -- I'm looking at this. This is coming from Elizabeth Player at MUSC saying, "Good morning Kris, Hope you had a nice week! I've attached the fully executed NDA between Intuitive Health and MUSC. I will plan to send you the completed data request in the next few days."

What data were you looking for from them?

A. There's probably three major categories, and so we'll ask for reimbursement rates by payor class. So, you know, there's gonna be commercial, that we wouldn't want them to provide us Blue Cross and United and Aetna. I just want that as a category.

And then we would request the same thing for their average Medicare reimbursement by level of service, Medicaid, self-pay. So reimbursement data for things that are applicable to our sites.

We would then ask for certain salary information because there's staff that we're gonna employ in the site and there's different wages and different markets. So we want to know how much nurses, CT techs, X-ray techs, front office folks make in that market. We want average physician

hourly rates for ER physicians. So we collect all that information.

And then we do ask for some utilization data. So for their hospital ER, what's the volume, level of service, payor mix, that sort of thing.

And then we go a step further and we ask for zip code of origin for those patients.

Q. Okay.

A. We don't always get that.

Q. But you ask for it?

A. We ask for it.

Q. Okay. And I assume you utilize that for purposes of building a pro forma for a facility?

A. That's correct.

Q. Okay. And did you get that information from MUSC?

A. I think we got all of it except maybe the zip code of origin. So we did get reimbursement data, salary information, payor mix volume from their facility. So, yes, we did get that. But I don't recall if we got the zip code origin data.

(Petitioner's Exhibit 71 referenced.)

Q. (BY MR. SUMMER) I'm gonna hand you what's been marked as Exhibit 71. This is a privileged

document from your client from the attorneys from Align. This is an added document, but it was previously circulated. This is a privilege log from INtuitive.

I'm looking at, say, page 281, Disc -- Disc ID 281. This says an Excel spreadsheet. "MUSC ED visit levels by Payor_Fiscal Year 17."

That data has been withheld, but that's actually data that MUSC has given to you; is that correct?

A. I would -- yeah, probably did.

Q. Okay. Why was that not turned over pursuant to the subpoena?

A. So my understanding is that that is proprietary data for MUSC. So this is their hospital level data, more than likely also has their reimbursement rates in there.

Q. Were you instructed not to share it with us?

A. They did not instruct us.

Q. Okay. Also, if you'd look at -- down the page, 285, "MUSC ED visit levels by payor."

Again, it's the same --

A. Same document.

Q. Okay. How about up towards the top? It

says Disc ID 280. It says, "MUSC ED information."

What would that have been?

A. So --

MR. VOLNEY: Do you mind if I interject since I'm the one who put this together?

MR. SUMMER: That would be great.

MR. VOLNEY: So this is John Volney. When there's a Bates number identified, we've actually produced that document that's the e-mail.

MR. SUMMER: Okay.

MR. VOLNEY: So the one you're looking at, Exhibit -- Disco ID 280, it actually -- that e-mail shows up at IH-105 to 106.

MR. SUMMER: But the attachment's been withheld?

MR. VOLNEY: Yeah, the attachment is 281. That was what we withheld. And you should -- I think in the production it shows up as a native file. I think Mark withheld that. That's what I think.

MR. SUMMER: Okay.

MR. VOLNEY: But sorry. I'm not trying to interrupt. I just want to make it easier since he wasn't the one who put this together.

MR. SUMMER: That's fine. All I'm

trying to do is find out what's going on.

Q. (BY MR. SUMMER) So your understanding is, is that because you believe it's proprietary to MUSC, you did not turn that information over?

A. That's correct.

Q. Okay.

(Petitioner's Exhibit 3b referenced.)

Q. (BY MR. SUMMER) Let's jump over to Exhibit 3b, please.

A. (Complied.)

Q. Looking on page 53 of that exhibit, this is from Kris to Elizabeth Player at MUSC. "I wanted to thank you again for the data."

I'm assuming that's the data we just discussed regarding Exhibit 3a.

A. That's right.

Q. Okay. "Our strategist is working on the financial review."

What is the financial review?

A. So Kris is pretty loose with her language a lot of times, but that's just the pro forma.

Q. Okay.

A. So we'll take -- first -- I mean, it's the pro forma, and then we also got to make sure that the data that they gave us is in the right form.

So sometimes we'll get reimbursement data that's clearly wrong, like it's including something it shouldn't, and so we try to figure that out; and then we'll have to go through iterations of collecting data.

Q. Okay. Look at page 52. And you'll see below that blue bar, about halfway down, "Thank you so much for checking in about how we'd like to review the market assessment deliverable."

What is the market assessment deliverable?

A. So when we -- when we approach a hospital, we say -- we always tell them that "We're gonna take a look at your market, so what we consider to be your primary service area." So within -- and actually, it's not -- "primary service area" has a specific definition.

Really what we're saying is "We'll take a look at a 35-mile radius around each of your acute care facilities, which is the limit of how far we can build one of these, and we're gonna show you where we think there are opportunities to open a successful combined ER/urgent care center." So that would be -- that's what that would be.

Q. I don't know that I found a market

assessment in what was produced, but I'm going to ask you to briefly look at -- if we do identify these as being market assessments, we'll go to your copies.

A. Sure.

(Petitioner's Exhibits 66 and 67 referenced.)

Q. (BY MR. SUMMER) But that's 66 and 67.

By any chance, is that the deliverable that you're referring to?

A. This is part of it, yeah. So this is part of it. So these were sites. But actually, you did have a map, at least in the -- there's a big map and it has a bunch of dots all over it. So that is really the market assessment.

And then this is the data that we plug in to make specific pro formas for some of those sites.

Q. And look at some of the pages attached to these exhibits and see if you don't see -- one of them may have had a map, and I'm not sure if this is in a map.

A. So this is one version of a map, and we have several different types of maps. But this is showing different catchment radius around specific

locations.

Q. Okay. So why don't we do this since we're talking about market assessments here with this exhibit. We're now looking at Exhibits 66 and 67. If you don't mind jumping over and getting your copies of those exhibits. It's --

A. Oh, 66 and 67.

Q. -- towards the -- almost at the very back of the stack. Just go to 66 and 67.

A. (Complied.)

Q. And let's just look at these to see if either one of them might have been what was sent with that e-mail back in 2017. And if not, it's not. But I'm just trying to . . .

A. You know, this is --

(Examined exhibit.) So one of these is probably not that Summerville site that you're looking for, because we've got that Summerville data up above.

Q. Yep.

A. I don't know why it says "Historical."

But I know that there's more than 33,000 in the 15-minute drive around that site. So I -- not that this is pertinent to this deposition, but I believe that that particular site is a Kiawah

location. That's why the population is so small.

And then if we --

Q. So you're looking at what number?

A. This is 66.

Q. Okay. So you think 66 -- okay.

A. So this is probably later than that initial market assessment because we did not look at Kiawah originally.

Q. Okay.

A. It was just something that happened later.

So I think we're comparing -- let's see. Here's Summerville up here, and then this is what that Kiawah site looked like.

Q. Okay.

A. But I'm guess- -- that's my best guess, just because of the population.

Q. So -- it's -- it's interesting, I mean, trying to understand this because you got Site 1, Site 1, and you've got a 15-minute drive time and a 20-minute drive time.

A. Um-hum.

Q. So you think 66 is -- actually, these numbers are identical, are they not?

A. They are the same. So I think that both of those are -- those have to do with that -- a

different site.

Q. Okay. All right. So -- but you would have done some deliverable like this for Summerville.

A. Um-hum.

Q. And we're going back now. I know we're jumping around. But 3b.

A. Yeah. So on this one, you got Summerville on this side. So maybe it was not Kiawah. If you look on the map, the picture, it's got Site 1 and Site 2. You see Summerville in the lower left-hand side. It's not what we're centered on.

Q. Yep.

A. So it's some other site that we had looked at.

Q. In that Berkeley County area?

A. I don't know if it's in Berk- -- that looks like it's probably in Berkeley County. The other one, I'm not sure if it is or not --

Q. Okay.

A. -- Site 2. And -- but I think it's the second page of this Exhibit 67.

Q. Yes.

A. If you look at the population data --

Q. Yes.

A. -- you know, it's much -- much higher.

MR. SESSIONS: 84 and 184.

Q. (BY MR. SUMMER) And you're looking at 15-minute drive times and 20-minute drive times.

This goes back to the notion of that ED being a neighborhood facility, right?

A. Yeah. Yeah. And we -- yeah, we use a different -- smaller radius a lot of times, too, so . . .

Q. Okay.

MR. SUMMER: We're gonna take a quick five-minute break.

THE WITNESS: Okay.

MR. SUMMER: Taking a quick break y'all.

(A recess was taken from 1:54 p.m. to 2:03 p.m.)

THE COURT REPORTER: Back on the record.

Q. (BY MR. SUMMER) All right. We're going back to Exhibit 3b. It looks like that -- I'm looking at page -- top of page 52 of that document that you're gonna try to set up a webinar to go over this deliverable.

Do you remember that webinar?

A. Not specifically, but I recall having webinars, or at least a webinar with them.

Q. Okay. And would it have been similar to the documents we saw at 66 and 67 where you're doing basically a market assessment?

A. Yeah, it more than likely would, along with the pro forma.

Q. Okay.

A. A lot of times you spend more time on the map. So there was like a pretty substantial map. We worked with a local broker to put that together.

Q. And there are some, and we may find them as we go through.

A. Yeah. I'm pretty sure we -- the documents we sent you included at least one of those maps.

(Petitioner's Exhibit 3c referenced.)

Q. (BY MR. SUMMER) Okay. I'm trying to pick up the pace a little bit. But if you go over to Exhibit 3c --

A. (Complied.)

Q. -- it looks to me like it's just, again, trying to set up a time to go through this webinar on this deliverable.

A. Yeah.

Q. Is that what you remember?

A. Yeah. So one of the things that happens in this process is it's never linear. There's new parties that need to be brought in. Things take way longer than you would think to get scheduled. They get scheduled, they get canceled, and then you keep -- you know, part of Kris's job is really to just keep trying to move it along.

(Petitioner's Exhibit 4 referenced.)

Q. (BY MR. SUMMER) All right. If you turn over to Petitioner's Exhibit Number 4. This, I believe, is the NDA that's been referred to in the prior exhibits.

A. (Complied.)

Q. I'm gonna ask you to look on page 9 of Exhibit Number 4, and that is Pat McColpin signing on your behalf?

A. He's signing, yeah, on behalf of the company.

Q. Right. I have a bad habit of just saying "you" and "your" when I'm talking about your company, so --

A. Okay.

Q. -- do call me out when I do.

A. All right.

Q. If I look at the beginning of this

document, it refers to, on the first page, "('Proposed Transaction') concerning a market assessment for healthcare services."

Is that what we were just discussing in the prior exhibits, the market assessment?

A. Correct.

Q. So the NDA creates the confidential relationship for purposes of doing the market assessment, but the NDA does not -- it doesn't serve as a letter of intent or anything like that, does it?

A. Not at all. It just says that we're gonna share some data we don't want you sharing with somebody else. We got to keep it private.

Q. Okay. Did you understand that MUSC is a governmental entity?

A. Yes.

Q. Okay. And did you also understand it was subject to the South Carolina Freedom of Information Act?

A. Yes.

Q. Okay.

(Petitioner's Exhibit 5 referenced.)

Q. (BY MR. SUMMER) Go over to Petitioner's Exhibit Number 5.

A. (Complied.)

Q. Urgent Care Market Assessment Presentation. This is just e-mails. It says, "Intuitive Health will be presenting the market assessment and pro forma developed for consideration of a center using their hybrid ED/Urgent Care model. Materials to be provided to participants in advance of meeting."

In preparing for your deposition today, did you see this document that is being referred to in Exhibit 5 that was going to be sent in advance to all the people participating?

A. I don't know because it -- it's a hard document control, so it is difficult for me to go back and know exactly which versions. We have made many, many versions of the pro forma.

So to know exactly which one was presented at this particular call, I don't know, but I would have seen it.

Q. So what would have been presented, if I understand you correctly, is some type of a market assessment similar in format to what we saw in Exhibits No. 66 and 67, right?

A. Yes, plus the actual pro forma part. That was just the -- just shown in the market capture.

Q. Correct. And so the pro forma would be an operational pro forma for the entity?

A. That's right.

Q. Okay. All right. I have not seen that, but we'll keep plugging along and see what turns up.

A. Okay.

Q. Would you do me a favor? I'm gonna -- I want you to take documents, Exhibits 6 and 7, and set them off to the side because they're not in chronological order. So just set them off to the side, and we'll come back to them later.

A. (Complied.)

Q. Perfect.

A. All right.

(Petitioner's Exhibit 8 referenced.)

Q. (BY MR. SUMMER) Let's go to Number 8, please, sir.

A. (Complied.) There's one of the maps.

Q. There we go. So Number 8 is the market overview, Exhibit 8, and we've got two different attachments to that.

A. Um-hum.

Q. One is a graphic and one appears to be an aerial.

So do you want to talk to me a little

bit about what's being depicted here?

A. Sure. So this is the market assessment, this first page. So essentially --

MR. VOLNEY: Is there a Bates label on it?

THE WITNESS: I can't read it. It's really small.

MR. VOLNEY: It's small. Sorry. You can't see it?

THE WITNESS: No. But I don't know if that's it or not.

MR. SUMMER: Yeah, it's shrunken.

THE WITNESS: Because this is a really large document.

MR. SUMMER: Right.

MR. VOLNEY: It would be page 90, IH 90.

THE WITNESS: Thank you. Okay.

MR. SUMMER: So IH 90.

THE WITNESS: Okay.

A. So what this shows is -- so there's the legend. You'll notice that there's a whole number of dots that come in four colors. So each one of those dots represents a retail area. So it might be a grocery store anchor or something like a Walmart

or a Target.

And then the colors represent where that particular grocery store anchor or retail center falls in our ranking.

So the yellows are the top 25 percent.

And then blue are the next, so the second tier.

Orange are the third tier.

And then any red dots are the bottom quartile.

And that takes into -- we have a fairly complex algorithm that includes things like demographics, projected payor mix, also household density. There's about 25 different things that go into that. So that's one of our criteria evaluation methodologies, but that's what those dots represent.

And then we want to show in relation to those dots what kind of competition or alternative sites of care are available in those areas, and those are represented -- we're just showing ERs and urgent care centers.

Q. (BY MR. SUMMER) Gotcha.

A. So the crosses are urgent care centers. We broke those into three different categories.

The triangles or the Hs are either

freestanding ERs or hospital campus emergency departments.

Q. Okay.

A. And then the circles are just a circle -- I don't know the radius -- I guess the rings are 3 miles, is what it says.

Q. Okay.

A. But each one of those circles is a 3-mile radius around one of those other types of care providers, and it's really just around the different hospitals.

And then it says which system they're part of. So Trident, for instance, is in red. All the red circles are Trident.

Green circles, MUSC, et cetera.

Q. All right. So when we look at -- from your algorithm standpoint --

A. Um-hum.

Q. -- yellow being the most advantageous --

A. Yep.

Q. -- and so yellow would be your greatest likelihood for a positive return on investment, and red would be your least likely opportunity for a return on investment.

Is that a fair statement?

A. At 30,000 feet, this is our first look at it. That was -- that's how it would come out, that's right.

Q. So you're looking to where you can be the most financially successful?

A. Yeah. It's also just volume. So what kind of demand. So if you have a higher density of options in an area, you know, maybe there's enough, and we can look somewhere else, but it's a combination of those things.

Q. Okay. The second -- the third page, which we can read is num- -- is 91.

A. Yep.

Q. A little bit different presentation.

What is this?

A. So this is kind of focusing in more -- so it's not such a high level and just looking at different trade areas. So we have a way to identify trade areas.

And so in this picture, we identified three distinct trade areas. It's got the Summerville, Goose Creek, and North Charleston.

And in those polygons, we -- custom polygons, we identified the demographics in each of those areas.

Q. Okay.

A. And that's just an 8-mile -- roughly, 8-mile drive time for each of them.

Q. So I'm interested, because it looks to me like Goose Creek is higher density and higher population than Summerville.

So why did you not think Goose Creek would be a good place to put one?

A. We might have.

(Petitioner's Exhibit 9 referenced.)

Q. (BY MR. SUMMER) Going over to Petitioner's Exhibit Number 9.

A. (Complied.)

Q. This is from somebody named Ansel Bunch, CBRE Real Estate in Columbia, South Carolina. I actually know him. Seems to be a more detailed document.

Do I have these attachments with the correct e-mail? Can you tell? Because these look like your internal e-mail documents, or are they his?

A. So are you asking if he sent them to us or we sent them to him?

Q. Yeah. I'm just trying to figure out . . .

A. We probably sent this map --

Q. To him?

A. -- to him, and then he may have pulled together the one that says "CBRE" on it.

Q. Gotcha.

What was his role in this venture?

A. So he's just a broker. So he's a real estate agent. So we told him, "Here's some areas that either we were interested in or MUSC was interested in. Please find us the best properties based on these criteria in those areas."

Q. Okay. Did -- interesting.

Who would actually have had the brokerage agreement with him? Would that have been your company or MUSC?

A. I'm not sure if we executed a brokerage agreement with them directly. So a lot of times what happens is we start the search, and then it's a developer that we bring in that executes the brokerage agreement because they're the ones that are gonna purchase the land or site.

Q. So what developer were you working with on this project?

A. I don't think we got far enough to engage a developer on this. So this was all just speculation, like help us do some research.

Q. Did you ever work with Equity, LLC?

A. Well, we work with them in Indiana right now. So they're opening -- they're our developer for the four sites there, and we're also working with them in Florida.

Q. But you're not working with them in South Carolina?

A. We're not doing anything. We have no business in South Carolina.

Q. Okay.

A. MUSC told us they're not moving forward with us on the Summerville location, so we don't have anything in South Carolina.

Q. And when were you told that?

A. It's been well over -- I mean, over six months, probably.

Q. Okay.

A. I don't know the exact date. It's been quite a while.

Q. Was it in 2018 or 2019?

A. It might have -- it could be early 2019. I don't know for sure if it was. Probably early 2019.

(Petitioner's Exhibit 10 referenced.)

Q. (BY MR. SUMMER) Okay. Let's go on to

Number 10, please, sir. Exhibit Number 10.

A. Okay.

Q. Looks like you're presenting another market assessment and pro forma in March.

Does that make sense?

A. It does. So you see we started working with a local broker. We were able to get more specific information. So the first one is a general overview.

The second one, you know, he's able to start getting us, you know, inventory that's available. So it just becomes a more specific discussion.

Q. And, again, you would have provided these materials in advance, according to this e-mail, right?

A. Well, sometimes they would like us to. Usually, we would try our best to.

Now, whether it actually went out in advance, it doesn't always happen that way.

Q. Do you typically at least e-mail it at the time that you're doing the call?

A. Either e-mail it or it could be a webinar.

Q. Okay.

A. It just depends on what type of material

it is. So like the maps, you can see that it would be really hard to present this in a -- you know, something the size of a laptop.

So, usually, that's a much -- it's a big document, so we're not sending that. Well, that's if we are in person, we'll roll the very large document on the table, but we don't share that with them.

Q. Okay.

A. We don't send it to them.

Q. All right.

(Petitioner's Exhibit 11 referenced.)

Q. (BY MR. SUMMER) Again, 10 and 11 both look like they're basically setting up different calls for the 12th.

Is that what it looks like to you?

A. (Complied.) Looks like it.

Q. Okay. Do you know whether or not you participated in those calls?

A. Yeah. Yes, I did.

Q. Okay. And Joe Hutts, why would a member of your board be participating in this?

A. So he is not a normal board member. He's almost like part of our business development team part-time. So there's a little history there.

So when the private equity investors that bought what was Legacy ER & Urgent Care back in 2014, bought it, they didn't have a CEO. And they knew that they needed to hire one, but they didn't know the space really well.

And so they asked Joe to be the chairman of the board, and then in the interim serve as the CEO and help them hire somebody full-time.

And so he did that. But, you know, once I was on board, then, you know, he just now mostly helps us on different business development opportunities.

(Petitioner's Exhibit 12 referenced.)

Q. (BY MR. SUMMER) Go over to Exhibit -- Petitioner's Exhibit Number 12.

A. Okay.

Q. It looks to me like you're having some kind of issue with data.

If you look on page 103, this is Elizabeth Player saying, "I received the MUSC ED data and in reviewing it, noticed that our Analytics group did not provide payments/revenue despite my request for this field."

Do you remember what the stumbling block was in this exchange?

A. Yeah. So more than likely, the revenue that we were provided was overly inflated because it did not include contractual adjustments. So we had to get them to give us the right information. You know, I was talking about how we do multiple versions of these things.

Q. You had gross, but you didn't have net?

A. Yeah, exactly. So huge difference, so we just had to get the right information in order to have a more accurate looking pro forma.

Q. So it looks like you're doing, yet again, another iteration of a pro forma --

A. Yeah.

Q. -- at this point in time several months later, correct?

A. That sounds right.

Q. All right.

A. Which is not uncommon.

Q. Well, hopefully you're refining it and refining it and getting it sharper and sharper, correct?

A. That's the process, yeah, with the health system.

(Petitioner's Exhibit 13 referenced.)

Q. (BY MR. SUMMER) Look over on Petitioner's

Exhibit Number 13, and I'm trying to understand what Azar is referring to with these Level 5s.

And, again, there are -- if I'm looking at it from an institutional perspective, the acuity levels are reversed from the physician perspectives.

Because my understanding is if I have Levels 4 and 5 from a facility-based ER visit, those are low acuities. Number 1 being the highest.

My understanding is the physician coding and nomenclature is exactly the opposite.

Am I correct on that?

A. No.

Q. Okay.

A. So Level 5 is the highest level for a hospital or a physician for an ED visit.

Q. Okay.

A. So 99285 is the highest. You've got 99281 through 285. 1, 2, 3, 4, 5.

Q. And so 5 is the highest --

A. 5 is highest level --

Q. -- of acuity --

A. -- of the hospital.

Q. I'm sorry. We're talking over each other.

A. Oh, sorry.

Q. I apologize. Go ahead.

A. Yeah. So Level 5 would be the highest level ER visit for the hospital and for a physician.

Q. Okay.

A. I think what you might be referring to is a Level 1 trauma center, which is the highest acuity trauma center that you have. Level 2 is lower, Level 3 is lower than that.

Q. We've actually had several hospital folks talk about a separate rating that is different, but I understand where this is coming from.

A. Okay.

Q. I understand that.

So this is Azar saying, "I assume most of those are Level 5 are critical care. Ideally we would want to include those visits but only allocate the ED charges for those codes to the visit (versus the DRG or inpatient charges)."

Is this basically trying to segregate some inpatient numbers from some ED numbers? Is that what he's trying to do?

A. Yeah. So more than likely what has happened -- this has happened with several health systems -- is when we get the data back, you know, Medicare reimburses on a DRG basis.

And so if a patient comes into the ED and there's a Level 5 ED visit, and then the patient is subsequently admitted to the hospital, they're still tagging all the charges, the inpatient admission, everything to that ED visit.

Which, in reality, that's the reimbursement for the inpatient station, not be allocated to the emergency department. And so sometimes we'll see some overly inflated looking Level 5s, maybe even some of that in Level 4s, and it takes, you know, a trained eye to identify when that's happening.

But if we catch it, we can usually work with their analytics department to pull out any inpatient allocation.

Q. Okay. Got it.

(Petitioner's Exhibit 15 referenced.)

Q. (BY MR. SUMMER) I think let's skip 14 only because it dovetails into 15. Both of them, again, talking about charges and building your pro forma and your data.

If we look over on Petitioner's Exhibit 15, page 121, this is basically identifying new data that's being transmitted to your company in April of 2018, correct?

A. So this is for Urgent Care, and this might be . . .

(Examined exhibit.) Is this even related to -- I think this is our utilization for a payor --

Q. Okay.

A. -- in the table on page 119 --

Q. Correct.

A. --and not the hospital's.

Q. I'm looking at 121, and this appears to be a transmittal e-mail. "Again, did not get the data, but I've attached a new file."

This is Elizabeth Player, which contains emergency encounters, E&M only, items and service codes.

To me, it looks like it's another data transmission to you?

A. Um-hum.

Q. And this would've been in April of 2018, correct?

A. (Examined exhibit.) That is correct. Yeah, it took -- as I recall it, it took quite a while to get clean data from them.

Q. To mine it?

A. Yeah.

Q. But, again, this is part of the data that you did not produce because you believed it was proprietary to MUSC, correct?

A. Correct.

(Petitioner's Exhibits 16 and 17 referenced.)

Q. (BY MR. SUMMER) Let's look at 16 and 17 together, if you don't mind.

This is Petitioner's Exhibit 16, Petitioner's Exhibit 17, all of which looks to be trying to set up calls regarding ED rates and pro formas.

Is that your understanding?

A. (Examined exhibits.) Yeah. So I think almost -- my guess is almost any invite that has Haylee McBrayer on the line --

Q. Okay.

A. -- I believe she was an analyst, so I think she's just trying to help us figure out what the data is.

Q. Crunching numbers?

A. Yeah.

Q. Okay.

(Petitioner's Exhibit 18 referenced.)

Q. (BY MR. SUMMER) Go to Petitioner's

Exhibit 18, please.

A. (Complied.) Okay.

Q. This is referencing, I believe, a site visit to MUSC.

Do you recall when you went for your site visit?

A. (Examined exhibit.) I mean, I had gone out there a couple of times, and I know that there was at least one meeting in person where I was not able to attend, but Kris and I think Azar and possibly Joe Hutts went. I just don't know the date on that one.

Q. Okay.

(Petitioner's Exhibit 19 referenced.)

Q. (BY MR. SUMMER) Go over to Petitioner's Exhibit 19, please.

A. (Complied.)

Q. Basically, the Subject line is, "HOLD: INtuitive Health onsite meeting."

Attendees appear to be Thom Herrmann, Joe Hutts, Azar, and Kris. It looks likes everybody is headed towards a meeting on April 18th.

Does this sound familiar?

A. Yeah. (Examined exhibit.) Yes.

Q. Okay.

(Petitioner's Exhibit 20 referenced.)

Q. (BY MR. SUMMER) And then, again, I'm doing my best to put things together.

If you go to Petitioner's Exhibit Number 20, this is another iteration of the presentation we've already looked at.

A. (Examined exhibit.) Yeah.

Q. But it appears to be that you would've given this as an on-site presentation as well?

A. Yeah. The reason being is there were some new players that were introduced into the process, so they had a new SVP of operations, I believe, or strategy that had recently come over, and they brought in, I think, someone who was the head of their emergency department. There were just some people that had not had the presen- -- you know, really knew who we were yet, and so we were bringing them up to speed.

Q. Okay. So, again, you would've disseminated this presentation at least a second time in April of 2018?

A. That's right.

Q. Okay.

(Petitioner's Exhibit 21 referenced.)

Q. (BY MR. SUMMER) Go to Petitioner's

Exhibit Number 21.

A. (Complied.)

Q. If you look on page 156 of Exhibit 21, Elizabeth apparently has some things she wants to share.

"Hi, Azar. We have the files ready to share - do you have a secure upload/sharefile site where I can upload them? The total charge file is quite large, so it would be best not to email the files."

Do you know what she's trying to transmit?

A. I think it's the reimbursement information minus the DRG data. So just . . .

Q. More revenue data?

A. Yeah.

(Petitioner's Exhibit 22 referenced.)

Q. (BY MR. SUMMER) Okay. Go to Petitioner's Exhibit 22, please.

A. (Complied.)

Q. It looks like that y'all are acknowledging that you got the data, correct?

A. Correct.

Q. If you look down on the bottom of page 162, she's describing the data specifically.

"I've uploaded 2 files to the MUSC Box file that you should be able to access.

"The first file is titled MUSC ED Charge Data, fiscal year '17 and contains all the hospital-based charged data for MUSC ED patients for fiscal year '17.

"The, the second file is titled MUSC ED Average Reimbursement Rates by Financial Class, Fiscal Year '17."

Again, this is what you're gonna be utilizing to refine your pro forma, correct?

A. That's correct.

Q. And that's part of the data that you've withheld, correct?

A. Correct.

(Petitioner's Exhibit 23 referenced.)

Q. (BY MR. SUMMER) Go to Petitioner's Exhibit 23, please.

A. (Complied.)

Q. Again, this is just discussions on this data and what you guys are doing to refine it, correct?

A. That's right.

Q. Now, we're gonna start a series of exhibits that appear to be dealing with site

selection.

As a preliminary matter, why did INtuitive think it was important to select a different site than the Nexton site that they had?

A. The Nexton site that we had?

Q. MUSC filed a certificate, they needed an application for a Nexton site, which was a site to be developed with Palmetto Primary Care.

A. Oh, yes. I don't know a hundred percent all of their decision -- you know, what went into their decision-making process. All I know is what we recommended.

Q. Okay.

A. And so when we looked at that particular location, given that this is a service that it's important to have visibility, we felt like that was a disadvantageous site because you had to go back into an area that people would only go to if they were seeking services in that area in order to ever see it.

Q. Your algorithm would not have put it in yellow.

A. It would not have picked that spot.

Q. It would not have been yellow on your chart?

A. No, it wouldn't.

Q. Okay.

(Petitioner's Exhibit 24 referenced.)

Q. (BY MR. SUMMER) All right. So if we look at Petitioner's Exhibit Number 24. It appears to be setting up a discussion for potential sites for a call; is that correct?

A. (Examined exhibit.) With that group, yeah, it would appear to be.

Q. It says, "Follow up to site selection discussion for MUSC potentials HOPD ER/UC Centers," and it says that would've been on Thursday, May 3rd; is that correct?

A. That's correct.

Q. Okay. The organizer was Kris Webster of your company?

A. Correct.

Q. All right.

(Petitioner's Exhibit 25 referenced.)

Q. (BY MR. SUMMER) Go over to Petitioner's Exhibit 25, please.

A. (Complied.)

Q. This is, yet again, another call to discuss new locations, again, organized by Kris Webster for May 11th of 2018, correct?

A. Correct.

(Petitioner's Exhibit 26 referenced.)

Q. (BY MR. SUMMER) On May 16 -- this is Petitioner's Exhibit Number 26 -- a real estate discussion, again, organized by Kris Webster of your company, right?

A. (Examined exhibit.) That's right.

(Petitioner's Exhibit 27 referenced.)

Q. (BY MR. SUMMER) All right. Then we get to Petitioner's Exhibit 27. This appears to be a discussion regarding alternative Summerville sites, is it not?

A. (Examined exhibit.) Appears to be, yes.

Q. Okay. And then we have attached to that -- we actually have an attachment for this one, and it looks like it's coming from CBRE, and it has a host of restaurants: Mellow Mushroom, Applebee's, the First Citizen's site, a Sigma Drive site.

A number of different sites, correct?

A. Correct.

Q. Were you on this call? Do you recall this call?

A. I do not think I was on this call.

Q. Okay. What's the process that Kris is taking them through at this point in time?

A. So they're showing them available inventory, and then Azar would discuss the pros and cons of each of these locations.

Q. Okay. And I don't want to go through a lot of discussion on this. It seems like Mellow Mushroom was the favorite to begin with, but you ended up settling on Applebee's.

Do you recall what the discussion was and why?

A. Well, so the Mellow Mushroom was in an area that had ideal traffic counts, had more of a 360-degree site, meaning there was roof tops all the way around it. So it was an area that we liked very much, but then -- it was on a corner, I believe.

And the reason that we didn't end up -- and MUSC didn't move forward with that site is someone else put a binding letter of intent on the site before they did it.

Q. That'll ruin a party, won't it?

A. Yeah.

(Petitioner's Exhibit 28 referenced.)

Q. (BY MR. SUMMER) Again, a lot of work was going into selecting a site.

So we've got Petitioner's 28, another site call; is that correct?

A. (Examined exhibit.) That's correct.

(Petitioner's Exhibit 29 referenced.)

Q. (BY MR. SUMMER) And then if you go to Petitioner's Exhibit 29, June 7, 2018, it looks like another presentation involving these properties. It say, "Analysis follow-up."

A. (Complied.)

Q. And you were on this call, it looks like?

A. Yeah. I think you can probably see what's happening. It starts at a certain level of the organization. As they get buy in, more folks are added to the discussion until you bring it to the larger group.

Q. For a decision?

A. Yeah. Which we always got a decision, but usually it's, "Let's continue looking."

Q. Looking at the -- again, on Petitioner's Exhibit 29, but looking at the last page of that, which is 184, is this a document you would've generated or is that a CBRE document?

A. It's a CBRE document.

Q. Okay. Just showing what's in the neighborhood?

A. Um-hum.

Q. Okay.

(Petitioner's Exhibit 30 referenced.)

Q. (BY MR. SUMMER) It looks like Petitioner's Exhibit 30 there's another call regarding the sites?

A. (Examined exhibit.) This is just an internal call.

Q. Okay. And it looks like we may have somebody from CBRE on that one?

A. That's what I'm -- yeah, I mean, nobody from MUSC.

Q. Nobody from MUSC.

(Petitioner's Exhibit 31 referenced.)

Q. (BY MR. SUMMER) Exhibit 31, "INtuitive Health call to review assumptions."

What assumptions were you reviewing?

A. (Examined exhibit.) Probably reviewing the demographic assumptions, the financial assumptions of what inputs we put in there. And then try and get a better idea of how we determined what our capture rate would be. That's usually what those are about.

Q. When you're talking about capture rate, are you talking about market share?

A. Yeah, or volumes. You could look at it as market share, although -- yeah, that's one way of

looking at it. But it's just looking at utilization data, how far folks will travel for this type of service and, you know, what share of that that we're capturing.

Q. And I understand -- and I don't want this, but I understand that your -- I don't want to say "secret suit," but you have your own methodology that you utilized to assess markets and to assess a capture rate.

And so I assume what you're doing is plugging in all those numbers for that particular location, and then telling MUSC, "You ought to have X volumes coming off of this property" --

A. Correct.

Q. -- "in Year 1."

A. That's right. And we're wrong every single time, but we're in the ballpark.

Q. Right.

A. So sometimes we're much higher, sometimes we're a bit lower, but it's the best educated guess that we have at this time.

Q. The purpose of a pro forma, somebody told me one time, they said that you can be 10 percent wrong and not 100 percent wrong.

A. Right.

Q. Okay. So you would've given -- for the Applebee's sites, you would've given volume projections for your pro forma?

A. We would have.

Q. Okay.

(Petitioner's Exhibit 32 referenced.)

Q. (BY MR. SUMMER) Go to Petitioner's Exhibit Number 32, please.

A. (Complied.)

Q. I think this is still just trying to nail down the Applebee's site.

Is that what's going on?

A. (Examined exhibit.) Yeah, it appears.

Q. There's a reference to Ruby Tuesday's, but I don't know what that's about.

A. There is a second site that they must have added.

Q. Okay.

(Petitioner's Exhibit 33 referenced.)

Q. (BY MR. SUMMER) Go to Petitioner's Exhibit 33, please, sir.

A. (Complied.)

Q. (BY MR. SUMMER) "Intuitive Pro Forma review," so it looks like you scheduled a call from July 24th, 2018, specifically to review a pro forma;

is that correct?

A. (Examined exhibit.) Appears to be, yes.

Q. All right. And that would have been a pro forma based upon a specific site?

A. It would have been site specific.

Q. Okay. And I'm assuming, at this stage of the game, it's the Applebee's site, because it looks like that's what you've narrowed it down to?

A. Yes.

Q. Okay.

(Petitioner's Exhibit 34 referenced.)

Q. (BY MR. SUMMER) Go to Petitioner's Exhibit 34, please. It looks to be just another call on the site selection.

A. (Examined exhibit.) Correct.

Q. That would've occurred on July 24th, 2018, correct?

A. Correct.

(Petitioner's Exhibit 35 referenced.)

Q. (BY MR. SUMMER) Petitioner's Exhibit 35. On July 26th, two days later, yet again, another review call.

This one you would have been on?

A. (Examined exhibit.) Yeah.

Q. I assume you're still evaluating that site

and probably using the pro forma to make that decision.

A. Or just to -- yeah, to give input to it.

Q. Okay.

(Petitioner's Exhibits 36 and 37 referenced.)

Q. (BY MR. SUMMER) Then I've got -- if we look at 36 and 37, both make reference to a presentation to the strategic committee.

Do you know what that is?

A. (Examined exhibit.) Yeah, I do. And this -- I believe this is the meeting that was in person that I was not able to make, and this is one that Joe Hutts joined since I couldn't be there.

Q. Okay.

A. But I believe it's an internal approval process that MUSC has, so any new project has to go through and get approval from the strategic planning committee. And so this was the opportunity to have that on the -- have the -- I guess the Summerville location on that agenda.

Q. All right. And Joe Hutts would have attended that meeting at MUSC?

A. Yes, with Azar and Kris.

Q. Got it. Okay. And that's Petitioner's

Exhibit 37. Okay.

(Petitioner's Exhibit 38 referenced.)

Q. (BY MR. SUMMER) To me, it looks like there was also a call with the CFO on August the 7th of 2018; is that correct?

A. The CFO?

Q. This is Petitioner's 38.

A. (Examined exhibit.) Is this Carmen Rice or Lisa Goodlett, the CFO?

Q. Lisa Goodlett is.

A. Okay.

Q. But it just says, "INtuitive Health Conference Calls with CFO."

Do you recall what that might have been about?

A. No. No.

Q. Okay.

(Petitioner's Exhibit 39 referenced.)

Q. (BY MR. SUMMER) All right. Go to Petitioner's Exhibit 39, please.

A. (Complied.)

Q. It says, "Real Estate review for potential Summerville locations for proposed MUSC Partnership."

Again, another call scheduled for

August 7th. Appeared to have been a very busy day.

A. Yeah.

Q. Do you recall who that call was with and what it was about? It looks like it's internal for you.

A. Yeah, it's just -- and then I think we had their -- the brokers in Charleston give us an update.

So after losing Mellow Mushroom, I'm sure that they were scrambling to make sure that they knew what was going on with that Applebee's site.

Q. Okay. When you make this reference to the "proposed MUSC Partnership," how are you using the phrase "partnership" there?

A. So what we had proposed, which they did not accept, was that we would not -- we would have a -- create a new management company with MUSC Strategic Ventures, so not the hospital. It's a separate legal entity.

And we would form that -- form a new LLC. We would buy the land using a developer. And then we would enter into a management services agreement with the hospital to operate that location.

Q. Okay.

(Petitioner's Exhibit 40 referenced.)

Q. (BY MR. SUMMER) All right. Go to Petitioner's Exhibit 40, please, sir.

A. (Complied.)

Q. (BY MR. SUMMER) Who is Karyn Rae?

A. Karyn Rae?

Q. R-a-e. The topic on Petitioner's Exhibit 40 on the top Re line -- or Subject line is "HOLD: INtuitive Health On site Discussions with Karyn Rae."

A. I have no idea.

Q. Me neither. I was hoping you could tell me.

A. Karyn Rae. I don't know who that is.

Q. And when I look at the invites, this all looks pretty much internal to me. It looks to be your folks.

Does Sonya Floyd work for you?

A. No.

Q. So maybe there were some MUSC people here.

A. Caroline Cotter is MUSC.

Q. She's the organizer?

A. Yeah.

Q. Okay. So would this have been -- yes,

again, this is the meeting you were discussing. This is August 7th.

So this was -- this was another on-site meeting where your people were physically there.

A. Yeah. I wasn't at that meeting.

Q. That was the Joe Hutts' one.

This makes sense to me now. I couldn't understand why we were having all this activity on the 7th. It's because you're physically present.

(Petitioner's Exhibit 41 referenced.)

Q. (BY MR. SUMMER) If you look at Petitioner's Exhibit 41, it's another plug-in. This one was with the COO.

A. (Complied.) Yeah. So that's what they were trying to do was just make use of the time. So they sat down with the real estate brokers and they had as many meetings as they could fit in with the team at MUSC.

Q. Got it.

(Petitioner's Exhibit 42 referenced.)

Q. (BY MR. SUMMER) If you'll go over to Petitioner's 42, please.

And this is, I take it, the real

estate opportunities?

A. (Examined exhibit.) Yeah. So this was interesting. They really liked the work that Azar had done on real estate, and so they actually tried to get Azar to help them with certain -- just some real estate assessment on some projects that were completely unrelated to anything that our company does.

Q. Did they pay you for that?

A. We talked about how we might be able to set that up or whether we wanted to let him participate in that.

Q. Got it.

All right. I'm trying to be cognizant of your time.

(Petitioner's Exhibit 43 referenced.)

Q. (BY MR. SUMMER) Look at Exhibit 43 for me, please, sir.

A. (Complied.) Okay.

Q. Looks to me like we're scheduling another call on August 20th regarding the potential Summerville locations, correct?

A. Correct.

(Petitioner's Exhibit 44 referenced.)

Q. (BY MR. SUMMER) So Petitioner's Exhibit

44 is, yet again, more site analysis for different sites, correct?

A. (Examined exhibit.) Correct.

(Petitioner's Exhibit 45 referenced.)

Q. (BY MR. SUMMER) Go to Petitioner's Exhibit 45 for me, please.

A. (Complied.) Okay.

Q. Looks like we've got some fit testing going on for sites. I can't tell which one this one is. It looks to me like the architect's trying to plug it in.

A. That's right.

Q. Can you tell what site this was for?

A. I thought at this point we had lost Mellow Mushroom and so it would have been for the Applebee's site.

Now, there is a map here. There's a Perkins Family Restaurant.

(Examined exhibit.) Actually, that's not.

Q. Yeah. It's hard to tell.

A. Yeah. North Main Street. I think it's not the Summerville site. It's in a different location.

(Petitioner's Exhibit 50 referenced.)

Q. (BY MR. SUMMER) Let's jump over. I'm gonna try to keep this in chronological order, so I'm gonna go now to Petitioner's Exhibit 50.

A. (Complied.)

Q. (BY MR. SUMMER) This is on August the 30th. The Subject is "Clarification on the CON process for proposed freestanding ED Summerville," and it's from Kris to Caroline Cotter.

You'll notice there are several questions, which it appears that Caroline answers on pages 249 and 250 of Exhibit 50.

A. (Examined exhibit.)

Q. I guess what you're doing is you just want to understand the CON process better.

Is that what this give-and-take is about?

A. Yeah. I mean, just to provide a little context, you can see we've done a lot of work up until this point, and it's been dragging on for a long time. And so, yeah, I want to get an answer, are they gonna work with us or not.

And so Kris is trying to get an answer as to -- because we keep hearing about CON, and so we're just trying to better understand the process so we can figure out, like, how do we move this to a

partnership.

Q. Yeah. The first question is: "Has MUSC notified Palmetto Primary Care about the pending change of location?"

Why was that relevant to you?

A. Well, that's a -- so that would -- you're looking to see if your potential partner has made definitive steps to move forward or not. If they still have their foot in a different -- you know, a different camp, which was building this site that we wouldn't want to be a part of --

Q. Right.

A. -- then we know they're not moving forward with us.

So if they had told them they're not doing that, then that would be a pretty definitive indication that they're planning to at least look at one of the sites we recommended.

Now, whether they move with us or not is a whole other question.

Q. I get it. Thank you.

(Petitioner's Exhibit 51 referenced.)

Q. (BY MR. SUMMER) All right. And if you would jump over to Number 51 -- Petitioner's Exhibit 51.

A. (Complied.)

Q. "MUSC Update Call." This would have been September 5th. Looks like you've got -- this looks like it's a broker's call --

A. Yeah.

Q. -- trying to find a piece of property.

All right. Now, let's go back to -- if I can find it. See if I pulled it out. Number 6. And bear with me while I try to find my copies, where I put mine, which I think Number 6 is now in chronological order there.

A. I don't know. 52 looks like it's back in September, and this is in December.

Q. Hang on to that, and let's leave that. Leave 6 out. Maybe I have moved it already.

(Petitioner's Exhibit 52 referenced.)

Q. (BY MR. SUMMER) Yeah. Ignore 6, and let's go ahead to Number 52.

A. Okay. (Complied.)

Q. 52 looks to be a site visit by MUSC to Texas.

A. Correct.

Q. What precipitated this?

A. So oftentimes before a customer moves forward with us, they're gonna want to actually see

an operation and kick the tires a little bit, so we are always open to that and encourage anybody who wants to work with us to go through that process.

Q. All right. So if we look at the first page of Petitioner's Exhibit 52, it tells us who was participating in the day's events, correct?

A. Correct.

Q. So Dr. Cawley came. Matt Wain came. Tom Crawford came. Sarah Bacik and Caroline Cotter on behalf of MUSC.

A. That's right.

Q. Okay. And said there was a facility tour at Frisco West, Legacy Drive.

Is that your original facility?

A. That is. It's our first one.

Q. Okay. When did that facility open?

A. 2008.

Q. Okay. And then at 12:30, you must have driven over to Allen, Texas?

A. Correct.

Q. Okay. And how old is that facility?

A. That one opened in 2013, somewhere around there.

Q. And working lunch would have been at your offices in Plano?

A. Correct.

Q. And then it looks like you would have had from 1:30 to 3:00, basically, in-office presentation; is that right?

A. That's right.

Q. Okay. So let's look at what's attached. This is a long, rambling group of exhibits, but let's start with page 260 of Petitioner's Exhibit 52.

Who would have presented this packet of material to the MUSC folks?

A. I would have.

Q. Okay. Looks like you've proposed two alternative legal structures; is that correct?

A. We did not go through the second legal structure.

Q. Okay. So you're looking at the Legal Structure on page 261?

A. Correct.

Q. And is that the same legal structure you've been describing where the management company is co-owned by the two partners?

A. That's correct.

Q. Okay. 263 is what we saw at page 90, right?

A. Um-hum.

Q. Okay. Again, this would have been in a much larger format?

A. Yes. So they can actually see it.

Q. Look over at the footprints on page 264.

A. (Complied.)

Q. If you don't mind, just kind of tell me what you told MUSC regarding these options for footprints.

A. We just explained how this is designed to speci- -- to allow efficiency for the way that we manage ER and urgent care in the same facility.

Q. Okay.

A. And there's a large and a small footprint option which gives you more options for retail space.

Q. Okay. Is there a third option on page 265?

A. Yes. It's not applicable to Summerville.

Q. Okay. Let's look at the pro forma assumptions.

Are these the assumptions you would have utilized in building the financial pro forma that appears in this document?

A. So this is a page that is included but not

always updated, so I cannot say that all of these assumptions are accurate.

Q. Okay.

A. So Azar puts the pro forma together, and sometimes he fails to actually update these assumptions and they just stay in there and they're the same.

Q. Okay.

A. Even though there's different information in the pro forma itself.

Q. So is your testimony that this is not -- these assumptions are not specific to this pro forma?

A. Correct. Now, most of them probably are accurate, but they -- I would not be surprised if there is an inconsistency in the assumptions as stated on this page in the actual pro forma.

Q. Okay. Let's look at market capture analysis.

A. (Complied.)

Q. I haven't gone back to see if this ticks and ties with like Exhibit 66 or 67, but is that the same type of analysis that we saw in 66 and 67 as what we have here?

A. Yes. And it can change a little bit based

on the location of the final site. So that like it might have said 104,000 earlier, and now this one with the same drive time is 101,000.

Q. Gotcha.

A. So it could be a little bit different, but it should be very similar.

Q. All right. And you're basing this on your algorithms, and then also utilizing payor mix and rates and everything else that you get from the client?

A. So we use their rates --

Q. Yep.

A. -- and we use the payor mix and then our historical average, put the payor mix from the demographics in that drive time radius.

Q. Yep.

A. So MUSC's radius that they pull from is very different than just what we're looking at as a 13-minute drive time at Summerville.

Q. Um-hum.

A. So we -- we're really heavily looking at what we expect the payor mix to be at that Summerville site, and then we're using that with our algorithm to kick out.

Q. So by this point in time, is this probably

an Applebee's-specific site at this point in time?

A. Yeah, I -- that is my guess. I can't say that with a hundred percent certainty, but my guess is that we are talking about the Applebee's site.

Q. And Mellow Mushroom and Applebee's are side by side --

A. They're similar.

Q. -- so the capture rate is going to be very similar?

A. Correct.

Q. Let's look at page 268, the Urgent Care Financial Model.

A. Okay.

Q. I'm not gonna ask you to -- I don't have my readers, and I'm not gonna ask you to read all of this.

But this is basically a pro forma --

A. Yep.

Q. -- for the combined ER and financial care model, right?

A. That's right.

Q. Okay.

A. So you have vol- -- like the number of ER patients that we're -- year one, we're projecting 16.4 ER patients --

Q. Yep.

A. -- a day. For urgent care, 31.7. And then you can see it grows a little bit each year.

Q. Got it.

And then we get into a lot of nonresponsive stuff, or some nonresponsive stuff. So we're just gonna skip those pages.

A. Yeah. Those would just be different locations, not in Berkeley County.

Q. Gotcha. Again, and we've seen these numbers before, but this was produced to us -- some of this was, anyway, produced to us.

So, again, this is just a capacity model, right, on page 271?

A. Yeah. Which these sites aren't that busy from -- so they're not gonna bump up into a capacity constraint.

Q. Okay. Billing Methodology, that's on page 273.

A. Yep.

Q. You've got an asterisk there for Details and Memo. The memos that were produced to us regarding this particular information were two memos from Foley & Lardner, one dated May of '17, and the other dated September of 2018.

Are you familiar with those memos?

A. Yes.

Q. Okay. My understanding of those memos is, is that because they're hospital-based, these urgent care visits wouldn't be able to -- would be able to bill CMS for a facility fee, correct?

A. They have to.

Q. Whether or not a private payor pays, that facility fee has to be negotiated?

A. We would prefer that they didn't.

Q. Okay.

A. We'd prefer Medicare didn't, but unfortunately, we have to bill the facility and the professional.

Q. Okay. I'm just looking. It looks to me, then -- if you look at page 275, it looks like there was circulated a new deck where they substituted out page 6.

Is that how you read that?

A. (Examined exhibit.) Yeah, and that's for a site that's not in Summerville.

Q. That's not for us to worry about. Okay?

So in all other respects, it's the same exhibit?

A. It appears to be.

(Petitioner's Exhibit 53 referenced.)

Q. (BY MR. SUMMER) Let's go to Number 53 for me, please, sir.

A. (Complied.) Yes, sir.

Q. This is going back to some of this freebie stuff.

A. Yeah.

Q. Okay. Let's skip that.

(Petitioner's Exhibit 54 referenced.)

Q. (BY MR. SUMMER) Petitioner's Exhibit 54, "Action Items from INtuitive Health." This is from -- if you look at Exhibit 54, if you look at the bottom of page 295, "Caroline, Please see the listed 'items' identified. If I've missed anything please let me know."

"Schedule Partner Call."

What is that for?

A. (Examined exhibit.) Is this from Kris Webster?

Q. Yeah. It's dated 20 -- September 21. "Jessica to schedule call."

I mean, if you don't recall, you don't recall.

A. I don't recall.

Q. The second bullet point, "LOI execution

for Applebee's."

So clearly, this is dated September 12. You're focused now on the Applebee's site, correct?

A. Correct.

Q. And it just says working with the real estate group.

And then the second -- the third bullet says, "MUSC to send LOI redline to Intuitive."

I'm assuming that was an LOI between INtuitive and MUSC; is that correct?

A. Correct.

Q. Did you ever get an LOI executed with MUSC?

A. No.

Q. Okay. I haven't seen any draft LOIs.

Have you -- do you have any?

A. We drafted one and gave it to them.

Q. Okay. That would have been contemporaneous with this document, September of 2018?

A. Yes.

Q. And then the rest is nonresponsive. All right. Thank you.

(Petitioner's Exhibit 55 referenced.)

Q. (BY MR. SUMMER) Let's go to Petitioner's 55, please.

A. (Complied.)

Q. Again, we're talking about two different LOIs.

A. Yeah. It's a little confusing, but it's two different LOIs, yeah.

Q. You want one with them, and then they need one for the Applebee's, correct?

A. Correct.

(Petitioner's Exhibit 56 referenced.)

Q. (BY MR. SUMMER) Petitioner's 56, please.

A. (Complied.)

Q. September 12, 2018, I think this was nothing more than a call that didn't get scheduled. Let me make sure there wasn't anything else in here I wanted to --

Looks like we have a hurricane blowing through town.

A. That's right.

Q. Which is why I don't live in Charleston.

(Petitioner's Exhibit 57 referenced.)

Q. (BY MR. SUMMER) Let's go to Petitioner's Exhibit 57.

A. (Complied.)

Q. I find it interesting that we're trying to get -- you are trying to schedule a telephone conference with Foley & Lardner and MUSC; is that correct?

A. I'm just reading through this here.

Q. If you look on page 347, I think it becomes clear.

A. Yes.

Q. Why did MUSC want to talk to Foley & Lardner?

A. It was more -- I think I wanted to get our legal counsel together with their legal counsel because they had some concerns about the -- our term sheet. So we just wanted to get them together to talk and work out those issues.

Q. But this would have been the LOI?

A. Yeah.

Q. This was an LOI drafting discussion, basically?

A. Well, we had already drafted an LOI. It was, "Let's get our attorneys together to see what you have concerns about."

Q. Got it. Okay.

Did that call ever take place?

A. Yes.

Q. Okay. Did you make any progress?

A. Yeah. I think conceptually we did, but didn't turn into anything.

(Petitioner's Exhibit 6 referenced.)

Q. (BY MR. SUMMER) Looking at Petitioner's Exhibit Number 6 now.

A. (Complied.)

Q. Now I've got it closer to chronological order.

A. Yeah.

Q. This appears to be a multilocation presentation, most of which has been redacted except what pertains to Summerville, right?

A. That's correct.

Q. Are you developing any sites right now with MUSC?

A. No. We would like to, but we are not.

Q. Let's see. I'm gonna pick back up now with -- if you could jump back. I may have already covered -- no, we haven't.

Got Petitioner's Exhibits 46 and 47 and 48. I think we skipped over those, so if you go back.

MR. VOLNEY: Right here.

THE WITNESS: Oh.

(Petitioner's Exhibit 46 referenced.)

Q. (BY MR. SUMMER) Petitioner's Exhibit 46 is dated December the 5th, and it looks like -- I'm assuming that -- well, I don't have to assume. It says E4H is an architect.

A. (Examined exhibit.) Yeah, that's our architect.

Q. Okay. It's just basically just trying to do site fits?

A. Correct.

Q. And is this a site fit for Applebee's? I can't tell.

A. Yes. It says Summerville, South Carolina. It would have to be.

(Petitioner's Exhibit 47 referenced.)

Q. (BY MR. SUMMER) All right. Go to Petitioner's Exhibit 47, please, sir.

A. (Complied.)

Q. So your architect is doing the site fit?

A. Um-hum. Well, it's not -- they're not doing a final site fit. They're -- this -- this isn't formal. This is like would it fit, does it look -- you know, they haven't been engaged to go through the actual work of doing it.

Q. But you're --
A. It's preliminary.
Q. -- utilizing them for due diligence --
A. Yes.
Q. -- to decide whether or not to purchase the property?
A. Yes.
Q. Okay. Petitioner's Exhibit 47, again, it just looks to me to be more site planning for Applebee's, right?
A. Correct.
Q. It looks like they've pretty much committed themselves to a 10,700-square-foot building, or at least that's what this e-mail says. Or can you tell?
A. I think it's 97 square -- hundred square foot. It says, "The items Jared listed below will still exist in the 9700 square foot plan."
Q. Okay.
(Petitioner's Exhibit 7 referenced.)
Q. (BY MR. SUMMER) All right. See if you can find Petitioner's Number 7 in front of you.
A. Got it.
Q. This is from Kris to Sarah Bacik talking about potential locations. This is on Thursday,

December 6th.

These are just factors of your algorithm, right?

A. Yeah, just a few.

Q. "Quantity of traffic counts and quality of traffic . . ."

What's the difference between -- a quantity, I know what that is. But what's a quality traffic count?

A. It's the difference between somebody just driving through and then somebody that spends time there since you can get -- there's different --

Q. Tourist traffic as opposed to resident traffic?

A. Yeah. Where, you know, one corner might -- they might go through, but if they spend more time on one side of the street versus the other, you want to know that.

Q. When you talk about "relative population," are you talking about just the population or are you talking about the population and its demographics?

A. I don't know what she's talking about.

Q. So your testimony is you don't know what she's referring to?

A. I don't, which is not uncommon. I mean,

she's trying to sell and just saying things that sometimes it's right on and sometimes it's not exactly right.

Q. That's the difference between development and operations.

A. Yes.

Q. Okay.

(Petitioner's Exhibit 48 referenced.)

Q. (BY MR. SUMMER) If you can turn to Petitioner's Exhibit 48, please.

A. (Complied.)

Q. Let's start back on page 372 of Petitioner's Exhibit 48. And this is from Caroline Cotter to Azar.

"As I mentioned yesterday we will need a few key items from your team for our location change submissions to DHEC.

"Letter of intent for the lands - Sarah to follow up.

"Updated floor plans.

"Site plan.

"Map of use site."

Do you know what assistance your company provided with DHEC?

A. None directly.

Q. Okay.
A. That was in September.
Q. Yeah. This chain is long --
A. Okay.
Q. -- and old.
A. Yeah.
Q. Okay. If you'd go next to -- before we leave Petitioner's 48, at the very bottom, Caroline Cotter to Kris, Wednesday, December 5, "Hey Kris, I hope you're having a great week! We are meeting with the DHEC CON team on Friday" -- which would've been Pearl Harbor Day, December 7th of 2018 -- "to discuss relocation of freestanding ED in Summerville to the Applebee's land."

So she's -- it looks to me she's like requesting a floor plan here for that meeting.

A. Um-hum. I think we did go through that on a previous exhibit from E4H --
Q. Okay.
A. -- or at least comments to it.

(Petitioner's Exhibit 49 referenced.)

Q. (BY MR. SUMMER) All right. Petitioner's Exhibit 49.

This is Thursday December 6th, Caroline Kotter. "Below is an excerpt from our

development procedure manual and provides a partial list of due diligence activities."

This basically reinstates the due diligence list, doesn't it?

A. (Examined exhibit.) Um-hum.

MR. VOLNEY: Answer "yes."

A. Yes.

Q. (BY MR. SUMMER) Do you know whether or not they purchased the Applebee's property or not?

A. I do not. For sure -- I don't know for sure.

Q. Okay.

(Petitioner's Exhibit 58 referenced.)

Q. (BY MR. SUMMER) Look at Petitioner's Exhibit 58, if you would, please, sir.

A. (Examined exhibit.)

Q. It looks like there's an attempt to have another legal call December 10, 2018.

A. That's right.

Q. Okay. Do you know whether or not that call took place?

A. Do not.

Q. I'm assuming that that call was to work on the LOI?

A. It would've been -- well, actually David

McLean.

THE WITNESS: Is David on? Who else is on the line?

Q. (BY MR. SUMMER) There's somebody Selden from Foley.

A. On this call?

Q. Oh. No, the page.

A. Yeah, then that would have been for our LOI.

Q. 382. If you look at page 382, you'll see the attendee is C. Selden.

A. Yeah, she's -- that was -- yes, that would be absolutely a call regarding our LOI.

Q. So you're still trying to get an LOI negotiated in December --

A. Yep.

Q. -- of 2018?

A. Still kinda trying.

Q. Okay.

A. I don't give up easily.

(Petitioner's Exhibit 59 referenced.)

Q. (BY MR. SUMMER) I'm looking at Petitioner's 59. It looks to me that that's merely them trying get the Foley advice from you.

A. That's right.

Q. Here's what I find interesting.

Between -- you know what? I have a big gap here. After the 20th of December, I don't -- of 2018, I don't see any communication between your company and MUSC until May the 30th of 2019.

Were they radio silent that long?

A. They might've been with Kris and -- so we were told that they weren't gonna work with us on the Summerville location. I don't remember the exact date, as I've mentioned, but they still wanted to work with us on some other locations that were outside of the Summerville site and those were not Kris's responsibility; they were Sean McGranaghan's.

So you'll notice he's on this e-mail here, May 30th, 2019. And so there's a -- sites that are near Charleston, Kris would -- those would be hers.

Anything that's outside Charleston would be Sean's. And so we have been continuing to try to get something going with them on some of these other locations.

But we were told to -- basically, we weren't going to be working with them on Summerville.

Q. Because after December 20th, they're incommunicado with you -- if I've got everything, they're incommunicado with you about Summerville after December the 20th of 2018?

A. That sounds right.

Q. And y'all have spent hundreds of man-hours and tens of thousands of dollars on some?

A. We're still talking to them about other sites, though.

Q. Best I can tell, you went to Charleston three times.

A. Yes.

Q. Okay.

A. I've been to Wichita four times and still haven't gotten that deal. I'd much rather go to Charleston.

Q. No kidding.

(Petitioner's Exhibit 60 referenced.)

Q. (BY MR. SUMMER) All right. I think these are gonna move quickly now for these last couple.

Let's talk about -- I'm not sure what Petitioner's Exhibit 60 is. I was hoping you might be able to tell me what it is.

A. Perkins Family Restaurant.

Q. Okay.

A. This came -- there was a picture of this earlier, too. I don't remember why we had pictures of the Perkins and then going after the Applebee's. I'm not sure why.

(Petitioner's Exhibit 61 referenced.)

Q. (BY MR. SUMMER) Petitioner's Exhibit 61 looks like to be the Mellow Mushroom site?

A. (Examined exhibit.) Yeah.

(Petitioner's Exhibit 62 referenced.)

Q. (BY MR. SUMMER) Petitioner's Exhibit 62 appears to be, yet again, another iteration of that presentation. It's, I think, predominantly the same?

A. (Examined exhibit.) Yeah. There are a few different slides here.

Q. There are a few different slides. Do you know . . .

A. (Examined exhibit.)

Q. I assumed that you would have used different iterations on different visits and different trips?

A. That's correct.

(Petitioner's Exhibit 63 referenced.)

Q. (BY MR. SUMMER) And is Petitioner's Exhibit 63 the same thing?

A. It's a different deck, but it's just a different version.

Q. Okay.

A. Similar.

So one thing that's worth pointing out, and that might be why you're seeing so many different versions, is we do a whole lot of different iterations internal and then share them internally and they never make it to the client. So it's very possible that some of these never went to the client at all.

Q. Got it.

(Petitioner's Exhibit 64 referenced.)

Q. (BY MR. SUMMER) Look at Petitioner's Exhibit 64.

A. (Complied.)

Q. I'm not sure what this is, but what I was trying to figure out is -- I don't know where Lutheran Hospital is.

A. Yeah, I don't know if that's a . . .

Q. A ghost?

A. Yeah. Just a relic from a previous . . .

Q. Deal?

A. Yeah. Possible. I'm not familiar with a Lutheran in Charleston.

Q. Me neither.

(Petitioner's Exhibit 65 referenced.)

Q. (BY MR. SUMMER) All right. Let's look at Petitioner's Exhibit 65.

A. (Complied.)

Q. You've got breakdowns on drive distance and population.

Both of these sites look to be -- one's much closer to Summerville than the other.

A. Yeah.

Q. Site 1 looks to be more like a Goose Creek site -- well, no. Maybe that's the Nexton site?

A. Yeah. It could've been the original site.

Q. The original Nexton site, I think so.

Do you know?

A. I don't know for sure. Look at -- just memory, I think in the general vicinity of where that new physician development was going, was over there, so it's my guess.

Q. Okay. I think Site Number 2, based upon this proximity to I-26 and the fact that it's in the city limits of Summerville, is the Applebee's site.

Would you agree with that?

A. Site 2?

Q. Yes.

A. I'm not sure, because it -- I mean, it's hard to tell from this map, but it looks like it's closer to -- I thought the Applebee's was to the southwest of that freeway right there.

Q. Well, if you look, you can see the interstate sign at the very, very top corner.

A. Yeah.

Q. If you pull that down, that's I-26.

A. Okay.

Q. So it's on the southern side of --

A. Oh, yeah.

Q. -- of I-26, which is where Applebee's is.

A. Yeah. Yeah, that might be. It would make sense because we were trying to pull them over that way.

Q. Yeah. And then it gives you the 10-minute, 15-minute, and 20-minute populations --

A. Yeah.

Q. -- which are huge. Okay.

Then we're back to 67 and 66, which you don't know exactly when those were created, do you?

A. No, I don't, not -- but they, yeah.

But there's probably several versions, but they wouldn't change much.

(Petitioner's Exhibits 68, 69, and 70 referenced.)

Q. (BY MR. SUMMER) Then there are three CBRE exhibits.

So those should be Petitioner's Exhibit 68, Petitioner's Exhibit 69, Petitioner's Exhibit 70, and I assume that these are just demographic summaries for different properties?

A. (Examined exhibit.) Correct.

Q. Petitioner's Exhibit 68 looks to be address specific.

A. Um-hum.

Q. Whereas the other two appear to be community specific.

A. Yep.

Q. Am I reading that correctly?

A. That's the way I'm reading it.

Q. Again, you just had these in your file; you did not generate these documents?

A. We did not.

Q. When's the last time you spoke to anybody from MUSC?

A. Probably had a call with Sarah and -- kids were still in school because I took it from the school. I think it was -- it was probably May.

Q. That would be Sarah Basik?
A. Correct.
Q. And did that involve Summerville?
A. Did not. So we were talking about alternative sites. I mean, I always bring Summerville up just in case of an opening, but she was not -- didn't want to talk about that. So we were talking about the other sites that we're looking at with them.
Q. Okay. And can you recall anybody else you've talked to from MUSC in 2019?
A. Me personally, I think my only communication with anybody there has been Sarah in 2019.
Q. Okay.
A. Prior to 2019 I'd talked to Tom Crawford and some other folks over there.
Q. Okay. I think we got the privilege login in Number 71.

If MUSC gives you permission, would you release the data that they provided to you?

A. Yes.
Q. Okay.

MR. SUMMER: All right. If we can take about a five-minute break, I'm getting pretty

close to done.

THE WITNESS: Okay. Sounds good.

THE COURT REPORTER: Off the record.

(A recess was taken from 3:32 p.m. to 3:42 p.m.)

THE COURT REPORTER: Back on the record.

Q. (BY MR. SUMMER) Did you or anyone in your company ever have any discussions with David Carroll who's at Palmetto Primary Care?

A. No, not that I'm aware of.

Q. Okay. Do you recall if your company had any discussions with anyone at Palmetto Primary Care?

A. No, not that I'm aware of.

Q. Okay.

A. It was a fairly sensitive subject. The health system has a relationship and that's the last thing we want to get in the middle of.

Q. You never talk about ex girlfriends. Just don't do it.

A. Yep.

Q. How about Health Facilities Planning Partners? Do you know who that is?

A. I don't know who that is.

Q. Okay. That's an ED group based in Nashville, Tennessee, and I just didn't know if you had any interaction with them.

A. No, I don't -- not that I'm aware of.

Q. Okay. How about Equity, LLC, as it pertains to Summerville?

A. So we have a relationship with Equity prior to us ever entering into conversations with MUSC, and then we found out that Equity was the developer on the PPMC'S project.

Q. Yeah.

A. So we did -- I did call Steve Wathen and just asked him a little back -- about the background on that project, you know, what he knew, if MUSC had committed to any, you know, property in that -- in that development, but that's really it.

Q. Okay. What did he tell you?

A. He just said that -- he just kind of gave me the history of why they were building it, really who PPMC was, and not being from Charleston, I didn't know the primary care market that well.

So he made it pretty clear of how significant of a primary care provider they are in the area. He explained that -- I think that his understanding was that MUSC may be leasing some

space in the new development for an urgent care center, and that was really about it.

Q. Okay. What did you do to prepare for today's deposition?

A. So me personally, I -- as far as producing the documents or just preparing for today's --

Q. Let's start first with who did you talk to other than your attorney in preparation for today's deposition?

A. Sure. Kris Webster.

Pat McColpin.

Talked to Sean McGranaghan, although he's really not involved in the Summerville location.

Joe Hutts.

I did not talk to Azar. He's been out of the country.

And then we then, after that, just went and downloaded all the documents that we could find on the project.

Q. Okay. Talk to me about how you went about looking for documents internally.

What did you do?

A. So for -- so for Azar it was pretty straightforward because we have all of his files now

that he doesn't work for us any longer, on our share drive, and he had a file folder that was labeled MUSC. So took everything out of his file folder.

And then we ran a query on -- I shouldn't say "we." Our chief -- our IT -- director of IT ran a query on all e-mails with the MUSC domain name and so we were able to collect all those.

Did the same thing in my e-mail, and everybody that's worked on it did the same thing, put that into a shared folder.

And then any of us that had any contact with MUSC went through our files to gather anything related to the Summerville location and put it into that share folder.

Q. Okay. All right. The last thing I want to do is to thank you for your efforts and your time. Third-party discovery's always a pain in the neck because you didn't buy it --

A. Yeah.

Q. -- and especially here because you don't have much to show for it yet.

A. Don't rub it in.

Q. So I want to thank you for taking the time and providing this information. I'm probably coming

back to you because I'm gonna go ask the judge to get MUSC to instruct you to release that data for us.

A. Okay.

MR. SUMMER: But other than that, I think I'm done.

So does anybody on the phone have any questions?

MS. GLOBER: I have a few questions.

EXAMINATION

BY MS. GLOBER:

Q. This is Emily Glober. I didn't introduce myself at the beginning. I represent CareAlliance Health Services, one of the petitioners in this case. And I wanted to ask you about the --

Can you hear me okay?

A. Yes.

Q. Okay.

THE WITNESS: Is she addressing me?

THE COURT REPORTER: Yes.

Q. (BY MS. GLOBER) -- about the site analysis that we've seen with the drive times. And it looks like you have those extended to 20 minutes.

Is a 20-minute drive time -- I'll call it radius -- the typical radius that you extend out

to for a freestanding ED?

A. No, it's not. Usually --

Q. Okay.

A. Usually 13 minutes is as far as we go. So I'm not sure exactly why they went -- had 20 in that analysis, but usually we use a 13-minute drive time.

Q. Okay. And would that be because patients aren't gonna travel as far for a freestanding ED?

A. Yeah. In our experience, roughly 90 percent of our volume comes within 13 minutes of the location.

Q. Okay. And do you have a standard radius in miles that you expect patients to come from for a freestanding ED?

A. No.

Q. Okay. So you just use the drive time?

A. Yes.

Q. Okay. And then you also mentioned transferring to a hospital, I believe, towards the beginning of your deposition.

If a freestanding ED is an extension of a hospital, how far do you expect or do you generally want the freestanding ED to be from what I'm gonna call the mother hospital?

A. You know, I don't know -- so there's

probably a question in a question there.

Q. Okay.

A. We have the legal ability to be within 35 miles. Now, if it's gonna cause any potential degradation of the patient's clinical condition to pass a hospital along the way to another hospital, then first of all, I don't think the EMS service would do that and we wouldn't recommend that.

So it's a little hard to answer. And, again, it's also hard to answer because it depends on the level of clinical service.

So, you know, like if it's MUSC and they're the only Level 1 trauma center and somehow a trauma patient ends up in our ER and they shouldn't have been there, they're gonna get transferred to that Level 1 trauma center and they might have to bypass a few other hospitals and might go further than you usually would expect.

And so I don't know that there's a set -- you know, just a very specific mile or distance that I can use to answer that question.

Q. But maybe the upper range would be 35 miles?

A. Well, that's as far as we're legally allowed to go. And I -- but I -- again, I think in

most circumstances, there's gonna be another hospital between -- if you're out 35 miles, there's gonna be some other hospital that's closer to that facility, that freestanding ER than the one that's 35 miles away, at least in most communities.

And so I think in a lot of circumstances, any patients requiring inpatient admission probably would go to a different hospital if they had the services available at that facility.

Q. And then my last question would be related to MUSC's decision not to move forward with INtuitive.

How did you find out about that?

A. I received a phone call from Sarah Basik.

Q. And what was the reason that they said they didn't want to move forward?

A. Just that they felt like they needed to do this one on their own and a lot of it had to do with the process that they're going through right now, that they didn't want to jeopardize being able to open a site. They felt like having an outside partner might make it more difficult to get approval.

MS. GLOBER: Okay. Those are all the questions I have. Thank you very much.

THE COURT REPORTER: Anyone else?

MS. BIGGERS: This is Ashley Biggers. I don't have any questions.

MR. SUMMER: Dan, you got anything?

MR. WESTBROOK: (No response.)

MR. SUMMER: John, do you have anything?

MR. VOLNEY: I don't have any questions.

MR. SUMMER: I've just got a quick follow-up on something that Emily asked.

FURTHER EXAMINATION

BY MR. SUMMER:

Q. Did Sarah at any point in time say that DHEC had a problem with adding a management company or a partner at this stage of the process?

A. She didn't -- no, not -- no.

Q. Okay. And did you ever have any follow-up -- did anyone in your company ever have any follow-up with MUSC after it met with DHEC on December the 7th of 2018?

A. I don't know. I didn't even know they met with DHEC on December the -- did you say the 17th?

MR. WESTBROOK: Excuse me. This is Dan. Sorry. I just want to object to the form of

that question.

And go ahead, Mr. Herrmann, and answer, please.

THE WITNESS: Okay.

Q. (BY MR. SUMMER) Yeah, December 7th, 2018.

A. I wasn't aware they met with DHEC.

Q. Okay.

MR. SUMMER: That's all I've got.

MR. VOLNEY: Dan, do you have any questions?

MR. WESTBROOK: No, I don't.

THE COURT REPORTER: Would you like the witness to read and sign?

MR. VOLNEY: It's not necessary. Thank you.

THE WITNESS: I will waive.

THE COURT REPORTER: Ms. Glober, do you know when and how you would like the final delivered?

MS. GLOBER: Electronic is fine. If someone tells me otherwise, I'll let you know.

THE COURT REPORTER: And would you also like a rough?

MS. GLOBER: I would like a rough as well.

(Deposition concluded at 3:58 p.m.,
July 18, 2019.)

(Signature Waived.)

CAUSE NO. 417-02948-2019

| | | |
|---|---|---|
| TRIDENT MEDICAL CENTER, LLC, D/B/A TRIDENT MEDICAL CENTER AND SUMMERVILLE MEDICAL CENTER, | § | IN THE DISTRICT COURT |
| Plaintiff, | § | |
| vs. | § | COLLIN COUNTY, TEXAS |
| SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL AND MEDICAL UNIVERSITY HOSPITAL AUTHORITY, D/B/A MUSC HEALTH EMERGENCY SERVICES, | § | |
| Defendants. | § | 417TH JUDICIAL DISTRICT |

REPORTER'S CERTIFICATION

DEPOSITION OF THOMAS MATTHEW HERRMANN

JULY 18, 2019

I, Karen L.D. Schoeve, Certified Shorthand Reporter in and for the State of Texas, hereby certify to the following:

That the witness, THOMAS MATTHEW HERRMANN, was duly sworn by the officer and that the transcript of the oral deposition is a true record of the

testimony given by the witness;

That examination and signature of the witness to the deposition transcript was waived by the witness and agreement of the parties at the time of the deposition;

That the original deposition was delivered to DAVID B. SUMMER JR.;

That the amount of time used by each party at the deposition is as follows:

DAVID B. SUMMER JR. - 02 HOUR(S):27 MINUTE(S)
Petitioner Trident Medical Center, LLC, d/b/a Trident Medical Center

ANDERSON SESSIONS - 00 HOUR(S):00 MINUTE(S)
Petitioner Trident Medical Center, LLC, d/b/a Trident Medical Center

DANIEL J. WESTBROOK - 00 HOUR(S):00 MINUTE(S)
For Respondent Medical University Hospital Authority d/b/a MUSC Health Emergency Services

EMILY L. GLOBER - 00 HOUR(S):05 MINUTE(S)
For Respondent CareAlliance Health Services d/b/a Roper St. Francis Healthcare

JENNIFER HOLLINGSWORTH - 00 HOUR(S):00 MINUTE(S)
For Respondent CareAlliance Health Services d/b/a Roper St. Francis Healthcare

ASHLEY C. BIGGERS - 00 HOUR(S):00 MINUTE(S)
For Respondent South Carolina Department of Health and Environmental Control

JOHN VOLNEY - 00 HOUR(S):00 MINUTE(S)
For Third-Party INTUITIVE HEALTH

That $_____ is the deposition officer's charges to the Party for preparing the original deposition transcript and any copies of exhibits;

That pursuant to information given to the deposition officer at the time said testimony was taken, the following includes all parties of record:

FOR PETITIONER TRIDENT MEDICAL CENTER, LLC, d/b/a TRIDENT MEDICAL CENTER:

DAVID B. SUMMER JR., ESQUIRE
PARKER POE ADAMS & BERNSTEIN LLP
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D: 803.253.8910
T: 803.255.8000
F: 803.255.8017
davidsummer@parkerpoe.com

--and--

ANDERSON SESSIONS, ESQUIRE
FERGUSON BRASWELL FRASER KUBASTA PC
2500 Dallas Parkway, Suite 600
Plano, Texas 75093
T: 972.378.9111
F: 972.378.9115
asessions@fbfk.law

FOR RESPONDENT MEDICAL UNIVERSITY HOSPITAL AUTHORITY d/b/a MUSC HEALTH EMERGENCY SERVICES: (Appeared Telephonically)

DANIEL J. WESTBROOK, ESQUIRE
NELSON MULLINS RILEY & SCARBOROUGH, LLP
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T: 800.237.2000
F: 803.255.5164
dan.westbrook@nelsonmullins.com

FOR RESPONDENT CAREALLIANCE HEALTH SERVICE d/b/a ROPER ST. FRANCIS HEALTHCARE:
(Both Appeared Telephonically)

EMILY L. GLOBER, ESQUIRE
JENNIFER J. HOLLINGSWORTH, ESQUIRE
NEXSEN PRUET, LLC
1230 Main Street, Suite 700
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T: 803.540.2164 (Ms. Glober)
F: 803.727.1485
T: 803.540.2112 (Ms. Hollingsworth)
F: 803.727.1446
EGlober@nexsenpruet.com
JHollingsworth@nexsenpruet.com

FOR RESPONDENT SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL:
(Appeared Telephonically)

ASHLEY C. BIGGERS, ESQUIRE
SOUTH CAROLINA DEPARTMENT OF HEALTH & ENVIRONMENTAL CONTROL
2600 Bull Street
Columbia, South Carolina 29201
T: 803.898.3362
biggerac@dhec.sc.gov

FOR THIRD-PARTY INTUITIVE HEALTH:

JOHN VOLNEY, ESQUIRE
LYNN PINKER COX & HURST, LLP
2100 Ross Avenue, Suite 2700
Dallas, Texas 75201
D: 214.981.3815
T: 214.981.3800
F: 214.981.3839
jvolney@lynnllp.com

That a copy of this certificate was served on all parties shown herein on _____ and filed with the Clerk pursuant to Rule 203.3.

I further certify that I am neither counsel for, related to, nor employed by any of the parties or attorneys in the action in which this proceeding was taken, and further that I am not financially or otherwise interested in the outcome of the action.

Certified to by me this 19th day of July, 2019.

Karen L.D. Schoeve, CSR, RDR, CRR
Realtime Systems Administrator
Texas CSR No. 3354, Exp.: 10-31-2021
NCRA Exp. Date: 09-30-21
Lexitas-NG Reporting
Firm Registration #736
999 Old Eagle School Road, Suite 118
Wayne, Pennsylvania 19087
215-494-7650

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

| | | |
|---|---|---|
| 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 MUSC Health Emergency Services, Respondents. | § | Docket No.: 17-ALJ-07-0441-CC |
| CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital, Petitioners, vs. South Carolina Department of Health and Environmental Control and Medical University Hospital Authority, d/b/a MUSC Health Emergency Services, Respondents. | § | Docket No.: 17-ALJ-07-0444-CC |

REPORTER'S CERTIFICATE

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DEPOSITION OF THOMAS MATTHEW HERRMANN

TAKEN JULY 18, 2019

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I, Karen L. D. Schoeve, Registered Diplomate Reporter, Certified Realtime Reporter, and Realtime Systems Administrator, residing in the State of Texas, do hereby certify that the foregoing proceedings were reported by me and that the foregoing transcript constitutes a full, true, and correct transcription of my stenographic notes, to the best of my ability and hereby certify to the following:

That the witness, THOMAS MATTHEW HERRMANN, was duly sworn by the officer and that the transcript of the oral deposition is a true record of the testimony given by the witness;

That the original deposition was delivered to DAVID B. SUMMER JR., custodial attorney;

That a copy of this certificate was served on all parties and/or the witness shown herein on

_____.

I further certify that the signature of the

deponent was not requested by the deponent or a party before the completion of the deposition.

That pursuant to information given to the deposition officer at the time said testimony was taken, the following includes counsel for all parties of record:

FOR PETITIONER TRIDENT MEDICAL CENTER, LLC, d/b/a TRIDENT MEDICAL CENTER:

DAVID B. SUMMER JR., ESQUIRE
PARKER POE ADAMS & BERNSTEIN LLP
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FOR RESPONDENT CAREALLIANCE HEALTH SERVICES d/b/a ROPER ST. FRANCIS HEALTHCARE:
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I further certify that I am neither counsel for, related to, nor employed by any of the parties

in the action in which this proceeding was taken, and further that I am not financially or otherwise interested in the outcome of the action.

Subscribed and sworn to on this the 19th day of July, 2019.

Karen L.D. Schoeve, CSR, RDR, CRR
Realtime Systems Administrator
Texas CSR No. 3354, Exp.: 10-31-2021
NCRA Exp. Date: 09-30-21
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