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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
Ralph King Anderson, III, Administrative Law Judge

Appellate Case No. 2020-001323

Case No. 18-ALJ-07-0358-CC
Case No. 18-ALJ-07-0360-CC
Case No. 18-ALJ-07-0366-CC

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

v.

South Carolina Department of Health and Environmental Control, and Medical University Hospital Authority, d/b/a MUHA Community Hospital,..... Respondents,

AND

Walterboro Community Hospital, Inc., d/b/a Colleton Medical Center, ...Appellant,

South Carolina Department of Health and Environmental Control, and Medical University Hospital Authority, d/b/a MUHA Community Hospital,..... Respondents,

AND

Trident Medical Center, LLC, d/b/a Trident Medical Center and Summerville Medical Center, ...Appellant,

v.

South Carolina Department of Health and Environmental Control, and Medical University Hospital Authority, d/b/a MUHA Community Hospital,..... Respondents.

FINAL BRIEF OF RESPONDENT MEDICAL UNIVERSITY HOSPITAL AUTHORITY d/b/a MUHA COMMUNITY HOSPITAL

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Constitution and Statutes

STATEMENT OF ISSUES

1. The appellants' interpretation of Standard 5 of the 2017-2018 State Health Plan has no merit.

2. The ALC's correctly interpreted and applied Standard 5 of the 2017-2018 State Health Plan, including the meaning of "at the chosen site."

3. The ALC's ruling on the meaning of "at the chose site" as used in Standard 5 of the 2017-2018 State Health Plan is the law of the case, because the appellants' arguments against it are too conclusory to present any issue on appeal.

4. The appellants' "burden of proof" arguments have not merit, and any procedural error by DHEC was cured by the *de novo* hearing before the ALC.

5. The appellants' "burden of proof" arguments are not preserved for appeal, because the appellants did not raise these issues during the review process by DHEC staff.

6. The substantial evidence of record supports all findings and rulings by the ALC.

7. The appellants have failed to demonstrate any prejudice to their substantial rights resulting from any alleged errors by DHEC or the ALC.

8. The appellants' argument on the "freestanding emergency room" issue is a red herring, because MUHA will close it as required by the ALC and the CON Act.

9. The bond requirement imposed by S.C. Code Ann. § 44-7-220(B) (Rev. 2018) does not violate the appellants' right to due process.

10. The bond requirement imposed by S.C. Code Ann. § 44-7-220(B) (Rev. 2018) does not violate the appellants' right to equal protection.

11. The General Assembly has the power to impose the bond required by S.C. Code Ann. § 44-7-220(B) (Rev. 2018), because it created all of the appellants' rights in this matter, and because nothing in the South Carolina Constitution clearly excludes the General Assembly's power to do so.

12. The Motions Panel of this Court erred in reforming and reducing the appeal bonds imposed by S.C. Code Ann. § 44-7-220(B) (Rev. 2018).

STATEMENT OF THE CASE

This is an appeal from the South Carolina Administrative Law Court (ALC). The issue is whether the ALC erred in granting an application under the State Certification of Need and Health Facility Licensure Act (the CON Act) to build and operate a new hospital.[1]

The purpose of the CON Act is to regulate and advance the quality of healthcare provided to South Carolina's citizens.[2] Respondent South Carolina Department of Health and Environmental Control (DHEC) is the state agency that administers the CON program created by the CON Act, including applications to build new hospitals.[3] Its duties include the preparation and publication of a State Health Plan at least once every two years to direct the administration of the CON program.[4]

Respondent Medical University Hospital Authority (MUHA) is a state agency that owns and operates the healthcare facilities where it provides healthcare services and where the Medical University of South Carolina (MUSC), a separate state agency, provides healthcare related services that include educating and training future doctors, nurses, and other healthcare professionals.[5] MUHA filed an application with DHEC for a Certificate of Need (CON) to build and operate a new hospital in Berkeley County, near Summerville. The 2017-2018 State Health Plan applied to MUHA's application to build this hospital.

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[1] The CON Act is set forth at S.C. Code Ann. §§ 44-7-110 to -394 (Rev. 2018 & Supp. 2020).

[2] *Dema v. Tenet Phys. Servs. – Hilton Head, Inc.*, 678 S.E.2d 430, 433 (S.C. 2009); see also S.C. Code Ann. § 44-7-120 (Rev. 2018).

[3] S.C. Code Ann. § 44-7-140 (Rev. 2018) (DHEC is "the sole state agency for control and administration of the granting of Certificates of Need and licensure of health facilities and other activities necessary to be carried out under [the CON Act]").

[4] S.C. Code Ann. §§ 44-7-120(3) (Rev. 2018) ("preparation and publication of a State Health Plan"); S.C. Code Ann. §§ 44-7-180(C) (Rev. 2018) "(the South Carolina Health Plan must be submitted at least once every two years to the [DHEC] board for final revision and adoption").

[5] See generally S.C. Code Ann. §§ 59-123-10 *et seq.* (Rev. 2020 & Supp. 2020).

Appellants Trident Medical Center, LLC, and Walterboro Community Hospital, Inc., are for-profit subsidiaries of the Hospital Corporation of America. They appeared before DHEC and opposed MUHA's application. DHEC approved the proposed hospital, and the appellants petitioned the ALC for a contested case hearing.[6]

The ALC conducted a *de novo* evidentiary hearing over 11 days with numerous witnesses and thousands of pages of exhibits. The hearing was on the following issues:

a. the need for the proposed hospital;
b. whether there was an unnecessary duplication of services;
c. the adverse effects of the proposed hospital on the appellant hospitals;
d. the financial feasibility of the proposed hospital;
e. MUHA's ability to complete the Project; and
f. alternatives to the Project (i.e., alternative locations for the hospital beds/services).

(R-1 at 5; 6; 57). On appeal, the appellant hospitals focus on the issues of "need" and "adverse effects." (App. Br. Arg. I-II). The ALC devoted half of its 70-page order to these questions and the related issues of access, distribution, and duplication of services. (R-1 at 18-20; 31-35; 51-53; 57-63; 66-68; 69-70). After an exhaustive and thorough review of the evidence, including numerous, classic battles of the experts on the issues, the ALC found that MUHA had established compliance with and satisfaction of all requirements for the proposed hospital, including the 2017-2018 State Health Plan. The appellant hospitals filed a motion to reconsider, which the ALC denied.

The two appellants timely appealed and filed separate notices of appeal, triggering a mandatory appeal bond of $1.5 Million under S.C. Code Ann. § 44-7-220(B) (Rev. 2018) from each of them for a total of $3.0 Million. They moved to strike § 44-7-220(B) as a

[6] This matter began as three separate contested case hearings, which the ALC consolidated for the purposes of trial. (R-1 at 5). CareAlliance Health Services was a petitioner in the ALC; it also appealed separately from the ALC's order but thereafter settled with MUHA. CareAlliance technically remains a "respondent" in this appeal, because the notices of appeal by the appellant hospitals named CareAlliance as a respondent, but it has no ongoing interest in this matter.

violation of their constitutional rights to due process and equal protection. MUHA moved to dismiss their appeals for failure to post the bonds. This Court's Motions Panel denied both motions but *sua sponte* reformed the bonds into a single, "collective" bond in the reduced total amount of $1.5 Million and invited further argument in the appellate briefs. The appellants posted the reduced bond and this appeal ensued.

STANDARD OF REVIEW

A contested case hearing is a *de novo* evidentiary hearing. The ALC is the sole fact finder, takes its own view of the evidence, may receive evidence not presented to DHEC, and determines the weight and credibility of the evidence.[7] The ALC also determines the weight and credibility of expert testimony, including any battle of experts.[8]

Section 1-23-610(B) of the South Carolina Code establishes the standard of review for appeals from the ALC. It specifies that an appellate court may not substitute its judgment for the ALC's judgment on the weight and credibility of the evidence.[9] Here,

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[7] *Brown v. S.C. Dept. of Health and Envtl. Control*, 560 S.E.2d 410, 413 (S.C. 2002) (trier of fact); *South Carolina Cable Tel. Ass'n v. Southern Bell Tel. & Tel. Co.*, 417 S.E.2d 586, 589 (S.C. 1992) (weight and credibility); *Marlboro Park Hosp. v. S.C. Dept. of Health and Envtl. Control*, 595 S.E.2d 851, 853-854 (S.C. App. 2004) (*de novo* hearing).

[8] *DIRECTV v. South Carolina Dep't of Rev.*, 804 S.E.2d 633, 644 (S.C. App. 2017).

[9] S.C. Code Ann. § 1-23-610(B) (Supp. 2020) establishes the standard of review in ALC appeals (emphasis added):

> The review of the administrative law judge's order must be *confined to the record*. The court *may not substitute its judgment* for the judgment of the administrative law judge *as to the weight of the evidence on questions of fact*. The court of appeals may affirm the decision or remand the case for further proceedings; or, it may reverse or modify the decision *if the substantive rights of the petitioner have been prejudiced* because the finding, conclusion, or decision is:
>
> (a) in violation of constitutional or statutory provisions;
> (b) in excess of the statutory authority of the agency;
> (c) *made upon unlawful procedure*;
> (d) *affected by other error of law*;
> (e) *clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record*; or
> (f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

the appellants do not make the classic argument that the "reliable, probative, and substantial evidence on the whole record" does not support the ALC's order. (App. Br., *passim*). Rather, they contend that the ALC committed errors of law. Questions of law are reviewed *de novo*, but the appellants must demonstrate prejudice to their substantive rights.[10]

In CON cases, DHEC, the ALC, and this Court must consider the State Health Plan existing at the time of the application and may consider the Plan existing at the time of their decisions.[11] Here, the 2017-2018 State Health Plan existed at the time of MUHA's application. It is included in the record as DHEC Exhibit 4 at R-12 at 5346-5491, and this brief references it as the State Health Plan without the date. The current plan is the 2020 State Health Plan; it is available at scdhec.gov; a different Plan may exist when this Court decides this case. For purposes of the arguments made in this brief, there are no significant differences between the 2017-2018 and 2020 Plans.

BACKGROUND FACTS

The State Health Plan creates service areas for hospital services. Most service areas are a single county, but here the service area is a three-county service area comprised of Berkeley, Charleston, and Dorchester counties. (Tri-County Service Area). (R-12 at 5377). The Tri-County area has experienced significant industry growth, and it has a mobile, rapidly growing population. These facts are significant factors in achieving the healthcare planning goals of putting services and providers where the people are, where they will be, and where they can best access the providers and services. (R-1 at 20).

[10] *Id.* (appellant must show its "substantive rights … have been prejudiced"); *Atkins v. Wilson*, 788 S.E.2d 228, 232 (S.C. App. 2016) (errors of law reviewed *de* novo).

[11] S.C. Code Ann. § 44-7-225 (Rev. 2018).

MUHA owns and operates healthcare facilities in downtown Charleston (MUHA Downtown). (R-1 at 6). MUSC provides healthcare related services at MUHA Downtown as the state's only academic medical center. (R.-1 at 6-7).[12] MUHA's healthcare services include quaternary services not available anywhere else in the state, and tertiary services available at only two other hospitals in the Tri-County Service Area. (Id.). Approximately 56% of MUHA Downtown's current patients come from the Tri-County Service Area. (R-1 at 13).

Appellant Trident Medical Center, LLC (Trident) owns and operates two of the appellant hospitals, one in North Charleston, Charleston County (TMC) and the other in Summerville, Dorchester County (SMC), within the Tri-County Service Area. (R-1 at 8). Appellant Walterboro Community Hospital, Inc. owns and operates the other appellant hospital in Walterboro, Colleton County (CMC), outside the Tri-County Service Area. (Id.). These two appellants are referenced herein jointly as the "appellant hospitals" or the "appellants." When necessary for clarity, these two appellants are referenced separately as Trident and CMC. Former appellant CareAlliance operates a hospital in Moncks Corner. (Id.).[13] Despite the location of these hospitals, 29% of MUHA Downtown's current patients come from the North Charleston, Summerville, and Moncks Corner areas; only 5% come from the downtown Charleston peninsula. (R-1 at 13).

Long before Covid-19, MUHA Downtown experienced serious overcrowding and bed shortage problems, including the following:

1. "boarding" problems, *i.e.*, patients too sick to go home so having to spend the night in the ER while waiting for a bed, and patients lying on gurneys in the hallways of units while waiting for a room in that unit, sometimes for hours;

[12] The State Health Plan refers to MUHA Downtown as the MUSC Medical Center. (R-12 at 5377).

[13] CareAlliance settled its appeal and has no continuing interest in this matter. See n.6, *supra*.

2. "OR" probems, *i.e.*, shutting down the operating rooms because there are no rooms for the patients after they come out of surgery;

3. "cohorting" problems, *i.e.*, unable to group patients together based on the type of care and type of physician needed, and having to scatter them throughout the hospital with the resulting loss of efficiencies; and

4. "transfer" problems, *i.e.*, refusing 50-60 requests per month from other hospitals, including the appellant hospitals, to transfer a patient to MUHA Downtown.

(R-7 at 3161-3174; 3183; 3185-3187; 3366-3372; 3374-3380; 3384-3385).[14] These problems are the result of high patient demand for MUHA's services and the rapid population growth in the Tri-County Service Area, particularly the general area surrounding the site of MUHA's proposed hospital. (R-1 at 12; 18-19). As a result of this overcrowding and high demand that hampers access to MUHA's services, MUHA Downtown has an admitted and undisputed "bed need" of 147 beds. (R-1 at 18). Other patient access problems (and visitor access problems) result from MUHA Downtown being located on a small but densely populated, heavily developed peninsula, *e.g.*, high traffic volume and congestion, limited parking, limited space, and flooding, etc. (R-1 at 18-19; 21 & n.25; 51-53).[15]

[14] It is a crime to disturb hospital patients with radios or musical instruments. S.C. Code Ann. § 44-7-20 (Rev. 2018). It is far more disturbing for a sick patient to wait hours in the ER or on a gurney in a hallway.

[15] The opposing experts admitted that MUHA had a "bed need" at MUHA Downtown on the Charleston peninsula. They opined, however, that MUHA did not demonstrate a need at the site of the proposed hospital and could only demonstrate a need on the Charleston peninsula, because that is where the need originated. The ALC found that these opinions "ignore[d] where MUHA's patients actually originate from to focus on where they travel to for care." (R-1 at 20). Only 5% of the patients came from the peninsula, and 29% came from submarkets surrounding the chosen site, *i.e.*, Summerville, Moncks Corner, and North Charleston. Indeed, 18% came from North Charleston, the biggest single source of patients. All of this "diminishe[d] [the] argument that MUHA should locate the additional beds on the peninsula" 'and "[i]n fact, it is *much more reasonable* to place the new hospital … a place from which a large percentage of the patients currently originate[.]" (R-1 at 20; 21) (emphasis added). Also, the population in these submarkets "is predicted to grow at a strong rate" and locating the hospital in this population growth area is "*consistent with the health planning tenant* of placing healthcare facilities where the people are and where they can best access it, which is currently the I-26 corridor." (R-1 at 20-21) (emphasis added).

MUHA studied numerous alternatives for meeting its bed need with new and renovated buildings on the Charleston peninsula, but ultimately concluded that building a new hospital at a location more accessible to its patient base was the best alternative. (R-1 at 51-53). MUHA chose a site in southern Berkeley County adjacent to I-26 (Exit 197) and centrally located to MUHA's existing patient base (29%) in the submarkets of North Charleston, Summerville, and Moncks Corner, areas with rapidly growing populations. (R-1 at 13). The proposed hospital is approximately 10.7 and 11.2 miles from Appellant Trident's hospitals in Summerville and North Charleston. (R-1 at 8). Appellant CMC's hospital is approximately 35 miles away in Walterboro. (Id.).[16]

Standard 5 of the State Health Plan permits a hospital with existing bed need to create a new hospital at a different site and transfer its bed need to the new hospital.[17] An applicant must justify the need for building a new hospital "at the chosen site" rather than adding beds to its existing site with "patient origin and other data." An applicant must also justify the possible adverse impact that the new hospital "at the chosen site" may have on

[16] As noted by DHEC, the 2020 State Health Plan projects that Berkeley County will need an additional 185 hospital beds by 2024, even after counting the 128 beds at the proposed hospital and the 50 beds at Trident's approved but unbuilt 50 bed hospital in Moncks Corner (BMC). (DHEC Init. Resp. Br. 3, n.2). The ALC noted that Trident obtained a CON for BMC in 2016 but had not yet started construction due to ongoing drainage issues and, therefore, the ALC found it unnecessary to consider BMC due to the speculative nature of its ultimate construction. (R-1 at 39 & n.50). The ALC was prescient. After obtaining three extensions on the CON for BMC, Trident recently withdrew its fourth extension request resulting in the CON becoming void. As a result, Berkeley County's projected bed need rises to 235 hospital beds by 2024.

[17] Standard 5 of the State Health Plan provides in full as follows:

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

(R-12 at 5360-5361).

other hospitals in the "service area." Any possible adverse impact must be weighed equally against the benefits of improved access. (R-12 at 5363).

MUHA applied under Standard 5 to build a new hospital with 128 beds in southern Berkeley County. DHEC approved the proposed hospital, and the appellant hospitals petitioned the ALC for a contested case hearing to challenge DHEC's approval. The ALC thoroughly reviewed the central issues of need, adverse impact, distribution, duplication, and improved access, including the "battles of the experts" presented by the parties' experts on these key issues. (See generally R-1 at 18-45; 51-53; 57-68; 69-71, *passim*). As to "need," the ALC found MUHA had proven it by the greater weight of the evidence.[18] As to "adverse impact," the ALC found MUHA had justified it by demonstrating the impact was minimal and outweighed by the benefit of improved access.[19]

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[18] The ALC found as follows:

> I *find the greater weight of the evidence* justifies the need for a 128-bed hospital as presented in the CON application. *MUHA has demonstrated its proposed hospital is needed* based upon such factors as: an overwhelming need to redirect patients from the peninsula hospital; the significant population growth in the area; and the reasonableness of its service area, patient redirection percentages, ALOS, and projected utilizations based upon its historic patient origin data.
>
> * * * *
>
> *I find MUHA has demonstrated a need*. Furthermore, *the evidence shows* MUHA *justified the need for a 128-bed hospital* based upon the significant percentage of its patient that originate in the Tri-County Service Area (including the submarkets near the [proposed hospital]); the significant population growth in the area; and the reasonableness of its service area, patient redirection percentages, ALOS, and projected utilizations. . . .MUHA *established a bed need* for MUHA Berkeley based upon patient origins and other data. . . .. Accordingly, MUHA *established a need for the proposed hospital in accordance with Standard 5* in the 2017-2018 [Plan].

(R-1 at 30; 62-63) (emphasis added).

[19] As to the appellant hospitals operated by Trident Medical Services, LLC, the ALC found the following:

> Overall, *I find the evidence of record demonstrates* Trident will only be marginally adversely impacted by MUHA Berkeley. It will lose some market share, but that adverse impact is not the kind of material adverse impact that justifies denying MUHA's application in light of Trident's strong presence in the region and current utilization. *Moreover, when balanced against the benefits of increased access at MUHA Berkeley, the benefits of access outweigh the small impact to Trident.*

(R-1 at 38) (emphasis added). As to CMC, the hospital operated by appellant Walterboro Community Hospital, Inc., in Walterboro, the ALC reached the following conclusion:

For the convenience of the court, this brief includes Endnotes 1 and 2, *infra,* at pp. 42-45. The endnotes compile detailed excerpts from the ALC's order on the dominant issues of need, adverse impact, distribution, duplication, and access. These excerpts demonstrate *inter alia* that the ALC found that MUHA's evidence more credible than the appellant hospitals' evidence and, more importantly, that MUHA had proven compliance with and satisfaction of all requirements for the proposed hospital.

SUMMARY OF ARGUMENT

This Court should dismiss these appeals for failure to post the appeal bonds required by § 44-7-220(B). (Arg. IV, *infra*). Dismissal on this ground moots all other issues.

The appellant hospitals do not challenge the sufficiency of the evidence of record to support the ALC's order. Rather, they argue that Standard 5 imposes a rule of evidence that limits the relevant evidence to patients living within a 10-mile radius of the proposed hospital. (App. Br. Arg. II). Based on this imaginary evidentiary wall, the appellants complain that the ALC erred in considering evidence from the entire Tri-County Service Area. (Id.). This argument is manifestly without merit because *inter alia* Standard 5

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

(R-1 at 42, emphasis added). The appellants' brief makes only passing references to CMC and does not challenge the findings and rulings about CMC. (App. Br., *passim*).

As to former appellant CareAlliance, which owns and operates the "Roper" hospitals, and which settled with MUHA before filing a brief, the ALC reached the same conclusions based upon MUHA's evidence having demonstrated compliance with and satisfaction of all requirements for the proposed hospital, including need, adverse impact, and the balance between adverse impact and increased access. (See generally R-1 at 39-41).

contains no 10-mile language and accepting the appellants' interpretation would interfere with the healthcare planning purpose of the State Health Plan. (See Arg. I, *infra*).

The appellant hospitals also argue that procedural errors by DHEC during its review process precluded DHEC from conducting a meaningful review of the proposed hospital. As a result, DHEC approved the application, which meant the appellants were the petitioners in the ALC with the burden of proof. They contend that the *de novo* hearing before the ALC could not and did not cure the prejudice of being the party with the burden of proof in the ALC. (App. Br. Arg. I). This "burden of proof" argument has no merit, because it misperceives how the burden of proof operates in a *de novo* hearing governed by the "preponderance of evidence" standard of proof. More importantly, the appellants ignore the ALC's actual and repeated factual findings that MUHA established compliance with and satisfaction of all requirements for the proposed hospital (despite not having the burden of proof). (See Arg. II, *infra*; see also Endnotes 1 and 2, *infra* at 42-45).[20]

ARGUMENT[21]

Overview of the State Health Plan

DHEC is the sole state agency for administering the CON program created by the CON Act.[22] DHEC's mission is to "guide the establishment of health facilities and services which will *best serve public needs,* and ensure that high quality services are provided in

[20] The appellants also complain about MUHA's separately proposed freestanding emergency room. (App. Br. Arg. III). This is a red herring. MUHA will close it upon opening the new hospital. (See Arg. III, *infra*).

[21] MUHA adopts and incorporates the arguments presented by DHEC in support of the appealed order.

[22] S.C. Code Ann. § 44-7-140 (Rev. 2018) ("the sole state agency for control and administration of the granting of Certificates of Need and licensure of health facilities and other activities necessary to be carried out under [the CON Act]").

health facilities in this State." (Emphasis added).[23] To that end, the CON Act directs DHEC to do two things relevant here. First, DHEC must promulgate by regulation the Project Review Criteria (PRC) for evaluating all CON applications.[24] Second, DHEC must produce a State Health Plan at least once every two years.[25]

The CON Act creates a health planning committee to advise the DHEC staff in drafting a State Health Plan "for use in the administration of the [CON] program."[26] The committee submits the draft to the DHEC Board "for final review and adoption."[27] The Plan must include "a *general statement* as to the project review criteria considered most important in evaluating [CON] applications *for each type* of facility [and service], including a finding as to *whether the benefits of improved accessibility* . . . may *outweigh the adverse effects* caused by the duplication of any existing facility [and service]."[28]

The State Health Plan includes the following general provisions on DHEC's use of the Plan as a tool in administering the CON program:

1. As required by the CON Act, the Plan contains a "the project review criteria considered to be the most important in evaluating [CON] applications for each type of facility [and service]." (R-12 at 5351-5352). This "*general statement* has been

[23] The General Assembly specifically declared the purpose of the CON Act in S.C. Code Ann. § 44-7-120 (Rev. 2018), which provides in full as follows:

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

[24] S.C. Code Ann. §§ 44-7-190 (Rev. 2018).

[25] S.C. Code Ann. §§ 44-7-120(3) (Rev. 2018) (prepare/publish) and -180(C) (Rev. 2018) (every two years).

[26] S.C. Code Ann. § 44-7-180 (A) & (B) (Rev. 2018).

[27] S.C. Code Ann. § 44-7-180(C) (Rev. 2018).

[28] S.C. Code Ann. § 44-7-180(B)(4) (Rev. 2018) (emphasis added).

added to most sections of the Plan" and, "[w]here appropriate, the Plan contains a finding as to whether" the benefits of improved access outweigh any adverse effects caused by duplication of any existing facility and service. (Id. at R-12 at 5352) (emphasis added).

2. "The *need* for a service is analyzed by assessment of existing resources and need *in the relevant service area*, along with other factors set forth in this Plan, applicable statutes and regulations." (Id. at R-12 at 5355) (emphasis added).

3. "The *need* for general hospital beds [like those at issue here] is determined through the consideration of current *utilization* and *projected population* growth with the goal of having beds *available* within approximately thirty (300 minutes' travel time for the majority of residents of the State." (Id. at R-12 at 5359) (emphasis added).

The State Health Plan identifies seven "project review criteria" as the "general statement" on which project review criteria are considered most important in evaluating proposed hospitals.[29] The Plan further directs that the "*benefits of improved accessibility* will be *equally weighed* with the *adverse effects of duplication* in evaluating [CON] applications for these beds." (R-12 at 5363) (emphasis added).[30]

I. The appellant hospitals' interpretation of Standard 5 of the State Health Plan is manifestly without merit.

A. Introduction

Standard 5 of the State Health Plan allows an existing hospital with an existing bed need (like MUHA Downtown) to build a new hospital at a different site and transfer those beds to the new hospital rather than enlarging the existing hospital. Standard 5 requires the existing hospital to present "patient origin and other data" to justify the proposed hospital as follows:

[29] This brief focuses on need, adverse impact, distribution, and access, because these factors relate directly to the appellants' appellate arguments. As to the other issues, about which the appellants make no argument or complaint, the ALC's order also finds that MUHA proved compliance with and satisfaction of all requirements. (R-1 at 4-73, *passim*).

[30] See Arg. I, *infra*, for a discussion of these criteria, the ALC's findings on these criteria, and the appellants' arguments about those criteria.

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

(R-12 at 5360-5361) (emphasis added). The meaning of "at the chosen site" as used in Standard 5 became an issue before the ALC.

The appellant hospitals argued that "at the chosen site" defined and limited the permissible scope of evidence under Standard 5 in two ways. First, the "patient origin and other data" used to justify need must show there is a need "'near' the geographic site of the new hospital," which the appellants now argue is a 10-mile radius around the proposed hospital. (R-1 at 59; Init. App. Br. Arg. II). Second, Standard 5 thus precludes consideration of evidence from the entire service area, *i.e.*, the Tri-County Service Area, despite the fact "service areas" are the fundamental building block for healthcare planning under the State Health Plan. (Id.).

The ALC rejected these arguments in a detailed analysis spanning three pages.[31] The ALC concluded that patient origin and other data should be based upon the service area in

[31] The ALC analyzed and ruled upon the appellants' arguments as follows:

1. The ordinary rules of statutory construction apply to issues on the meaning of the State Health Plan, including the following rules.
    a. The plain meaning of the words used in Standard 5 are a primary inquiry.
    b. Standard 5 cannot be construed by concentrating on the isolated phrase of "at the chosen site."
    c. Rather, the meaning of "at the chosen site" must be determined in the context of Standard 5 as a whole, as well as the role of Standard 5 in the State Health Plan as a whole, together with the underlying purpose and intent of the drafter.
2. The appellant hospitals' construction of Standard 5 and "at the chosen site" as a geographic limitation on the permissible evidence fails for the following reasons.

the State Health Plan, because it is "the most practical and reasonable interpretation that is consonant with the purpose, design, and policy of lawmakers [DHEC Board]." (R-1 at 62).

B. The appellants fail to challenge the ALC's analysis and ruling, thereby making it the law of this case.

On appeal, the appellant hospitals quote parts of the ALC's 3-page analysis and summarily dismiss it with the phrases "contorts the plain language of Standard" and "strained construction of Standard 5." (Init. App. Br. 24). These conclusory sentence fragments are insufficient to challenge the ALC's analysis of the issue and its ruling; the issue is therefore deemed abandoned.[32] There being no challenge to the ALC's analysis

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a. The appellants ignore the plain meaning of "at the chosen site" within the context of Standard 5 as whole. It is an adjective phrase that describes the new hospital and its location so as to differentiate it from the existing hospital and its location.

b. The phrase "at the chosen site" is used twice within Standard 5, and the appellants' interpretation of it makes no sense for its second use in Standard 5, *.i.e.,* the second use of "at the chosen site" is in the context of a directive to consider the entire service area.

c. Accepting the appellants' interpretation would result in a conflict with how the State Health Plan as a whole treats the issue of "need" as being a service area issue. If the drafters of the State Health Plan [DHEC Board] intended Standard 5 to introduce a new geographic term, they would have defined that term.

d. The purpose of Standard 5 is to allow the transfer of beds within the service area, and that same service area is the context for justifying need, just like it is for adverse impact.

e. The appellants' isolate the term "at," define it to mean "near," then use "near" to mean a short distance from the site of the new hospital, and ultimately define "near" (i.e., "at") to mean a 10-mile radius around the site the new hospital. This argument fails for the following reasons.

f. The appellants' interpretation is questionable on its face, because being 10 miles away is a substantial distance that does not comport with what many would perceive as being "near" the site of the hospital.

g. Moreover, if the service area is not the relevant geographic area, then the relevant area would be the "30-minute drive time" area used elsewhere in the State Health Plan. Accepting the appellants' 10-mile radius would require an unreasonable assumption that cars in the area average only 20 miles per hour.

h. Thus, the appellants' construction of "at the chosen site" to mean a "short distance" from the proposed hospital is not practical or reasonable.

(R-1 at 59-62).

[32] See *Englert, Inc. v. Netherlands Ins. Co.*, 433 S.E.2d 871, 873 n.2 (S.C. App. 2011) (single sentence argument too conclusory to present issue on appeal); *Bean v. South Carolina Cent. R.R. Co.*, 709 S.E.2d 99, 113 (S.C. App. 2011) (same).

and ruling, it becomes the law of this case and, right or wrong, requires affirmance.[33] In any event, the ALC's analysis and ruling is correct for the detailed reasons set forth in the appealed order and should be affirmed for those reasons. Moreover, the ALC's ruling should be affirmed for the additional reasons set forth below.

C. The appellant hospitals' appellate arguments have no merit.

On appeal, the appellant hospitals construct an argument that concludes the only "patient origin and other data" allowed to justify "need" and "adverse impact" under Standard 5 must come from within a 10-mile radius around the proposed hospital site:

1. a need for hospital services "must actually exist[] in the geographic area where the [new] hospital is to be located" and that is not true in this case, because appellant Trident's two hospitals are within a 10-mile radius of the new hospital and provide the same services in sufficient numbers (Init. App. Br. 23);

2. the phrase "at the chosen site" is "a geographic boundary on the proof needed under Standard 5 to justify a new hospital" (Id. at 25);

3. the ALC's ruling "renders geographic proximity and the words 'at the chosen site' meaningless because it would allow an applicant to move its bed need and create a new hospital without a consideration of the proximity of the new hospital to other existing providers and the services they provide" (Id. at 26); and

4. Standard 5 requires proof "that the patients at the chosen site of the new hospital in Berkeley 'need' the community hospital services being offered by" the new hospital. (Id.).

Armed with this imaginary 10-mile evidence rule, the appellants complain that the ALC allowed MUHA's plan to decant low acuity patients from MUHA Downtown to the new hospital and thereby make room for more high acuity patients at MUHA Downtown "to substitute for need at the chosen site." (Id.). In short, the appellant hospitals contend that Standard 5 limits the "patient origin and other data" that can justify the need for and the

[33] See *Buckner v. Preferred Mut. Ins. Co.*, 177 S.E.2d 544, 544 (S.C. 1970) (unchallenged ruling is the law of the case and, right or wrong, requires affirmance).

adverse impact of a proposed hospital to evidence emanating from within a 10-mile radius of the proposed hospital. This argument is manifestly without merit for numerous reasons.

First, it is axiomatic that the controlling inquiry on the meaning of "at the chosen site" and Standard 5, to which all other interpretation rules are subservient, is the intent of the DHEC Board as the author of the State Health Plan and in light of the purpose of the Plan and Standard 5.[34] The DHEC Board issued the State Health Plan to guide DHEC's administration of the CON program. Nothing in the language of Standard 5 or State Health Plan imposes any specific and limited geographic boundary on relevant evidence other than the service area. If the Board had intended to impose a 10-mile radius limit on the evidence in every Standard 5 application filed with DHEC, surely it would have said so.[35] It did not, and this is not surprising. Drawing an arbitrary circle around all proposed hospitals throughout the entire state under Standard 5 is not good healthcare planning, which focuses on the realities on the ground now and in the future.

Second, the State Health Plan is a planning document designed to forecast the need for expanding and adding healthcare facilities and services throughout the state, a fact highlighted by the statutory mandate that it be issued at least once every two years. Its purpose is to direct DHEC in administering the CON program with an emphasis on putting healthcare services where the people are now and will be in the future. It is against this backdrop that one must interpret and apply Standard 5, which plainly contemplates and authorizes the transfer of existing bed need from one hospital to create a new hospital like

[34] *E.g.*, *State v. Kinard*, 831 S.E.2d 138, 140 (S.C. App. 2020) ("All rules of statutory construction are subservient to the one that the legislative intent must prevail if it can be reasonably discovered in the language used, and that language must be construed in the light of the intended purpose of the statute."); *Cobb v. Benjamin*, 482 S.E.2d 589, 595 (S.C. App. 1997) (same).

[35] *E.g.*, *Buist v. Huggins*, 625 S.E.2d 636, 640 (S.C. 2006) (if the General Assembly had intended a specific result in a statute, it would have said so).

the one proposed in this case. Read as a whole, and in conjunction with the other provisions of the State Health Plan, the clear intent is for Standard 5 to operate as follows:

1. An existing hospital with an existing bed need at its existing site may build a new hospital at a "different site" and transfer its existing bed need to the new hospital.

2. To do so, the existing hospital must "justify" the need to transfer those beds to a new hospital at the "chosen site," *i.e.*, the "different site," rather than the existing hospital at the existing site.

3. The existing hospital must also "justify" the potential adverse impact that transferring its existing bed need to this new hospital at the "chosen site," *i.e.*, the "different site," rather than the existing hospital at the existing site, could have on other existing hospitals in the service area.

4. To meet the requirements that it "justify" the new hospital, the existing hospital must use "patient origin and other data."

5. In considering the project review criteria, the benefit of improved access must be weighed equally against any adverse impact. (R-12 at 5363).

It is undisputed that MUHA presented sufficient evidence to justify the new hospital under the foregoing interpretation of Standard 5. The appellants do not argue otherwise. Rather, they argue that the only permissible evidence must come from within the 10-mile radius around the new hospital that the appellants creatively but erroneously add to Standard 5.

Third, contrary to the appellants' argument, the ALC did not approve the new hospital without considering "the proximity of the new hospital to other existing providers and the services they provide," *i.e.*, the appellant hospitals. (Init. App. Br. at 25-26). The ALC's order is a comprehensive consideration of the appellant hospitals with a focus on the factors relevant here. (R-1 at 18-45; 51-53; 57-68; 69-71, *passim*). This argument is therefore manifestly without merit.

Fourth, also contrary to the appellants' argument, erecting a 10-mile radius evidentiary wall is not needed to ensure "a consideration of the proximity of the new

hospital to other existing providers and the services they provide." (Init. App. Br. at 25-26). The last sentence of Standard 5 expressly requires it without the appellants' imaginary wall; it expressly requires consideration and justification of "the potential adverse impact a new hospital *at the chosen site* could have on the *existing hospitals in the service area*." (Emphasis added). This argument is therefore manifestly without merit.

Fifth, the phrase "at the chosen site" appears twice in Standard 5. The appellant hospitals focus on the "need" issue when they argue that "at the chosen site" is a 10-mile radius evidentiary rule. (See App.Br. Arg. II, *passim*). This meaning of "at the chosen site" is irreconcilable with the second use of that same phrase in Standard 5 on "adverse impact," which requires consideration of existing hospitals in the service area, *i.e.*, which requires evidence from the entire service area.

Sixth, the ALC focused on MUHA's historic patient origin and other data as directed by Standard 5. This evidence showed that 29% of MUHA Downtown's existing patient base resides in the general surrounding areas of North Charleston, Summerville, and Moncks Corner, *i.e.*, the submarkets near the new hospital. The undisputed evidence also showed that this area has a rapidly growing population, a key consideration under the State Health Plan. The appellants seek to avoid this evidence, because it shows that MUHA has a substantial patient base in a rapidly growing area that is the reasonably predicted core of MUHA's future patients at the proposed hospital. All of this demonstrates that, contrary to the appellants' argument, the ALC did not rely solely MUHA's desire to decant patients from MUHA Downtown to the proposed hospital. Rather, the ALC focused on the facts that MUHA had an existing patient base in the surrounding and rapidly growing population. This justified putting the hospital at the proposed site.

Finally, the appellants' "interpretation" of Standard 5 as imposing a 10-mile radius rule of evidence is, in reality, an attempt to hide a battle of experts that they lost in the ALC and cannot win on appeal. The ALC, not the appellate courts, determines the weight and credibility of expert testimony.[36] The appellants' experts used a 10-mile radius analysis to combat the testimony of MUHA's expert, which was based on historic evidence of patient origin and utilization, *i.e.*, the historic data that demonstrated 29% of MUHA's patients comes from the submarkets around the site of the proposed hospital. (*E.g.*, *compare* R-10 at 4339-4340 *with id.* R-11 at 5017-5054; 5055-5073; and 5306-5307). The appellants lost this weight-and-credibility-driven battle of the experts before the ALC, and they have no straightforward basis for re-engaging in this battle on appeal due to the standard of review. To avoid this, the appellants recast their experts' opinion as a legal argument on the meaning of Standard 5 in the hopes of triggering a *de novo* review by this Court. Their argument fails under either standard of review, and this Court should reject the attempt to convert a question of fact into a question of law.

D. Conclusion

The substantial evidence of record fully supports the ALC's comprehensive factual findings that MUHA established compliance with and satisfaction of all requirements for the proposed hospital. The appellants do not argue otherwise. Rather, they convert their experts' factual theories and opinions into an argument on the meaning of Standard 5, with the goal of building an imaginary evidentiary wall bordering the 10-mile radius around the site of the proposed hospital. Nothing in Standard 5 or any other part of the State Health Plan supports the construction of this imaginary wall. Indeed, this artificial and arbitrary

[36] See nn.7-10 and accompanying text, *supra*.

limitation on considering all of the facts on the ground is the antithesis of and interferes with statewide, regional, and service area healthcare planning, which is the overriding purpose of the State Health Plan.

II. The appellants' "burden of proof" argument is manifestly without merit.

A. Introduction

The ALC opened its 70-page order with the overall finding and conclusion that MHUA had satisfied all requirements for the proposed hospital:

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

(R-1 at 6) (emphasis added). In the ensuing comprehensive analysis, the ALC found that MUHA's evidence established compliance with each requirement for the proposed hospital. (R-1 at 18-72, *passim*). This fact-intensive analysis included credibility determinations and resolved numerous "weight of the evidence" questions, including pervasive battles of the experts. (Id.). The ALC closed its order as follows:

> *Petitioners have failed to meet their burden* to show MUHA's application does not meet the requirements or fulfill the purposes of the CON Act, the PRC, and the State Health Plan. As a result, I conclude MUHA should be granted a CON for the construction of MUHA Berkeley.

(R-1 at 72-73) (emphasis added). The appellant hospitals seize upon the above-emphasized language to make the following three-part argument:

1. the ALC decided this case based on the appellants having the burden of proof;
2. the appellants should not have had the burden of proof because, "but for" DHEC's procedural errors, DHEC would have rejected the proposed hospital and, therefore;
3. MUHA should have been the ALC petitioner with the burden of proof.

(App. Br. at Arg. I, *passim*). Here again, the appellants do not challenge the sufficiency of the substantial evidence of record to support the ALC's actual findings and rulings. Rather, they construct a meritless "burden of proof" argument that *inter alia* ignores how that burden operates in a preponderance of evidence case and ignores the ALC's actual rulings.

B. The appellants' arguments are not preserved for appeal.

For the reasons set forth in DHEC's Brief of Respondent, the appellants' arguments are not preserved for appeal. In any event, as shown below, the appellants' arguments have no merit, and they have failed their appellate burden of demonstrating reversible error.[37]

C. The procedural errors in the DHEC review process.

The appellants claim that two procedural errors by DHEC caused them irreparable harm that could not be cured by the *de novo* hearing before the ALC. First, DHEC mistakenly failed to mail its "deemed complete" letter before publishing the "deemed complete" notice in the *State Register*. As a result, the appellants had only 12 days to respond to the "deemed complete" letter. They claim that the mistakenly shortened review process prejudiced them in the following manner: (1) they did not have enough time to object meaningfully to the application; and (2) DHEC did not have enough time to meaningfully review the application. (App. Br. Arg. I).

Second, the "deemed complete" letter listed four project review criteria as considered most important by DHEC, but it did not include all criteria listed in the State

[37] "[A]n appealed order comes to the appellate court with a presumption of correctness and the burden is on appellant to demonstrate reversible error." *McCall v. IKON*, 670 S.E.2d 695, 701 (S.C. App. 2008) (citation omitted). "It is axiomatic that no error is reversible, unless it is prejudicial." *First Union Nat'l Bank v. Hitman*, 411 S.E.2d 681, 682 (S.C. App. 1991). In an appeal from an ALC order, the appellate court cannot reverse the ALC unless "the *substantive rights* of the petitioner [appellant] have been prejudiced." S.C. Code Ann. § 1-23-610(B) (Supp. 2020) (emphasis added).

Health Plan for hospitals, including the issue of adverse impact.[38] As a result, the appellants claim that DHEC granted the application without properly considering adverse impact. Coupled with this argument, the appellants argue that DHEC's erroneous acceptance of MUHA's "100% redirection theory" is the reason DHEC failed to consider adverse impact properly. (App. Br. Arg. I).

The appellants cast DHEC's mistakes as violations of mandatory procedures, but they must nevertheless demonstrate that the violations caused them to suffer prejudice to their substantial rights.[39] As shown below, they fail to demonstrate any resulting prejudice.

D. The appellants' claimed prejudice from DHEC's procedural errors.

The appellant hospitals assert that DHEC's procedural errors caused them to suffer the following harm:

1. Due to the improperly shortened review cycle, the appellant hospitals did not have sufficient time to prepare its opposition to MUHA's application, and DHEC did not have sufficient time to conduct a meaningful review.

2. Due to DHEC's erroneous acceptance of MUHA's 100% redirection theory and the resulting failure to list adverse impact in its "deemed complete" letter, DHEC failed to consider the issue of adverse impact properly.

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[38] DHEC's "deemed complete" letter listed four PRC's that DHEC considered most important in reviewing MUHA's application: [1] Need Outlined in the State Health Plan (PRC 1); [2] Community Need Documentation (PRC 2); [3] Distribution (Accessibility) (PRC 3); and [4] Ability to Complete the Project (PRC 14). (R-12 at 5314-5315). The State Health Plan identified seven PRC's as generally most important for licensing a general hospital: [1] Need Outlined in the State Health Plan (PRC 1); [2] Community Need Documentation (PRC 2); [3] Distribution (Accessibility) (PRC 3); [4] Acceptability (PRC 4); [5] Record of the Applicant (PRC 13); [6] Cost Containment (PRC 16); and [7] Adverse Effect on Other Facilities (PRC 23). (R-12 at 5362). The State Health Plan further provided that with respect to these criteria "[t]he benefits of improved accessibility will be equally weighed with the adverse effects of duplication [of services] in evaluating" the CON application. (R-12 at 5363). The appellants note but never argue the following differences between the "deemed complete" letter and the State Health Plan as being prejudicial to them. First, the "deemed complete" letter included the criteria of Ability to Complete the Project, which is not listed in the State Health Plan as generally one of the most important criteria. Second, the letter excluded three other criteria listed in the State Health Plan as generally one of the most important criteria, to-wit, Acceptability, Record of the Applicant, and Cost Containment. (Init. App. Br. 14-15). The appellants never argue these difference caused them any prejudice and, more importantly, they never mention nor challenge the ALC's rulings on these criteria. (Id.).

[39] *Gardner v. South Carolina Dep't of Rev.*, 577 S.E.2d 190, 197 (S.C. 2003) ("As a general rule, a party must establish prejudice as the result of another's failure to follow mandatory statutory procedure.").

(App. Br. Arg. I). Three things must be noted from the outset. First, the appellants had ample time in the ALC proceedings to prepare and present their opposition to the proposed hospital. Their preparation in the ALC proceedings included extensive discovery over a one-year period and an 11-day hearing, neither of which were available in the DHEC review process. Their presentation to the ALC included live witnesses and the cross-examination of opposing witnesses, neither of which was available in the DHEC review process. Second, the ALC had ample time to conduct a meaningful review of the application, including the receipt of far more detailed evidence, testimony, exhibits, etc. than was presented in the DHEC review process. Third, the ALC did not accept MUHA's 100% redirection theory, agreed that DHEC had erred in accepting this theory, and agreed that DHEC had therefore failed to consider adverse impact adequately. (R-1 at 39 n.50; 41; 64). The ALC, however, fully considered the issue of adverse impact and all other issues. The ALC found that the preponderance of the evidence demonstrated that MUHA complied with and satisfied all requirements for the proposed hospital, including the requirements related to adverse impact. (R-1 at 4-73, *passim*).

E. The appellants have failed to demonstrate reversible error.

To demonstrate reversible error, the appellants must first demonstrate that "but for" the procedural errors, DHEC staff and the DHEC Board "would have" ruled in the appellants' favor, *i.e.*, DHEC "would have" denied MUHA's application and, therefore, MUHA would have been the petitioner with the burden of proof in the ALC proceedings. The appellants fail to demonstrate this, and they fail to argue it specifically. Moreover, the evidence shows that DHEC "would have" nevertheless granted the application.

Margaret Murdock, the Director of the CON Division, was responsible for reviewing MUHA's application and deciding whether to grant it. Her testimony demonstrates her belief that she meaningfully reviewed the application and all criteria despite the problems with the timeline and "deemed complete" letter. Moreover, taken as a whole, her testimony demonstrates that she would have granted the application even in the absence of the process errors raised by the appellants. (See R-6/R-7 at 2790-3135, *passim*).[40]

Second, the appellants' "burden of proof" argument fails under the axiomatic rules on how one prevails in a case controlled by the "preponderance of evidence" standard of proof applicable here:[41]

1. A preponderance of the evidence case begins with balanced scales of justice.

2. For the party with the burden of proof to prevail, the fact finder (the ALC here) must conclude that the evidence tips the scales in favor of the party with the burden of proof, *i.e.*, the appellant hospitals here.

3. By contrast, the party with the burden of proof can lose in one of two ways:

[40] Murdock reviewed the MUHA application and submitted documentation from all parties against all of the regulatory PRC's and the standards in the State Health Plan to determine which PRC's that DHEC considered most important in reviewing the MUHA application; she did not ignore any PRC's but did not make a written finding on all of them. (R-6 at 2808-2809; 2812; 2818-2825; 2831; 2840-2849). The letter did not list adverse effect on existing facilities, because no hospitals existed in Berkeley County at the time. (R-6 at 2825-2826). Nevertheless, DHEC (Murdock) specifically considered adverse effects with regard to the approved but not yet operational 50-bed hospital being built by former appellant CareAlliance in Moncks Corner, Berkeley County (Roper Berkeley), as well as the two hospitals operated by Trident in North Charleston, Charleston County (Trident Medical Center (TMC)) and Summerville, Dorchester County (Summerville Medical Center (SMC)). (R-6 at 2826-2828; 2911-2914). She also considered the rapidly growing population in the general area of the MUHA Berkeley proposed site and how that growth likely ameliorated any adverse impact on Trident's market share; she also considered the past and present (and growing) bed-utilization rates for the Trident hospitals in Summerville and North Charleston (SMC and BMC) and Trident's free standing emergency rooms in the same area. (R-6 at 2851-2852; 2856-2859; 2885-2887; see also R-6 at 2877-2885; 2888-2896; 2916-2917; 2920-2924, re: ongoing population growth in the area and high utilization of Trident hospitals and ER's in the area that continued after approval of MUHA's CON, as well as MUHA's existing significant patient base in that same area, and how all of that also justifies approval of MUHA's application).

[41] *Be Mi, Inc. v. South Carolina Dep't of Rev.*, 758 S.E.2d 737, 740 (S.C. App. 2014) (standard of proof in ALC is preponderance of the evidence).

a. After reviewing the evidence, the fact finder (the ALC here) concludes that the party with the burden of proof has failed to move the scales of justice, *i.e.*, the scales remain evenly balanced; or

b. After reviewing the evidence, the fact finder (the ALC here) concludes that the other party (MUHA here) has proven its position by a preponderance of the evidence, *i.e.*, the scales have been tipped in favor of the other party even though it did not have the burden of proof.

The erroneous assignment of the burden of proof in a preponderance of the evidence case is itself prejudicial *if, but only if*, the party with the burden of proof loses because the scales remain evenly balanced after the fact finder's consideration and weighing of the evidence. Here, the ALC did not rule on the basis of the scales remaining evenly balanced. To the contrary, the ALC ruled on every determinative issue that MUHA had proven its position, *i.e.*, that MUHA had tipped the scales in its favor with evidence demonstrating that its CON application should be granted. Thus, any presumed error resulting in the appellant hospitals erroneously having the burden of proof did not prejudice their substantive rights.

Third, even if one assumes that DHEC "would have" denied MUHA's application "but for" DHEC's procedural errors, and even if one further assumes that MUHA therefore "would have" had the burden of proof in the ALC proceedings, the appellants fail to demonstrate any reversible error. The ALC's 70-page order is an "*exhaustive and thorough review*" of the evidence in this case. (R-1 at 6) (emphasis added). On every issue, including the need, adverse impact, distribution, duplication, and access issues central to the appellants' appellate arguments, the ALC repeatedly and consistently found that the proposed hospital complied with and satisfied all CON requirements. Thus, even if DHEC had denied the application, the ALC's order demonstrates that MUHA would have thereafter prevailed in the ALC despite being the petitioner with the burden of proof. DHEC's procedural errors, therefore, did not and could not cause the appellant hospitals to

suffer any prejudice to their substantial rights as required by the controlling standard of review in S.C. Code Ann. § 1-23-610(B) (Supp. 2020) (appellate court may reverse "if the substantive rights of the petitioner have been prejudiced").

F. The appellants' "specific" arguments have no merit.

The appellants identify two specific errors as prejudicial. First, Margaret Murdock, the DHEC staff person responsible for MUHA's application, requested additional "patient origin" information from MUHA. She was having trouble "connecting the dots" in MUHA's "zip code" analysis of the nearby submarkets and MUHA's predictions on how many patients from those areas would seek services at the proposed hospital. She received this additional information on the same day that DHEC issued its staff decision, and she admitted that the appellants did not have sufficient time to review this additional information meaningfully. (R-7 at 3097-3098). Murdock testified that, despite the time crunch, the information was sufficient to clear up her "connect the dots" confusion. (R-7 at 3122-3123). Thus, the appellants fail to make the critical showing that more time would have changed DHEC's decision. Moreover, the appellants never challenge the sufficiency of the evidence presented to the ALC on this matter and, as with their entire "burden of proof" argument, they fail to show that the result would have been different in the DHEC review or the ALC contested case hearing.[42]

[42] The appellants mis-read Murdock's testimony as an admission that DHEC did not have time for a meaningful review of the new information provided by MUHA in response to her "connect the dots" question. (Init. App. Br. 20). The questions and answers cited by the appellants relate to CareAlliance's (Roper's) response to the new information from MUHA. The questioning began by referencing DHEC Exh. 1 at page 988 (R-12 at 5302), which is an email from Roper's attorney. (See R-7 at 3097). He sent this email at 4:59 p.m. in response to the new information from MUHA. (R-12 at 5302; R-7 at 3098). By this time, the staff decision to grant MUHA's application "was already signed and on its way out." (R-7 at 3098). It was this response, not MUHA's information, that Murdock "didn't have time to give [a] meaningful review." (R-7 at 3098). This is the only specific matter that the appellants specifically claim resulted in DHEC not having enough time to conduct a meaningful review, and it is based upon a mistaken reading of Murdock's testimony. In any event, Murdock later made it clear that the information from MUHA cleared up her

Second, the appellants specifically complain about MUHA's assertion of the "100% redirection theory" in its application, *i.e.*, that 100% of the patients that would use the new hospital would be patients that already used MUHA Downtown. Under this theory, the appellant hospitals could not suffer any adverse impact from the new hospital, because they would not lose any patients that already used their hospitals. (Init. App. Br. at 20-21). This argument fails to demonstrate reversible error for the following reasons:

1. MUHA did not rely on this 100% redirection theory in the ALC proceedings. (R-1 at 35, n.44).

2. MUHA presented other adverse impact evidence to the ALC, which the ALC found established that any adverse impact was minimal and outweighed by the benefits of improved access. (R-1 at 37-38; 41-42; 64-65). The appellants do not challenge the sufficiency of the evidence to support this ruling by the ALC.

3. Contrary to the appellants' assertion, the ALC did not resolve the "adverse impact" issues based upon the appellants having the burden of proof and failing "to prove there would be adverse impact." (Init. App. Br. 21).[43] Rather, the ALC rejected the 100% theory but found that MUHA's other evidence demonstrated that any adverse impact would be minimal and was outweighed by improved access. (R-1 at 41; 64; 70).

In sum, the appellants' specific arguments fail for the same reasons that its general argument fails. The appellants fail to show that DHEC would have reached a different decision absent the purported errors. The ALC did not decide the question based on the burden of proof, *i.e.*, the ALC did not find the scales on the adverse impact issues remained

questions: "If I hadn't been satisfied by [MUHA's] supplementary information, I would have denied the application." (R-7 at 3123). Here again, therefore, the appellants fail to demonstrate that more time "would have" caused DHEC deny the application.

[43] The appellants cite three pages in the ALC's order to support this assertion: "R-1 at 29, n.35; 35; 50." (Init. App. Br. 21). Page 47 of the order has nothing to do with any "adverse impact" issues; it is part of the ALC's consideration of "MUHA's Capacity for Debt Service," an issue that the appellants lost and do not appeal. (See R-1 at 50). Page 26 and footnote 35 of the order also do not support the appellants' assertion. To the contrary, the ALC specifically finds that MUHA"s 100% theory "to be unreasonable" and agreed with the appellants that the proposed hospital "is likely to capture some market share" from the appellant hospitals. (See R-1 at 29 & n.35). Page 32 of the order likewise does not support the appellants' assertion; the ALC again specifically finds that MUHA's 100% theory "is unreasonable." (See R-1 at 35).

balanced after considering the parties' evidence. Most importantly, the appealed order demonstrates that the ALC would have approved the proposed hospital, even if MUHA had lost in the DHEC process and been the petitioner in the ALC with the burden of proof.

III. The "freestanding emergency department" issue is a red herring.

In a separate CON case, MUHA sought approval to build a freestanding emergency department (FSED) two miles from the site for the proposed hospital. (R-1 at 7 & n.8). DHEC approved the FSED, but the ALC disapproved it in May 2020. (Id.). MUHA appealed, and that appeal is currently pending in this Court. (Id.).[44]

In the CON application for the proposed hospital, MUHA stated that it would close the FSED upon opening the proposed hospital. (R-1 at 7). At the hearing before the ALC, a MUHA witness indicated that MUHA had reconsidered this position after DHEC approved the proposed hospital. (R-7 at 3268-3269).

An approved CON is valid only for the project described in the application, and implementing the project or operating the facility not in accordance with the application may be considered a violation of the CON Act.[45] DHEC may revoke licenses for violating a provision of the CON Act.[46] Thus, MUHA must close the FSED upon opening the proposed hospital, because not doing so would be a violation of the CON Act. Moreover, the appellant hospitals will not take "yes" for an answer.

In approving MUHA's application, the ALC ruled that MUHA must close the FSED upon opening the proposed hospital. The appellant hospitals nevertheless raised the

[44] See *Trident Medical Center, LLC v. S.C. DHEC*, S.C. Ct. App. Appellate Case No. 2020-001072).

[45] S.C. Code Ann. § 44-7-230(A) (Rev. 2018).

[46] S.C. Code Ann. § 44-7-320(A)(1)(a) (Rev. 2018).

specter of MUHA not doing so in their motion to reconsider. (R-3 at 1389-1392). MUHA conceded in its return that it will close the FSED upon opening the proposed hospital. (R-3 at 1403-1404). The ALC again ruled that MUHA must close the FSED. (R-1 at 42-43). The appellants again raise the FSED issue in their Argument III.

MUHA did not appeal the ALC's order. MUHA hereby again concedes to this Court in this appeal, with the intent that its concession be binding upon it in this appeal and hereafter, that it will close the subject FSED upon opening the proposed hospital.[47]

IV. The appeals should be dismissed immediately for failure to post the bonds required by S.C. Code Ann. § 44-7-220(B) (Rev. 2018).

A. Introduction

The two appellants (Trident and CMC) filed separate appeals on October 2, 2020. Each of these filings triggered S.C. Code Ann. § 44-7-220(B) (Rev. 2018), which the parties agree required each of the appellants to deposit a $1.5 Million bond with this Court within five calendar days after filing their appeals.[48] The bonds were due on October 7,

[47] MUHA's counsel in this appeal hereby certify to this Court that MUHA has authorized them to make this binding concession in this appeal.

[48] Section 4-7-220(B) sets the bond amount at 5% of the project cost or $100,000.00, whichever is greater, up to a maximum of $1.5 Million Dollars. Here, the total cost of the proposed hospital is $325 Million. (R-1 at 2). Five percent of $325 Million is $16.25 Million, so the bonds due from Trident and CMC were the statutory maximum of $1.5 Million Dollars each. Section 4-7-220(B)provides in full as follows:

> (B) If the relief requested in the appeal is the reversal of the Administrative Law Court's decision to approve the Certificate of Need application or approve the request for exemption under Section 44-7-170 or approve the determination that Section 44-7-160 is not applicable, the party filing the appeal shall deposit a bond with the Clerk of the Court of Appeals within five calendar days after filing the petition to appeal. The bond must be secured by cash or a surety authorized to do business in this State in an amount equal to five percent of the total cost of the project or one hundred thousand dollars, whichever is greater, up to a maximum of one million five hundred thousand dollars. If the Court of Appeals affirms the Administrative Law Court's decision or dismisses the appeal, the Court of Appeals shall award to the party whose project is the subject of the appeal all of the bond and also may award reasonable attorney's fees and costs incurred in the appeal. If a party appeals the denial of its own Certificate of Need application or of an exemption request under Section 44-7-170 or appeals the determination that Section 44-7-160 is applicable and there is no competing application involved in the appeal, the party filing the appeal is not required to deposit a bond with the Court of Appeals.

2020. Rather than file the bonds, conditionally or otherwise, the appellants filed a joint motion for relief from the bonds.

The appellants conceded in their joint motion that § 44-7-220(B) required each of them to file a $1.5 Million. (R-3 at 1425-1439). They further conceded that they would abandon their appeals if required to post these bonds, claiming a financial inability to do so. (Id.).[49] They argued that they should not be required to file any bond under § 44-7-220(B), because it violates their constitutional rights to due process and equal protection. (Id.). MUHA filed a motion to dismiss both appeals for failure to comply with § 44-7-220(B).

This Court's Motions Panel denied both motions but *sua sponte* reformed the bond requirement in § 44-7-220(B) and granted relief not requested or argued by any party and not authorized by § 44-7-220(B). The Motions Panel ordered that the appellants must post a "*collective* $1.5 Million *bond*" or their appeals will be dismissed, *i.e.*, the Panel reformed the bond requirement to a single bond and reduced the total amount by one half. (R-1 at 2) (emphasis added). The Panel noted that the parties could address "the issues raised in the current motions" in their appellate briefs. (R-1 at 2, n.3). The appellants timely filed the reformed and reduced bond.

[49] It is more accurate to say the appellants were unwilling, as opposed to truly unable, to post the bonds required by the statute. The supporting affidavits for their joint motion show that they **prefer** to spend the $1.5 Million Dollars elsewhere. (R-3 at 1442-1450, *passim*). These affiants ignore the facts that the appellants **are able to** post a surety rather than cash and that the bond is returned to the appellants if they prevail in this appeal. (Id., *passim*). Moreover, as shown by MUHA's counter-affidavit, Trident has the financial ability to post the statutory bond but simply chooses not to do so. (R-3 at 1465-1468). The Hospital Corporation of America (HCA) is the parent of both appellants, and it is the largest hospital system in the United States according to Becker's Hospital Review, January 15, 2020. MUHA's counter-affidavit shows that HCA has enormous financial ability to assist Trident and CMC, assuming either of them actually needs assistance as opposed to simply not wanting to post the statutory bond. (Id.). The appellants do not dispute HCA's financial ability to post the required bonds in the required amount. In any event, financial hardship is not an exception to the bond statute and, if the Appellants believe it should be, their recourse is with the General Assembly, not this Court. See *Wheeler, infra* (appellate court has no discretionary power over mandatory statutory bond).

B. The Motions Panel erred in *sua sponte* reducing the bond amount and, therefore, this Court should dismiss the appeal immediately for failure to comply with § 44-7-220(B).

A court must enforce a statute as written unless it is unconstitutional, regardless of whether the court agrees or disagrees with the wisdom of the statute or the public policy underlying it.[50] The appellate courts have no discretionary power over mandatory appeal bonds imposed by statute, and the courts must dismiss the appeal if the appellant fails to post the required bond.[51]

Nothing in § 44-7-220(B) creates or authorizes any exception to filing the statutory bond in the prescribed amount, and nothing allows an appellant to challenge the bond rather than file it. The appellants did not request a reduction in the bond amounts; indeed, they conceded that § 44-7-220(B) required each of them to file a $1.5 Million bond before they could pursue this appeal. (R-3 at 1426; 1431 & n. 3; 1432). They continue to concede this on appeal. (Init. App. Br. 32). Accordingly, the Motions Panel erred in reducing the amount of the bonds to be filed by the appellants, because no one requested this relief and, more importantly, because the statute does not permit this relief.

The appellants also conceded to this Court that they would not post the $3.0 Million in appeal bonds required by § 44-7-220(B) and would not pursue this appeal if required to do so. (R-3 at 1431-1432). This concession, combined with the Motions Panel's error in reducing the bond amounts, requires the immediate dismissal of the appellants' appeals for failure to comply with the mandatory requirements of § 44-7-220(B). An immediate dismissal on this ground moots the other issues in this appeal.

[50] *Keyserling v. Beasley*, 470 S.E.2d 100, 101 (S.C. 1996).

[51] *Wheeler v. Hyde*, 91 S.E.2d 265, 265-266 (S.C. 1956).

C. The General Assembly created the appellants' "right" to object to MUHA's CON application and, therefore, the General Assembly may impose such conditions on that right that it deems appropriate, including the mandatory bond imposed by § 44-7-220(B).

The CON Act created the appellants' right to object to MUHA's application during the DHEC review process, to challenge DHEC's decision to grant the application in a contested case hearing before the ALC, and to appeal from the ALC to this Court. Absent the CON Act, the appellants would not have any of these "rights." When the General Assembly creates a right, it may impose such terms and conditions that it deems appropriate on the exercise of that right and, absent compliance with those terms and conditions, there is no right.[52] Therefore, the appellants must comply with the requirements of the CON Act, including § 44-7-220(B), to assert their statutory rights under the CON Act. This rule is particularly pertinent here for two reasons.

First, the purpose of the CON Act is to promote and establish healthcare facilities and services that will best serve the needs of the public and ensure high quality healthcare for South Carolina's citizens.[53] This is a matter peculiarly within the province of the General Assembly, because it involves the weighing of competing public policies after studying the issues in detail.[54] Second, the CON Act is a comprehensive and detailed

[52] *See, e.g., National Exchange Bank v. Holman*, 9 S.E. 824, 825 (S.C. 1889) (stating general rule); see also *Boone's Masonry Constr. Co. v. South Carolina Second Injury Fund*, 227 S.E.2d 659, 661 (S.C. 1976) (rights and remedies created by the Second Injury Fund statutes); *Gunnells v. Raybestos-Manhattan, Inc.*, 198 S.E.2d 535, 536 (S.C. 1973) (statutory right of dependents to recover for decedent's death from occupational disease); *Muckenfuss v. Atlanta & C.A.L.R. Co.*, 113 S.E. 367, 369 (S.C. 1922) (rights created by strict liability statute); *Bradley v. Doe*, 649 S.E.2d 153, 157-160 (S.C. App. 2007) (right to recover from UIM carrier when adverse driver unknown).

[53] § 44-7-120 (CON Act's purpose "is to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State."); *Dema v. Tenet Phys. Servs. – Hilton Head, Inc.*, 678 S.E.2d 430, 433 (S.C. 2009) (with the CON Act, "the Legislature intended to advance the quality of healthcare provided in the State for all people receiving the care").

[54] *Holman v. Bulldog Trucking Co.*, 428 S.E.2d 889, 893 (S.C. App. 1993) (public policy is the province of the legislature, not the courts, and the "legislature, not the judiciary, is the proper branch of government to

treatment of the entire CON program, including special rules for the DHEC review process, for ALC contested case hearings, and for appeals from the ALC to this Court.[55] This level of detail demonstrates a "legislative intent that [CON] matters *must be decided* only in the manner specified in [the CON Act]."[56] This includes the bond required by § 44-7-220(B).

The appellants complain that other general statutes and rules would protect MUHA from delay damages, frivolous appeals, etc. This is a matter for the General Assembly, not this Court, because the question is whether the General Assembly has the power to impose a statutory bond, not whether the General Assembly wisely exercised that power.[57] The General Assembly has that power, because it created the appellants' rights. The appellants claim the General Assembly has exceeded its power, because § 44-7-220(B) violates their constitutional rights to due process and equal protection. These arguments have no merit.

D. Section 44-7-220(B) is not unconstitutional.

The appellants argue that § 44-7-220(B) violates their constitutional rights to due process and equal protection. They bear the heavy burden of proving *clearly* and *beyond*

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consider and balance competing interests and policies"); *accord Government Employees Ins. Co. v. Poole*, 817 S.E.2d 283, 287 (S.C. 2018) (the General Assembly is better suited to determine public policy, because it has the ability to conduct studies, collect information, and weigh the various alternatives) *and Fullbright v. Spinaker Resorts, Inc.*, 802 S.E.2d 794, 797 (S.C. 2017) (public policy is matter within the sole province of the General Assembly).

[55] See generally S.C. Code Ann. §§ 44-7-110 to -394 (Rev. 2018 & Supp. 2020).

[56] *Greenville County v. Kenwood Enters., Inc.*, 577 S.E.2d 428, 433 (S.C. App. 2003) (all emphasis added) (considering comprehensive zoning acts), *quoting I'On, L.L.C. v. Town of Mt. Pleasant*, 526 S.E.2d 716, 721 (S.C. 2000).

[57] *Horn v. Blackwell*, 48 S.E.2d 322, 323 (S.C. 1948) ("We are not unaware of the fact that [the] requirement [of a bond in appeals from eviction orders] may impose a hardship upon some tenants, but we are here dealing with the power of the General Assembly and not with the question of whether such power was wisely exercised."); *Adkins v. Comcar Indus., Inc.*, 447 S.E.2d 228, 230 (S.C. App. 1994) ("the responsibility for the justice or wisdom of legislation rests exclusively with the legislature, whether or not we agree with the laws it enacts."), *aff'd* 475 S.E.2d 762 (S.C. 1996).

a reasonable doubt that § 44-7-220(B) is unconstitutional.[58] The courts indulge every presumption in favor of finding statutes constitutional and, if at all possible, will construe a statute so that is constitutional and valid.[59]

1. Section 44-7-220(B) does not violate due process.

The appellants do not make the classic due process argument of notice and an opportunity to be heard. Rather, they claim an "unfettered right" to an appeal to this Court under Article I, § 22 of the South Carolina Constitution that cannot be burdened by the General Assembly in any manner, including the imposition of an appeal bond. (Init. App. Br. 36). This argument has no merit.

As the Supreme Court stated in *Horn v. Blackwell*, it is "well settled that the right of appeal is not an inherent or vested right, but is a matter of grace."[60] Thus, the General Assembly "in its *discretion* may *abridge* or *regulate* the right of appeal."[61] This discretion includes the power to impose a mandatory bond requirement unless that power is "clearly excluded" by the constitution.[62] The appellate courts have no discretionary power over mandatory bonds and must dismiss the appeal if the appellant does not post the bond.[63]

Article I, §22 provides in pertinent part that "[n]o person *shall be finally bound* by a judicial or quasi-judicial decision of an administrative agency affecting *private rights* except on due notice and an opportunity to be heard; . . . and he shall have in all such

[58] *Bodman v. State*, 742 S.E.2d 363, 365-366 (S.C. 2013).

[59] *Id.*

[60] *Horn v. Blackwell*, 48 S.E.2d 322, 323 (S.C. 1948).

[61] *Id.* (emphasis added).

[62] *Id.* (all emphasis added).

[63] *Wheeler v. Hyde*, 91 S.E.2d 265, 265-266 (S.C. 1956).

instances the right to judicial review." (Emphasis added). The appellants' rights in this case are not "private rights" as envisioned by Article I, § 22. The General Assembly created the appellants' "rights" in the CON Act. Moreover, the appellants are not "bound" as envisioned by Article I, § 22 – the ALC did not order them to do or not do anything.

In any event, nothing in Article I, § 22 or any other constitutional provision "clearly excludes" the power of the General Assembly to impose conditions on the appellants' right to appeal. Thus, the General Assembly has the power to require an appeal bond under long-standing principles of constitutional jurisprudence:

> Under its general authority to regulate appellate procedure the *legislature has the power to require the giving of a bond* or undertaking as a condition precedent to the right to appeal or sue out a writ of error, *unless such power is clearly excluded by the constitution*. Such statutes *do not violate constitutional provisions granting the right of appeal, as they do not restrict or deny the right, but merely regulate the manner of exercising it* ….

(Emphasis added).[64] The wisdom of § 44-7-220(B), including any presumed hardship in pursuing an appeal, is a matter for the General Assembly.[65]

In summary, Article I, § 22 does not "clearly exclude" the General Assembly's power to regulate the judicial review afforded by Article I, § 22. Therefore, under long-standing principles of law that pre-date Article I, § 22 and include *Horn v. Blackwell, supra*, the General Assembly may require a bond as a condition precedent to the right to appeal. Thus, the appellants do not have an "unfettered right" to an appeal.[66]

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[64] *Horn v. Blackwell*, 48 S.E.2d at 323, *quoting* 4 C.J.S., Appeal and Error, § 502.

[65] *Id.* 323("We are not unaware of the fact that [the] requirement [of a bond in appeals from eviction orders] may impose a hardship upon some tenants, but we are here dealing with the power of the General Assembly and not with the question of whether such power was wisely exercised.").

[66] The appellants attempt to explain why *Horn v. Blackwell* does not control here. (Init. App. Br. at 33-35). They note that the appellant in *Horn* received one level of "judicial review" from the magistrate before having to post an appeal bond to seek further judicial review in the appellate court. The magistrate did not provide "judicial review" as contemplated by Article I, § 22, *i.e.*, review after a ruling by the fact finder. In *Horn*,

2. Section 44-7-220(B) does not violate equal protection.

The appellants do not claim a suspect class or the abridgement of a fundamental right. Thus, the "rational basis test" controls their equal protection claim. That test has the following three elements: "(1) whether the law treats similarly situated entities differently; (2) *if so*, whether the legislative body has a rational basis for the disparate treatment; and (3) whether the disparate treatment bears a rational relationship to a legitimate government purpose."[67] The first element of treating similarly situated entities differently is the gateway inquiry. If it is not satisfied, then there is no further inquiry.

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the magistrate was the trial court and fact finder like the ALC in this case, and the first "judicial review" was in the appellate court, as it is here.

The appellants also note that the constitutional provision on appeals from magistrates provided that appeals would be under "such rules and regulations" as established by the General Assembly, whereas Article I, § 22 does not contain this provision. (Init. App. Br. 35). Article I, § 22 is a limitation on executive power, not legislative power, and it is silent on the meaning of "judicial review." That meaning is supplied by Article V, which creates the unified judicial system that is the only constitutional source of any judicial review, including the judicial review envisioned by Article I, § 22. (See Art. V, § 1, creating unified judicial system). In §§ 5 and 9, Article V directs the General Assembly to prescribe the "regulations" for the Supreme Court and the "jurisdiction" of the Court of Appeals. Thus, the General Assembly has the power to impose a bond in CON cases.

Finally, the appellants complain that the bond statute in *Horn* imposed a stay on the eviction of the appellant tenant, but the bond statute here does not impose a stay. (Init. App. Br. 34). The appellants do not request a stay or argue that this Court should interpret § 44-7-220(B) as imposing a stay, so their point here is unclear. In any event, the appellants can only be harmed if MUHA Berkeley begins accepting patients before this appeal is finished. It will take 45 months to complete the project so, even if MUHA commences the project during this appeal, it is very likely the appeal will be finished before the appellants can possibly suffer any harm.

[67] *Joseph v. South Carolina Dep't of Labor, Lic. & Reg.*, 790 S.E.2d 763, 771 (S.C. 2016) (emphasis added).

a. The bond statute does not treat similarly situated persons differently.

The courts give "great deference to the General Assembly's decision to create a classification." Challengers like the appellants must "negate every conceivable basis which might support it." The fact that a classification may result in some inequity does not make it unconstitutional, and challengers like the appellants must show beyond a reasonable doubt that it is "not supported by any rational basis."[68]

Here, the appellants challenge the classification under § 44-7-220(B), because "it applies to only a small subset of appeals from the ALC." This is true, but it does not show any violation of equal protection. The entire CON program is a "small subset" of ALC cases, but all challengers to a CON application are treated the same within the CON program, including in appeals from an ALC order. Thus, there is no equal protection violation. To avoid this, the appellants rely on the decision in *Lindsey v. Normet*, 405 U.S. 56 (1972). Their reliance is misplaced.

In *Lindsey*, the Court considered a tenant's appeal from an eviction order under Oregon law. In Oregon, all civil appellants had to file an appeal bond that covered all damages, costs and disbursements that might be awarded against him in the appeal. 405 U.S. at 74. An evicted tenant, however, unlike any other civil appellant, had to file this bond **plus** an additional bond for twice the rental value of the rented property. *Id.* at 75-76.

South Carolina does not have a mandatory general bond statute applicable to all civil appeals that the appellants must post in addition to the bond required by the Act that gave them their right to object to the CON. Rather, the General Assembly has enacted

[68] *Bodman v. State*, 742 S.E.2d 363, 367-368 (S.C. 2013); *accord Boiter v. South Carolina Dep't of Transp.*, 712 S.E.2d 401, 403 (S.C. 2011).

numerous appeal bond statutes tailored to specific types of cases. Thus, there is no disparate treatment like that in *Lindsey*.

Moreover, the appellants' argument is a "forum based" theory that makes no sense. They argue that § 44-7-220(B) violates equal protection, because it applies only to CON cases but not any other case that comes before the ALC. Acceptance of this theory would mean that every appeal from the Court of Common Pleas must be subjected to the same bond requirement, and any deviation from that universal requirement in a particular class of cases would violate equal protection. This would invalidate every civil appeal bond statute in South Carolina, because no statute applies to every case. Manifestly, the General Assembly has the constitutional power and discretion to treat different types of cases differently, and that is what it did in § 44-7-220(B).[69]

b. Assuming some disparate treatment of similarly situated persons, Appellants have failed to prove the bond statute is not rational.

Assuming the appellants have satisfied their heavy burden in challenging the classification of CON appeals (and they have not), they fail to satisfy their burdens under the "rational basis" and "rational relationship" elements of the rational basis test. As shown earlier, the CON Act is an essential part of the General Assembly's implementation of its

[69] The following is a non-exhaustive list of appeal bond statutes for specific types of civil appeals:
§ 6-1-1030 (bonds for appeal of assessment of development impact fee against developer)
§ 12-21-2500 (bond in appeal of business license revocation)
§ 12-60-3370 (taxpayer must pay taxes under protest or post bond for those taxes before appealing)
§§ 15-67-620 and -640 (appeal bond when ejected as a trespasser)
§ 15-69-150 (bond in appeal of claim and delivery judgment for purpose of collecting a debt)
§ 18-7-10 and § 14-25-95 (bonds when appeal is to circuit court)
§ 18-9-130(A)(1) & (A)(2) and § 18-9-170 (money judgments and property sales during appeal)
§ 18-9-150 (bond for order directing the assignment or delivery of documents or personal property)
§ 22-3-310 (bond in appeals from magistrate's judgment for claim and delivery of personal property)
§ 27-37-130 and § 27-40-800 (bond in ejectment action)
§ 49-17-330 (bond for appeal challenging inclusion of property in a drainage or levee district)
§ 58-1-30 and § 58-11-70 (bonds in appeals on rates for public utilities and radio common carriers)
§ 59-150-180 (bond in appeals involving lottery retailer contracts)

public policy decisions on promoting and establishing healthcare facilities and services that will best serve the needs of the public and ensure high quality healthcare to South Carolina's citizens.[70] This overriding public interest justifies the imposition of the statutory bond, particularly given that the appellants would have no rights in this matter but for the CON Act, which itself imposes the statutory bond. At the very least, the public interest in promoting high quality healthcare throughout South Carolina triggers judicial deference to the General Assembly in this peculiarly legislative matter, and the appellants have failed to prove beyond a reasonable doubt that the classification is not rationally related to the public policy and public interest objectives of the CON Act.

E. Conclusion

The CON Act is the source of the appellants' rights. The General Assembly created those rights and, therefore, the General Assembly may impose terms and conditions that it deems appropriate on the exercise of those rights, including the posting of a bond as required by§ 44-7-220(B). The appellants fail to carry their heavy burden in demonstrating violations of due process or equal protection. The Motions Panel erred in reducing the bonds imposed by § 44-7-220(B), and the appellants concede they will not post the bond if this Court reverses that reduction. This Court should immediately require the appellants to post the full bond amount of $3.0 Million and dismiss the appellants' appeals.

[70] § 44-7-120 (purpose of Act is to establish health facilities and ensure high quality services are provided).

CONCLUSION

These appeals should be dismissed and the bond awarded to MUHA. Absent dismissal, the appealed order should be affirmed and the bond awarded to MUHA.

Respectfully Submitted,

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ENDNOTES

Endnote 1
Excerpts from ALC Order, re: Need for the Proposed Hospital
(All emphasis added)

A. Need under Standard 5

"*MUHA demonstrated* a large portion of the patient population that it seeks to transfer originates in the Tri-County Service Area, and more particularly the Nexton area [where the hospital is to be located], based upon its historic patient origin data. *MUHA thus justified* the need for its proposed hospital through its patient original data." (ALC Order at 17). In making these findings, the ALC weighed the competing opinions from the parties' experts, ultimately accepting MUHA's expert over the others. (R-1 at 19-21).

B. Need in the Service Area

"[A]fter *thoroughly considering and weighing the evidence* in this case, I *find* that despite the surplus of beds in the Tri-County Area, *MUHA has demonstrated* that its proposed hospital *is needed* for the reasons already stated and those that follow." (R-1 at 23).

C. Community Need

MUHA contended that the local service area for its proposed hospital would be larger than that for other community hospitals in the Tri-County Service Area – the opposing experts disagreed. "I *find*" that MUHA is correct because "[t]he breadth of MUHA's patient origins is unique compared to other hospitals" and, "[t]herefore, I *find Petitioner's evidence* of what other community hospitals in the area have experienced to be *less persuasive than MUHA's* historic patient origin data." (R-1 at 24).

MUHA also relied on evidence of projected population growth in the surrounding submarkets, and its evidence "is a *reasonable* projection of the growth in the area" that "is *in line with* accepted demographic methodologies and *consistent with* the state demographer's date and methodologies." (R-1 at 24). "Therefore, *MUHA has demonstrated* a need in the target population." (R-1 at 25).

MUHA presented evidence of need and utiliztion based on a "drive-time redirection analysis" of patients from 94 zip codes. The opposing experts disputed MUHA's analysis. (Id.at 22). "Overall, I *find* MUHA's redirection analysis to be *sound*." (Id. at 23). Although MUHA may have overestimated redirection in some areas, "I *find* it also underestimated them in others" and none of the overestimations "is great enough to offset [MUHA's] *overall justification*. (R-1 at 26-27).

The parties presented competing expert opinions on the need-related issue of the "average length of stay" (ALOS) by patients at the hospital. "I *find* [MUHA's estimate] is *reasonable*" and that the opposing experts' "estimates [are] *unreasonable*" and based on a faulty analysis. (Id. at 24, 25). "Therefore, I *find* it is reasonable to predict that MUHA's community hospital will have a higher than average ALOS compared to other community hospitals in the area." (R-1 at 28).

D. Conclusion

"I *find the greater weight of the evidence* justifies the need for a 128-bed hospital as presented in the CON application. *MUHA has demonstrated* its proposed hospital is needed based upon [the evidence presented by MUHA]." (R-1 at 30).

"*I find MUHA has demonstrated* a need. Furthermore, *the evidence shows* MUHA justified the need [based on the evidence presented by MUHA]." (R-1 at 62).

The appellant hospitals' interpretation of "at the chosen site" in Standard 5 as limiting the evidence need under Standard 5 to data physically near the "chosen site" is not reasonable. (R-1 at 59-62). "However, in this case, it ultimately does not matter whether the factual analysis is based upon Petitioners' interpretation that the Court consider only patient origins and date 'near' the chosen site or the State Health Plan's geographical area because, under either scenario, *MUHA established* a bed need for MUHA Berkeley based upon patient origins and other data. For instance, *the evidence established* that 29% of MUHA's existing patients originates in the submarkets 'near' the proposed site and this baseline need, along with *numerous other facts* cited in this case that reflect the patient need in the area, is *sufficient to justify a need* near MUHA Berkeley. Accordingly, *MUHA established a need* for the proposed hospital in accordance with Standard 5 in the 2017-2018 [State Health Plan]." (R-1 at 62-63).

"I *find* MUHA's application complies with need outlined in the State Health Plan" in PRC 1 and PRC 2. (R-1 at 66) (emphasis added). "*MUHA demonstrated* an identified need in the target population and its approach to identifying the need was *reasonable*. Finally, MUHA used appropriate and reasonable assumptions to project the utilization of its Project, and the project utilization is *sufficient to justify* the Project. Therefore, the *evidence supports* approval of MUHA's proposed 128-bed hospital." (R-1 at 66-67).

Endnote 2
Excerpts from ALC Order, re: Adverse Effects/Impact of the Proposed Hospital
(All emphasis added)

A. MUHA's 100% Redirection Theory

"MUHA's assertion [in the application] that it will not have any impact on other [hospitals] because 100% of its patients will be redirected from its existing patient population is *unreasonable*" and [a]lthough *MUHA did not rely upon this assertion at trial*," I address the issue here." (R-1 at 35 & n.44; see also id. R-1 at 29 & n.35). Trident's attack upon MUHA's reliance on 100% redirection in its application is ironic, given its reliance on the same theory in its application for BMC. (Id. at R-1 at 39, n.50).

"MUHA's decision to locate its hospital in the southern part of Berkeley County is *reasonable based upon* where the growing portion of Berkeley County is located, which is in the southern portion of the county, and the location's proximity to Interstate 26, which provides good access to the hospital for the population living in that area." (R-1 at 36).

B. Market Share

"Because of Trident's longstanding presence in, and commitment to, the northeast portion of the Tri-County [Service Area], and its current utilization levels, *I find any adverse impact* on Trident will be *minimal and* the impact is *justified* by the increased accessibility MUHA Berkeley will offer." (R-1 at 37).

"Overall, *I find the evidence of record demonstrates* Trident will only be marginally adversely impacted by MUHA Berkeley. It will lose some market share, but that adverse impact is not the kind of material adverse impact that justifies denying MUHA's application in light of Trident's strong presence in the region and current utilization. Moreover, when balanced against the benefits of increased access at MUHA Berkeley, the benefits of access outweigh the small impact to Trident." (R-1 at 38).

"[W]hile I find that MUHA's reliance upon 100% redirection [in its application] is unreasonable, *the preponderance of the evidence demonstrates* [at trial] that the vast majority of MUHA's patients will be redirected and the impact to market share will be small. Balanced against the increased access MUHA Berkeley will provide, *I do not find* Petitioner Roper presented *convincing* evidence that MUHA will have an adverse impact on Roper Berkeley such that MUHA's application should be denied." (R-1 at 41).

"*I find* that the extent to which MUHA Berkeley has an adverse effect on CMC, this impact would be more a product of CMC's already precarious financial situation rather than a product of bad healthcare planning. . . . *I do not find* [CMC's expert's patient redirection] analysis to be *persuasive*." (R-1 at 41-42). CMC's existing financial problems may make any patient loss more material, but that loss "is likely to be small" and "must be weighed against the benefits of increasing access" to patients in the area and the fact that CMC is "locat[ed] outside the [Tri-County] service area. This Court "*conclude[s]* that the minimal adverse impact to CMC does not outweigh the benefits of increased accessibility provided by MUHA" and "I *find* any adverse impact to CMC is *justified* and the benefits of MUHA's hospital *outweigh any adverse impact* to CMC." (R-1 at 42).

The appellants complained that MUHA should have added the 128 beds to the downtown area by building a new facility or refurbishing existing facilities. (R-1 at 52-53). Their "*evidence failed to rebu*t MUHA's reasons for choosing to locate MUHA Berkeley at the proposed location. Rather, the evidence supporting MUHA Berkeley's location was *more persuasive*." (R-1 at 53). "I *find* the application complies with PRC 19. MUHA considered alternatives and *reasonably concluded* there is no better alternative that to build the Project. . . . *MUHA has also clearly demonstrated* that continuing to serve patients under the status quo is untenable and results in many patients being turned away from care." (R-1 at 69-70).

C. Justified Adverse Impact

Although MUHA's 100% redirection theory is unreasonable, "this is a *de novo* hearing and the *Court must review all of the evidence to determine* whether MUHA failed to meet the requirements of Standard 5. And, ultimately, [the appellant hospitals] failed to show by a preponderance of the evidence that MUHA's application does not meet the requirements of Standard 5. *Rather, the evidence established that* any potential adverse impact is justified by the benefits of accessibility MUHA Berkeley will offer." (R-1 at 64).

Although any impact to a hospital's market share is adverse, "it does not immediately follow that the CON must be denied. Trident will suffer some loss of market share, *but the impact will be minimal* compared to its operations as a whole and, since TMC already has high patient volumes, there is room for another provider in the area, *especially considering the strong population growth in the area*. . . . Additionally, the potential for impact to Trident must be viewed in light of the demonstrated need for the new hospital. The *clear existence of MUHA's need by its current patient base* will allow MUHA Berkeley to successful[ly] operate without cannibalizing Trident's patients. Thus, while there is a potential adverse impact toTrident, that *impact would be minimal and is justified* in light of the *benefits* the [proposed hospital] will provide to *patients in the area*." (R-1 at 64-65).

Moreover, MUHA's proposed hospital is justified by the redirection of its existing patients alone. . . . [T]he *evidence established* that [any loss of market share] would most likely be small and completely offset by the population growth. Therefore, *MUHA justified* any potential adverse impact *by showing* its hospital *is needed* and can be *supported by its existing patient base*." (R-1 at 65).

D. Balancing Adverse Effects with Benefits of Access

The State Health Plan requires a balancing of access benefits with adverse effects. "I *find* MUHA's application complies with the [State Health Plan] in this regard. Although [the appellant hospitals] provide similar services in the area, I *do not find* any duplication of services to be unnecessary. MUHA's proposed hospital *will improve accessibility* in the Tri-County [Service] Area for the target population and reduce capacity constraints for patients who continue to utilize MUHA's downtown campus. Any potential adverse effects will likely be small. *Weighing these considerations equally, I do not find* the potential adverse effects of duplication necessitate denying the CON." (R-1 at 65).

E. Adverse Effect on Other Facilities

"For the reasons already stated in the conclusions of law section discussing adverse impact under Standard 5 and in the section weighing adverse impacts with accessibility, *I conclude* MUHA's project *complies* with [this project review criteria] *despite* MUHA's faulty theory of 100% redirection in its application." (R-1 at 70).

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CERTIFICATE OF COUNSEL

The undersigned certifies that this Final Brief of Respondent complies with Rule 211(b) SCACR and the Supreme Court Order of August 13, 2007.

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