STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center d/b/a Fort Mill Medical Center, Petitioner, v. South Carolina Department of Health and Environmental Control and The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center-Fort Mill, Respondents.	Docket No. 11-ALJ-07-0575-CC **FINAL ORDER AND DECISION**

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

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

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

STATEMENT OF THE CASE

This matter is before the Administrative Law Court (ALC or court) pursuant to the request for a contested case hearing filed by Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center (Piedmont). Piedmont is challenging the decision of the South Carolina Department of Health and Environmental Control (DHEC) to grant a certificate of need (CON) to The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas Medical Center-Fort Mill Carolinas Healthcare System (CHS) to build a general acute care hospital in York County, South Carolina. The hearing was held over the course of fifteen days between April 8, 2013, and May 7, 2013. For the reasons set forth herein, the court concludes that the CON application should be granted to Piedmont for the purpose of building a one hundred (100) bed general acute care hospital in York County, South Carolina.

BACKGROUND

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

The 2004-05 South Carolina Health Plan (State Health Plan or Plan) identified a need for 64 additional acute care hospital beds in York County. Based on the need identified in the Plan, DHEC received four applications for a Certificate of Need (CON) to build a hospital near the town of Fort Mill. The four applicants were Piedmont, CHS, Presbyterian Healthcare System (Presbyterian), and Hospital Partners of America, Inc. (HPA). In January 2005, Piedmont applied to construct and operate a sixty-four (64) bed hospital. On March 11, 2005, CHS, Presbyterian, and HPA each filed competing applications to construct and operate a 64 bed hospital. On October 6, 2005, Piedmont withdrew its January 2005 application and submitted a new application for a 100 bed hospital. The 100 bed hospital would include 64 general acute care hospital beds for which the Plan showed a need as well as thirty-six 36 licensed general acute care hospital beds to be transferred from the Piedmont Medical Center in Rock Hill to a new facility in Fort Mill. Piedmont's proposed hospital would be called Fort Mill Medical Center (FMMC). CHS's proposed hospital would be called Carolinas Medical Center – Fort Mill (CMC-FM).

By decision letters dated May 30, 2006, DHEC approved Piedmont's application to construct a 100 bed general acute hospital in York County and denied the applications of Presbyterian, CHS, and HPA for 64 bed hospitals. In response to DHEC's decision, CHS and Presbyterian filed separate requests for contested case hearings at the ALC.[1] The cases were assigned to the Honorable Carolyn C. Matthews and consolidated into The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System and Presbyterian Healthcare System d/b/a Presbyterian Hospital-York, LLC v. South Carolina Department of Health and Environmental Control and Amisub of South Carolina, Inc. d/b/a Piedmont Healthcare System d/b/a Fort Mill Medical Center, Docket No. 06-ALJ-07-0713-CC.

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

The contested case hearing was held in September 2009. At the conclusion of the presentation of evidence by Petitioners CHS and Presbyterian, both parties moved for summary judgment, arguing that DHEC erred in interpreting the Plan in such a manner as to allow only Piedmont, as the existing facility in York County for which the Plan designated additional beds, to be approved and to require the denial of all other applicants. Piedmont moved for partial summary judgment on the issue of whether it was a "competing applicant." On December 9, 2009, Judge Matthews issued an Order that upheld DHEC's finding that Piedmont was a competing applicant for the CON at issue in this matter. However, Judge Matthews found that DHEC erroneously interpreted the Plan to allow only existing providers—in this case, Piedmont Medical Center—to obtain a CON. Based on this finding, Judge Matthews remanded the matter to DHEC with instructions:

> 1. Review the Presbyterian, Carolinas [CHS], and FMMC [Piedmont] CON applications to determine "which of the applicants, if any, most fully complies with the requirements, goals, and purposes of this article and the State Health Plan, Project Review Criteria, and the regulations adopted by the department" as required by S.C. Code Ann. § 44-7-210(C).
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> 7. The Department's decisions must be made based upon the fact that each of the parties is in equal compliance with 24A S.C. Code Reg. 61-15 § 802.1. The Department's decisions must be accompanied by written findings as to each applicant's compliance with the relevant Project Review Criteria and which party best meets each project review criterion and the basis thereof.

Charlotte-Mecklenburg Hosp. Auth. v. S.C. Dep't of Health & Envtl. Control, Docket No. 06-ALJ-07-0713-CC (Dec. 9, 2009), pp. 27-28 (emphasis in original). On appeal, the South Carolina Supreme Court concluded that the Order of December 9, 2009, was interlocutory because a final determination as to the CON had not been made. Charlotte-Mecklenburg Hosp. Auth. v. S.C. Dep't of Health & Envtl. Control, 387 S.C. 265, 692 S.E.2d 894 (2010).[2] The parties, therefore, proceeded with the remand instructions.

The parties consented to a deadline of October 4, 2010, for filing updated information with DHEC. All three parties submitted supplemental information to update their previous CON applications. During the ensuing eleven months, each applicant submitted additional information concerning its CON application to DHEC, either on its own initiative or in response to numerous

[2] For purposes of this Order, the court will defer to Judge Matthews' finding that Piedmont's application qualified as a competing application and that all of the applicants were in equal compliance with S.C. Code Ann. Regs. 61-15 § 802.1.

requests by DHEC staff for additional information. The volume of material submitted by the applicants to DHEC during this period was extensive. DHEC held a Project Review Meeting on June 29, 2011, which provided the opportunity for each applicant to make a presentation and answer questions posed by DHEC staff.

On September 9, 2011, DHEC issued three decision letters, this time granting CHS's application and denying the applications of Presbyterian and Piedmont. The decision letters each included three or four numbered paragraphs highlighting the basis for the decision contained therein, and they also referenced the Project Review Criteria Analysis that was attached to all three decisions. The ten-page Project Review Criteria Analysis, along with the Project Review Summary for each applicant, serves as the Summary of Staff Findings.

After the DHEC Board denied the request for a final review conference, the decision letters of September 9, 2011 became the final decisions of DHEC. Presbyterian and Piedmont timely requested contested case review of these decision letters. This court consolidated the cases on January 31, 2012. Pursuant to its motion to withdraw, this court dismissed Presbyterian as a party by Order dated February 1, 2013.

FINDINGS OF FACT

Having carefully considered all testimony, exhibits, and arguments presented at the hearing of this matter, and taking into account the credibility of the witnesses and the accuracy of the evidence, I make the following findings of fact by a preponderance of the evidence:

1. Piedmont Medical Center is an existing two-hundred-eighty-eight (288) bed acute care hospital located in Rock Hill, York County, South Carolina.[3] Piedmont Medical Center is operated by Amisub of South Carolina, Inc., which is a subsidiary of Tenet Healthcare Corporation (Tenet). Tenet is a for-profit, publicly traded company that is headquartered in Dallas, Texas and owns forty-nine (49) hospitals in ten (10) states. Piedmont has a medical staff of approximately three hundred fifty (350) physicians and employs more than one thousand five hundred (1,500) persons, including six hundred seventeen (617) nurses, one hundred forty-one (141) of which live in Northern York County or Mecklenburg County. In addition to standard community hospital services, Piedmont Medical Center provides specialized services not usually offered by a hospital its size, including open heart surgery, neurosurgery, cardiac catheterization,

[3] Piedmont Medical Center has 288 beds, which includes 268 acute care beds and 20 beds for psychiatric services. This case focuses on the addition of 64 acute care beds. As a result, most of the discussion pertains to the 268 acute care beds, rather than the psychiatric beds.

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

2. CHS is a public hospital system created by North Carolina statute and headquartered in Charlotte. CHS owns or manages forty-two (42) hospitals, in addition to various healthcare facilities. CHS's largest hospital is Carolinas Medical Center (CMC-Main), located in Charlotte, North Carolina. CMC-Main has more than eight hundred (800) beds and provides highly specialized tertiary and quaternary services. The closest CHS hospital to Piedmont Medical Center is CMC-Pineville, located just across the state line in Pineville, North Carolina, an approximately twenty-five (25) minute drive from Rock Hill. From 2002 to 2013, CHS spent more than $300 million expanding CMC-Pineville from ninety-seven (97) to two hundred six (206) beds. During this period CHS also expanded CMC-Pineville's services to include specialized tertiary services similar to those provided at Piedmont Medical Center.

3. DHEC is a state agency charged with, among other things, implementing South Carolina's CON regulatory program, which includes licensing standards for the establishment of acute care hospitals. S.C. Code Ann. § 44-7-140. By statute, DHEC is "the sole agency for control and administration of the granting of [CONs] and licensure of health facilities." Id. As part of its duties, DHEC is required to publish, at least every other year, a South Carolina Health Plan, outlining the need for medical facilities and services in the State. The South Carolina Health Plan includes an inventory of existing facilities and services, projections of need for additional facilities and services, standards for distribution of facilities and services, and general statements regarding project review criteria for consideration of CON applications. S.C. Code Ann. § 44-7-180(B).

4. The original CON applications in this case were based on the need identified in the 2004-05 South Carolina Health Plan. In that Plan, DHEC projected the population in York County would grow from 172,090 in 2003 to 192,300 in 2010. The Plan also recognized that the occupancy rate at Piedmont Medical Center, the only general acute care hospital in York County, had increased from sixty-five and two-tenths percent (65.2%) in 2001 to seventy-five and one-tenth percent (75.1%) in 2003. Based on historical occupancy rates at Piedmont Medical Center, and the projected growth of the York County population, DHEC identified a need for three hundred thirty-two (332) acute care beds. The Plan, therefore, identified a need for an additional

64 acute care hospital beds over and above Piedmont Medical Center's existing two hundred sixty-eight (268) acute care beds.

5. The other relevant plan is the 2012-13 South Carolina Health Plan, which became effective November 9, 2012, and is currently in effect. In that plan, DHEC revealed that the occupancy rate at Piedmont Medical Center, the only existing acute care hospital in York County, decreased from seventy-five and one-tenth percent (75.1%) in 2003 to fifty-seven and one-tenth percent (57.1%) in 2009. Although the occupancy rate subsequently increased to fifty-eight percent (58%) in 2010 and sixty-two and one-tenth percent (62.1%) in 2011, it still has not returned to its 2001 occupancy rate. DHEC also projected that the population of York County would increase from 229,600 in 2011 to 253,900 in 2018. Based on historical occupancy rates at Piedmont Medical Center, and the projected growth of the York County population, DHEC identified a need for sixteen (16) acute care hospital beds in addition to the 332 acute care beds identified in the 2004-05 South Carolina Health Plan. Thus, DHEC's current plan identifies a need for a total of three hundred forty-eight (348) acute care beds in York County.

6. CHS proposes to construct a sixty-four (64) bed hospital to be located in Fort Mill, South Carolina, at a total project cost of $79,101,360. CHS intends to serve patients that are already aligned with its system. The proposed CHS Fort Mill hospital is a smaller acute care hospital that will serve a different acuity level of patients than Piedmont's larger, tertiary hospital. Redirecting a sizeable portion of the CHS-aligned patients in Northern York County to a new CHS hospital in Fort Mill will cause the new hospital to be well-utilized.

7. Piedmont proposes to construct a one hundred (100) bed hospital to be located in Fort Mill, South Carolina, at a total project cost of $119,808,964, without financing, or $146,522,042, which includes financing costs during construction. In addition to the 64 beds for which a need is recognized in the 2004-2005 South Carolina Health Plan, Piedmont plans to transfer thirty-six (36) beds from Piedmont Medical Center, its existing hospital in Rock Hill, to its proposed hospital in Fort Mill. Currently, Piedmont Medical Center has a daily census of one hundred eighty (180) beds, meaning that on any given day the facility has one hundred (100) or more empty beds. Of the 36 beds it proposes to transfer from Piedmont Medical Center to its Fort Mill facility, nineteen were not being staffed or used for patient care. By transferring the beds, Piedmont intends to redeploy resources from Rock Hill to the Fort Mill Area where there is a greater need for them.

8. At the time of the review of the CON applications on remand, Beverly Brandt was the DHEC Chief of Bureau of Health Facilities and Services Development. Ms. Brandt, who was not involved in the original review in 2006, relied on the ranking of the Project Review Criteria that was established by DHEC during its original review. In a letter from Mary Fechtel dated March 27, 2006, DHEC established the relative importance of the project review criteria, listing the most important criteria first, as follows:

Rank 1	Need (1)
Rank 2	Community Need Documentation (2a-2e)
	Distribution (Accessibility) (3a-3g)
	Distribution (22)
Rank 3	Projected Revenues (6a, 6b)
	Projected Expenses (7)
	Net Income (9)
	Financial Feasibility (15)
	Cost Containment (16a-16c)
	Efficiency (17)
Rank 4	Record of the Applicant (13a, 13b, 13d)
	Acceptability (4a-4c)
	Adverse Effects on Other Facilities (23a, 23b)

These criteria are grouped in the DHEC regulation in the general categories of Need for the Proposed Project, Economic Consideration, and Health System Resources. § 801(1). Thus, DHEC's ranking established that these categories would be the focus of its review of the CON applications for building a hospital in Fort Mill. DHEC also established that all other relevant criteria would be given equal importance. The remaining criteria are grouped in the DHEC regulation in the general categories of Site Suitability and Special Consideration. § 801(1).

York County Contract

9. Since 1980 Piedmont has been party to a contract with York County (York County Contract) that does not expire until 2045. The York County Contract places certain restrictions on how much Piedmont can charge for services, requires quarterly and annual public financial reports to the county, and further requires Piedmont to make certain annual capital investments in facilities or equipment. The contract also requires Piedmont to provide various non-hospital based services, including county-wide ambulance services at no charge to the County and an urgent care center in Western York County. Over the years the parties have amended the contract on nine occasions and are currently negotiating a tenth addendum. In the

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

10. Piedmont provides some of these services at a loss. For example, it operates the county-wide ambulance service at a loss of approximately $4 - 4.5 million per year, even though the service transports a significant number of patients to hospitals other than Piedmont located outside of York County. In addition, Piedmont agreed under the Ninth Addendum to the contract to provide full-time (24/7) physician coverage at its urgent care center in Western York County. Because of the limited demand for urgent care services in Western York County, Piedmont lost $800,000 a year for each of the five years it staffed the center at the level requested by York County. Under the Sixth Addendum, Piedmont undertook to pay an indigent care tax to the state of approximately $450,000 per year that would otherwise be assumed by York County.

11. This court is impressed with the commitment Piedmont has made to its community through the York County contract. The citizens of York County derive innumerable benefits as a result of the transparency and enforceable obligations of the contract. While Piedmont could have withdrawn from the contract at points during the past three decades, Piedmont has continued to maintain its commitment to reasonable pricing, capital reinvestment, ambulance services that operate at a substantial loss to Piedmont, and comprehensive annual reports on the operation of the hospital and its performance under the contract.

Utilization

12. From 1997 to 2005, the utilization of Piedmont by York County residents increased forty (40) percent, from approximately 10,000 to 14,000 inpatient discharges. During that period, Piedmont's market share of York County patients who received inpatient hospital services was generally flat, registering a high of sixty-seven (67) percent in 2002 to a low of sixty-four (64) percent in 2005. The utilization increase Piedmont experienced in the period occurred proportionately during this period with other hospitals serving York County residents.

13. Several significant developments occurred between the time of the filing of the Fort Mill Area CON applications in 2005 and the filing of the updated applications in 2010 following the remand of this case. The first was the decrease in utilization of Piedmont by York County residents. During this period, Piedmont's utilization dropped from approximately 14,000

to 11,000 discharges. This decline in patient volume nearly erased the growth in utilization Piedmont experienced from 1997 to 2005. Piedmont's market share of York County inpatient hospital services dropped from 64 percent in 2005 to fifty-five (55) percent in 2011. This decline in patient volume occurred during a period when York County's population grew twenty-two (22) percent.

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

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

> Referrals to CMHA Facilities. As a condition to the receipt of consideration provided for in this Agreement, Physician agrees to refer all patients in need of hospitalization, diagnosis or treatment on an outpatient or an inpatient basis to a facility owned, operated or managed, directly or indirectly, by CMHA and/or to a practitioner who is a member of the medical staff of any such facility (or any such practitioner's group practice) unless: (a) the patient expresses a preference for a different facility or practitioner; (b) the patient's insurer determines the facility or practitioner; or (c) the referral is not in the patient's best medical interests according to Physician's judgment. The above requirement shall not apply with respect to any ambulatory surgery center owned in part, directly or indirectly, by CMHA and in part by practitioners or group practices.

In the absence of the express exceptions listed, CPN physicians must refer their patients to CHS facilities or to physicians on the medical staffs of such facilities who agree to admit the patients to such facilities. During the period from 2009 to 2012, CPN referrals to CHS facilities and

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

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

17. Piedmont utilization records demonstrate a direct correlation between these changes in CPN physician referral patterns and the reduction of services at Piedmont between 2005 and 2011. Piedmont's overall market share of inpatient acute hospital services for York County residents dropped eleven (11) percentage points from sixty-three (63) percent in 2005 to fifty-two (52) percent in 2011. In contrast, the market share for CHS facilities grew by twelve (12) percentage points, increasing from twenty (20) to thirty-two (32) percent. An examination of Piedmont's market share of complex cases for sicker York County patients shows even greater changes. From 2005 to 2011, Piedmont's share fell from fifty (50) percent to thirty-six (36) percent. During that same period, CHS market share grew from approximately thirty (30) percent to forty (42) percent, reflecting the increasing number of CPN practice referrals discussed above. As a result, by 2011 more residents of York County left to receive complex services than stayed.

Impact of Proposed Projects

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

[4] Presbyterian also altered its physician network strategies, however, because it has withdrawn as a party from this matter, this order makes no findings in that regard.

satellite hospital would also strengthen Piedmont's services to residents throughout York County by increasing the number of patients treated at Piedmont's Rock Hill facility.

19. Piedmont projects a fifty-eight (58) percent occupancy rate for FMMC by its third year of operations. The projected occupancy rates of FMMC are consistent with similar facilities in the service area and the state. The only hospital in the service area is Piedmont Medical Center, whose occupancy rates for 2009 to 2011 were fifty-seven (57), fifty-eight (58), and sixty-two (62) percent, respectively. According to the 2012-2013 State Health Plan, the average occupancy rate for South Carolina hospitals from 2009 to 2011 was less than 58 percent, as was the average rate for hospitals in Region II, the region that includes York County.

20. In addition to transferring some of Piedmont's existing patients to the new facility, Piedmont seeks to halt outmigration by expanding its emergency department, recruiting physicians, and building FMMC. The emergency department is significant because sixty-nine (69) percent of Piedmont's inpatients access the hospital through its emergency room. DHEC recently approved a CON for Piedmont to double the size of its emergency room, a project that will be completed in 2014. FMMC would provide Piedmont with a second emergency department and would enhance Piedmont's ability to recruit physicians.

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

22. The court finds CHS's assumption that it would take no patients or market share from Piedmont by operation of CMC-FM unreliable. Even if CHS had no desire to serve new patients, which seems unlikely, it would not have the ability to control patient admissions into its proposed Fort Mill hospital. In addition to patients being admitted by its CHS-employed physicians, CMC-FM would also admit patients through its emergency department, as well as by non-CHS physicians who would join hospital's medical staff and other independent physicians who would become affiliated exclusively with CHS.

23. In 2012, the percent of emergency department admissions in CHS Charlotte-area hospitals ranged from forty-five (45) percent at CMC-Mercy to approximately eighty (80) percent at CMC-Lincoln. Roughly fifty (50) percent of the patients at CHS's hospital in Pineville, North Carolina (CMC-Pineville) were admitted through the emergency department. These data show that, like other hospitals, CHS cannot control who presents at the emergency departments of its hospitals. Undoubtedly, some patients who will present at CMC-FM will be individuals who have historically used Piedmont. As CHS expert Dawn Carter acknowledged, "Usually a majority of inpatient admissions come through the emergency department." The proximity of CMC-FM's emergency department to Rock Hill would certainly attract Fort Mill area patients who would otherwise go to Piedmont and be admitted there.

24. Each of the three independent physicians called as witnesses by Piedmont testified that they would obtain privileges at CMC-FM if it were approved. Although these physicians testified that they have had privileges at Piedmont for years and supported the approval of its application, they believed that patients they had served at Piedmont would want to be served at any new hospital that would be built in the Fort Mill Area, whether the facility was established by CHS or Piedmont. In order to maintain their relationship with those patients, the physicians expect to obtain privileges at the new facility so they can continue to serve the patients they have treated at Piedmont, even if the shift of patients to CMC-FM would have an adverse affect on Piedmont. Otherwise, the practitioners would be at risk of losing their patients to CHS-employed physicians and others practicing at CMC-FM. The testimony of these three practitioners was consistent with the reports Piedmont experts David S. Levitt and Daniel J. Sullivan received from Piedmont medical staff members.

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

and ninety (90) percent of the cardiology services at Piedmont. Dr. Singhi recognized the demands that would exist if CMC-FM was approved, and which would not permit his practice to maintain its independent status. If the Carolina Cardiology physicians become employed by CHS, Dr. Singhi acknowledged that CHS would expect his group to comply with the CPN physician network referral policy and move patients from Piedmont to CHS facilities.

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

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

28. The incentive CHS identified for the establishment of CMC-FM was not economic, but the need for additional capacity to relieve the utilization demands on the CHS Charlotte-area facilities. Ms. Carter testified that CMC-FM would enable CHS to "decompress" utilization at CHS facilities, particularly CMC-Main. Mr. Levitt, however, countered that the effect of any relief provided to CHS's Charlotte-area facilities by the redirection of York County patients to CMC-FM would be insignificant. Considering the effect on CMC-Main alone, the shift of York County patients from that facility to CMC-FM would affect only two and two-tenths (2.2) percent of the patient demand at CMC-Main.

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

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

30. Mr. Levitt and Mr. Sullivan testified that CMC-FM, in combination with CHS's growing physician network, would result in continued outmigration, particularly for specialty patients with complex medical needs who would be referred to CHS network hospitals such as CMC-Pineville and CMC-Main.

31. Mr. Levitt testified that he analyzed the changes in Piedmont's market share in the complex cases of various product lines from 2005 to 2011. These are cases that would be less likely to be performed at small community hospitals, and would be referred instead to larger facilities such as the CHS-Charlotte area hospitals or Piedmont.

32. For complex cardiac catheterization and electrophysiology cases during this period, Piedmont's share dropped from seventy-six (76) percent to forty-two (42) percent, while CHS's more than doubled from fifteen (15) percent to forty (40) percent. Similarly, an analysis of all complex heart-related procedures in 2005, including open heart surgeries, shows that Piedmont's market share was sixty (60) percent and CHS's was twenty-one (21) percent. By 2011, their market share was identical. A review of complex surgery cases from the same time period shows a similar trend. Piedmont had a fifty (50) percent market share that was nearly twice that of CHS's share of twenty-eight (28) percent. By 2011, however, CHS's share of complex surgeries performed on York County residents exceeded Piedmont's.

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

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

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

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

35. Mr. Levitt testified that a hospital's payor mix is the key to its ability to cover the costs of services for those patients who are uninsured or whose insurers, such as Medicaid, pay limited reimbursement. To maintain services to such medically underserved groups and to maintain profitability, a hospital payor mix must contain a significant percentage of managed care and commercial patients. From 2005 to 2011, Piedmont's payor mix declined substantially as CHS's market share of York County patients grew. During that period, Piedmont's managed care patients fell sixteen (16) percent, while its Medicaid patients increased by the same amount and its charity care cases doubled.

Adverse Impact

36. Three independent York County physicians, not employed by either applicant but who refer a majority of their patients to Piedmont, testified that if CMC-FM were constructed, it would adversely affect Piedmont. One physician testified that CMC-FM would increase the loss of outpatient and inpatient services, particularly of complex cases that Piedmont has been experiencing in recent years. He also testified that in his opinion the quality of care would be adversely affected: "the quality of any hospital or any individual [physician] is dependent on the quantity that they see, as well as the quality of cases that they see." As a result, it would be difficult to maintain the same scope and quality of pulmonary services at Piedmont if CMC-FM were approved.

37. Another physician testified that the approval of CMC-FM would cause a further deterioration of Piedmont's payor mix as well as the payor mix of his practice, decreasing the

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

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

38. Among the greatest threats to Piedmont is that if CMC-FM were approved it would reduce the volume of services referred to independent specialists on the Piedmont medical staff and degrade the payor mix of those practices to the point where the practitioners would have little choice but to join the CPN network to maintain their financial viability. Two doctors testified that their practices would have to give serious consideration to becoming employed by the CHS physician network if CMC-FM was constructed. One doctor testified that if the physicians in his practice, which is the principal provider of OB/GYN services at Piedmont, became employed by CHS and shifted their patients to CMC-FM and other CHS facilities, it would likely force the closure of Piedmont's Women's Tower, which would cause the hospital to lose its neonatal service.

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

40. Mr. Sullivan criticized the lookback approach for failing to give effect to population growth. By way of example, he discussed a hypothetical existing hospital (Hospital A) with a twenty (20) percent occupancy rate. A CON application for a new hospital (Hospital B) was approved in Hospital A's service area and, five years later, Hospital A's occupancy rate remains at 20 percent. The lookback approach would conclude that no adverse impact had occurred at Hospital A, even though its occupancy rate would have been forty (40) percent had Hospital B not been built, due to high population growth in the service area. Alternatively, the incremental approach would take into account the high population grown in the area and conclude that Hospital A had been adversely impacted by the construction of Hospital B.

41. Mr. Levitt used the incremental approach in his adverse impact analysis. Mr. Levitt projected Piedmont's utilization and income in 2017 if CMC-FM were approved and operational. He compared those projections to Piedmont's projected utilization and income in 2017 without CMC-FM. He concluded that CMC-FM would cause an impact of 3,076 fewer cases annually and $12,087,942 less annual income for Piedmont. This analysis was based on the assumption that sixty-seven (67) percent of CMC-FM's patients would come from Piedmont. Mr. Levitt also forecast the effect if half of CMC-FM's patients were to come from Piedmont. Under that scenario, the impact on Piedmont would be a loss of some 2,000 inpatient cases a year that would reduce Piedmont's income by approximately $8 million annually.

42. CHS expert Kathryn Platt produced a similar result when she applied the incremental adverse impact model, although her assumption that Piedmont's losses would be proportionate to its market share reduced the degree of the adverse impact in comparison to Mr. Levitt's analysis. Under Ms. Platt's incremental analysis, Piedmont would lose 1,623 patient cases a year, constituting a negative financial impact of $6.5 million annually. Assuming CHS would shift existing patients to CMC-FM, Ms. Platt characterized her incremental analysis as a worst case scenario for Piedmont.

43. CHS experts argued that because CMC-FM would be utilized primarily by existing CHS patients who would be shifted from facilities in North Carolina, CMC-FM would have no adverse impact on Piedmont. As a fallback, however, CHS's experts also advocated a lookback approach. Ms. Platt prepared a lookback adverse impact analysis that compared Piedmont's projected performance in 2017 with what it was in 2009. Under her analysis, which did not give effect to growth in demand or growth in population, she projected that Piedmont would have only sixty-two (62) fewer patients in 2017 than it did in 2009. Ms. Carter performed a similar lookback analysis, using more current baseline data from 2011 instead of 2009. Under Ms. Carter's lookback projection, Piedmont would lose six hundred seventy-six (676) inpatient cases each year that would have an adverse financial impact on Piedmont of $2.7 million annually.

44. Ms. Carter testified that even if Piedmont incurred losses projected by Mr. Levitt, that the impact would not be adverse, determining that the adjusted margins of 2.1 percent to 5.4 percent were within an acceptable range. However, Ms. Carter's analysis only took into consideration the financial effect of Piedmont's loss of inpatient cases. In rebuttal, Mr. Levitt

testified that the inpatient financial losses were so great that he did not quantify the additional loss of outpatient services Piedmont would incur. However, after Ms. Carter testified that the financial impact of the projected inpatient losses was insignificant, Mr. Levitt calculated the additional loss of outpatient services. Using the same assumptions he applied to his original adverse impact analysis, Mr. Levitt determined that the outpatient impact ranged from a low of $5.5 million applied to Ms. Platt's projection to a high of $10.5 million. When considered in the aggregate, the negative impact ranges from $12.1 million for Ms. Platt's model to $22.3 million for the highest projected loss calculated by Mr. Levitt.

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

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

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

46. Each of these sets of projections represents what would be a substantial and adverse impact on Piedmont. The calculations, however, do not account for all of the potential adverse financial impact on Piedmont. They do not include effect of the loss of complex cases, such as cardiac and neurosurgical cases. Additionally, these projected losses are based on pre-tax income from 2009–2012. They are not adjusted for inflation to reflect the full extent of the projected losses in the event CMC-FM became operational after 2017.

Bed Need and Need Projections

47. The methodology by which acute care hospital bed need is determined in the State Health Plan is a function of the utilization of particular hospitals, not the utilization of residents of a county. In the 2004-05 Health Plan, DHEC projected York County would need three hundred thirty-two (332) acute care beds by 2010. In the 2012-13 Health Plan, DHEC projected York County would need three hundred forty-eight (348) acute care beds by 2018.

48. Piedmont and CHS each base their projections of bed need on similar assumptions about the distribution of utilization throughout York County. Piedmont assumed twenty-nine (29) percent of its beds would be used by residents of the Northern York County area; CHS assumed thirty (30) percent. Both parties assumed twenty-three (23) percent of their beds would be used by residents from the greater Rock Hill area. CHS projected somewhat greater utilization by residents of the western York area, eight and one-tenth (8.1) percent compared to three (3) percent for Piedmont. Based on these assumptions, projections of the bed need distribution within York County relied on by each applicant are consistent.

49. CHS relied on its utilization projections to demonstrate the need for its 64 bed facility. The critical element of its projections was the assumption that it would redirect substantial portions of its market share of York County patients to CMC-FM – seventy-five (75) percent of Northern York County, eighty-five (85) percent of greater Rock Hill, and fifty (50) percent of Western York County. To calculate the projected utilization, CHS applied its 2009 market share to the CMC-FM utilization forecasts.

50. Mr. Levitt testified that even if CHS's assumptions were accurate, applying CHS's more recent market share would show that the 64 bed facility would be inadequate. From 2009 to 2011, CHS's market share of York County patients continued to grow. Applying the higher 2011 market share to CHS's assumptions about the extent to which it expected patients to be redirected to CMC-FM would result in an occupancy rate of over eighty-eight (88) percent by 2017. By 2020, under CHS's utilization model, occupancy would exceed ninety (96) percent.

51. Based on this updated calculation, CHS would need ninety-five (95) beds at CMC-FM. If, however, CMC-FM were to take market share from Piedmont, which this court has found is a reasonable assumption, it would need even more beds. To illustrate the point, Mr. Levitt testified that if CMC-FM were to increase its market share by five points, the facility

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

52. Because of the growth projections in Northern York County, the hospital in Fort Mill should be designed to respond to the increased demands that will be placed on the facility over time. FMMC is designed to accommodate up to two hundred fifty (250) beds. CMC-FM's design, however, envisions a potential future expansion of only eighteen (18) to twenty (20) beds. The CMC-FM design contains no empty space reserved for future expansion ("shell space"). CHS presented no evidence of other space it could convert to accommodate additional space in the event of expansion. Adding additional beds would therefore require construction, which is expensive and potentially disruptive. Adding beds would also require an additional CON, which could be expensive and time-consuming.

53. Piedmont's proposal is intended primarily to meet the needs of residents leaving the county by establishing 100 beds at FMMC. Even with the transfer of the 36 beds, Piedmont would have more than seventy (70) empty beds available on an average day. Piedmont, therefore, would be able to accommodate significant spikes and fluctuations in occupancy that occur in York County throughout the year.

54. During the DHEC staff review, CHS presented a model in support of its contention that a 64 bed facility was needed in the Fort Mill Area, and not the 100 bed hospital Piedmont proposed. Based on the data it presented, CHS argued that Piedmont's transfer of 36 beds to FMMC in Northern York County results in a "tremendous maldistribution" of hospital beds in York County with a disproportionate number of beds in Northern York County that would restrict access for patients in the rest of the county.

55. Beverly Brandt, DHEC's CON Director at the time of the agency's decision, relied heavily on CHS's maldistribution model in presenting the grounds for her decision, stating that she was concerned with the effect of Piedmont's proposal on the "balance of the distribution [of beds] to the target population." More specifically, in her analysis of the applications, Ms. Brandt used virtually the same language advanced by CHS in finding that "the replacement/relocation of the 36 beds in Northern York County does not appear to equitably distribute beds within the county and reduces accessibility to greater Rock Hill and western York."

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

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

57. The more reasonable period for projecting the bed-to-population ratio would be in 2020, not 2015. Updated population estimates based on the most recent census project that the three zip codes in Northern York County are expected to grow at over twice the rate of the greater Rock Hill and Western York County areas. These official population projections demonstrate that the location of a 100-bed hospital in Northern York County would result in an equitable distribution of beds and will better meet the need for a new hospital in the Fort Mill Area.

Access to Medically Underserved

58. DHEC requires CON applicants to project the level of charity care they will provide, expressed as a percentage of its projected gross revenue. 24A S.C. Code Ann. Regs. 61-15 § 202(2)(c)(1)(d). After a CON is approved and a project is implemented, however, DHEC does not verify whether the applicant actually meets its charity care projections.

59. In the 2005 applications, the applicants projected charity care levels consistent with one another. Piedmont projected it would provide charity care valued at three (3) percent of its gross revenue.[7] CHS projected charity care for CMC-FM that equaled three and five-tenths (3.5) percent of its gross revenue. In its October 4, 2010 updated application, Piedmont again projected 3 percent. However, when CHS submitted its updated projections in December 2010, it increased CMC-FM's charity care projection to six and three-tenths (6.3) percent.

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

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

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

61. Donald G. Stewart, the CHS planner who developed the 6.3 percent projection, testified that he based the new projection on 2009 internal financial reports of CMC-Pineville and another CHS hospital, CMC-University. Mr. Stewart did not consider York County employment data, income data, CPN physician data, data from recently built South Carolina hospitals, or data from cost reports.

62. The internal data on which Mr. Stewart relied showed 2009 gross revenue for CMC-Pineville of $385,034,797. The 2009 gross revenue for CMC-University was $382,847,000. Mr. Stewart testified that the same data showed that in 2009 CMC-Pineville provided $19,486,000 in charity care [five and one-tenth (5.1) percent of its gross revenue] and CMC-University $31,042,000 in charity care [eight and one tenth (8.1) percent of its gross revenue]. The weighted average of these percentages was 6.3 percent, the number Mr. Stewart projected for CMC-FM.

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

64. The PeopleSoft reports classified uncompensated care into five different categories: charity care, Mecklenburg County inpatient contractual adjustments, bad debt expense, bad debt recovery, and self-pay discount. CHS later reclassified portions of the bad debt and self pay amounts as charity care. After the reclassifications, CMC-Pineville's 2009 charity care jumped from $510,847 to $19,486,000 and CMC-University's from $2,173,922 to $31,042,000. CHS reclassified the status of many patients from bad debt or self-pay to charity care. CHS made these reclassifications at various times. Sometimes CHS would reclassify a patient as charity care during his or her hospital stay, at other times the reclassification did not occur until after discharge.

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

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

66. Piedmont introduced evidence from multiple sources that showed CHS physicians based in York County place restrictions on the acceptance of medically underserved patients. These patients include uninsured patients, Medicaid patients, and, in some cases, Medicare patients. The effect of these restrictions by CHS-owed physician practices has not only been to limit access of medically underserved individuals to primary medical care but would be to limit access of those same individuals to non-emergency admissions at CMC-FM, which would be heavily dependent on CHS-employed physicians.

67. This court is persuaded by the evidence showing relatively low percentages of Medicaid and uninsured care by CHS York County practices. CHS records reflect that in 2012, Medicaid patients of Medical Associates of Fort Mill represented three-tenths (0.3) percent of all patients of the office. For Medical Associates of Rock Hill in 2012, Medicaid patients represented one-tenth (0.1) percent of all patients of that office. A similar pattern exists in the other CPN York County primary care practice, Shiland Family Practice: one (1) percent Medicaid patients at the Rock Hill office and six-tenths (0.6) percent Medicaid patients in Shiland's Fort Mill office. Similarly, the percentage of Medicaid patients of the Sanger Clinic, a CHS-owned cardiology group that serves York County patients, was equally low, consisting of one and five-tenths (1.5) percent in its Fort Mill office and one and six-tenths (1.6) percent in its Rock Hill office. The percentage of uninsured patients these practices served in 2012 was significantly below the 6.3 percent charity care projection provided by CHS for the CMC-FM facility, ranging from one and three-tenths (1.3) to two and five-tenths (2.5) percent.

68. In contrast, the current Medicaid participation of Dr. Adlakha's pulmonology practice is fifteen (15) percent and of Dr. Taylor's OB/GYN practice is fifty (50) percent. Piedmont's payor mix reflects the heavier charity and Medicaid load that its medical staff members carry. In 2011, nearly eleven (11) percent of Piedmont's patients were classified as self-pay or charity in contrast to six (6) percent of York County patients served by CHS who were self-pay or charity. The pattern is substantially the same for Medicaid patients from York County, which constituted eleven (11) percent of the payor mix for CHS in 2011, and eighteen (18) percent for Piedmont.

69. Based on the evidence provided, this court finds little support for CHS's projected charity care as 6.3 percent is unreasonable. First, CHS nearly doubled its projection for charity care from 3.5 percent in 2005 to 6.3 percent in 2010. Second, the CHS hospitals have an average charity care of approximately four and five-tenths (4.5) percent, with the highest being five (5) at CMC-Main in Charlotte. York County has one of the highest median household incomes in South Carolina and Fort Mill is the most affluent area within York County based on median household income. Given that CMC-FM will be situated in this affluent area, it is not reasonable to believe that CMC-FM's charity care percentage would be higher than the charity care percentage at its main hospital in downtown Charlotte, North Carolina.

Financial Considerations

70. Joel Grice, a thirty year veteran and former director of DHEC's CON division, testified that the function of the financial project review criteria has been to evaluate the financial feasibility of proposed projects by considering the reasonableness of proposed revenues and expenses. Instead of measuring applicants' projections against each other because of the variability of assumptions and the potential for one applicant making adjustments in *pro forma* budgets to gain a competitive advantage over another, DHEC has historically evaluated the reasonableness of financial projections based on existing projects it has approved.

71. In identifying total capital costs for FMMC, Piedmont projected its costs differently than CHS. To permit the projected costs of the two projects to be accurately compared, they needed to be based on the same factors. Mr. Levitt testified that he made the following adjustments to FMMC's total project costs to achieve that affect: he excluded capitalized interest as CHS had; he eliminated an inflationary factor for future construction cost that CHS had not included; and he applied a large volume purchaser discount on medical equipment available to Tenet or CHS, rather than list equipment cost at retail charges. The adjusted total capital cost for FMMC was reduced from $146 million to $119.8 million.

72. The total project cost per bed for the 100 bed FMMC is $1.2 million per bed. For CMC-FM, the total project cost per bed for the 64 bed, $77.5 million facility is $1.2 million. When the total project costs of these facilities are compared with the costs of recent CONs for new satellite and replacement hospitals, the costs per bed proposed by Piedmont and CHS are consistent with those experienced by similar facilities. In 2008, Ms. Brandt, as director of the

CON division, approved applications for two satellite hospitals, Trident-Berkeley and Roper-Berkeley, at a projected cost of $2.3 million per bed. CHS is an owner of the Roper St. Francis HealthSystem that filed the Roper-Berkeley CON application. Another CHS-affiliated satellite hospital, Roper Mt. Pleasant, was approved in 2005 at a cost of $1.5 million per bed. The cost per bed for some new hospitals have been lower than those projected by Piedmont and CHS, without adjusting for inflation, but overall the capital costs of the proposed projects are reasonable when compared with the costs of similar facilities. Neither DHEC nor CHS presented any evidence that addressed the issue of whether the total capital costs of the proposed projects are consistent with those of similar facilities.

73. Mr. Levitt also compared the proposed operating costs of FMMC and CMC-FM with other satellite hospitals that have been approved by DHEC. He demonstrated how CMC-FM's projected 2010 operating costs are comparable to those approved for Roper Mt. Pleasant in 2005, without adjusting for inflation. Mr. Levitt also showed how FMMC's 2010 proposed operating costs were consistent with the 2006 operating costs of Palmetto Parkridge, without adjusting for inflation. Mr. Levitt concluded that the projected total operating costs were reasonable and consistent with those approved for existing facilities. CHS presented no evidence addressing the operating costs of similar facilities other than its own.

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

75. FMMC and CMC-FM proposed budgets each reflect a positive increase in each hospital's financial performance over the first three years of operation. FMMC's financial performance improves from a deficit of $5.4 million in the first year of operation to more than $300,000 in net income by year three. CMC-FM projects net income of $663,000 in its first year, climbing to over $2.7 million by year three.

76. Mr. Levitt compared the projected financial performance of Roper-Berkeley and Trident-Berkeley, the two most recently approved new hospital CON applications, with FMMC and CMC-FM. The projected performances of these projects are comparable to FMMC's projected performance, but not to CMC-FM's projected financial performance. Roper-Berkeley, a project of Roper St. Francis HealthSystem that is owned in part and managed by CHS, actually showed a nearly $15 million loss over its first three years of operation, far greater than those projected by FMMC. However, DHEC found the Roper-Berkeley project had sufficient net

income and was financially feasible. Trident-Berkeley's financial performance projections were consistent with those projected by FMMC, and were again found to be financially feasible.

77. Mr. Grice examined a broader selection of projects, including all new hospital CON applications filed and approved since 2005. He testified that it is very common for new hospitals to incur losses in the first year or two of operation. In reviewing competing applications, Mr. Grice testified that he has never found one applicant more financially feasible than another if they show a positive trend by the third year. There is no issue as to whether either applicant will be able to build and sustain their respective projects.

78. CHS proposed to use cash to finance the construction of CMC-FM. Piedmont presented a letter from its parent corporation, Tenet Healthcare Corporation, stating that the company would fund the project and finance it "with the most appropriate and cost-effective capital structure at the time utilizing existing cash reserves, existing lines of credit, or the issuance of debt or equity." Both financing proposals are reasonable, and both applicants can afford to build the projects. Additionally, both applicants appear to be committed to funding their respective projects and both are capable of doing so.

79. This court finds that it is more efficient to build a 100 bed hospital capable of meeting future need for services than to build a 64 bed facility that requires expansion within a few years of opening. When expansion is needed to accommodate the projected growth in Northern York County, FMMC would be in the better position to respond. FMMC is designed for a capacity of up to 250 beds. CMC-FM's design, however, would permit expansion of no more than 20 beds for a total of 84 beds. Without the availability of shell space to accommodate the growth, bed expansion at CMC-FM would be more expensive and less efficient than at FMMC.

Public Support and Opposition

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

Proposed Hospital Sites

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

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

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

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

CONCLUSIONS OF LAW

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

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

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

1. The ALC has jurisdiction over this contested case proceeding pursuant to S.C. Code Ann. § 44-1-60(F) (Supp. 2006) and § 1-23-600(A) (2005). In DHEC permitting cases, the Administrative Law Judge is the finder of fact. Brown v. S.C. Dep't of Health & Envtl. Control, 348 S.C. 507, 560 S.E.2d 410 (2002). This court's review of a DHEC decision on a CON application is *de novo*. Marlboro Park Hosp. v. S.C. Dep't of Health & Envtl. Control, 358 S.C. 573, 595 S.E.2d 851 (Ct. App. 2004).

2. The State Certification of Need and Health Facility Licensure Act, S.C. Code Ann. §§ 44-7-110 to -394 (CON Act), requires a person or health care facility to obtain a CON before undertaking the construction or establishment of a new health care facility, including a hospital. S.C. Code Ann. §§ 44-7-130(10), -160(1) (Supp. 2010).

3. The purpose of the CON Act "is to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State." S.C. Code Ann. § 44-7-120 (2002).

4. DHEC is responsible for administering the CON program in South Carolina. S.C. Code Ann. § 44-7-140 (2002). As such, DHEC's duties include promulgating regulations, S.C. Code Ann. § 44-7-150(3) (2002), and preparing a South Carolina Health Plan, S.C. Code Ann. § 44-7-180(B) (Supp. 2010).

5. DHEC promulgated Regulation 61-15 in order to administer the CON program to achieve the purpose of the CON Act. Regulation 61-15 § 802 sets forth thirty-three project review criteria applicable to CON applications. These criteria fall into five general categories: (1) need for the proposed project; (2) economic considerations of the project; (3) the project's impact on the resources of the health care system; (4) suitability of the site of the project; and (5) certain special circumstances. S.C. Reg. 61-15 §§ 801-802. During the application review process, DHEC establishes the relative importance of these project review criteria and notifies each applicant of the ranking. S.C. Code Ann. Regs. 61-15 §§ 304, 801(2). While a project does not have to satisfy every project review criterion to be approved, no project may be approved unless it is consistent with the South Carolina Health Plan. S.C. Code Ann. Regs. 61-15 §

801(3); see also S.C. Code Ann. Regs. 61-15 § 802(1) ("proposal shall not be approved unless it is in compliance with the South Carolina Health Plan").

6. In determining whether to grant or deny a CON application, DHEC evaluates the proposed project under the project review criteria found in Regulation 61-15 § 802 and under the policies and standards in the applicable State Health Plan. S.C. Code Ann. § 44-7-210(C). Pursuant to the CON Act, the Department may not issue a CON to an applicant "unless the application complies with the South Carolina Heath Plan, Project Review Criteria, and other regulations." S.C. Code Ann. § 44-7-210(C); see also MRI at Belfair, LLC v. S.C. Dep't of Health & Envtl. Control, 379 S.C. 1, 9, 664 S.E.2d 471, 475 (2008) (holding that compliance with the State Health Plan and the Project Review Criteria are independent requirements for approval of a CON).

7. In the case of competing applications, DHEC must award the CON, if appropriate, to the applicant who most fully complies with the requirements, goals, and purposes of the CON Act, the State Health Plan, the project review criteria, and other applicable regulations. S.C. Code Ann. § 44-7-210(B); S.C. Code Ann. Regs. 61-15 § 307(2). Here, Piedmont, CHS, Presbyterian, and HPA filed competing CON applications to provide similar services or facilities in the same service area. See S.C. Code Ann. § 44-7-130(5) (2002); S.C. Code Ann. Regs. 61-15 § 103(6). DHEC granted CHS's application to construct a 64 bed general acute hospital in York County.

8. Piedmont timely filed a request for contested case hearing challenging DHEC's decision to approve CHS's CON application. As a result, Piedmont, as the moving party, bears the burden of proof in this contested case. See Leventis v. S.C. Dep't of Health & Envtl. Control, 340 S.C. 118, 132-33, 530 S.E.2d 643, 651 (Ct. App. 2000) (holding that the burden of proof in administrative proceedings generally rests upon the party asserting the affirmative of an issue). Therefore, Piedmont must prove by a preponderance of the evidence that DHEC erred in approving CHS's CON application. See Anonymous v. State Bd. of Med. Exam'rs, 329 S.C. 371, 375, 496 S.E.2d 17, 19 (1998) (holding that the standard of proof in an administrative proceeding is generally the preponderance of the evidence); Nat'l Health Corp. v. S.C. Dep't of Health & Envtl. Control, 298 S.C. 373, 379, 380 S.E.2d 841, 844 (Ct. App. 1989) (stating that the preponderance of the evidence standard applies in CON disputes).

9. At the contested case hearing before this court, the issues to be considered are limited to those presented to or considered by DHEC during the staff review and decision-making process. S.C. Code Ann. § 44-7-210(E). As long as no new issues are considered in these contested case proceedings, any evidence pertinent to the issues considered by DHEC staff may be considered by this court. Marlboro Park Hosp. v. S.C. Dep't of Health & Envtl. Control, 358 S.C. 573, 578-79, 595 S.E.2d 851, 854 (Ct. App. 2004).

10. This court must consider the South Carolina Health Plan in effect at the time the CON applications were filed but also may consider the South Carolina Health Plan in effect at the time of this decision. S.C. Code Ann. § 44-7-225 (Supp. 2010). Thus, this court must consider the 2004-05 South Carolina Health Plan and may also consider the 2012-13 South Carolina Health Plan. Both of these plans were admitted as evidence at the contested case hearing.

11. The weight and credibility assigned to evidence presented at the hearing of a matter is within the province of the trier of fact. See S.C. Cable Television Ass'n v. S. Bell Tel. & Tel. Co., 308 S.C. 216, 222, 417 S.E.2d 586, 589 (1992). Furthermore, a trial judge who observes a witness is in the best position to judge the witness's demeanor and veracity and to evaluate the credibility of his testimony. See, e.g., Woodall v. Woodall, 322 S.C. 7, 10, 471 S.E.2d 154, 157 (1996); Wallace v. Milliken & Co., 300 S.C. 553, 556, 389 S.E.2d 448, 450 (Ct. App. 1990).

12. Under Rule 702 of the South Carolina Rules of Evidence, "[i]f scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise." An expert is granted wide latitude in determining the basis of his opinion, and where an expert's testimony is based upon facts sufficient to form an opinion, the trier of fact must weigh its probative value. Small v. Pioneer Mach., Inc., 329 S.C. 448, 470, 494 S.E.2d 835, 846 (Ct. App. 1997).

13. "[E]xpert testimony is essential in cases which involve a subject of special technical science, skill, or occupation of which the members of the jury or the trial court are not presumed to be specially informed." 32A C.J.S. Evidence § 729, at 85 (1996). For example, the South Carolina Supreme Court has held that in medical malpractice cases "the plaintiff must use expert testimony . . . unless the subject matter lies within the ambit of common knowledge and

experience, so that no special learning is needed to evaluate the conduct of the defendant." Pederson v. Gould, 288 S.C. 141, 143, 341 S.E.2d 633, 634 (1986).

14. In general, "expert opinion evidence is to be considered or weighed by the triers of the facts like any other testimony or evidence ... [;] the triers of fact cannot, and are not required to, arbitrarily or lightly disregard, or capriciously reject, the testimony of experts or skilled witnesses, and make an unsupported finding to the contrary of the opinion." 32A C.J.S. Evidence § 727, at 82-83 (1996). However, the trier of fact may give an expert's testimony the weight he or she determines it deserves. Florence County Dep't of Soc. Servs. v. Ward, 310 S.C. 69, 72-73, 425 S.E.2d 61, 63 (Ct. App. 1992). Further, the trier of fact may accept the testimony of one expert over that of another. See S.C. Cable Television Ass'n v. S. Bell Tel. & Tel. Co., 308 S.C. 216, 417 S.E.2d 586 (1992).

15. The parties do not dispute DHEC's findings that Piedmont and CHS equally meet the following project review criteria:

1	Compliance with the State Health Plan
3c	Location allows for timely delivery of necessary support services at a reasonable cost
3e	Documentation of means by which persons will access services
6a	Proposed/comparable charges
7	Consistent with similar facilities
13a	Successful operations and management experience
13b	Ability to obtain financing
13d	Record of compliance
4a	Support of affected persons
4c	Possible transfer agreements

With there being no evidence in the record to the contrary, the court concludes that DHEC did not err in finding that Piedmont and CHS equally met these Project Review Criteria.

Need (2a, 2b, 2c, 2d, 2e, 3a)

16. Project Review Criteria 2a requires identification of the target population while Criteria 2b requires projections of anticipated population changes to be reasonable and based upon accepted methodologies.

17. Project Review Criteria 2c requires that the proposed project provide services that meet an identified need of the target population, and Project Review Criteria 2e provides that the projected utilization should be sufficient to justify the implementation of the proposed service.

18. Expert witnesses presented by both parties agreed on one core issue: a need exists for a new hospital in Northern York County. No consensus was reached, however, on the fundamental question presented whether that need is for CHS's 64 bed facility or Piedmont's 100 bed facility. As noted in the Findings of Fact, this court was persuaded that Piedmont proved by a preponderance of the evidence that a 100 bed hospital would better meet the needs of the residents of York County than the 64 bed facility CHS proposed. CHS relied on its maldistribution theory during staff review as the primary basis for challenging the need for Piedmont's larger facility. When updated census data were applied to its methodology during trial, however, it revealed that the beds in York County would be more equitably distributed through the FMMC 100 bed hospital than they would by the construction of CMC-FM. FMMC's capacity to expand to 250 beds in the future also reflects the facility would be better positioned to meet the needs of the rapidly growing Fort Mill Area than CMC-FM. CMC-FM's own projections show that, by the third year of operation, it would be operating at an occupancy level that would justify the approval of new beds. These projections are further evidence that CHS's proposed facility would be too small to fully meet the demand.

19. In addition to meeting the need for new hospital services, Piedmont's application was specifically intended to strengthen the York County healthcare system by reducing outmigration. While patients have sought medical services in the Charlotte area for years, the outmigration accelerated from 2005 to 2011. The effects of the outmigration, which are detailed in the Findings of Fact, have reduced the ability of Piedmont and many of the independent physicians on Piedmont's medical staff to meet the healthcare needs of York County residents. Piedmont demonstrated by a preponderance of the evidence that the establishment of FMMC would strengthen the capacity of existing York County providers to meet those needs. For these reasons, Piedmont best meets § 802.2(a, b, c, e).

20. Project Review Criteria 2d addresses the reduction, relocation, or elimination of a facility or service. Since only Piedmont's application proposes to relocate beds, this criterion applies to Piedmont only. The court finds that the transfer of 36 beds to FMMC will not adversely affect the population served at Piedmont because even with the transfer of the 36 beds, Piedmont would have more than 70 empty beds available on an average day. The court further finds that these beds will be better utilized at FMMC.

21. Project Review Criteria 3a provides that unnecessary duplication of services will not be approved. The court concludes that Piedmont's transfer of 36 beds would not unnecessarily duplicate services, but rather it would redeploy beds to an area of greater need.

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

22. DHEC accepted CHS's projections that CMC-FM would provide charity care equaling 6.3 percent of its gross revenue. The State Health Plan defines indigent care, also referred to as charity care, as

> medical care (measured in dollars) provided to an individual who has been determined to be unable to pay for this care prior to admission in non-emergency situations, and as soon as possible but before the discharge in emergency situations and for which only one billing has occurred and no other efforts have been undertaken to collect such debt. Indigent care does not include debt; contractual adjustments; or care that is reimbursed by a governmental program (Medicare, Medicaid, County indigent care program), church, or philanthrophic organizations.

2004-05 State Health Plan at I-5, I-6.

23. Project Review Criterion 3b requires that the project should be located so that it may serve medically underserved areas.

24. Project Review Criterion 3d requires that the proposed facility should not restrict admissions. DHEC found that Piedmont and CHS equally met this criterion. However, CPN internal records suggest CPN practices in York County limit access for indigent, Medicaid, and even Medicare patients.

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

26. CHS's proposed charity care does not meet the definition quoted above. Mr. Stewart's testimony and CHS internal documents reveal that CHS's charity care projections include large amounts of bad debt that CHS reclassifies as charity care. Contrary to the State Health Plan's requirements, these reclassifications occurred before, during, and after patients' hospital stays.

27. As discussed in the Findings of Fact, the greater weight of the evidence suggests CMC-FM's charity care will be significantly less than 6.3 percent of its gross revenue. This evidence includes past cost reports filed by CHS for CMC-Pineville and CMC-Mercy, showing those hospitals provided charity care valued at 2.6 percent of gross revenue.

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

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

29. At trial, Piedmont's witnesses objected to DHEC's exclusion of Criteria 3h and the relative low ranking that DHEC gave Criteria 23a and 23b. S.C. Code Ann. § 44-7-210(E) limits the issues to be considered at the contested case hearing to those presented to or considered by DHEC during the staff review and decision-making process. By failing to raise the issues related to the exclusion and importance of certain Project Review Criteria to DHEC prior to the contested case, Piedmont cannot raise these objections in the contested case. Accordingly, the court rejects Piedmont's arguments that DHEC erred in failing to consider Criterion 3h and in ranking Criteria 23a and 23b as among the least important criteria in its review. As a result, the court will consider these criteria according to the ranking established by DHEC in its letter of March 27, 2006. This does not require the court to ignore Criterion 3h but rather the court should give no greater weight to this criterion than it does to any of the other criteria that was not specifically listed in DHEC's ranking.[10]

30. The effect on Piedmont of the loss of over a thousand patients and millions of dollars a year will make it more difficult for the hospital to cover its fixed costs. Its cost per unit of services associated with such costs would increase. As a result, the operation of CMC-FM would have an adverse effect on existing providers. For that reason, Piedmont best meets § 802.16(c).

31. Project Review Criterion 22 requires that the proposed project's effect on the distribution of health services should be carefully considered to functionally balance the distribution to the target population. The court concludes that the operation of CMC-FM would have an adverse effect on the distribution of services provided by existing healthcare providers to

[10] Ms. Fechtel's letter of March 27, 2006, explained that all other relevant criteria—the criteria not specifically listed in the letter—would be given equal importance. Thus, any criteria that was not listed but was relevant to consideration of the CON applications would be given equal importance.

the residents of York County. Section 802.22 calls for an evaluation of the effect of the proposed facility or service not only on Piedmont but other healthcare providers. The testimony of the three physicians as well as the letters to DHEC during staff review from over forty (40) independent physicians is compelling evidence that the ability of existing York County healthcare providers to serve residents of the county would be jeopardized by the operation of CMC-FM. Piedmont best meets § 802.22.

32. Criterion 23a requires the consideration of the impact on the current and projected occupancy rates or use rates of existing facilities and services, weighed against the increased accessibility offered by the proposed services. 803(23)(a). For reasons detailed in the Findings of Fact, this court finds unreasonable the position asserted by CHS and DHEC that by shifting patients from CHS facilities in North Carolina, CMC-FM will cause little, if any, adverse impact on Piedmont. CHS lacks both the incentive and the ability to accomplish such a shift or to control admissions to CMC-FM. Although CMC-FM will undoubtedly serve CHS patients, the court finds Piedmont has demonstrated, by a preponderance of the evidence, that CHS would continue to take market share from Piedmont if CMC-FM were established. It would do so through services provided by CMC-FM as well as by the increased outmigration of patients to CHS facilities in North Carolina for more specialized services.

33. Given the rapid population growth projected for Northern York County, the court concludes that the incremental approach is more reasonable than the lookback approach in calculating CMC-FM's impact on Piedmont. Under the incremental approach, Piedmont would lose from 1,600 to 3,000 inpatients per year. When the loss of outpatients is projected, the total annual lost income caused by the operation of CMC-FM would range from $12 to $22 million, depending upon which expert's analysis is considered. This court is persuaded by the analysis of other courts which have found that significantly smaller losses constitute adverse impact. See e.g., Lexington County Health Servs. Dist., Inc. v. DHEC, 04-ALJ-07-0365-CC, 2006 WL 2899943 (ALC Sept. 15, 2006) ($3.2-$4.5 million annual loss to Palmetto Health is adverse impact); Edisto Surgery Center v. DHEC, 1998 WL 404373 at 17 (ALC, July 2, 1998) (annual loss of $2.7 - $3.1 million would be substantial negative impact on The Regional Medical Center of Orangeburg and Calhoun Counties). Moreover, Piedmont's projected loss represents between thirty-three (33) and ninety (90) percent of its annual pretax income. See Marlboro Park Hosp. v. DHEC, 2000 WL1274366 at 9 (ALC, July 27, 2000) (32 percent reduction in pretax income

constitutes substantial adverse impact); see id. (a reasonable profit is necessary for hospitals to make capital investments such as new equipment).

34. Criterion 23b requires that the staffing of the proposed hospital should be provided without unnecessarily depleting the staffing of existing hospitals or services. 23b. As discussed in the Findings of Fact, operation of CMC-FM would have an adverse effect on the distribution of services provided by existing healthcare providers to the residents of York County. Section 802.22 calls for an evaluation of the effect of the proposed facility or service not only on Piedmont, but on other healthcare providers as well. The testimony of three physicians in addition to the letters to DHEC during staff review from forty (40) independent physicians is compelling evidence that the ability of existing York County healthcare providers to serve residents of the county would be jeopardized by the operation of CMC-FM. Piedmont. Therefore, this court finds that Piedmont best meets § 802.22.

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

35. The court concludes that Piedmont and CHS equally meet Regulation 61-15 § 802(6)(a), as the proposed changes of both applicants are "comparable to those changes established by other facilities for similar services within the service area or state." Piedmont and CHS also equally satisfy Regulation 61-15 § 802(7), as their projected expenses are "consistent with those experienced by similar facilities." The court also agrees with Piedmont and CHS that Project Review Criterion 16b is not applicable.

36. Project Review Criterion 6b requires that projected levels of utilization should be reasonably consistent with those experienced by similar facilities and consistent with the need of the target population. As described in the court's Findings of Fact, CMC-FM will be well-utilized, however, with its smaller size and a projected occupancy rate approaching 70 percent in its third year of operation, CMC-FM may need to expand to meet the growing needs of rapidly expanding Northern York County. FMMC's projected levels of utilization are lower, with a projected occupancy rate of 58% in its third year of operation. However, evidence was presented that FMMC's projected occupancy rates were consistent with similar facilities in the service area and the state. Additionally, FMMC's proposed larger size, created by the transfer of 36 beds from Piedmont Medical Center to FMMC, place it in a better position to accommodate the expanding population of fast growing Northern York County. For these reasons, this court concludes that both Piedmont and CHS equally meet Project Review Criterion 6b.

37. Both applicants equally satisfy Regulation 61-15 § 802(9), as both show an improvement in net revenue over time. Both equally satisfy Regulation 61-15 § 802(15), as both have projected the immediate and long-term financial feasibility of their projects. Id. Both applicants equally satisfy Regulation 61-15 § 802(16)(a), in that both have identified feasible methods of funding.

38. Section 802(17) provides that "[t]he proposed project should improve efficiency by avoiding duplication of services, promoting shared services, and fostering economies of scale." Piedmont better satisfies this criterion because its proposal fosters economies of scale by spreading costs over a greater number of beds. Not only will FMMC's 100 beds better accommodate future growth, FMMC is better designed for expansion than CMC-FM.

Public Support and Opposition (4b)

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

Conclusion

40. Piedmont and CHS both presented outstanding cases. DHEC conducted a thorough review process for the applications. DHEC staff asked numerous questions of both applicants seeking additional information and held a project review meeting to thoroughly discuss and understand the proposed projects. The Project Review Criteria Analysis was thorough and detailed. This court finds that the Department properly reviewed and analyzed both applications. To the extent that the court disagrees with aspects of Ms. Brandt's analysis, it was persuaded by the testimony of Mr. Grice and Ms. Fechtel, both of whom worked within the CON program for many years and possessed greater experience and institutional knowledge.

41. This court concludes that either hospital would promote cost containment. Both applicants have the ability to use cash to build its facility. Although the total cost to build FMMC is higher than the cost to build CMC-FM, the court concludes the per bed cost of the two

facilities is comparable. Because the need for 100 beds has been established, the greater cost necessary for the construction of the larger facility is a necessary expenditure that meets the public need. Another factor contributing to the greater cost required to construct FMMC is that it is designed to accommodate growth of up to 250 beds, while CMC-FM is designed to add no more than 20 beds.

42. This court concludes that neither proposed Fort Mill Area hospital would unnecessarily duplicate the services provided by Piedmont. Moreover, Piedmont has justified the transfer of 36 beds as a reasonable use of those resources to address the growing demand for healthcare services in Northern York County.

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

44. This court concludes that either applicant would be capable of providing high quality healthcare services at its proposed Fort Mill area hospital. One of the principal differences between the two applicants is that the approval of CMC-FM would have the effect of causing the erosion of quality of care at Piedmont and among specialists practicing there as a result of the diminution in the volume of patients and the degradation of the payor mix of the patients who would continue to be seen at Piedmont. Consequently, there would be no hospital in York County providing many of the high quality and tertiary services that Piedmont has added. Alternatively, the establishment of FMMC will ensure that high quality services continue to be added and provided within York County.

45. Piedmont made a proffer of evidence on the "bed need" issue identified in this court's Order on Motion in Limine date April 5, 2013 and Piedmont's argument in the prior contested case hearing before Judge Matthews, but I conclude that Judge Matthews' prior ruling is dispositive of this issue.

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

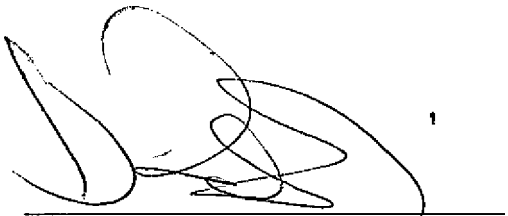
47. Due to the enormous amount of discovery involved in this case, the large volume of evidence gathered and presented, and the occurrence of unforeseen but unavoidable delays associated with the hearing, the court finds substantial cause justifying the issuance of the final decision in this matter falling outside of the eighteen month timeline set forth in S.C. Code Ann. §44-76-220(g)(Supp. 2013).

ORDER

After careful review of the evidence presented in this matter, and based upon the findings of fact and conclusions of law stated above, the court finds that Piedmont's application to establish FMMC most fully complies with the State Health Plan, the Project Review Criteria, and the purposes of the CON Act and, therefore, should be approved while CHS's application to construct CMC-FM should be denied.

IT IS HEREBY ORDERED that the Department shall issue the CON application to Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center d/b/a Fort Mill Medical Center for the purpose of building a 100 bed general acute care hospital in York County, South Carolina.

AND IT IS SO ORDERED.



S. Phillip Lenski
Administrative Law Judge

March 31, 2014
Columbia, South Carolina

CERTIFICATE OF SERVICE

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

Leah Garland

Leah E. Garland
Judicial Law Clerk

March 31, 2014
Columbia, South Carolina