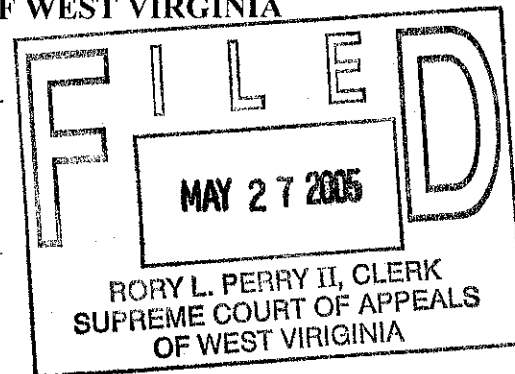


IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

\_\_\_\_\_  
NO. 32565  
\_\_\_\_\_



**FAMILY MEDICAL IMAGING, LLC,  
GARY L. POLING, D.O. and  
SCOTT C. LOSTETTER, D.O.,  
Appellants/Applicants Below**

v.

**WEST VIRGINIA HEALTHCARE AUTHORITY,  
Appellee/Respondent Below**

\_\_\_\_\_  
**Honorable H. L. Kirkpatrick, III  
Circuit Court of Raleigh County  
Civil Action No. 04-AA-15-K**  
\_\_\_\_\_

**BRIEF OF APPELLANTS  
IN RESPONSE TO BRIEFS OF APPELLEE, INTERVENOR,  
AND *AMICUS BRIEF* OF WEST VIRGINIA HOSPITAL ASSOCIATION**

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## POINTS AND AUTHORITIES RELIED UPON

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## INTRODUCTION

Come now the Appellants by counsel and offer the following in response to the briefs filed herein on behalf of the Appellee, the Intervenor and in response to the *amicus curiae* brief filed on behalf of the West Virginia Hospital Association.

Since the factual background of this matter has been recited by all parties, the Appellants will address only those factual matters which are in dispute and the legal arguments and positions set forth by the parties at this time.

## ARGUMENT

All of the parties have agreed upon the standard of review to be applied to the matters pending before the Court on this appeal. However, there are clear differences as to how that application should be focused and the outcome resulting therefrom.

All three of the parties opposing this appeal argue that the decision of the Healthcare Authority (hereafter HCA) should be given great weight and should not be overturned by this Court. See Intervenor's Brief, page 5; Appellee's Brief, page 13; and West Virginia Hospital Association (hereafter WVHA) Brief, page 6-7. However, there is a difference of opinion among these three parties as to whether the service area standards pertaining to Certificate of Need (hereafter CON) applications are legislative rules entitled to this deferential treatment<sup>1</sup>, or is merely an application of plain language. WVHA Brief, pages 15-16. However, all three opposing parties argue that the decision of the HCA should not be overturned unless it is clearly wrong.

As previously addressed in their Brief, the Appellants take the position that the standards applicable to CON applications do rise to the level of a legislative rule based upon West Virginia

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<sup>1</sup>The West Virginia Hospital Association argues that the service area standards "do not rise to the level of a statute or legislative rule. See WVHA Brief, page 7.

Code §29A-1-2-(d), which states:

“Legislative rule includes every rule which, **when promulgated after or pursuant to authorization of the legislature**, has (1) the force of law, or (2) supplies a basis for the imposition of civil or criminal liability, or (3) grants or denies a specific benefit.” *West Virginia Code* §29A-1-2-(d). (Emphasis added).

The WVHA argues that because the CON Standards were not “promulgated by specific authorization of the Legislature, all as required by W. Va. Code §29A-1-2-(d)”, that the standards do reach the level of a legislative rule. WVHA Brief, page 16. However, as pointed out in Appellants’ Brief and also by counsel for the HCA, the HCA has been charged by the Legislature in W. Va. Code §16-2D-5 with the responsibility for

“coordinating and developing the health planning research efforts of the state and for amending and modifying the state health plan which includes the certificate of need standards.” HCA Brief, page 4, footnote 1.

Since the state health plan, including the certificate of need standards have been authorized by the Legislature, and are directly tied to whether a benefit is granted or denied, then the standards do rise to the level of a legislative rule, and therefore are subject to the same analysis and review as all legislative rules.

Therefore, as argued by the Appellants in their brief, the review of the HCA’s application of the acute care facility standards to a diagnostic center application was an arbitrary application of a standard which has not been adopted as applicable to a diagnostic center through the correct legislative process. The WVHA agrees “that it would have been improper for the Authority to impose 25-10 acute care study area upon the Appellants”. WVHA Brief, page 17.

This misapplication of the 25/10 standard, which is contrary to the law, is not entitled to the deference given by the Office of Judges or the Circuit Court of Raleigh County. Furthermore,

since the HCA based its decision based upon this application, the decision is clearly wrong, the result of an improper application of the law, arbitrary and should not be permitted as a basis for defeating the Appellants' application for a CON.

As an alternative argument to this assignment of error, all three opposing parties argue that the HCA did not apply the 25/10 standard, but merely used the same reasoning behind the acute care facility standards, in evaluating FMI's application, and argue that the application of the reasoning is not the same as applying the standard. Surely this Court can see that the HCA has applied the acute care facility standards when it applied the same quantitative criteria contained in the acute care facility standards and used the ruling from an acute care facility application<sup>2</sup> as the basis for its opinion.

If it is improper to apply the standard, as agreed by the WVHA, then it is also improper to apply all of the criteria of the standard and/or the reasoning behind the standard, but merely label the action as interpretation. Furthermore, an agency's interpretation of a statute or legislative rule is only entitled to deference if the intent of the statute or legislative rule is not clear. HCCRA v. Boone Memorial Hospital, 196 W. Va. 687, 458 S.E.2d 411 (1996), citing Chevron U.S. A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 104 S.Ct. 2778, 81 L.E.2d 694 (1984). The CON standards are clear and therefore not subject to interpretation.

Again, the WVHA recognizes that if the HCA's decision was based upon "a mistaken impression of the legal principles involved, the aforementioned deferential standards have

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<sup>2</sup>The HCA cites and relies upon *Raleigh General Hospital v. West Virginia Health Care Cost Review Authority*, Civil App. No. 97-AP-09-B, affirming, *Raleigh General Hospital*, App. Docket # 95-HC-14, affirming, *Raleigh General Hospital*, CON File #92-1-3872-H, as cited on page 20 of Appellee's Brief.

diminished application.” WVHA Brief, page 7.

The HCA , RGH and the WVHA all argue that part of reason for the application of the 25-10 standard is to keep the parties on equal footing or on a level playing field. WVHA Brief, page 10: However, a close review of the acute care study area as cited in footnote 13 of WVHA’s brief, would practically eliminate any county other than a physician’s home county, from a proposed service area under the WVHA, RGH and the HCA’s reasoning. This is based upon the fact that said study area specifically requires a significant impact before a county can be included in the study area. As cited by the WVHA, the case of Princeton Community Hospital v. SHPDA, states:

“A significantly impacted county is defined as: (i) a county wherein at least 25% of the residents rely on or will rely on the acute care services in the county of proposal; or (ii) a county which generates or will generate at least 10% of the patient load in the county of proposal. Princeton Community Hospital v. SHPDA, 174 W. Va. 558, 328 S.E.2d 164 (1985).

This definition highlights the reasons why application of this standard to diagnostic centers would create an uneven playing field, and should not be applied to diagnostic centers. First, acute care facilities offer a larger variety of services and thereby have a wider range of services to provide individuals and thereby spread their services to a larger population.

Additionally, this standard does not focus on providing one type of service to the population, but includes all of the services provided by the acute care facility. Since the number of acute care facilities is less than the number of diagnostic centers (including small groups of physicians), it is also impractical to place the same threshold on the percentage of the population which must be served by the diagnostic center, when there are so many options available to the population. It would be unreasonable to expect that any physician or diagnostic center could

serve 10% of a county's population.

It is undisputed in this matter, that no case law, statute, rule, regulation or other authority requires a diagnostic center CON applicant to serve a "significant percentage" of the proposed service area population. As previously stated, the only criteria for defining the service area of a diagnostic center, is the area from which the applicant "expects to draw patients". It is important to note, that the CON standard does not state that the applicant must expect to draw a significant percentage of its clients from each county of the proposed area, it does not state that any specific percentage of the population of each county must be treated by the applicant to be included, nor does the standard require that any specific amount of patient load must be generated by each county of the proposed area.

Notwithstanding the lack of any language placing "significant" requirements in the applicable CON standards, the HCA and the opposing parties want this Court to approve the HCA's arbitrary application of the standards to include specific quantitative requirements which have never been adopted or approved by the Legislature or the Governor, and have never been specified as being applicable to diagnostic centers. The application of specific quantitative requirements is contrary to the clear language of the standards, contrary to the law and therefore an arbitrary application which is clearly wrong.

A second area of focus pertaining to the proposed service area, deals with the oppositions' allegations that the Appellants failed to document any statistical basis for its position that they would draw patients from the proposed service area. See WVHA Brief, page 11, 13; HCA Brief, page 12; and Intervenor's Brief, page 8. All three opponents argue that the Appellant is required to submit either national data, statistics, projections or other quantitative evidence to support its

position that they expect to draw patients from the proposed service area. *Id.*

This position is not correct. The standard which is applicable to the Appellants' application, clearly states:

“... the applicant **may** submit testimony or documentation on the expected service area, based upon national data or statistics, or upon projections generally relied upon by professionals engaged in health planning or the development of health services.” Standards, Ambulatory Care Centers, II(A) (emphasis added).

In the present case, the Appellants provided documentation in their application and through the testimony of Dr. Gary Poling, that they not only **expect** to draw patients from the proposed service area, but that he and Dr. Lostetter were both already serving patients from the proposed service area. What form of evidence could be more reliable to show an expectation of service than a current practice already servicing patients from the counties. Again, the problem arises because, even though the standards do not set specific thresholds which must be met, both the HCA and RGH want to impose quantitative limits which have not been approved by the Legislature and the Governor.

While it may seem that this point is insignificant, it is important to remember, that the Appellants, acting pro se, acting with the assistance of HCA staff, supplied the information requested in the application and as specified in the rules, regulations and standards, based upon a reasonable reading of those documents and as guided by the HCA. Since the Appellants would be providing ultrasound services to some of their patients from those “questionable” counties, they reasonably expected to draw patients from those counties, and therefore identified those counties as part of their service area.

The HCA, Raleigh General Hospital (hereafter RGH), and the WVHA all argue that it is

impractical to expect patients to travel from some of the proposed counties because the proposed services are not specialized and are offered by other providers in the proposed area. HCA Brief, page 19-20; Intervener's Brief, page 13. However, this ignores the fact that patients from those areas are already traveling to the Appellants for their basic healthcare needs. Furthermore, none of the parties offered any studies to support their position. In a time when health care costs are sky rocketing and individuals are having trouble finding a "family physician" they can trust, it is not unreasonable to expect individuals to drive further for non-emergency, high quality and less expensive health care.

It should be noted, that once a CON is issued to an applicant, there is no restriction on the service area from which patients can originate. Therefore, once a CON application is approved, the applicant is free to treat any number of patients from any locale, and is not restricted to only treating patients from the service area proposed in the application, nor is the applicant limited to only those counties wherein a significant number of patients reside.

A closer review of the CON standards indicates that perhaps part of the problem associated with this case has arisen because the HCA did not fully developed the CON standards to include the requirements they are trying to impose on the Appellants, even though the HCA was authorized to amend the standards.

It appears that the Standard for Ambulatory Centers identified above, which mentions the use of expectations and projections, deals more with the development of **new** diagnostic centers, than the expansion of an existing practice. Each of these forms of evidence are more relevant when there is no historical data to rely upon. Perhaps additional standards should have been generated for existing diagnostic centers which required disclosure of current statistical

information, if that is what the HCA wanted to apply as a standard.

However, it is clear, that the HCA has not taken the steps to properly include such requirements in the current standard, even though the HCA had the authority to amend the State Health Plan and the CON standards to include the exact requirements they are trying to apply in this case. Since the HCA did not take the appropriate steps to have the desired language adopted in the CON standards, they should not be allowed to impose said requirements under the guise of interpretation.

As another attack on the application, it has been argued that the Appellants expanded their proposed service area to include certain counties to insure a showing of need. This argument is convenient for RGH and the WVHA since the counties in question clearly support the Appellants' assertion of an unmet need. However, all of the counties proposed in the service are counties from which the Appellants are currently drawing patients, and no county was included from which the Appellants do not expect to draw patients in the future. It is reasonable to expect, that once the CON is approved, the Appellants will increase their patient base associated with ultrasound referrals, thereby increasing their presence in these other counties.

If the counties in question would not have supported the Appellants' claim would RGH have complained? Also, if the included counties did not support the showing of an unmet need and the Appellants would have omitted those counties, the HCA and RGH could have argued that the Appellants should have included those counties since the Appellants should expect to draw patients from those counties based upon the current treatment of patients from those areas.

An additional problem with an attempt to impose specific thresholds on applicants in the CON process deals with the availability of evidence. The HCA in rejecting the Appellants'

position that the undisputed evidence supported a need in at least a four (4) county service area, has argued that **“it is impossible for the Authority to determine how many of these machines are located in the reduced four county service area”**. HCA Brief, page 23 (Emphasis added). This is incorrect. Ms. Kinneberg, the expert called by RGH testified that there were 22 ultrasound machines in the four (4) county area, including the Appellants’ machine. Transcript page 217, lines 8-10. Again, it is clear, the HCA ignored the evidence which would support the Appellants’ application. (The Appellants would refer the Court to the appeal brief for a discussion of the calculations of need based upon these undisputed figures).

Also, in an attempt to obtain statistical information, the Appellants contacted the HCA for necessary statistics, sent out a survey to determine the number of ultrasound machines available in the proposed service area and to determine how many procedures were being performed in the proposed service area by those surveyed. See Application, page 27. The Appellants supplied the information received as part of its application. Since no requirements were specified in the Application on what information was required or how the information was to be presented or categorized, the Appellants supplied the limited information obtained to the best of its ability.

Another area of concern associated with the HCA’s arbitrary handling of the Appellants’ CON application focuses on the HCA’s acceptance and reliance upon inconsistent calculations of the number of ultrasound procedures an ultrasound machine can perform. For purposes of calculating whether there is an unmet need, the HCA adopted and applied a use rate of eight (8) ultrasound exams per machine, per day of operation, per two hundred fifty (250) operational days per year, which results in a use rate of two thousand (2,000) examinations per machine for availability purposes.

In evaluating the Appellants' application, for the purposes of determining the number of ultrasound examinations available in the proposed service area and whether there was an unmet need, the HCA attributed a full two thousand (2,000) examinations per year to all machines located in the proposed area, including the Appellants' machine, the machines located at the Veteran's Hospital, and machines located in specialized practices which were identified as being used only one (1) day per week.

However, for purposes of evaluating the Appellants' financial viability, the HCA accepted a lesser number of examinations per year for the Appellants' machine based upon page 66A3 of the Appellants' application and the testimony of Mr. Pack. See Application and Transcript page 182. In accepting this lower number, the HCA ignored Dr. Poling's testimony that the "estimates" provided in the application were based upon FMI's current practice and a "conservative" estimate of the referrals they would receive. Transcript, page 25-27.

By accepting and applying different estimates of the number of examinations for the Appellants' machine, the HCA acted arbitrarily and inconsistently. In order to be consistent, the HCA should have applied the accepted use rate of 2000 examinations per machine, per year, for aspects of evaluating the application, including the financial projections. By accepting differing numbers of examinations for the Appellants' machine, for different aspects of the application, the HCA's actions can not be anything but an arbitrary and inconsistent application and was clearly wrong.

Further evidence of the HCA's arbitrary actions in reviewing this application pertain to the ultrasound machines of the Veteran's Hospital in Beckley. The HCA included the Veteran's Hospital (VA) machines in the calculations of available procedures for the proposed service area,

but it failed to consider the expanded service area of the Veteran's Hospital in the calculation of the service area population. If the HCA was going to accept the full use of the VA's machines, it should have included the population of all the counties served by the VA as the potential service area population to be served by those machines.

The VA Hospital has a service area encompassing eleven (11) counties in Southern West Virginia and one (1) county in Virginia. The failure of the HCA to use the entire VA service area population for purposes of the population to be served by the machines, or to limit the availability of the machines, since they are only available to veterans, resulted in an arbitrary application of the figures used for the calculations accepted by the HCA. This failure to apply the evidence consistently improperly skewed the need and available service calculations.

Finally, when it comes to determining the need for an ultrasound machine, the HCA did not consider any modification to the use rate or methodology for determining availability for machines which are limited in the amount of time they are used, or for those machines used in specialized practices (as are two (2) of the machines in the proposed service area). Also, the HCA made no adjustments and made distinctions for calculating the difference arising from the between machines which are operating with a CON and those which are operating without a CON in a small office setting or limited practice fields.

The failure of the HCA to fully develop the CON program should not be available for a basis for denying the Appellants' their application, when the Appellants have fully complied with all properly adopted and approved standards, rules, regulations and statutes existing at the time of their application. An applicant should not be held to higher standard than which is publicized and available at the time an application is submitted.

Although the opposing parties argue that the Appellants should have provided better documentation of the need for the ultrasound services, all opponents have elected to ignore the additional sources supporting an unmet need—the letters in support of the application filed with the Appellants' application, (See Application file) and the testimony of Michael Baker, director of radiology at RGH.

Letters were sent to the HCA on behalf of physicians and patients which expressed their opinions that there was a need for additional ultrasound services in the proposed service area. At the hearing before the HCA, Michael Baker, testifying on behalf of RGH, stated that an appointment for any procedure taking longer than one hour, would have a waiting period of eight (8) days. Transcript, page 133, lines 3-8.

Again, although these letters and the testimony did not contain statistical basis for their opinions, all of this evidence indicates a need for additional services in the proposed service area, based upon the individuals' personal dealings with ultrasound services and the length of delays in obtaining examinations in non-emergency cases. Surely, the length of delay in getting an appointment for evaluation is indicative of a lack of availability of the service. However, the HCA completely disregarded this evidence in evaluating the need for ultrasound services in the area.

The next area of the appeal which the opponents attack, deals with the assignment of error pertaining to the admission of evidence from the expert witnesses offered by RGH. The Appellants filed a pre-hearing Motion to Exclude the testimony and evidence of all witnesses, to the extent said evidence was not properly identified in response to discovery requests filed by the Appellant. In responding to this error, the HCA and RGH focus on the information which was supplied by RGH in response to the HCA's pretrial requirements and do not focus on the failure

to disclosure information requested through the discovery process and Rules of Civil Procedure.

While the Appellants concede that RGH did provide a list of potential witnesses as required by the HCA's pretrial Notice and filing requirements, the remaining information which was filed, did not satisfy the responsibility to fully respond to the Appellant's properly filed discovery requests. While the HCA's filing requirements may have only required a "summary of the expected testimony" of the witnesses, the Appellants' discovery requests went further.

Not only did the Appellants' discovery request a list of the witnesses expected to be called, but they specifically requested a **complete summary** of information each witness has pertaining to this matter, **the information each witness has reviewed in connection with the application**, and the **expected testimony of each witness**. Appellants' Discovery Request, Interrogatory No. 1. (Emphasis added).

The HCA and RGH have taken the position that the limited "summary" supplied by RGH satisfied RGH's discovery obligation. Clearly, for reasons cited in the Appellants' Brief previously filed, the withholding of evidence, including but not limited to the substance of the experts' expected testimony, the information which formed the basis for the experts' opinions, and the failure to disclose the other information requested by the Appellants resulted in prejudice to the Appellants, and should have been resulted in the exclusion of the experts' evidence by the HCA.

Not only did the failure of RGH to disclose the information sought through discovery prejudice the Appellants in the preparation and presentation of their case, but said evidence once wrongfully admitted, formed the basis for the HCA's decision to deny the Appellants' application. But for the testimony of these experts, the HCA, by its own admission would have no basis for

disputing the evidence on the number of ultrasound machines in the proposed service, as contained in the Appellants' application.

Although the Appellants have always contended that the evidence submitted by RGH's experts should not have been permitted, the Appellants argued that once the HCA did allow their testimony, that any information offered by the experts on other matters should have been closely reviewed and considered, even if it favored the Appellants.

This argument focuses, first, on the testimony of Ms. Kinneberg on the issue of need and available services. The Appellants have argued and continue argue that during cross examination of Ms. Kinneberg, sufficient, undisputed evidence was presented to show an unmet need for ultrasound services in the four (4) counties that Ms. Kinneberg conceded would be a proper service area. Appellants' Brief, page 31-32, and Transcript pages 199-202. However, the HCA and RGH ignored this information. Both the HCA and RGH have taken the position that since the Appellants included two (2) counties which they believe are outside of a reasonable service area, based upon the lack of service to significant portion of the population, that no further review or inquiry was appropriate or required.

Surely, if the goal of the HCA is to insure proper care options for the people of West Virginia, all information received in a hearing should be fully evaluated, once it is admitted. In the present case, the HCA says that regardless of what is uncontested, they could not consider anything which was viewed as a modification of the application's proposed service area. Since the granting of a CON does not result in a limitation of the service to the proposed area, why should the HCA not be more concerned with what the undisputed evidence shows? Perhaps, the HCA was merely looking for a way to deny the application.

The final area of the appeal addressed by the rebuttal briefs, focuses on the financial viability of the Appellants. The HCA adopted the opinions of Mr. Pack, over the objection of the Appellants, and without any documentation to support his opinions. Again, RGH and the HCA allege that the Appellants failed to consider the impact of providing indigent treatment to patients and the financial impact of said treatment on its income. HCA Brief page 22; RGH Brief, page 15.

As pointed previously by the Appellants in their brief, this position is not supported by the evidence and the testimony. First, Dr. Poling testified that the average income per exam used in their application, was based upon a figure which was the result of averaging the charges for the ultrasound procedures, based upon amounts normally received for other services. Transcript page 44-45. Although Dr. Poling did not specifically reduce the net revenue for bad debt, charity or other specific factors, those factors were part of the basis for the averaging used in the calculation of the average net revenue figure.

Furthermore, as pointed out previously, the figure used by Mr. Pack and evidently adopted by the HCA, and the figure used by the Appellants in their application both are substantial less than the average income per scan provided by RGH in discovery responses. If RGH averages a higher income per scan than that used by FMI in its application, considering RGH's argument that they have a higher write-off rate than private offices, logic will indicate that the figure used by FMI was, if anything, too low and not too high, even if write-offs are considered.

Also, as pointed out on page 42 of the appeal brief, if Mr. Pack's estimated figures are off by only \$6.67 (even if you use the lower number of 1500 examinations per year and not the 2000

examinations per machine, per year, used by Ms. Kinneberg in her calculation of the available services) then the Appellants will be financially sound in the third year, even if all of the non-required expenses identified by Mr. Pack are incurred. If those non-mandatory expenses identified by Mr. Pack (legal fees, accounting fees, marketing, etc., Transcript page 173) are not incurred or incurred at a lower amount than that stated by Mr. Pack, the \$6.67 per examination for the lesser number of examination, is reduced even further. Since the third year was the only year questioned by Mr. Pack, a closer review of the evidence indicates that the Appellants will be financially viable in that year also.

However, once again, the HCA did not take the time to review the figures or to check the math associated with the testimony of Mr. Pack. Perhaps, if RGH had properly filed a summary of the information Mr. Pack was going to rely upon in his testimony, in response to the Appellants' discovery requests, not only would the Appellants have been in a better position to rebut Mr. Pack's figures and show that the figures being used were not consistent with the other experts testimony (number of examinations expected), but the HCA would have been able to see that his calculations were not consistent with those figures offered by Ms. Kinneberg, and could have seen that Mr. Pack's figures were not correct, and if the correct figures had been used, Mr. Pack's opinion would be incorrect.

If the HCA would have required the proper disclosure of the information relied upon by RGH's expert witnesses, the documentation would have been available to see that the figures had been manipulated to decrease the number of scans attributed to FMI in the third year for income purposes to 1500, when for purposes of the calculation of the number of examines available, Ms. Kinneberg attributed 2000 examinations to FMI's ultrasound machines. Therefore, Mr. Pack

based his calculations on 500 less examinations than that testified to by RGH's expert on issues pertaining to need and services available.

A close review of the HCA's blind acceptance of the testimony of RGH's expert witnesses shows that the process of evaluating the Appellants' application was arbitrary and clearly wrong. Since the HCA is charged with reviewing the evidence, it must fully review the evidence and determine if the evidence offered is consistent. The HCA's acceptance of the experts' opinions even though the figures relied upon by the experts are contradictory, shows an arbitrary action by the HCA. The only way to accept the opinions of both experts is to accept different opinions on the same issue—the number of examinations a machine can perform in one year.

### **CONCLUSION**

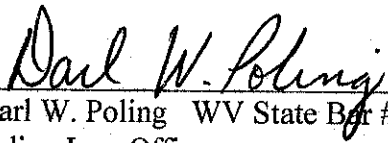
It is clear, that the Appellants complied with the requirements in existence at the time of their application, and based upon the guidelines in existence at that time and the most readily accepted standards, the Appellants showed a need for the proposed service in the proposed service area and in the undisputed service area, showed that the service was financially viable and showed that the application was consistent with the state health plan. Therefore, the application should have been granted.

### **RELIEF REQUESTED**

Based upon all the arguments presented in the Appeal Brief and in this Response Brief, the Appellants request that this Court reverse the ruling of the Circuit Court, the Office of Judges and the Health Care Authority, and request that the Court approve the Appellants' application for a

Certificate of Need., and request such other relief as the Court deems proper to prevent the Appellants from continuing to suffer a financial hardship based upon the Health Care Authority's ruling.

RESPECTFULLY SUBMITTED  
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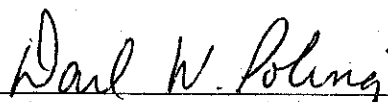
CERTIFICATE OF SERVICE

I, Darl W. Poling, counsel for Family Medical Imaging, LLC, Dr. Gary L. Poling, D.O., and Dr. Scott Lostetter, D.O., do hereby certify that a true and exact copy of this Brief of Appellants In Response to Briefs of Appellee, Intervenor, and Amicus Brief of West Virginia Hospitl Association have been served upon counsel for all parties, by United States mail, postage paid, this the 26<sup>th</sup> day of May, 2005, to the following individuals:

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