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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

The Honorable Ralph King Anderson, III
Chief Administrative Law Judge

APPELLATE CASE No. 2020-001323

ADMINISTRATIVE LAW COURT CASE No.: 18-ALJ-07-0358-CC
ADMINISTRATIVE LAW COURT CASE No.: 18-ALJ-07-0360-CC
ADMINISTRATIVE LAW COURT CASE No.: 18-ALJ-07-0366-CC

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

v.

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

AND

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

v.

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

AND

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

v.

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

RECORD ON APPEAL - VOLUME 4 OF 12

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**APPELLANTS TRIDENT MEDICAL CENTER, LLC AND WALTERBORO COMMUNITY
HOSPITAL, INC.'S REPLY TO RESPONDENT MEDICAL UNIVERSITY HOSPITAL
AUTHORITY'S MOTION TO DISMISS APPEAL AND RETURN TO JOINT MOTION FOR
RELIEF FROM APPEAL BOND**

The Appellants Trident Medical Center, LLC, d/b/a Trident Medical Center and Summerville Medical Center and Walterboro Community Hospital, Inc. d/b/a Colleton Medical Center offer this Reply to MUHA's Return opposing Appellants' Motion for relief from the posting of an Appeal Bond established in § 44-7-220(B) of the State Certification of Need and Health Facility Licensure Act ("CON Act"). Appellants address below specific contentions and arguments made by MUHA in its Return but also incorporate by reference all of the arguments set forth in the original Motion.

In its Reply, MUHA argues that, because the General Assembly created the right to object to a CON application in promulgating the CON Act, the General Assembly is empowered to impose on that right whatever conditions it deems appropriate. (MUHA Return, pp. 4-5). In making this argument, MUHA attempts to portray the Appeal Bond simply as part of the larger scheme of the CON Act's purposes and goals 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."¹ S.C. Code Ann. § 44-7-120 (2018). MUHA contends that the balancing of competing public health policies involved in promulgating the CON Act, including

¹ In its Return, MUHA contends that Appellants do not dispute the need for MUHA's proposed 128-bed community hospital; rather, they simply object to its location in Berkeley County. (MUHA Return, p. 4, n. 4). MUHA portrays Appellants' objections as trivial and claims that the "delay in construction likely caused by this appeal" will harm patients. This claim is a misleading oversimplification of the issues raised by Appellants before the Department and the ALC. MUHA chose to establish its proposed hospital under Standard 5 of the 2017-2018 S.C. State Health Plan, which allows a provider with projected bed need under the Plan to relocate that need to a new facility, provided the applicant can "justify, through patient origin and other data, the need for a new hospital at the chosen site and the potential adverse impact a new hospital at the chosen site could have on the existing hospitals in the service area." The issues of need and potential adverse impact *at the proposed site* of MUHA's hospital in Berkeley County are the controlling legal issues in this case. Moreover, Appellants have not sought to stay MUHA's project, and, unless and until they do so, any delay is entirely within MUHA's control. See S.C. Code Ann. §§ 1-23-380(2) and 1-23-610(A)(1); SCACR, Rule 241(b)(11).

the requirement of a punitive and arbitrary Appeal Bond, makes this matter “peculiarly within the province of the General Assembly.” (MUHA Return, p. 4).

This argument, however, ignores the crux of Appellants’ Motion that the right to judicial review of the final administrative decision on MUHA’s CON application in this case is guaranteed by Article I, § 22 of the South Carolina Constitution, and the General Assembly cannot abridge or deny this right through the imposition of an arbitrary and inequitable Appeal Bond. Consequently, while the General Assembly is free to balance competing policies and establish a process for the Department to implement and regulate the activities of healthcare providers in furtherance of those policies, in doing so, it cannot exceed the limitations placed on it by the State or Federal Constitutions. *See Gaud v. Walker*, 214 S.C. 451, 462, 53 S.E.2d 316, 320 (1949)(“[T]he provisions of our State Constitution are not a grant but a limitation of legislative power, so that the General Assembly may enact any law not expressly, or by clear implication, prohibited by the State or Federal Constitution.”). Thus, contrary to MUHA’s assertions, the General Assembly does not enjoy unlimited authority to legislate the rights of parties participating in the CON process even though it initially created the process.

In *Fullbright v. Spinnaker Resorts, Inc.*, 420 S.C. 265, 277-278, 802 S.E.2d 794, 801 (2017), the South Carolina Supreme Court answered in the negative a certified question regarding whether determinations of the South Carolina Real Estate Commission (“REC”) regarding violations of the Timeshare Act are binding on courts of the judicial branch. In *Fullbright*, the resort developer defendants contended that the conferral of authority on the REC precluded the courts from hearing disputes arising under the Timeshare Act, which the defendants characterized as a comprehensive regulatory scheme intended both to protect consumers from unscrupulous business practices and to provide stability for developers. *Id.* at 275, 802 S.E.2d at 799.

In rejecting the defendants attempt to curtail judicial review of the administrative decisions of the REC, the Court found:

We are mindful that this question implicates the separation of powers vital to the proper functioning of our government and reiterate that “the judicial branch retains the ultimate authority in deciding when agency decisions comport with established law. Thus, judicial review of administrative decisions requires a balancing between an agency’s specialization and authority, and the checks and balances deeply rooted in our democratic government.” *Kiawah Dev. Partners, II v. S.C. Dep’t of Health & Envtl. Control*, 411 S.C. 16, 53, 766 S.E.2d 707, 728 (2014) (Toal, C.J., dissenting). We therefore hold that the REC’s decisions must be subject to judicial review and answer the third certified question “no,” as qualified below.

The state constitution declares, “No person shall be finally bound by a judicial or quasi-judicial decision of an administrative agency affecting private rights except on due notice and an opportunity to be heard ..., and he shall have in all such instances the right to judicial review.” S.C. Const. art. I, § 22. The Administrative Procedures Act (the APA) provides that “[i]n a contested case, all parties must be afforded an opportunity for hearing after notice of not less than thirty days.” S.C. Code Ann. § 1-23-320(A) (Supp. 2016). “A party who has exhausted all administrative remedies available within the agency and who is aggrieved by a final decision in a contested case is entitled to judicial review....” *Id.* § 1-23-380 (Supp. 2016). This entitlement “does not limit utilization of or the scope of judicial review available under other means of review, redress, relief, or trial de novo provided by law.” *Id.* A court can reverse an agency’s decision if, for example, the agency’s decision was contrary to constitutional or statutory provisions or otherwise affected by an error of law. *Id.* § 1-23-380(5)(a), (d) (Supp. 2016); *see also id.* § 1-23-610(B)(a), (d) (Supp. 2016) (establishing the same grounds for reversal of a decision of the administrative law court).

* * *

Our law only requires there be some avenue for a court to determine the validity of the REC’s ruling. If the court satisfies itself that the decision was lawful, there will be no further inquiry into the wisdom of the REC’s decision. This procedure properly balances a person’s constitutional and statutory right to challenge an administrative agency’s decision with the deference that should be given to an agency tasked by the legislature with administering a particular statutory scheme.

Id. at 277-281, 802 S.E.2d at 801-802.

The Court’s recognition of the necessity of ensuring “some avenue” for judicial review of administrative decisions, albeit limited in scope, is consistent with the intent of Article I, § 22,

which was added to the South Carolina Constitution in 1970 “as a safeguard for the protection of liberty and property of citizens.” *Ross v. Medical University of South Carolina*, 328 S.C. 51 492 S.E.2d 62 (1997)(citing *Final Report of the Committee to Make a Study of the South Carolina Constitution of 1895*, p. 21 (1969)).² In this case, the General Assembly exercised its authority to articulate healthcare policies and establish a scheme for implementation of its policies in the form of the CON Act. In imposing an onerous and arbitrary Appeal Bond on the exercise of the right to judicial review, however, the General Assembly exceeded the limits imposed by Article I, § 22.

As a further related contention in its Return, MUHA asserts that Appellants’ arguments concerning the lack of a legitimate purpose for the Appeal Bond fail because it is not within the purview of the Court to question the wisdom of the Appeal Bond provision. (MUHA Return, p. 5). MUHA again misapprehends Appellants’ arguments in this regard.

In their Motion, Appellants discuss the numerous existing provisions in the law that provide for attorney's fees, costs, security, and damages for delay and for frivolous appeals and note that, unlike the Appeal Bond, the existing protections extend to both appellants and respondents and cover cases other than those that arise under the CON Act. (Motion, pp. 5–7). Appellants contend that the existence of these available protections belies any claim that

² The comments to the *Final Report*, at p. 21, state the purpose behind the Committee’s recommendation that Article 1, § 22 be added to the Constitution as:

More and more governmental decisions are being made under powers delegated to administrative divisions of State Government. In many cases, the decisions of administrative divisions are more significant than laws enacted by the General Assembly or decisions made by the courts. The Committee agrees with many other constitutional study groups throughout the country that judicial and quasi-judicial decisions of administrative agencies should be consistent with due process of law and complete fairness to the citizen. This provision is recommended as a safeguard for the protection of liberty and property of citizens.

the Appeal Bond provided for in § 44-7-220(B) bears a rational relationship to a legitimate government purpose, as is required under the state and federal Equal Protection Clauses. Instead, Appellants assert that the Appeal Bond serves no purpose other than as an impermissible deterrent or barrier to the exercise of the Appellants' constitutional rights to judicial review of the final administrative decision rendered by the ALC in this case.³ (Motion, p. 11).

Finally, MUHA disputes Appellants' arguments concerning the constitutionality of the Appeal Bond requirement. MUHA particularly takes issue with Appellants' discussion of the differences between the case at bar and the few South Carolina appellate cases that consider the constitutionality of an appeal bond. (MUHA Return, pp. 6-8). Appellants incorporate by reference the specific arguments made in their Motion and specifically note that none of the landlord/tenant cases cited by MUHA concern appeals of final decisions of administrative agencies, which are governed by Article I, § 22.⁴ Therefore, these cases are not persuasive to the issue before the Court.

Similarly, MUHA provides a lengthy list of statutory provisions that purport to require appeal bonds. (MUHA Return, p. 10, n. 14). This list of existing bond provisions is not relevant to the issues raised by Appellants in this proceeding. First, many of these provisions are not true appeal bonds in that the posting of the bond is required only if the appellant wants a stay of the appealed judgment or order. Second, the vast majority of the statutory provisions cited by MUHA do not concern administrative appeals to which Article I, § 22 would apply. Finally,

³ MUHA also questions Appellants' statements that imposition of a total \$3 million would in fact chill Appellants' right to judicial review and makes the baseless assertion that Appellants' upstream parent company, HCA, should be considered capable of posting vast sums to support the appeal of its downstream subsidiaries in this case. The financial wherewithal of HCA is not relevant because HCA is not a party to this appeal.

⁴ See *Wheeler v. Hyler*, 228 S.C. 584, 91 S.E.2d 265 (1956) and *Horn v. Blackwell*, 212 S.C. 480, 483, 48 S.E.2d 322, 323 (1948).

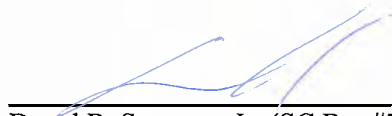
MUHA does not cite any cases considering the constitutionality of the bond provisions in question. To the extent that these provisions have gone unchallenged, their existence is not persuasive on the issue of the constitutionality of an attempt by the General Assembly to limit or deter the constitutional right of judicial review under Article I, § 22, which must be given “in all instances” to persons before they are finally bound by a decision of an administrative agency.⁵

CONCLUSION

For the reasons set forth herein and in Appellants Motion for Relief from Appeal Bond, the Appellants respectfully request that this Court find that the Appeal Bond requirement set forth in § 44-7-200(B) of the CON Act violates the Due Process requirements of U.S. Const. amend. XIV, § 1 and S.C. Const. art. I, §§ 3 and 22 and the Equal Protection guarantees of U. S. Const. amend. XIV, § 1 and S.C. Const. art. I, §§ 3. Further, Appellants request that the Court order that the Appellants are relieved from any obligation to comply with such unconstitutional Appeal Bond in maintaining their duly filed appeals in this case.

⁵ In its Return, MUHA argues that Appellants are not persons who can be finally bound by the decision of the ALC in this case because the ALC did not order Appellants to do anything. (MUHA Return, p. 7). This argument indicates a lack of understanding on MUHA’s part that, under the CON Act, all regulated healthcare providers must apply for CONs in order to provide or expand certain healthcare services or establish certain healthcare facilities. In doing so, they directly or indirectly compete against one another for the authority to fill a finite need for healthcare services and facilities. To the extent one provider is granted a CON for a service that fills a need determined by the Department in the South Carolina Health Plan, all other competing providers are bound by that decision and are foreclosed from seeking to provide those services until additional need is recognized. Further, the winning provider has the justified expectation under the CON Act that it will be allowed to serve the existing need covered by its CON without competition from other providers until additional need is recognized. In this case, Appellants are direct competitors with MUHA in the provision of hospital services in Charleston, Dorchester, and Berkeley Counties, who have been awarded Certificates of Need to provide services. As such, they are within the class of persons who are finally bound by a decision to grant a CON to a competitor in the service area. *See, e.g., S.C. Baptist Hosp. v. S.C. Dep’t of Health and Envtl. Control*, 291 S.C. 267, 353 S.E.2d 277 (1987)(discussing the origins of the CON program).

Respectfully submitted,



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PROOF OF SERVICE

The undersigned hereby certifies that on November 3, 2020, s/he has caused a copy of the **Appellants Trident Medical Center, LLC And Walterboro Community Hospital, Inc.'s Reply To Respondent Medical University Hospital Authority's Motion To Dismiss Appeal And Return To Joint Motion For Relief From Appeal Bond** to be served upon all parties of record by electronic mail and U.S. Mail, postage prepaid, addressed as follows:

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Columbia, South Carolina

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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

Appellate Case No. 2020-001323
Case No. 18-ALJ-07-0358-CC
Case No. 18-ALJ-07-0360-CC
Case No. 18-ALJ-07-0366-CC

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

v.

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

AND

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

v.

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

AND

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

v.

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

REPLY IN SUPPORT OF MOTION TO DISMISS APPEAL

REPLY ARGUMENT

Respondent Medical University Hospital Authority (MUHA) moved to dismiss Appellants' appeals for the following reasons: (1) § 44-7-220(B) required Appellants to post a bond; (2) the General Assembly had the power to require this bond, because it created all of Appellants' rights in this matter, and that power is not "clearly excluded" by Article I, 22; and (3) Appellants have not filed the statutory bond and concede that they will not file the bond. In their response, Appellants do not dispute the meaning of § 44-7-220(B) – they concede it requires them to post a bond. They also concede that the General Assembly created their rights in this matter and that the General Assembly generally has the power to place conditions upon rights that it created. They argue, however, that the General Assembly has exceeded that power here, because Article I, § 22 of the South Carolina Constitution grants them an "unfettered right" to the appeal before this Court. Appellants are mistaken.¹

Appellants cite two cases in support of their claim to an "unfettered right" to the present appeal. First, they cite *Gaud v. Walker*, 53 S.E.2d 316 (S.C. 1949) for the general rule that the General Assembly has plenary power absent a limitation imposed by the state or federal constitution.² This is true but proves too much, because nothing in either constitution limits the General Assembly's power to impose the appeal bond at issue here. It is firmly established that

¹ Appellants moved for relief from the statutory bond upon the grounds that they had the "unfettered right" to an appeal in this matter, and that the bond requirement in § 44-7-220(B) deprived them of due process and equal protection under the state and federal constitutions. MUHA filed a return to those arguments in conjunction with its motion to dismiss for failure to comply with § 44-7-220(B).

² *Gaud* was a pre-Home Rule case involving a taxpayer's challenge to an Act providing for a system of government in Charleston County. *Id.* at 319. The Supreme Court struck part of the Act as "special legislation" that delegated police powers upon one county but not all other counties. *Id.* at 326-327; see also *Ruggles v. Padgett*, 126 S.E.2d 553, 558 (S.C. 1962) ("The real vice of the legislation [in *Gaud*] was the fact that it permitted a county agency to define crimes."). Nothing in *Gaud* relates specifically to the question here presented on the General Assembly's power to impose a bond requirement in CON appeals, or any appeals.

the General Assembly may regulate the right to an appeal and may impose a bond requirement as a condition precedent to an appeal “unless such power is *clearly excluded* by the constitution.” *Horn v. Blackwell* 48 S.E.2d 322, 323 (S.C. 1948) (emphasis added). Nothing in Article I, § 22 “clearly excludes” the General Assembly’s power to impose a bond requirement. Moreover, the appellate courts have no discretionary power over mandatory appeal bonds imposed by statute and must dismiss the appeal if the appellant does not post the statutory bond. *Wheeler v. Hyde*, 91 S.E.2d 265, 265-266 (S.C. 1956). In short, nothing in Article I, § 22 “clearly excludes” the power of the General Assembly to regulate CON appeals. Therefore, the General Assembly has plenary power to impose a bond requirement in CON appeals.³

Second, Appellants cite *Fullbright v. Spinnaker Resorts, Inc.*, 802 S.E.2d 794 (S.C. 2017) for the general proposition that Article I, § 22 requires some level of judicial review. This is true but this does not mean that Appellants’ right to an appeal in this case is “unfettered.” In *Fullbright*, the Supreme Court answered certified questions from the South Carolina District Court, including the question of whether determinations by the South Carolina Real Estate Commission (REC) under the Timeshare Act were binding on the courts. *Id.* at 796. The appellant argued that the REC’s decisions were not subject to *any* judicial review. Not surprisingly, the Supreme Court rejected this “no review” argument, but it did not adopt the “unfettered right” rule advocated by Appellants here. To the contrary, the Supreme Court held that “[o]ur law *only requires* there be *some avenue* for a court to determine the validity of the [administrative agency’s] ruling.” *Id.* at 802 (emphasis added). Nothing in *Fullbright* or Article I, § 22 limits the plenary power granted

³ Appellants complain that *Horn* and *Wheeler* were landlord-tenant cases, not ALC cases. (App. Resp. at 6 & n. 4). Their point is unclear – they cited and discussed *Horn* in their motion for relief from the appeal bond. (See Jt. Mot. at 8-10). More importantly, *Horn* and *Wheeler* state the general law on the General Assembly’s power regarding appeals and appeal bonds, and then apply that law to landlord-tenant cases. Nothing in either opinion limits the rules applied therein to landlord-tenant cases, and applying those long-standing rules requires the dismissal of Appellants’ appeals.

to the General Assembly by the South Carolina Constitution, including the power to impose conditions on the right to appeal afforded by § 44-7-220(B).

Here, Appellants have a right to judicial review provided they satisfy the requirements imposed by the General Assembly, including the bond required by § 44-7-220(B), a requirement that is not “clearly excluded” by Article I, § 22. Section 44-7-220(B) provides the “avenue” for review contemplated in *Fullbright*, but Appellants have not complied with the conditions imposed on this avenue, and they concede they will not do so. Thus, their appeals must be dismissed.

In summary, Appellants contend that they have an “unfettered right” to the current appeal, but nothing in Article I, § 22 or any other constitutional provision “clearly excludes” the power of the General Assembly to impose conditions on their right to appeal. Absent a clear limitation imposed by the constitution, and there is none, the General Assembly has the power to regulate appeals under long-standing and widely accepted principles of constitutional jurisprudence:

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

Horn, 48 S.E.2d at 323, *quoting* 4 C. J. S., Appeal and Error, § 502. The wisdom of § 44-7-220(B), including any presumed hardship in pursuing an appeal, is a matter for the General Assembly. *Id.* (“We are not unaware of the fact that [the] requirement [of a bond in appeals from eviction orders] may impose a hardship upon some tenants, but we are here dealing with the power of the General Assembly and not with the question of whether such power was wisely exercised.”).⁴

⁴ Appellants complain that the bond is “onerous and arbitrary”. It is not. The General Assembly imposed a rational scheme based on five percent of the project’s cost with a cap of \$1.5 Million. This methodology is neither onerous nor arbitrary. Indeed, Appellants benefit from this rational scheme and its cap, because 5% of the total project cost would require an appeal bond of \$16.25 Million Dollars for the \$325 Million Dollar project approved by DHEC and the ALC for the benefit of the people of South Carolina. DHEC and the ALC did so in a detailed process specifically designed by the General Assembly to best serve and achieve its public policy determinations on public health.

CONCLUSION

Section 44-7-220(B) affords Appellants an avenue for judicial review by appeal to this Court, but it requires them to post a bond before perfecting the appeal. The General Assembly had the power to impose this requirement, because Article I, § 22 does not “clearly exclude” this power, and because the General Assembly created all of Appellants’ rights in this matter in the first instance. For these reasons, and for the reasons set forth above and in MUHA’s motion to dismiss and return to Appellants’ joint motion for relief from § 44-7-220(B), MUHA respectfully submits that this Court should dismiss Appellant’s appeal.

Respectfully Submitted,

/s/Robert L. Widener

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November 13, 2020
Columbia, SC

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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

Appellate Case No. 2020-001323
Case No. 18-ALJ-07-0358-CC
Case No. 18-ALJ-07-0360-CC
Case No. 18-ALJ-07-0366-CC

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

v.

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

AND

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

v.

South Carolina Department of Health and Environmental Control and
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Trident Medical Center, LLC, d/b/a Trident Medical Center
and Summerville Medical Center, ...Appellants,

v.

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

CERTIFICATE OF SERVICE

I, Robert L. Widener, Counsel for Respondent Medical University Hospital Authority,
hereby certify that a true and correct copy of Respondent's Reply in Support of Motion to Dismiss

Appeal was served upon counsel for all parties in the above-captioned matter, via email at the email addresses listed below pursuant to Supreme Court Order 2020-05029-02, this 13th day of November 2020, addressed as follows:

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Columbia, SC
November 13, 2020

/s/Robert L. Widener
Robert L. Widener

Transcript of the Testimony of
**ROPER SF, TRIDENT, ET AL. V. DHEC, MUHA,
ET AL.**

Date: November 6, 2019



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STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

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

Petitioners,) 18-ALJ-07-0358-CC
v.)

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

Respondents.)

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

Petitioners,) 18-ALJ-07-0360-CC
v.)

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

Respondents.)

Walterboro Community Hospital, Inc.,)
d/b/a Colleton Medical enter,)

Petitioners,) 18-ALJ-07-0366-CC
v.)

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

Respondents.)

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HEARING

6

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8

9

Wednesday, November 6, 2019

10

9:55 a.m. - 2:11 p.m.

11

Thursday, November 7, 2019

12

10:02 a.m. - 3:59 p.m.

13

Friday, November 8, 2019

14

9:31 a.m. - 4:22 p.m.

15

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17

18

The Hearing held before the Honorable Ralph K.

19

Anderson, III, was taken at the Edgar A. Brown

20

Building, 1205 Pendleton Street, Suite 224, Columbia,

21

South Carolina, on the 6th, 7th and 8th days of

22

November, 2019 before Amanda Creel Godfrey, Court

23

Reporter and Notary Public in and for the State of

24

South Carolina.

25

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Katie Buckner, Staff Attorney

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EXHIBITS

(DHEC Exhibits 1 through 9; Roper St. Francis Exhibits 1 through 134; Trident, Summerville, Colleton Exhibits 1 through 160 and MUHA Exhibits 1 through 38v were all marked prior to the hearing and provided to the Court. The Court's Exhibit List is incorporated herein by reference. Roper St. Francis Exhibits 135 and 136 were marked during the hearing as referenced in the Index above.)

STIPULATIONS

It is stipulated and agreed that this hearing is being taken pursuant to the rules of the Administrative Law Court and the South Carolina Rules of Civil Procedure.

1 DAY ONE - WEDNESDAY, NOVEMBER 6, 2019

2 CALL TO ORDER:

3 COURT REPORTER: All rise.

4 THE COURT: Y'all be seated.

5 (Off the record discussion.)

6 THE COURT: This is a hearing into the matter of,
7 and I'm gonna just call it, Docket Number
8 ALJ 07 0358-CC. And I'm not going to explicate
9 the caption because there's three of them and
10 they're all too long. So, and I think we all
11 know what it's about.

12 (Mr. Summer entered the courtroom.)

13 THE COURT: And I'll also -- oh, I'm sorry, I didn't
14 ...

15 MR. SUMMER: I apologize Your Honor.

16 THE COURT: No, no, I started early.

17 PRELIMINARY MATTERS - MOTIONS:

18 THE COURT: But y'all have made several motions.
19 I'll tell you, I didn't grant belated filing of
20 motions, so the formal consideration of the
21 motions I'm not going to make because they
22 weren't timely filed. But on the other hand,
23 every motion that was made, I consider in the
24 context of this trial, and I will do so.
25 The third thing was, probably y'all need to

1 give me a couple of days to get my strength
2 back. So, If I say something that doesn't
3 appear that I'm getting what you're talking
4 about, today will probably be a good one where
5 you just back up and say, Your Honor, I think
6 you may be missing my point.

7 So, with that said, any motions or
8 stipulations we need to consider before we
9 start hearing opening statements?

10 MR. SUMMER: If I might confer with co-counsel.

11 (Off the record discussion.)

12 STIPULATIONS AS TO EXHIBITS:

13 MS. CRUM: Your Honor, we have all conferred and if
14 it please The court, we would like to stipulate
15 to the admissibility of DHEC's Exhibits with
16 the exception of the 2020 Draft Health Plan, at
17 which point we would argue in the event that it
18 gets attempted to be introduced.

19 At the same time, we would -- we have an
20 order of witnesses that we had submitted, but
21 obviously the times may change.

22 THE COURT: I messed that up.

23 MS. CRUM: All right, sir. And so at that point,
24 and obviously at any point that we need to
25 break, none of us have any objection, so we'll

1 do whatever The Court wants.

2 THE COURT: All right. When you say admissibility
3 of the exhibits, you're ---

4 MS. CRUM: Nobody objects to DHEC's Exhibits 1 ---

5 THE COURT: Wait a second.

6 MS. CRUM: I'm sorry.

7 THE COURT: Are you saying for the truth of the
8 matter asserted in all those Exhibits or simply
9 just for the admissibility of those Exhibits.

10 MS. CRUM: The truth of the matter. Several of them
11 are State Health Plans. I think three or -- I
12 can't remember how many. The CON application
13 in this record, the record in this case is
14 Exhibit 1. And then the two 50-bed hospital
15 CON applications from the DHEC record.

16 THE COURT: Okay. I just want to make sure if
17 there's any statements made in those Exhibits
18 whether I'll -- go ahead.

19 MR. SUMMER: Your Honor, we couldn't agree to that
20 on the underlying application because that's
21 what -- the case were trying.

22 THE COURT: That's what I thought.

23 MR. SUMMER: So ---

24 THE COURT: I'm not that sick.

25 (Laughter.)

1 MR. SUMMER: So, I think what we're agreeing to is
2 that they're admissible.

3 THE COURT: Okay. All right ---

4 MR. SUMMER: We're not objecting to the ---

5 THE COURT: I get into some arguments about that,
6 oh, they were admitted and without objection,
7 and, you know ...

8 MR. SUMMER: We're not stipulating to the truth of
9 the matter, sir.

10 THE COURT: Okay.

11 (DHEC Exhibits 1 through 5, and 7 through 9 were
12 admitted into evidence by stipulation.)

13 THE COURT: All right. Anything else?

14 MS. CRUM: No, sir.

15 THE COURT: Okay. Opening statements.

16 MS. HOLLINGSWORTH: Well, Your Honor, may it please
17 the Court, Roper St. Francis will go first.

18 THE COURT: Okay.

19 OPENING STATEMENT BY MS. HOLLINGSWORTH:

20 MS. HOLLINGSWORTH: Good morning, Your Honor. May
21 it please the Court, Jennifer Hollingsworth
22 here on behalf of CareAlliance Health Service,
23 does business as Roper St. Francis Healthcare
24 and our four hospitals that we have: Roper
25 Hospital, Inc.; Roper Mount Pleasant; Bon

1 Secours-St. Francis; and Roper Hospital
2 Berkeley. I do what to introduce to The Court
3 my co-counsel, Ms. Cheryl Shoun.

4 MS. SHOUN: Go morning.

5 MS. HOLLINGSWORTH: As well as Ms. Shannon Lipham,
6 here with us.

7 And, Your Honor, on behalf of my Roper
8 clients, we have Brett Johnson, is here with
9 us. And Mr. Patrick Bosse. And our medical
10 planning expert, Mr. Richardson is with us.

11 And, Your Honor, we appreciate your time and
12 the time that I know you'll devote to this over
13 the next period of days; however those may be.
14 And I will be as brief as I can.

15 And so, Your Honor, here, just as I know
16 you're familiar with these parties in the area,
17 but just a great depiction of four hospitals
18 that do comprise our system, Roper Hospital.

19 THE COURT: I'm very familiar with the parties.

20 MS. HOLLINGSWORTH: Okay, Your Honor.

21 THE COURT: I'm not specifically familiar with
22 Berkeley County.

23 MS. HOLLINGSWORTH: Okay. Well, Your Honor, the --
24 there, towards the very top center of our map,
25 sort of a light blue star, that's Roper

1 Hospital Berkeley. That's the newest hospital
2 in our system, right up I-26 from downtown
3 peninsula. So the red star at the bottom shows
4 you where our flagship Roper Hospital is in
5 downtown Charleston. And then that goes
6 directly up that I-26 corridor. And we
7 certainly -- in fact, I know that you'll hear
8 a lot more about where we are and where folks
9 are going over these next few days. But I do
10 want to point out that yellow star, of course,
11 is our Mount Pleasant Hospital. And the blue
12 star would show you where we are west of the
13 Ashley at Bon Secours-St. Francis.

14 THE COURT: When you say where people are going, are
15 you already conceding that they're going to be
16 going there?

17 MS. HOLLINGSWORTH: No, Your Honor. I just know you
18 will hear a lot about where people are going.

19 THE COURT: Where they want to go or where they are
20 going?

21 MS. HOLLINGSWORTH: Depends on which one we're
22 talking about, Your Honor.

23 THE COURT: Okay. Oh, that's right. You've got
24 some that aren't completely online yet, the
25 hospitals.

1 MS. HOLLINGSWORTH: Nope. Roper Hospital Berkeley
2 is open and serving patients, Your Honor.

3 THE COURT: Okay. So everybody's ---

4 MS. HOLLINGSWORTH: Yes, we are, Your Honor.

5 And so we're here, of course, addressing an
6 application that was approved by the Department
7 for the Medical University to establish a new
8 325 million dollar hospital in Berkeley County.
9 And it's our position and we believe that you
10 will hear the evidence necessary to establish
11 that that application is supported only with a
12 facility-specific bed need, and the Department
13 did not consider or give sufficient weight to
14 it, because what we will establish is there is
15 no community need for an additional hospital
16 out there where the applicant proposes to place
17 it. And the Department didn't adequately
18 consider the material adverse impact that
19 hospital was going to have on providers that
20 are already in that community, to include, of
21 course, Roper St. Francis.

22 I do know the Court is very familiar with the
23 purposes of the program: promoting cost
24 containment; preventing unnecessary duplication
25 of facilities and services; guiding the

1 establishment of those facilities and services
2 to best serve our public needs; and ensure high
3 quality services are provided to the people in
4 South Carolina.

5 Briefly, Your Honor, the community hospital
6 that's proposed by Medical University is a 128-
7 bed community hospital. It is to be located in
8 Summerville. So, as you'll hear about the
9 geography and how that geography has sort of
10 developed over time because a lot of what the
11 Court will hear about is the applications that
12 Roper St. Francis filed back in 2008 at a time
13 when, sort of, the hubs of the Berkeley County
14 community were considered Goose Creek and
15 Moncks Corner. And some of that language
16 starts to change based on where and how the
17 communities developed. And so at this point,
18 Nexton, the Nexton area's within what is
19 considered the Summerville area of Berkeley
20 County, southern Berkeley County. The facility
21 proposed is over 300,000 square feet, five
22 floors on a 40-acre site. It has a project
23 cost of 325 million dollars, Your Honor. So,
24 of course, that cost per bed is a little over
25 2.5 million.

1 Our position that we intend to establish
2 before you is that the application must be
3 denied in this Court as part of your de novo
4 review. We believe that it fails to comply
5 with the Health Plan, the 2017 2018 Health
6 Plan, which was in effect at the time the
7 application was filed. It also fails to comply
8 with the 2018 Plan, which is the Health Plan
9 that's in place today here for all the matters
10 before you.

11 We also believe that we will show that it
12 fails to comply with Regulation 61 15 and the
13 project review criteria. Some of the -- to
14 summarize some of the criteria that you'll hear
15 a lot about is the community need criteria, and
16 we believe there is no community need for the
17 project, that it is an unnecessary duplication
18 of the facilities and services out there,
19 including our Berkeley Hospital and HCA
20 facilities that are in the area. We believe it
21 will have a material adverse impact on the
22 providers; that it doesn't contain costs; it's
23 not financially feasible; and we have
24 significant concerns about financial
25 circumstances that you'll hear about involving

1 the Medical University. We don't believe that
2 it increases access, nor does it improve
3 distribution of services.

4 THE COURT: Before you go on to the next slide.

5 MS. HOLLINGSWORTH: Yes, Your Honor.

6 THE COURT: You used conjointly the phrase community
7 need?

8 MS. HOLLINGSWORTH: Yes, Your Honor.

9 THE COURT: What is the parameters of the need that
10 I consider.

11 MS. HOLLINGSWORTH: Well, Your Honor, I think in
12 this instance you have specific direction in
13 this Health Plan and the Standards for the
14 services. What Standard 5 actually says that
15 the applicant must demonstrate, through patient
16 origin and other data, that the services are
17 needed where they propose to put the hospital.
18 And so the standard in the Health Plan for what
19 this applicant seeks to do is that you have to
20 show -- not that it's needed generally, not
21 that it's needed downtown ---

22 THE COURT: In the service area.

23 MS. HOLLINGSWORTH: --- where it's -- the proposed
24 site. I believe the word, Your Honor, is the
25 chosen site.

1 THE COURT: Chosen site, okay.

2 MS. HOLLINGSWORTH: There has to be need at the
3 chosen site. So, Your Honor, we believe that
4 informs the community need analysis for
5 purposes of an application for hospital beds
6 under this Health Plan.

7 THE COURT: Okay. Well worded.

8 MS. HOLLINGSWORTH: And so, Your Honor, a portion
9 out of it, this is Standard 5 in the 2017-2018
10 Health Plan, and this is what I would submit
11 is the most significant standard, and the
12 standard that we believe this application
13 cannot, does not comply with. And there at the
14 bottom, what we've highlighted, the applicant,
15 Medical University, must justify through
16 patient origin and other data the need for a
17 new hospital at the chosen site and the
18 potential adverse impact a new hospital at the
19 chosen site could have on the existing
20 hospitals in the service area. And, Your
21 Honor, we really think that is a significant
22 and determinative issue here in this case, that
23 there is no need for a new hospital at the
24 chosen site. And we have folks that you'll
25 hear from and documents that you'll see that we

1 believe where we more than meet our burden on
2 that issue.

3 And I did briefly, as I mentioned, it's our
4 position, of course, that the application
5 cannot comply with the 2018-2019 Health Plan
6 because in that Health Plan which is the Health
7 Plan in effect as we sit here today, in that
8 Health Plan the three-county service area of
9 Berkeley, Charleston and Dorchester was
10 separated. So, DHEC, in this plan, said each
11 county stands alone because in all other areas
12 of the state the service area was by county.
13 For a long time it had been a tri-county area,
14 service area, and here we have separated
15 counties. And so because the -- as we just saw
16 on that last slide, what MUHA seeks to do is
17 transfer bed need at their downtown hospital,
18 so the need for beds at the 656-bed
19 tertiary/quaternary level I trauma center
20 downtown, MUHA proposes to take a need in the
21 Health Plan and put it out in Berkeley County.
22 And under the 2018 2019 Health Plan that cannot
23 happen, because as of the 2018 2019 Health
24 Plan, Your Honor, our position is that the
25 service area for that bed need is Charleston

1 County. So that is a change in the Plan that
2 is now in effect today.

3 Justifying or discussing that there is no
4 need for the project, Your Honor, we will show
5 you that in the application itself, and I think
6 repeatedly in the documents, you'll see that
7 the Medical University certainly believes that
8 there is need for the project, but it is their
9 need, their institutional need. There's a lot
10 of discussion in their application about that
11 they need beds because of capacity constraints
12 downtown, because of issues with their downtown
13 facility. Well, Your Honor, certainly we
14 understand that the formula, the bed need
15 calculation is looking what an institution
16 needs, but what we are talking about in
17 community need under this Plan is there's no
18 need otherwise in the service area. And I will
19 submit that in the application, the applicant
20 did not make any attempt to say that there was
21 a need for these beds to be out at the chosen
22 sit in the next scenario of Berkeley County.

23 So we just put here for you some information
24 from the application. And in terms of
25 addressing capacity constraints or any other

1 indicia of need in that area, there's no
2 information about other providers in the
3 community except, at most, a graph or some
4 discussion that services are being used. And
5 I'd submit what we'll discuss is that they're
6 being used and those needs are being met by the
7 services in the area.

8 And so here again, just information from the
9 application that you'll see, what our position
10 is, that this facility-specific need at a
11 tertiary/quaternary hospital downtown does need
12 the support of a community hospital in Berkeley
13 County over 30 minutes away. And we submit
14 that sort of the constructs behind that we're
15 going to decant certain populations out into
16 Berkeley County. We submit that we're going to
17 establish for you that that's unreasonable and
18 that and won't happen. And so we submit that
19 ---

20 THE COURT: That's unreasonable and that won't
21 happen?

22 MS. HOLLINGSWORTH: We believe -- what we're going
23 to show you through testimony and documents,
24 Your Honor, is the suggestion of redirection,
25 for example, folks that live right ---

1 THE COURT: Okay, I got it.

2 MS. HOLLINGSWORTH: --- around downtown.

3 THE COURT: Go ahead.

4 MS. HOLLINGSWORTH: All right, Your Honor.

5 So our position overall was that the Medical
6 University's need is not the equivalent of a
7 community need.

8 And so we believe as evidence of the absence
9 of community need is there is no need in this
10 service area under the 17 18 Health Plan. The
11 combined service area had an excess of beds, so
12 we believe that is certainly evidence that
13 there isn't a need other than what Medical
14 University has a need for at their campus. And
15 under the 2018-2019 Plan, Your Honor, there's
16 no need for beds in Berkeley County. So we
17 think that will be important evidence for you
18 to consider.

19 What we just mentioned briefly, this is just
20 a snippet of the redirection plans and it shows
21 you the market, how the markets are looked at
22 by the Medical University and what we believe
23 we'll establish is it's only a very small
24 percentage of patients that the Medical
25 University sees that actually originate in the

1 area proximate to the chosen site, which is the
2 language in the Standard. And said, actually,
3 the greater volumes are in the North Charleston
4 area and then moving down to the peninsula.
5 And so our position is the concept behind these
6 redirection of large percentages of patients to
7 travel from North Charleston, Mount Pleasant
8 and up into the Berkeley County area, we submit
9 and we believe we will show that that's not a
10 reasonable plan. That's not how patients
11 travel, that's not consistent with what
12 planning, health planning would suggest, and so
13 that will be an important part of what we'll
14 talk to you about is this redirection
15 methodology.

16 And also we'll submit, of course, that the
17 reliance on the entirety of the downtown
18 patient experience, as the basis for
19 assumptions in this application, is also
20 unreasonable. But we have, as the Medical
21 University mentioned frequently in their
22 materials and their application is they are a
23 special, specialized care, they offer levels of
24 care that you can't find other places. Level
25 I trauma centers -- the only level I trauma

1 center in the Tri-County area, they have a very
2 high complexity of care and using that patient
3 base as the base of who would be treated at a
4 community hospital out in Summerville, Your
5 Honor, we believe is not reasonable.

6 And so looking at the unnecessary
7 duplication, we believe that there's actually
8 unnecessary duplication at this point of
9 Medical University's own planned services. At
10 the time of this application that was filed,
11 there had been an application for a
12 freestanding emergency department in Berkeley
13 County. The applicant told the Department that
14 they were going to close down and co-locate
15 that proposed freestanding ED in order to not
16 duplicate those services. The position taken
17 in this application was the freestanding
18 emergency department will ultimately be
19 relocated to the community hospital in order to
20 co-locate services and reduce duplication of
21 emergency services in the same zip code. And
22 so in the application for the community
23 hospital, the volumes and the revenues for that
24 freestanding ED are pulled into the community
25 hospital application. But what we know, since

1 the time the Department approved the hospital
2 application, Medical University has changed
3 their mind. They no longer intend to co-locate
4 the freestanding emergency department and it's
5 now their intention to continue both of those
6 emergency services in the service area. And we
7 believe, Your Honor, and we'll discuss with you
8 in this court, how that impacts the question of
9 duplication.

10 In addition to duplication of their own
11 services, of course, you'll hear a lot about
12 our position that the proposed hospital would
13 unnecessary duplicate other services in the
14 service area.

15 THE COURT: Nexton site?

16 MS. HOLLINGSWORTH: Yes, Your Honor.

17 THE COURT: Nexton is -- who's at the Nexton site?

18 MS. HOLLINGSWORTH: That's the community development

19 Roper St. Francis Berkeley is ---

20 THE COURT: Okay.

21 MS. HOLLINGSWORTH: --- is -- that's the same

22 community we serve, Your Honor.

23 THE COURT: Okay.

24 MS. HOLLINGSWORTH: I'll show that to you. And

25 certainly within 20 miles of that site, and I'm

1 talking about the specific site that is
2 proposed, not the larger community of Nexton,
3 but the site proposed for this hospital, within
4 20 miles you have 520 hospital beds and five
5 freestanding emergency departments operational
6 and approved. But significantly, Your Honor,
7 we're four miles away. Roper Hospital in
8 Berkeley is four miles away. We have all the
9 same services that are proposed by the Medical
10 University. We've invested well over 100
11 million dollars just in the project alone.
12 Everything that this applicant's proposing to
13 do, we are there and we are doing. And it was
14 something we were given permission to do a very
15 long time ago, ten years ago. And we worked
16 hard to bring that to life. It is here, it is
17 happening. And we believe, Your Honor, that
18 adding 128 beds four miles away would
19 absolutely violate the purposes of the CON
20 program.

21 We'll talk with you about other impact
22 issues, including various significant concerns
23 about staffing, in particular nurse staffing.
24 You'll hear a lot of evidence and testimony
25 about a very -- a very real and ongoing nursing

1 shortage in our area. And not just at Roper's
2 Berkeley Hospital. The other hospitals in the
3 area, you'll hear testimony from other
4 witnesses about the impact of that staffing
5 shortage. And this application is proposing
6 that they need at least 133 RNs in year one.
7 And I submit that the evidence will show that's
8 simply not going to happen without material
9 adverse impact on the other providers of those
10 services in the area.

11 We're Roper Berkeley Hospital, Your Honor,
12 we're proud of it and we look forward to
13 talking to you about it today and over the next
14 few days and weeks. We do have a 24 hour
15 emergency department and a full complement of
16 all the necessary services that an acute care
17 hospital needs. That's what we have, and
18 that's what we're doing. There's nothing that
19 the Medical University is proposing that's
20 different.

21 And that, Your Honor, is a graphic that
22 you'll see us talk more about, the proposed
23 site. That's actually not quite the proposed
24 site. This is a document from the Medical
25 University. The proposed site is actually even

1 closer to us, but this shows you the interstate
2 exit where -- close to where the Nexton
3 development is. That arrow points you to where
4 our hospital is and if you actually shift the
5 radius a little closer to us, about halfway
6 between the two you'll see where we are. Those
7 radius, Your Honor, are five -- I believe,
8 let's see, 10, 15 and 20 miles, I believe. We
9 completely overlap, Your Honor, so we are here
10 to talk to you about the very real concerns we
11 have, not only with that duplication, but
12 there's simply no improvement of access. The
13 folks, the patients, the residents in the -- at
14 the chosen site, those areas proximate that are
15 here, calculated in Medical University's
16 documents, they have hospital beds, they have
17 hospital services.

18 We'll talk to you about financial feasibility
19 and ability to complete the project. We
20 believe the financial projections are
21 overstated, and they are not reliable for you
22 in your de novo review. We're also going to
23 talk to you about the poor financial position.
24 All things that we brought up before the
25 Department, Your Honor, at length. The

1 Department, following their decision, there's
2 been significant more activity, a lot more debt
3 incurred and a lot more movement in the
4 negative by the Medical University. And we
5 think that's important evidence that we'll
6 bring to your attention, again, considering a
7 de novo review. And our position is going to
8 be where they stand today, it's over a billion
9 dollars in financial commitments, that this
10 additional 325 million dollar investment, which
11 has to be obtained through HUD backed
12 financing, is not feasible and, again, does not
13 comport with the purposes of the program.

14 And as I've just foreshadowed, we will talk
15 to you about some of the applications that we
16 have seen from the Medical University both
17 leading up to and following this application.
18 Applications that talk about the Shawn Jenkin's
19 Women and Children's Hospital. It's a
20 beautiful facility opening very soon as a
21 result of which an entire Children's hospital
22 downtown is going to be vacated. And we'll
23 talk with the Court about what could have been
24 done, what should have been done and what will
25 be done with that vacated space. But we know

1 from their materials that have been given to
2 the Department over the years, right now,
3 today, is that Children's hospital is still
4 being used. There's 158 beds. And so our
5 position that we'll take and talk with you
6 about is there are absolutely alternatives to
7 building a 325 million dollar hospital in
8 Berkeley County to satisfy that institution-
9 specific bed need. And in addition to that,
10 going back to the Children's hospital, in
11 several filings since that time, including this
12 one, that the University describes repeatedly
13 capacity restraints. And there have been a
14 number of projects where they have said this is
15 to relieve capacity constraints and this is to
16 redirect volume, and this is to improve things
17 downtown. And it's repeated over and over
18 again, Your Honor. We submit that to continued
19 to use that to justify this project. Is not
20 reasonable and is not a reason to support
21 approval.

22 Here on the left we have the information
23 provided to the Department in a musculoskeletal
24 CON application, which included redirecting
25 procedures from downtown into the community.

1 On the right we have an ambulatory surgery
2 center application, again involved redirection
3 that this was to decant volume out to the
4 community to improve capacity constraints.

5 And so we believe the failure of the
6 Department and the Medical University to
7 adequately consider and evaluate whether there
8 was a reasonable and more appropriate
9 alternative to a brand new 325 million dollar
10 hospital is something for this Court to
11 consider, and we believe supports denial of the
12 application. All the information that we have,
13 and certainly all that the Department had,
14 despite the near completion of a renovation or
15 replacement of the Children's hospital,
16 renovation was the -- it says -- I'm sorry, I
17 can't read that far away.

18 THE COURT: Neither can I.

19 (Laughter.)

20 MS. HOLLINGSWORTH: This -- in the 29-bed
21 application that's been filed recently, for
22 this application, the applicant said, here, we
23 can renovate some space, but we're only going
24 to renovate 29 beds. And we believe, Your
25 Honor, that certainly renovation of that space

1 is reasonable for more than just the 29 beds.
2 They've told the Department they can renovate
3 some and we believe that there's reason to try
4 and -- that they can renovate much more of
5 that, including to address the facility-
6 specific bed need, greater than just these 29
7 beds. The date of this, Your Honor, is July 1
8 of 2019, a very recent application.

9 And we will talk to you briefly, to kind of
10 move on with your time, but we will be talking
11 to you about things that the applicant has done
12 since the approval by the Department. And
13 these go to the financial ability to complete
14 the project, and the feasibility of approving
15 this project. The purchase of four community
16 health system hospitals on March 1, 2019. And
17 we'll be discussing both what that did for --
18 related to the reasons that the applicant gave
19 that they need this hospital; we'll also talk
20 to you about the impact that it has financially
21 on their system. There is also, just as
22 recently as last month, been yet another
23 freestanding emergency department filed,
24 application filed, and that's going to be 15
25 million dollars.

1 THE COURT: That one is just filed?

2 MS. HOLLINGSWORTH: Yes, Your Honor.

3 THE COURT: Okay.

4 MS. HOLLINGSWORTH: So they have asked the

5 Department and they've approved internally to
6 pursue a freestanding emergency department in,
7 I believe, the Johns Island area at 15 million
8 dollars. So yet another example of additional
9 financial commitments that the Medical
10 University is seeking permission for. And in
11 that one, again, in this application they tell
12 the Department that the purpose of the
13 freestanding emergency department is to address
14 capacities and space constraints. And so, you
15 know, these things continue to happen and yet
16 the applicant says we need to spend 325 million
17 dollars for a Berkeley County hospital as well.
18 And we would just submit, at some point, you
19 know, we need to start to question whether
20 these actually are reasons that support such a
21 significant investment of healthcare resources.
22 And we don't believe it does.

23 And, Your Honor, what we'll talk with some of
24 the Medical University witnesses about is there
25 have been even more approvals. And this is

1 information that is just being published to the
2 public. Two more hospital projects are planned
3 related to the hospitals acquired from CHS and
4 the relocation of beds. We have a replacement
5 hospital, we have a freestanding ED. Your
6 Honor, we just have a lot of financial
7 commitments being used when this 325 million
8 dollars is still hanging out there to be
9 addressed. We simply believe, Your Honor,
10 while we certainly recognize that financial
11 feasibility is typically not a significant
12 issue in CON cases, particularly for very large
13 systems, and I'll submit what you'll hear is
14 this is simply not typical. This is
15 significant and it warrants your close review,
16 so we can -- will reach a different conclusion
17 than the Department.

18 Some other project review criteria that we
19 will talk to you about, distribution
20 accessibility. We don't believe that this
21 duplication is justified, which of course, had
22 to be justified in order to be compliant with
23 the Plan and the project review criteria.
24 We'll talk to you about these financial issues.
25 And these are all criteria in the Regulation,

1 of course, the revenues, the debt service, all
2 financial information that we think is
3 significant for your review. The fact that we
4 -- if this project fails to contain costs, it
5 certainly doesn't minimize costs, then as we
6 sort of foreshadowed earlier, we'll be speaking
7 with you about alternative methods that
8 should've been considered and have not been
9 considered.

10 And so, Your Honor, we do submit, and I'm
11 here on behalf of Roper St. Francis, that we
12 look forward to presenting our case to you to
13 consider. We believe the evidence will show
14 you that this Nexton Hospital, the community
15 hospital planned in Berkeley County, it does
16 not comply with the Health Plan. It does not
17 comply with the project review criteria, and we
18 believe it violates the purpose of the CON
19 program. So we are asking the Court to change
20 the determination made by the Department, and
21 in your de novo review deny the application.

22 Thank you, Your Honor.

23 THE COURT: Go ahead.

24 OPENING STATEMENT BY MR. THOMAS:

25 MR. THOMAS: May it please the Court, Your Honor.

1 As my presentation is getting put up, that was
2 a great presentation by Ms. Hollingsworth. Of
3 course, mine's gonna be a little bit more
4 thematic, because I anticipated a very
5 technical presentation from her.

6 I am here today, Your Honor, on behalf of
7 Trident Medical Center located in North
8 Charleston, very approximate to Goose Creek,
9 Ladson, Hanahan and Berkeley County; and
10 Summerville Medical Center, which is in part of
11 Dorchester County; and Colleton Medical Center,
12 which if you know where Walterboro is, it's
13 right there in Walterboro proper.

14 Next slide, please.

15 There's a little bit of overlap with our
16 presentations, Your Honor, because there kind
17 of has to be, but again, 325 million dollar
18 project, 128-bed community hospital. And it's
19 not just a community hospital, you know, 128
20 beds at issues. It's and ED, it's MRI, it's
21 CT, it's ORs, it's lab, it's pharmacy. So it's
22 a much more expensive project than to say if
23 you were just to add a bed tower somewhere on
24 your own campus or perhaps renovate space,
25 because obviously you may not need all of those

1 coordinated services, and you'll hear about
2 that.

3 One thing that I heard you say earlier is you
4 don't know much about Berkeley County.
5 Berkeley County, if I can describe it, is,
6 you've kind of go Moncks Corner in the middle
7 with Lake Moultrie right there. It's almost
8 like a diamond. It's a very large county
9 geographically, but it's interesting because
10 the population's somewhat condensed in the
11 southern third of that diamond. We'll talk a
12 little bit more about that. But it's going to
13 be located just a few miles from the
14 southwestern county line, very proximate to
15 Dorchester County, and very -- and somewhat
16 proximate to North Charleston. And, of course,
17 as Ms. Hollingsworth mentioned, less than just
18 four miles away is a brand-new full-service
19 community hospital that I believe opened just
20 early last month, and that's Roper.

21 What's Trident? Trident's composed of
22 Trident Medical Center, which is 282 med-surg
23 beds. It also has rehab; it also has
24 psychiatric beds. Trident Health also has
25 Summerville Medical Center in Dorchester

1 County, and that's a 124-bed hospital with --
2 and both of them have very thriving EDs with
3 nearly 100 ED bays. And then Colleton Medical
4 Center is somewhat of an underused facility
5 because it's in rural Colleton County, but it
6 has a lot of the same community healthcare
7 services that MUHA is planning to offer in it's
8 Nexton location.

9 So, what is this case about, Your Honor?
10 Above and beyond the, kind of the technical
11 project review criteria in the CON Act, MUSC is
12 going to tell you it's about bringing services
13 closer to their patients. And you're going to
14 hear a lot about their patients. It's
15 interesting though, the evidence is actually
16 gonna show that the hospital actually places
17 these services further away from most of the
18 patients that MUHA claims they're going to
19 serve in the application.

20 You're also going to hear about their mission
21 of teaching, research and patient care, but I
22 think the evidence is going to be very patent,
23 Your Honor, that without this hospital not one
24 single element of that mission is compromised.

25 Third, they're gonna tell you it's about

1 bringing healthcare to Berkeley County. And it
2 actually uses this phrase in it's application
3 that it's staggeringly underserved. But the
4 evidence will actually show that that's not the
5 case and MUHA is really using the fiction of a
6 county line to obfuscate the facts. The
7 Berkeley County line is not in a geographical
8 barrier, it is not comprised of a river or a
9 moat or any kind of wall, and it doesn't cause
10 access issues for patients. So a patient who
11 lives in Goose Creek is not somehow prevented
12 from driving two miles from their house to
13 Trident Medical Center in Charleston County by
14 virtue of a county line. The fact is you're
15 gonna hear from Trident's witnesses, Your
16 Honor, Trident Medical Center was actually
17 created in the early 1970s when nobody else
18 would go up to North Charleston, Berkeley and
19 Dorchester areas, but it was actually created
20 in concert with Dorchester and Berkeley County
21 officials to open up there to serve those two
22 counties so that those two counties could save
23 money and close their hospitals that were
24 foundering. So, you're gonna hear a lot of --
25 MUSC say a lot of things that just simply

1 aren't the case.

2 What is this case about? And this is just my
3 themes, Your Honor. This case is about a
4 sandbox; James Cagney or a Johnny Come Lately,
5 if you've ever seen that early film; and hiding
6 the ball, Your Honor.

7 So, let's talk about first the sandbox.
8 During discovery what we kind of learned, Your
9 Honor, is that MUSC just thinks this is a
10 sandbox that it should be allowed to play in
11 and it should have a hospital. We actually
12 heard testimony during depositions that if
13 Roper gets to build one and Trident gets to
14 build one, MUSC should get to build one, too.
15 Well, that's not any type of community health
16 planning that I'm aware of that's set forth in
17 the law.

18 THE COURT: Of course on the other hand that means
19 y'all have y'all's sandbox and y'all don't want
20 to allow them to come play in it.

21 (Laughter.)

22 MR. THOMAS: That's one way to look at it. But, if
23 there's no need in that sandbox, then that's a
24 325 million dollar waste of money.

25 THE COURT: Yeah.

1 MR. THOMAS: Tax payer dollars, Your Honor.

2 This is a great slide that was presented by
3 MUSC, I believe one of their experts, but --
4 and it just shows that, hey look, here's what
5 Roper got to do. They got to move 85 beds to
6 Mount Pleasant, 198 beds to West Ashley and 50
7 beds up to Berkeley County. But I like this
8 little legend down in the little left-hand
9 corner because it really shows you what the
10 evolution of that was. That just didn't happen
11 overnight, that happened over 30 years. And so
12 that -- those were significant developments,
13 Roper planning to do things and get beds off
14 campus. And that's significant, Your Honor,
15 because at the end of the day what MUSC wants
16 to do is just take 128-bed, 325 million
17 hospital and drop it right in the back of the
18 primary service area, less than four miles away
19 from Roper, and less than ten miles away from
20 Summerville and Trident Medical Center.

21 More on the sandbox, Your Honor. Trident
22 Health has been serving these communities for
23 over 40 years, and they went out there before
24 anybody else would. And both of these systems,
25 Trident and Roper, have developed their

1 services and have grown as the community has
2 grown. So it's been over a period of decades,
3 and, you know, the fact of the matter is MUHA
4 had plenty of time to get out and off of it's
5 campus if it really wanted to go to Berkeley
6 County. The fact is, Trident and Roper have
7 the existing and planned resources to more than
8 adequately serve this area. And what you're
9 gonna see is that most of the Berkeley County
10 population is located within a 15 minute drive,
11 or closer, to the existing tertiary community
12 hospital. And here's a map. Ms. Hollingsworth
13 showed you some maps, but this is the -- pretty
14 much the actual location of where MUSC is.
15 It's in the middle of Berk- -- excuse me, of
16 that circle, southwestern Berkeley County. And
17 I'll show you another map in a minute. It's
18 about three and a half miles off the
19 interstate. That interstate run is -- very
20 closely mirrors the county line of Berkeley.
21 So, what MUSC does is it, if it's placing it
22 here, less than four miles from Roper, as you
23 see. And then you see in the lower third of
24 that, you see Trident Medical Center there on
25 the right and Summerville Medical Center on the

1 left. So, that's 456 beds that are there right
2 now and operational. And really, Your Honor,
3 where all the population is in Berkeley County,
4 is if you drew a line directly across that
5 circle on the lower third, that's where you're
6 gonna find most of the population in Berkeley
7 County.

8 Next slide, please.

9 And this is just a graphic, Your Honor, that
10 shows where the population of Berkeley is. And
11 the darker the green is where more of the
12 people live. And what you see here is you see
13 where Roper Hospital Berkeley just opened up
14 and it's on the kind of northern side of that
15 population concentration. You see where
16 Trident is in Charleston County, and we didn't
17 show what the population density was for
18 Charleston-Dorchester, well not Berkeley right
19 now. And you see where Summerville is, where
20 it gets -- it gets a lot of its patients from
21 the very zip code where MUHA wants to open.
22 And that's 29486, which was a relatively newly
23 created zip code from 29483, which those two
24 combined is where MUSC and Trident get a lot of
25 their patients, Your Honor.

1 Next slide.

2 This is just a graphic that you're going to
3 see in the trial, Your Honor, just showing that
4 that blue represents a 15 minute drive time,
5 and that blue is where most of the population
6 in Berkeley County is. And so, MUSC does
7 nothing to expand that. But all those patients
8 within that blue line, where all the population
9 of Berkeley County, most of the population is,
10 can get to Trident, Summerville and Roper
11 Berkeley without a problem. And here's an
12 interesting part. The southern, very southern
13 tip of Berkeley County is something called
14 Daniel Island, which kind of is -- on the other
15 side you've got the Cooper River and you've got
16 the Wando River to come in. I grew up four
17 miles away from there, so I'm kind of familiar
18 with the area.

19 THE COURT: I'm familiar with that area too.

20 MR. THOMAS: Yes, sir. 526 rolls right through it.

21 So if you ever go to Isle of Palms, Sullivan's
22 Island, Mount Pleasant, that's probably one of
23 the ways you went in. And that's a very
24 heavily concentrated area of population and
25 both of those -- that community has very good

1 access to East Cooper Medical Center and the
2 Mount Pleasant hospital within a 15 minute
3 drive away, too. So there's really very little
4 portions of Berkeley County that don't have
5 excellent access to a hospital. And that goes
6 to that access project review criteria.

7 Let's talk a little bit about James Cagney and
8 Johnny Come Lately. So, what did MUSC do?
9 They waited until December of 2017 to apply to
10 build their hospital in Berkeley County even
11 though, and you're gonna hear this term a lot,
12 and me and Mr. Summer have heard it a lot over
13 the last decade, explosive growth has been
14 occurring in this area for the better part of
15 a decade. And you'll see this in MUSC's own
16 documents. Well, why did MUSC wait so long to
17 apply? Well, we think the evidence will show
18 because this is what they've been doing.
19 They've been doing everything but trying to get
20 to Berkeley County in terms of a hospital. All
21 of these little dots represent some type of
22 presence that they have in the state of South
23 Carolina. So they're very well distributed
24 throughout the state. So, I don't think their
25 mission is particularly going to be hurt if

1 they can't open up a 128-bed hospital in
2 Berkeley County, especially with what they're
3 doing in Florence, Marion, Chester and
4 Lancaster County and now Williamsburg County as
5 well, Your Honor.

6 So, at the end of the day, let's talk a
7 little bit about this peninsula that is just
8 overcrowded, flooding in all of these
9 properties that you're gonna hear about ad
10 nauseam, Your Honor. The fact of the matter is
11 that MUSC has been building massive patient
12 towers on the peninsula over the last decade
13 and they're finishing one up now. In fact, I
14 thought it would be open by now, but that's the
15 Children's hospital that Ms. Hollingsworth
16 referenced in her presentation. So even though
17 MUSC has been seeing patients from the North
18 Charleston and Summerville areas and the Moncks
19 Corner, it now claims that it's imperative now
20 that they go out there, even though they've
21 just been building patient towers on their
22 downtown campus. And we believe that really
23 what this -- and you're gonna hear evidence
24 from our experts that say, this is really more
25 about getting up there and really serving

1 Dorchester County and the Summerville area. In
2 fact, they're located in a Summerville zip
3 code, than it is serving Berkeley County. But
4 again ---

5 THE COURT: And why is that?

6 MR. THOMAS: Why is that? Because they're --
7 because their patient origin data is lacking,
8 Your Honor. That's the only way I can describe
9 it.

10 And what you'll see is -- and I'm gonna get
11 into a little bit more in this opening, but
12 where they say their patients are coming from
13 just doesn't make sense from a health planning
14 perspective, because they're not coming from
15 Berkeley County.

16 Let's talk about hiding the ball. And this
17 is really to me a very important aspect of this
18 contested case. And the evidence is gonna show
19 you conclusively, Your Honor, that MUSC hid the
20 ball in this case in a number of ways. First
21 of all, by creating that illogical patient
22 utilization, saying this is where out patients
23 are gonna come from. Not only are they gonna
24 come from all these different areas, but
25 they're all gonna be the patients who would've

1 used us in the first place, okay. They're
2 gonna claim that their 325 million dollar
3 project will have no adverse impact on Roper,
4 Summerville, Colleton or Trident Medical Center
5 even though they're gonna be located within
6 the primary service areas of each of those
7 facilities. And you're gonna hear, oh well,
8 that's MUSC's primary service area, too. It
9 is, but they have a very small market share in
10 that area compared to these other facilities,
11 especially Trident and Summerville.

12 Now, this is one of the big things, the third
13 bullet point, is that MUSC failed to mention to
14 DHEC or anybody that one of their primary
15 motivations is to capture market share, it is
16 to capture patients. That's the word they used
17 in their internal documents and you'll see
18 that. And again, they created a false scenario
19 as to where their patients are actually gonna
20 come from and they call it -- they refer to it
21 as the Berkeley area, even though the Berkeley
22 area, apparently, contains a lot of Dorchester
23 patients, and a lot of North Charleston
24 patients. That's all the Berkeley area. Well,
25 I think that's an affront to people who live in

1 North Charleston, Your Honor, and they would
2 tell you that.

3 THE COURT: Well, back up ---

4 MR. THOMAS: Yes, sir.

5 THE COURT: --- one slide.

6 MR. THOMAS: Yes, sir.

7 THE COURT: When you say capture ---

8 MR. THOMAS: Yes, sir.

9 THE COURT: --- what are you -- capture for what
10 purpose?

11 MR. THOMAS: New patients. So what they're current
12 -- what you're gonna hear is that they're gonna
13 have no adverse affect or impact on any
14 existing healthcare system in the area because
15 100 percent of their patients are going to come
16 from patients who would've otherwise used them
17 in the first place. So, in other words, if
18 they're not there, that 128-bed hospital is not
19 there, those people would still travel all the
20 way downtown to use non-tertiary services. We
21 don't believe that's what's gonna happen. And
22 we -- well, we're gonna show you their own
23 internal documents that really are showing more
24 of an aggressive step -- stature to gain market
25 share, to capture new patients. And that's the

1 term they use, Your Honor, not the term we use.
2 We saw it in their own documents, so I'm
3 parroting it back to you from them.

4 Next slide, please.

5 Again, Ms. Hollingsworth showed you that
6 slide earlier, but kind of where their patients
7 are coming from now. And you see that they've
8 kind of broken their Tri-County area up into
9 submarkets, and they call them North
10 Charleston, Summerville, West Ashley, so on and
11 so forth. Well, MUSC -- the evidence is going
12 to show, Your Honor, that of the 4,158 med-surg
13 patients they say are going to use their
14 Berkeley County facility, they expect over half
15 to come from North Charleston and Summerville,
16 more than a third are expected to come from the
17 lower Charleston peninsula. So I'm talking
18 about where like, you know, Charleston Place
19 is, and, you know, those areas down there on
20 Legree Street and East Bay. And they also
21 think that a third -- so a third are expected
22 to come from the lower Charleston peninsula,
23 the Sea Islands, West Ashley and Mount Pleasant
24 combined. And this is where we start to think,
25 that doesn't make any sense. Why is someone

1 who lives a mile from MUSC downtown gonna drive
2 past North Summerville to use that facility for
3 inpatient care. It doesn't make a lot of
4 sense.

5 So, our question is, is this really about
6 Berkeley County, serving the patients in
7 Berkeley County, or is it really trying to get
8 up there and get patients from the Dorchester
9 area, because the patient origin just doesn't
10 make sense to our expert, Your Honor, and
11 you'll hear that.

12 So the evidence is also going to show that
13 what MUSC claimed that it's ED utilization
14 would transfer from a proposed freestanding ED
15 to a new hospital upon opening. Ms.
16 Hollingsworth referenced this. So they said,
17 well once we open this new hospital, we're
18 gonna close down that freestanding ED and those
19 ED patients will transfer here. Well now,
20 they're not saying that anymore, so there's
21 15,000 patients, ED visits they've got to
22 account for. MUSC also failed to inform DHEC
23 that's it's new hospital would enhance leverage
24 with insurers. Well, what does that mean?
25 That means increases cost to patients through

1 higher co-pays, deductibles and premiums, Your
2 Honor. That's what increased leverage means.
3 That was never told to DHEC.

4 MUSC also failed to inform DHEC that it could
5 not get traditional bank financing for a 38
6 million dollar project, which is 12 percent the
7 cost of this 325 million dollar hospital. In
8 other words, it cannot go to Bank of America
9 and some of the more traditional, TD Bank and
10 some of the other traditional banks to get the
11 financing. They can't do that any more, Your
12 Honor. They have to go to a lender of last
13 resort and it's gotta be a HUD backed loan.

14 So, and the other thing is that MUSC really
15 ---

16 THE COURT: They can't get that because of all the
17 other debt they have?

18 MR. THOMAS: That's what we believe Your Honor.

19 THE COURT: All right.

20 MR. THOMAS: They also failed to identify a study in
21 good faith of other likely cheaper alternatives
22 to a new full-service 325 million dollar
23 hospital that is not needed in the proposed
24 location. So why did they have to hide the
25 ball? Well, Ms. Hollingsworth did a great job

1 of outlining what Standard 5 is. And that's
2 the State Health Plan on the section for
3 general hospitals. And that requires
4 justification for a new hospital through
5 patient origin, okay, and effects on other
6 providers. And that's what they had to do,
7 they couldn't show that all of their patient
8 origin was gonna come mainly from Dorchester
9 and Berkeley County because then that would
10 have to, you know, that would then necessitate
11 them to provide an adverse impact analysis. So
12 they just said, no, we're gonna get 'em from
13 all over the place and 77 percent are gonna
14 come from outside Berkeley County and there
15 won't be any adverse impact on them. Well,
16 that's not good faith, Your Honor.

17 So they also needed to hide the ball to
18 satisfy the project review criteria that Ms.
19 Hollingsworth has already mentioned to you, and
20 I will move on. But at the end of the day,
21 what DHEC just decided to do was ignore the
22 protestations of five hospitals. And it wasn't
23 just the ones that are here today before you,
24 but even The Regional Medical Center of
25 Orangeburg made an appearance early on and

1 said, I mean, your own document, your own CON
2 says you're gonna get patients from Orangeburg.
3 Well, gosh, you know, we're already struggling
4 up here as a hospital. Although they did not
5 remain in the litigation, we're still going to
6 talk about it.

7 Again one of the things they had to do is
8 they had to decline to consider -- they had to
9 do this so DHEC wouldn't consider adverse
10 effects; they had to do this to show that
11 better alternatives did not exist; and
12 basically they needed to do this to get
13 approval from the Department. So the bottom
14 line is, Your Honor, when you're gonna capture
15 market share when you say you won't, when
16 you're gonna increase leverage with insurers,
17 which is not good for cost containment; and if
18 you admit that your hospital can't get
19 traditional financing for projects one-eighth
20 the cost of the hospital project, that's not
21 gonna win the day. So you can't come out and
22 actually say what your project's gonna do and
23 how it's gonna function because you're not
24 going to be approved.

25 Let's talk a little bit about this expansion

1 and these alternatives. We believe that the
2 petitioners can expand downtown through
3 renovation and new construction, even though
4 MUSC doesn't want to do that. And these were
5 kind of just throw-away rejections of a CON
6 application. There was no, as you will see,
7 the evidence is gonna show there really wasn't
8 any formal type of analysis done to see how
9 much would it cost us to renovate the
10 Children's hospital; how much would it cost us
11 to build a new patient tower on land that we
12 already own and that is very proximate to our
13 other patient towers; how much would it cost us
14 to build a parking garage that would service
15 some of that, because that's what you're
16 getting here from MUSC. Parking, wayfinding
17 and flooding; those are the three things they
18 talk about downtown and they talk about it a
19 lot. What they say about parking is that
20 there's not enough, but only recently did the
21 petitioners get some type of parking analysis
22 that we really can't figure out, but we only
23 got that a couple of months ago, maybe less.
24 They say that when patients go to MUSC they're
25 confused and they have problems wayfinding,

1 getting around campus.

2 THE COURT: They have problems with what finding?

3 MR. THOMAS: Wayfinding, Your Honor, it's ---

4 THE COURT: Way, W-A-Y?

5 MR. THOMAS: Wayfinding, yeah, yeah. Finding their
6 way about the campus. But what's interesting
7 is that, you know, you're gonna hear from their
8 own witnesses that they get very good, they're
9 called Press Ganey scores. So you may get
10 surveys in the mail after you go to the
11 hospital and they ask you, how was your
12 experience, blah, blah, blah. And they get
13 very good, excellent Press Ganey scores. And
14 they also do hundreds of thousands of patient
15 encounters on that campus downtown every single
16 year, Your Honor. I tell you, there may be
17 some people that -- you know, I have trouble
18 getting around downtown Columbia sometimes, but
19 at the end of the day, there's not a lot of
20 zombies walking around looking for where they
21 need to find their way down in the MUSC campus.
22 They do a good job of treating patients
23 downtown and this is just kind of a red
24 herring.

25 And then you're gonna hear about the

1 flooding, that this happens all the time.
2 That's what their expert testified to in his
3 deposition. It's every day there's a burst of
4 a rain shower, it's flooded down there. But
5 somehow this campus is teeming with students,
6 researchers and patients, they get found. Now,
7 your point, why am I putting up a picture of
8 flooding. On the campus where I'm talking
9 about that it doesn't happen -- I'm not saying
10 it doesn't happen. It does happen. It happens
11 in Columbia. It happens in Five Points. It
12 happens in Lake Katherine. But they took this
13 picture and they put it in their CON
14 application and they did it after a hurricane
15 or during the hurricane. Well, what do you see
16 in the background there, Your Honor? I'll tell
17 you, that's a 385 million dollar tower coming
18 out of the ground. They decided to build one
19 right there despite these absolutely horrible
20 flooding conditions. And there it is, coming
21 out of the ground, and it's about to be
22 completed. That's the Children's hospital.
23 So, despite the flooding, the parking, the
24 wayfinding, what do they do? They put their
25 major Children's hospital right down on the

1 peninsula right after they put in another big
2 tower which was called the Ashley River Tower.

3 So, how do we know this? How do we know
4 these are excuses for expanding downtown that
5 don't really hold water? Well, they've had two
6 opportunities in the last 12 years to move beds
7 off the campus and both occasions they kept
8 them on. And that was more than 1 million
9 square feet of space and over half a billion
10 dollars in costs. So, these two towers, both
11 of them, or one of them, are about twice the
12 size of this facility they want to build in
13 Berkeley County. That's what you'll see, Your
14 Honor. And it appears they were actually
15 cheaper to build the Children's hospital, which
16 is 600,000 square feet, they were able to build
17 for 385 million dollars. Well, a 128-bed
18 hospital down in Berkeley County is only
19 300,000 square feet, and that's costing 325
20 million dollars. So, you know, there's some
21 interesting issues there, Your Honor.

22 Let's go to the next slide.

23 So this is it. This is the Children's
24 hospital not during a hurricane, and you see
25 there it's coming out, it's more finished than

1 that now. And if you see that glass structure
2 behind the first one, that's the Ashley river
3 Tower that's open and operating today. And
4 that's a massive facility right there on the
5 block right next to the Children's hospital.

6 And I'm not going to go into this too much,
7 Your Honor, but one of the things that MUSC
8 does talk about is, if we can move patients off
9 -- I mean beds off the peninsula, we get
10 decant, that's their words, an interesting word
11 because I always think about wine when I think
12 about decanting.

13 THE COURT: Well, that's with an E-R on the end of
14 it.

15 MR. THOMAS: Right, right. And so they say they're
16 gonna take these patients and that's gonna open
17 up all this room downtown for these quaternary
18 and tertiary care patients that, I guess, they
19 claim they cannot treat today, but they seem to
20 have very good metrics there.

21 At the end of the day, Your Honor, they just
22 bought 714 beds at four different hospitals
23 throughout the state of South Carolina, all
24 from markets where they get a good number of
25 non-tertiary referrals. That's according to

1 their expert. And, you know, that's gonna give
2 them some breathing room, too. That's gonna
3 open up a lot of new beds because what their
4 big claim is, people want to use the MUHA
5 brand, that they want to go to MUHA. Well, now
6 the people from Florence who are driving all
7 the way past McLeod to go all the way down to
8 MUHA, there's their brand for their non-
9 tertiary services. There is now a MUHA
10 Florence; an MUHA Marion; an MUHA Chester; and
11 a MUHA Lancaster. So all the patients that
12 live in those areas who have been coming a long
13 way downtown, they're not gonna do that
14 anymore. That's gonna open up a lot of room on
15 that campus.

16 I'm not gonna go through these projects
17 because Ms. Hollingsworth already did, but at
18 the end of the day this goes to that decanting
19 issues.

20 But I do want to talk to you about this map
21 because this goes to something we were talking
22 about earlier. We're gonna see this map and
23 you can -- on the left-hand side you see a
24 large area that's got highlighter on it, that's
25 where we think they could build a tower, Your

1 Honor. It's right next to their Ashley River
2 Tower, which is right next to the Children's
3 hospital.

4 THE COURT: I see one, two, three, four, five ---

5 MR. THOMAS: Yeah.

6 THE COURT: --- highlighted ---

7 MR. THOMAS: And I'm not gonna -- this one here, you
8 don't have to worry about, I'm not gonna make
9 them take their horseshoe and build a tower
10 there. But I think they could build something
11 here, here, and then that flat parking lot is
12 a great area to build a garage. And I think
13 that's -- those are considerations that they
14 should've looked at more closely in order to
15 accommodate this bed need that was generated
16 from their hospital downtown, Your Honor.

17 So, what have we seen? You're gonna see from
18 their expert that he is going to apply
19 something called a statewide bed need
20 methodology. That's in the slides. And what
21 he did, is he said, oh, there's there all these
22 beds that are needed in Berkeley County if it
23 were an island. Well, the State Health Plan
24 shows there's no need for those beds, the
25 applicable State Health Plan. And I'm not

1 gonna get too much into the draft State Health
2 Plan, because that's going to be argued, I
3 think, as an evidentiary issues. But, needless
4 to say, Trident doesn't agree with it. It's
5 not the law. It's not -- you can't come in
6 based on the CON Act and I guess we'll get to
7 that when we get to that, Your Honor, but the
8 bottom line is, there is not a state bed-wide
9 need methodology in place in this state, and
10 therefore any, you know, any attempt to say
11 that Berkeley County needs X number of beds is
12 just invalid.

13 So, let's talk a little bit about financials
14 and I'll wrap it up, Your Honor. We believe,
15 and I think the evidence is gonna show that
16 MUSC played games with their pro formas. And
17 that's going to be very much revealed during
18 this hearing. You'll see that MUHA was able to
19 turn a third-year operating deficit into a 14
20 million dollar net income by arbitrarily
21 changing its assumptions about outpatient
22 utilization. We also believe, as Roper does,
23 that they're -- you know, they're overextended
24 and it's replying exclusively, MUSC is relying
25 exclusively on taxpayer protected debt from a

1 lender of last resort to finance this project.
2 And what's interesting, Your Honor, is even
3 their own CON application, HUD financing is not
4 guaranteed. And again, I was glad to see in
5 Roper's presentation, just because they can
6 borrow the money doesn't mean they should be
7 able to borrow the money. It's interesting
8 they have slides and internal documents that
9 show that while they meet some of the head
10 criteria, other criteria that apparently are
11 not enforced today but are somewhat advisory
12 criteria, they don't meet. But it's
13 interesting, you know what the HUD criteria is
14 for a operating margin to get a loan, just that
15 you have greater than zero percent. That, to
16 us, doesn't mean financial feasibility. MUSC's
17 own financial consultant admitted that if MUSC
18 did not have the backing of the state based on
19 it's financials, if it issued it's own bonds,
20 they would be junk bonds. As Ms. Hollingsworth
21 referenced, they have a net balance sheet
22 position of negative 623 million dollars which
23 it dismisses as nothing more than because of
24 our pension liabilities that we were forced to
25 put on our books. And you'll actually hear

1 that they think the state has a moral
2 obligation to cover that. Well, it's on the
3 balance sheet; it's on the balance sheet. And
4 maybe that's why they can't get traditional
5 bank financing because those banks see it on
6 the books, they don't see it as just something
7 you can, you know, explain away as a pension
8 liability, but it's, you know, focused in.
9 They also have a two percent operating margin,
10 which is razor thin on the revenues that they
11 generate, which is over a billion dollars.

12 So, to wrap things up, Your Honor, Trident,
13 Summerville, Colleton, we ask the Court to
14 reverse the Department's decision because it
15 doesn't comply with Standard 5; because the
16 assumptions that went into support their
17 argument of Standard 5 are invalid; there's
18 just no need for a hospital in this particular
19 area, Your Honor. And I want to -- you'll see
20 maps, but you've now seen enough to know that
21 Berkeley County, that area, Berkeley County,
22 Dorchester, tip of North Charleston, which is
23 right there where all that population, has
24 three hospital. East Cooper, which is now the
25 fourth-largest city in the state of South

1 Carolina, has two hospitals. Downtown has two
2 hospitals. West Ashley only has one. And
3 that's over there off of 526, and I think
4 Tecklenburg Boulevard, or something like that,
5 but that's -- that only has one. Maybe the
6 better place for distribution of hospital
7 services is along that side of the Ashley
8 River. But the fact of the matter is there's
9 not a need for a fourth hospital in an area
10 that has three.

11 And there are no access issues, Your Honor.
12 Okay, I showed you those graphs, those graphs
13 speak for themselves. People who need those
14 type of services, ED services and hospital
15 services, they have them within a very close
16 distance. And we believe there are better ways
17 that MUSC, a state agency, MUHA, which is the
18 authority that was created but they are tied to
19 MUSC, Your Honor, that a state agency can spend
20 325 million dollars, especially after just
21 buying four hospitals that haven't even been in
22 operation for a year under the MUHA brand.
23 Especially when their planning on building two
24 more hospitals, one in Williamsburg County and
25 northern Lancaster County which is going to

1 cost at least 200 million dollars. We haven't
2 gotten the CONS yet, but that's -- you know,
3 but we'll have that. So maybe they ought to
4 concentrate on what they have or what they're
5 going to plan to do rather than coming up to an
6 area that's already got plenty of hospital
7 services. Thank you, Your Honor.

8 THE COURT: Who's going next? Vito wins.

9 OPENING STATEMENT BY MR. WICEVIC:

10 MR. WICEVIC: May it please the Court. Thank you,
11 Your Honor. My name is Vito Wicevic and I
12 represent the Department of Health and
13 Environmental Control. This morning I have
14 here with me Rupin Grewal, assistant general
15 counsel for the Department.

16 And, kind of going along with your initial
17 question, Your Honor, I think it's good to
18 start off with some historical background for
19 general acute care hospitals in Berkeley
20 County. And I think that's necessary to really
21 understand MUHA's application. So, in 1970
22 Berkeley County had a population of just over
23 56,000 people. In 1973 the Dorchester and
24 Berkeley County hospitals closed with the
25 opening of Trident Medical Center. Like Mr.

1 Thomas said, Summerville Medical Center opened
2 around 20 years later in 1993 to provide
3 services for Dorchester and surrounding areas.
4 Fifteen years later, in 2008, both Roper and
5 Trident applied for CON applications for 50-bed
6 hospitals in Berkeley County. However, Roper's
7 application wasn't to add beds to the service
8 area. I think it's really important that their
9 application was to transfer existing beds from
10 that campus.

11 THE COURT: Transfer from where?

12 MR. WICEVIC: For the downtown campus.

13 THE COURT: Okay.

14 MR. WICEVIC: Trident's application ---

15 THE COURT: So they did some of what MUHA's
16 suggesting here?

17 MR. WICEVIC: No, sir. MUHA's using projected bed
18 need from the Plan.

19 THE COURT: Okay.

20 MR. WICEVIC: Whereas Trident was actually
21 transferring existing beds.

22 THE COURT: Existing beds, okay.

23 MR. WICEVIC: Does that make sense?

24 THE COURT: Oh, yeah.

25 MR. WICEVIC: So, Trident's ---

1 THE COURT: It's somewhat the same process, I
2 thought.

3 MR. WICEVIC: Correct. So Trident's application, on
4 the other hand, was to use some facility-
5 specific bed need. I think it was 17 beds, and
6 they sought to increase that to 50 beds for
7 construction of a cost-effective addition.
8 There was a specific provision in the 04-05
9 Plan. So the Department approved those
10 applications in 2009 and they were eventually
11 challenged before this Court. Judge McLeod
12 presided over those contested cases and he
13 wrote in his 2012 final order affirming the
14 Department's decisions finding "a lack of
15 hospital bed needs for general acute care
16 services in Berkeley County is especially
17 surprising given the explosive population
18 growth for the county in the last four
19 decades." And Mr. Thomas reference this
20 explosive population growth. And, you know,
21 this explosive growth the Judge McLeod
22 recognized has continued and is expected to
23 continue. The population of Berkeley County
24 has skyrocketed from not even 57,000 in 1970 to
25 177,843 in 2010. According to the most recent

1 population data that we've received, the
2 Berkeley County population in 2018 was 221,091.
3 And again, it's only growing. The data, the
4 projections that we received say that for 2024
5 Berkeley County population is supposed to be
6 255,510 people.

7 THE COURT: Where is that population coming ---

8 MR. WICEVIC: This is ---

9 THE COURT: --- emanating from.

10 MR. WICEVIC: It's from the Revenue and Fiscal
11 Affairs, the state demographer.

12 THE COURT: No, where do you project that the
13 population is coming from? Generally is the
14 growth in that area or is it a movement?

15 MR. WICEVIC: Industry growth in the area, it's been
16 growing for the, now, past five decades.

17 THE COURT: Okay.

18 MR. WICEVIC: So -- and, you know, not to discount
19 Dorchester and Charleston County either because
20 their population is growing, not at the rapid
21 rate that Berkeley is, and yet, despite this
22 explosive growth, there's only 100 CON approved
23 beds in Berkeley County, and only 50 of these
24 beds are currently licensed and operational.
25 And those 50 beds are, again, on a transfer of

1 existing beds for Roper. So, this
2 maldistribution of beds in tri-county, in the
3 tri-county service area with the bulk of the
4 beds being in Charleston County, it continues
5 to exist today. You know, one of the main --
6 one of the purposes of the CON Act is guiding
7 the establishment of healthcare facilities that
8 best serve the public needs. So this explosive
9 population growth in Berkeley and the lack of
10 proportional general acute care services in
11 Berkeley County support MUHA's project.

12 So the Department's decision in this matter,
13 which was made by our CON director, Maggie
14 Murdock, was to approve MUHA's application. In
15 reviewing this application, we complied with
16 all statutory and regulatory procedures. We
17 received the application on December 27th, of
18 2017. We did the requisite publications in the
19 State Register. Roper, Trident Medical Center,
20 Summerville Medical Center, Colleton Medical
21 Center and The Regional Medical Center of
22 Orangeburg and Calhoun Counties all submitted
23 letters to the Department notifying us that
24 they're affected persons in opposition to
25 MUHA's project. We eventually issued a deemed

1 complete letter in which we listed the relative
2 importance of the criteria that were to be used
3 in reviewing this application. First was
4 compliance with the need outlined in the plan;
5 second was community need documentation; the
6 third was distribution/accessibility; and the
7 fourth was the ability to complete the project.
8 The Department conducted a project review which
9 allowed applicants and various affected persons
10 to submit written opposition or support of the
11 MUHA project. And the various parties
12 submitted such written opposition and support.
13 On July 23rd, 2018, the last day of the review
14 cycle, and after careful consideration of the
15 entire administrative record, the Department
16 staff issued its decision approving the
17 application.

18 With regards to compliance with the Plan, the
19 2017 2018 Plan kind of sets forth several
20 different avenues in which an applicant can
21 establish a hospital or add general hospital
22 beds. And now while the service area had a
23 surplus of beds, MUHA had an individual need of
24 147 beds, and ultimately staff determine that
25 the project was consistent with Standard 4.

1 You know, they sought to use the projected bed
2 need to establish this new hospital and their
3 patient origin and another data, they justified
4 the need for the hospital at the chosen site.

5 THE COURT: You just said Standard 4?

6 MR. WICEVIC: Standard 5.

7 THE COURT: Yeah.

8 MR. WICEVIC: I'm sorry, Standard 5. And this data
9 is seen in Section B(11) under application.
10 And Ms. Murdock did a detailed analysis of this
11 and she's gonna provide testimony about that
12 analysis and our ultimate determination that
13 the project was consistent with the Plan.

14 Community -- moving on to the compliance with
15 the project review criteria. First one,
16 community need documentation. They identified
17 the target population and the primary service
18 area was Berkeley, Dorchester and Charleston.
19 And the secondary service area was surrounding
20 areas. They used population statistics from
21 Claritas, which again demonstrates a
22 significant population growth, particularly in
23 this primary service area. And it demonstrated
24 that this project will meet a need. Then all
25 of MUHA's general acute care hospital beds are

1 located at it's downtown campus, however a
2 substantial portion of patients are -- come
3 from the North Charleston, Dorchester and
4 Berkeley County areas. So the premise of their
5 project is that these adult lower acuity
6 patients originating from that area will be
7 seen and cared for at the project. The chosen
8 location, the Nexton area is an emerging
9 community and it's suitable, right there on I-
10 26 to serve these patients of MUHA.

11 THE COURT: How about their argument that some of
12 the patients are going to be coming from the
13 peninsula and they're gonna have to drive right
14 past the hospital.

15 MR. WICEVIC: Sure. And Ms. Murdock will provide
16 testimony about how she considered that.

17 THE COURT: Okay.

18 MR. WICEVIC: Yeah.

19 THE COURT: Ms. ---

20 MR. WICEVIC: Ms. Murdock, she'll provide testimony
21 of her consideration of those types of ---

22 THE COURT: She's with DHEC?

23 MR. WICEVIC: Yes; yes, Your Honor.

24 So, ultimately we felt like MUHA demonstrated
25 that the projected utilization of the project

1 was sufficient to justify it's implementation.
2 Again, she did an in-depth review, Ms. Murdock
3 did, of the projections and assumptions and the
4 methods, and ultimately determined that the
5 project met the criteria for community need
6 documentation.

7 Distribution/accessibility, MUHA's project,
8 again, is based upon serving these existing
9 adult lower acuity patients that originate from
10 areas close to the project. They made these
11 reasonable assumptions and adjustments. The
12 Department staff ultimately determined that
13 there's not going to be an unnecessary
14 duplication of services. It will include an
15 additional 128 beds in the area. This will
16 increase the availability and accessibility to
17 general acute care services in Berkeley. MUHA
18 represented that their patients will have
19 access to the project through self-referral and
20 internal and external referrals, and they're
21 not placing any kind of limits on the mission
22 to the facility. They're going to provide
23 healthcare regardless of a patient's ability to
24 pay.

25 The final criteria identified by the

1 Department was the ability to complete the
2 project. MUHA demonstrated that their
3 project's going to be completed within the time
4 frame of the application. They have a history
5 of timely completing applications and
6 implementing their CONs. Their CFO indicated
7 that they're going to finance this project
8 through an FHA insured, tax-exempt loan or
9 through a Ginnie Mae insured taxable loan, both
10 of which will be insured by the HUD Section
11 242, Hospital Mortgage Insurance Program.
12 Again, they have experience going through this
13 process and receiving mortgage insurance
14 through that process.

15 THE COURT: I heard something about 18 percent, I
16 think it was, of the loan's gonna have to go
17 through another loan, loaner, I guess I should
18 say. Did you consider that?

19 MR. WICEVIC: Did we consider that the -- the fact
20 that MUHA's having to go through HUD to get
21 financing?

22 THE COURT: Well, I don't know all the terms that
23 y'all argue ---

24 MR. WICEVIC: My understanding ---

25 THE COURT: They indicated that it was a more of a

1 risky type of loan or ---

2 MR. WICEVIC: Well, they've done it before.

3 THE COURT: Okay.

4 MR. WICEVIC: So they have a history of doing it.

5 The children -- the new Children's hospital, I
6 understand, was -- went through the same
7 program.

8 THE COURT: Okay.

9 MR. WICEVIC: So it's not something new that MUHA is
10 going through.

11 So, ultimately staff determined based upon
12 the information that MUHA submitted that they
13 do have that ability to complete the project
14 and they met that criteria.

15 The final thing is, in Section 501 findings,
16 because this is an institutional health
17 service, the Department was required to make
18 the Section 501 findings in order to grant the
19 CON. Ms. Murdock will provide testimony
20 regarding the bases for this finding, those
21 findings.

22 In conclusion, I think the Department did not
23 rubber stamp this application, they performed a
24 thoughtful and careful review of everything
25 that was submitted to them which included a

1 significant amount of written opposition from
2 the petitioners, and ultimately determined that
3 the application substantially complied with the
4 Plan and the relative importance criteria, and
5 accordingly, the staff granted the application.
6 The Department looks forward to presenting its
7 case and it requests that the Court uphold its
8 decision. Thank you.

9 THE COURT: How are y'all doing over there?

10 (No audible response.)

11 THE COURT: All right.

12 OPENING STATEMENT BY MS. CRUM:

13 MS. CRUM: Good morning, Your Honor. I'm Liz Crum
14 and with me today are my law partners Celeste
15 Jones and Pam Baker. And we also have with us
16 Ms. Caitlyn Bobo who is the program manager for
17 special projects for MUHA.

18 These cases, as Your Honor knows, arise from
19 the CON Act and the Administrative Procedures
20 Act. As one of the counsel said, this is a de
21 novo hearing. And as a de novo hearing, Your
22 Honor will consider not only what was before
23 DHEC in the CON DHEC record, but also the
24 actual testimony as supposed to argument of
25 counsel, like myself, that will be put before

1 you, the testimony and evidence. In order to
2 approve this application, it does not have to
3 satisfy every project review criterion, but it
4 does have to satisfy the State Health Plan.
5 Specifically the 2017 State Health Plan that's
6 in effect. And, as has been argued, you can
7 consider the 2018 Plan.

8 MUHA is one of the premier academic medical
9 centers in the United States of American. It
10 has been recognized as such by U.S. News and
11 World Report and other very credible
12 organizations. The petitioners do not and have
13 not contested that fact. MUHA is a state
14 agency. And as we said in our Motion to Lift
15 Stay, we're proud of the fact that we're a
16 state agency. It's mission is established by
17 our Generally Assembly. It has three prongs.
18 First, it is a teaching and training facility.
19 It teaches and trains our future physicians,
20 nurses, dentists, therapists and other allied
21 healthcare professionals to serve South
22 Carolina. Second, it is required to conduct
23 medical research, which clearly is a benefit to
24 the public and to the residents of South
25 Carolina, and in our case, beyond. Third, it

1 treats and takes care of the needs of the
2 citizens of South Carolina and beyond. That is
3 it's legislative mandate.

4 MUHA's bed need is uncontested. We have a
5 bed need for 147 beds under the State Health
6 Plan right now, the 2017 Plan. It is
7 institutional-specific, absolutely, we grant
8 that, but under Standard 5 of the State Health
9 Plan you can move those -- you can take those
10 transfer beds, those needed beds and transfer
11 them to anywhere in the tri-county area.
12 Berkeley is a part of that area. The 2018 Plan
13 shows a need for 157 beds. It's interesting
14 there's been a lot of argument that we could
15 put our beds and we can put all of our beds on
16 the downtown peninsula campus which is
17 absolutely crowded, has no parking, and, we
18 admit, is susceptible to flooding. There was
19 a need for 52 beds in the 2012-13 Health Plan.
20 We did get CONs to put those beds downtown.
21 The 2017 Plan showed an additional 147 beds.
22 So we put 52 back in. The 147, we wanted to
23 transfer and applied to transfer 128 to
24 Berkeley County. Let me just say one thing
25 here, to make sure this is clear, the 52-bed

1 CON application that Trident put in in 2008
2 under the 2004-5 Plan, they had a bed need, and
3 institutional-specific bed need for Trident
4 Medical Center in Charleston County of 42 beds.
5 They took 25 of those beds and they put them in
6 place at Trident Medical Center in Charleston
7 County. Then they took the 17 additional bed
8 needs and did a CON application to put those
9 beds in Berkeley County, transferring the bed
10 need just as we're proposing to do today, but
11 then they built the 50-bed hospital as an
12 economical hospital unit as allowed in the
13 2004-5 Plan and is still allowed today. But we
14 just transferred the 128 beds in Charleston
15 County to Berkeley, just like they did. That
16 hasn't changed.

17 Roper actually asked to put their CON of the
18 50 beds at their hospital in Carnes Crossroads.
19 It's close to Nexton, but the Nexton property,
20 you'll hear during this trial, you'll hear the
21 MUSC Berkeley County, MUHA Berkeley County
22 Hospital sometimes referred to as the Nexton
23 Hospital because it is actually in the Nexton
24 area.

25 Your Honor said that you weren't so familiar

1 with Berkeley County. Berkeley County, one
2 thing to know about it, the maps you saw,
3 they're large areas of Berkeley County that you
4 can't build anything on. Namely Lake Marion
5 and part of Lake Moultrie. In the east you
6 have Francis Marion National Forest, which is
7 a very large area that you can't build a
8 hospital, it's not accessible. It's federal
9 property and MUSC can't put their hospital
10 there. So, if we're gonna but beds in Berkeley
11 County, we are constrained as to where we can
12 put them. And as you have heard from everyone,
13 the growth in Berkeley County is, and the
14 growth in the tri-county area for that matter,
15 Your Honor, is up the I-26 corridor to the
16 north and west. The map that I believe Roper
17 put up very well shows from an aerial photo
18 where the growth is and where the population
19 is. And obviously from a health planning
20 standpoint, you have to have access to a
21 hospital. You can't just put it out in the
22 middle of nowhere or on farming market road
23 that doesn't have access.

24 THE COURT: You said from a health planning
25 standpoint you have to have access ---

1 MS. CRUM: Yes, sir. That's one ---

2 THE COURT: --- to the hospital?

3 MS. CRUM: Yes, sir. Accessibility is one of the
4 foundations of whether or not you increase
5 accessibility or not. It's one of the things
6 you have to look at. So putting a hospital out
7 on a road that has no population and limited
8 access makes no sense from an healthcare
9 standpoint.

10 Your Honor, we've heard a lot of testimony
11 about -- I'm sorry, a lot of argument about the
12 fact that MUHA downtown is congested. Well, it
13 is. And it is very busy. It's got the only
14 level I trauma center in the tri-county area,
15 and it has the only level I -- level IV NICU.
16 You have lots of folks coming right down I-26,
17 coming from East Cooper, coming from West
18 Ashley, and they are passing the hospitals that
19 you've seen on the maps in order to get to MUSC
20 and it is for non-tertiary care services, not
21 just tertiary and quaternary, but non-tertiary
22 and quaternary. Therefore, there is every
23 reason to expect that going up the corridor
24 they're gonna pass these same hospitals to get
25 to MUHA Berkeley. Everybody has agreed, Your

1 Honor, that patients have a choice in their
2 healthcare of their healthcare providers and
3 that good healthcare planning generally
4 includes following the population growth and
5 putting facilities where the population is.

6 There're gonna be a couple of things that
7 you're going to hear from MUHA witnesses that's
8 uncontested. First, that the Medical
9 University Center downtown, and you've heard
10 the reference to University and Children's, is
11 operating under severe capacity constraints in
12 terms of high patient utilization and occupancy
13 to the point that it is routine that patients
14 are having to be housed in hallways with only
15 screens protecting them. That's called
16 boarding. You're gonna hear Dr. Bohr (ph) who
17 is our medical officer who is going to testify
18 to the problems that they've had with that.

19 MUHA, the MUHA Berkeley Hospital will be an
20 integral part of the MUHA teaching and training
21 mission, and it will help train the physicians
22 and nurses that this state so desperately
23 needs. You heard a lot about the staffing.
24 Well, that's one of the ways to help solve it
25 is to have additional access to training sites,

1 and that's what MUS- -- MUHA Berkeley will
2 provide.

3 Going back to the constraints, you've heard
4 about the CHS hospitals. What has happened
5 with those purchases is that has helped -- that
6 has further exacerbated the constraints because
7 the testimony will show that patients from the
8 Florence and Lancaster areas that used to go to
9 North Carolina are now coming to MUSC.

10 It's interesting to me that the petitioners
11 who actually have to ---

12 THE COURT: So I guess you're filtering Duke?

13 MS. CRUM: I'm sorry?

14 THE COURT: You're filtering patients that used to
15 go to Duke back down to Medical University, is
16 that what you're saying?

17 MS. CRUM: No, sir. I'm not saying they refuse to
18 go anywhere.

19 THE COURT: No, I said filtering. You said they
20 used to go to North Carolina. I assume ---

21 MS. CRUM: Well, yes, sir. They used to go to North
22 Carolina and that would be Lancaster also
23 because in Lancaster they could go to either
24 Presbyterian or Atrium ---

25 THE COURT: Oh, okay. I got it now.

1 MS. CRUM: It's the two different areas, Your Honor.

2 THE COURT: Oh, okay.

3 MS. CRUM: Yes, sir.

4 The concept of the parties that have the
5 burden of proof trying to second guess the
6 Board of Trustees of the University and the
7 University's management to say, well, you know,
8 you've got these additional 147 beds and you
9 can just shoehorn them, that's my word not
10 their's, but you can just shoehorn them into
11 the space that was vacated by the -- from the
12 Children's hospital and University Hospital and
13 the beds that were moved to Shawn Jenkins when
14 that -- that will be moved when Shawn Jenkins
15 opens. It's kind of silly actually. First
16 off, the beds that were moved from the
17 Children's hospital, it's not the entire
18 hospital that's vacated. Bassinets, or 66 of
19 them. The bassinets are not -- they're not
20 beds. You know, Your Honor, they're just
21 little cubicles. They're not headboards that
22 you can put a bed in. The other thing with the
23 University Hospital and the current Children's
24 hospital, they're both older facilities and the
25 bed space does not meet the current standard of

1 care and best practices for provision of
2 services in healthcare facilities, particularly
3 not in academic medical centers. Clearly the
4 shoehorn approach that they have does not
5 comply with the CON purposes of best meeting
6 the public needs and ensuring high quality
7 services.

8 This -- the older conform- -- nonconforming
9 or the older space that doesn't meet best
10 practices is also needed by MUHA to be
11 renovated to help support the existing
12 quaternary and tertiary services which are
13 provided at the hospital. An example of that
14 is the need for additional organ transplant
15 space.

16 We'll have -- hear testimony from MUSC that
17 as an academic medical center it's patients
18 have a longer average length of stay than do
19 traditional hospitals and that our average
20 length of stay complies with the benchmarks of
21 our peer medical center, just like Roper, and
22 I should say Roper St. Francis, and Trident
23 Healthcare System or HCA. They have -- Roper
24 -- we have a loyal base of physicians and a
25 loyal base of patients. And the patients

1 choose to come see us. And by the way, Mr. --
2 well, Trident's counsel said that there were
3 five hospitals. In fact, there're two
4 healthcare systems, HCA which is the largest
5 healthcare system in the world, and the Roper
6 St. Francis Healthcare System, which consists
7 of four hospitals, that have actually sought a
8 contested case hearing, Your Honor. You're
9 gonna have testimony from our architect that
10 the cost to construct the MUHA Berkeley
11 Hospital is reasonable and our pro forma
12 actually contains a significant number of
13 contingencies.

14 Maldistribution. You heard Mr. Wicevic
15 testify about maldistribution in the tri-county
16 area. Right now -- and this is pure math, and
17 I can at least do pure math, not much else.
18 But 5.4 percent of the beds in Berkeley County
19 or 5 percent of the beds in the tri-county area
20 and Berkeley County, and Berkeley County has
21 28.6 percent of the population. Charleston
22 County 87.9 percent of the beds and 50.1
23 percent of the population.

24 I'm gonna talk just a little bit more about
25 the 2012 applications, not much because Mr.

1 Wicevic just covered that well. Roper sought
2 to transfer 50 beds from downtown to Berkeley
3 to make it more accessible to their patients.
4 It was specifically based on their patient need
5 under their CON application, not for the entire
6 county, their patients. The interesting thing,
7 Mr. Richardson, who is Roper's -- was Roper's
8 expert in the 2012 case and is their expert
9 here, testified that if Berkeley County were a
10 distinct unit, it would have a bed need for
11 non-tertiary beds for 286 beds in 2017. It's
12 2- -- it's the end of -- almost the end of 2019
13 now, Your Honor.

14 Your Honor, it's been almost 16 months since
15 DHEC approved MUHA's 128-bed application.
16 Here's what's happened. The constraints at
17 MUHA downtown have not gotten better, they've
18 gotten worse. Access to the Charleston
19 peninsula has only gotten worse due to
20 increased traffic and more frequent flooding.
21 You've got a lot of tourists visiting now.
22 Your Honor asked about the growth in Berkeley
23 County, a lot of that growth is driven by the
24 new industries such as Volvo, people moving in.
25 A lot of that growth is also driven by the fact

1 that people can't afford to live in Charleston
2 now, and they're moving out to affordable
3 housing in Berkeley and Dorchester counties and
4 driving every day into work.

5 THE COURT: Okay. Well, that's what I was asking
6 about.

7 MS. CRUM: Yes, sir. And the MUHA bed need has
8 increased. The number of patients MUHA gets
9 from Berkeley County has increased. And the
10 cost of construction has escalated. As our
11 architect testified in her deposition, every
12 day the lawyers have his hands on it, their
13 hands on it, the more the cost goes up.

14 The I-20 corridor and population continues to
15 increase and move up the corridor. The
16 population of Berkeley County, as shown by the
17 new data that Mr. Wicevic referenced, the 2019
18 population data from Revenue and Fiscal
19 Affairs, RFS, shows that the population in
20 Berkeley County has increased more than was
21 projected in the 2017 and '18 Plans, and the
22 population in Charleston County has increased
23 less than projected. And, in fact, the
24 population in Dorchester, the forecast is that
25 it will decrease slightly. Good health

1 planning dictates that the hospital be located
2 in Nexton, in the heart of the northward
3 population explosion in Berkeley County. And,
4 by the way, I'm not sorry to use the word
5 explosion because that's what it is. And that
6 the location be on or near the I-20 corridor.
7 We used a historical -- our historic service
8 area, and if you put the 120 beds in Berkeley
9 at Nexton, it makes the beds more accessible to
10 the MUHA lined patients and to the growth in
11 MUHA's historic service area, and prevents them
12 from having to continue going downtown, driving
13 past existing healthcare facilities and going
14 to the area that is increasingly congested and
15 has increasing traffic jams. MUHA's mission,
16 which is required by law to carry out, is
17 consistent with the purposes of the CON Act.
18 It defies good health planning, logic and
19 common sense to put 128 new beds on the land-
20 locked downtown campus with no parking increase
21 -- with no parking, increasingly congested
22 traffic and increasingly -- increase in
23 flooding. And, Your Honor, it's interesting
24 that they've suggested that we can build
25 downtown. That shows they don't contest the

1 need, all they really are contesting is the
2 location. It's an envy, not in my backyard.

3 Your Honor, good health planning, logic,
4 common sense and the purposes of the CON Act
5 dictate that the DHEC decision be upheld and
6 that this Court order the CON to be issued, and
7 we would so request. Thank you, sir.

8 THE COURT: All right, y'all. Are we gonna call a
9 witness or are we gonna take a break for lunch?

10 MS. HOLLINGSWORTH: Well, Your Honor, following along
11 kind of with the schedule that we had earlier
12 discussed, it would be my suggestion that we
13 take a break and maybe even sort of a little
14 bit longer lunch break. We just have one
15 witness that we'll put up. Mr. Bosse is here.
16 And I do think we will put him up and he will
17 be done in the afternoon, so.

18 THE COURT: Okay.

19 MS. HOLLINGSWORTH: If that suits your schedule,
20 Your Honor, we'd be happy to do that.

21 THE COURT: Well then, do we want to be back at one
22 o'clock, I guess?

23 MS. HOLLINGSWORTH: That suits us fine.

24 MR. SUMMER: Thank you, Your Honor.

25 THE COURT: All right, we'll do that. Thank y'all.

1 (A break was taken from 11:37 a.m. until 1:00 p.m.)

2 COURT REPORTER: All rise.

3 THE COURT: Y'all be seated. All right. Well, I'm
4 tired but I think this titillating testimony
5 that I'm about to hear is going to keep me
6 awake.

7 (Laughter.)

8 MS. JONES: Fingers crossed.

9 MS. HOLLINGSWORTH: I don't have any of Mr. Thomas'
10 slides from his PowerPoint available to me,
11 though, Your Honor, so I -- it's probably not
12 going to be near as entertaining.

13 THE COURT: Oh, you think his slides were
14 titillating?

15 MS. HOLLINGSWORTH: He does what he can.

16 THE COURT: I have to go look at the new definition
17 of titillating.

18 PETITIONER ROPER'S CASE IN CHIEF:

19 MS. HOLLINGSWORTH: Your Honor, we would like to
20 call Patrick Bosse to the stand.

21 COURT REPORTER: Right here. Before you sit, please
22 state and spell your name.

23 MR. BOSSE: Patrick Bosse. P-A-T-R-I-C-K. B-O-S-S-
24 E.

25 COURT REPORTER: You can come to this chair right

1 here and raise your right hand, please.

2 MR. BOSSE: (Witness complies.)

3 COURT REPORTER: Do you solemnly swear the testimony
4 you're about to give in this matter is the
5 truth, the whole truth and nothing but the
6 truth, so help you God?

7 MR. BOSSE: I do.

8 COURT REPORTER: Thank you.

9 MR. BOSSE - DIRECT EXAMINATION BY MS. HOLLINGSWORTH:

10 **Q: I'm sure your nerves are completely at ease now**
11 **that the pressure is on, Mr. Bosse. But, if**
12 **you would, you have the pleasure of starting us**
13 **off this afternoon. You've provided your name**
14 **for the record. Would you tell the Court just**
15 **a little bit about Roper St. Francis?**

16 **A: Sure. So, Roper St. Francis is a not-for-**
17 **profit healthcare system located in Charleston.**
18 **We've got about 5700 employees and outpatient**
19 **clinics throughout the lowcountry. We have four**
20 **acute care facilities: Roper Hospital, which is**
21 **downtown; Mount Pleasant, which is north of**
22 **Mount Pleasant; St. Francis, which is in West**
23 **Ashley; and then our newest hospital, Berkeley**
24 **Hospital, which is in Berkeley County.**

25 **Q: And the four hospitals, do you have any other**

1 outpatient departments in that area?

2 A: We do. We have Moncks Corner Medical Plaza,
3 which is -- it's on the Roper Hospital CON
4 license and it's an outpatient at -- has
5 outpatient services and a freestanding ED.

6 Q: All right. And do you have another
7 freestanding ED?

8 A: We do. Northwoods, which is kind of in the
9 North Charleston area, serving that area.

10 Q: All right. And how long has the -- and I think
11 we called it -- has it gone through a name
12 change, the Moncks Corner Medical Park?

13 A: It has, Medical Plaza.

14 Q: How long has that Medical Plaza been in Moncks
15 Corner?

16 A: Nearly 30 years. I think it's actually about
17 27.

18 Q: And before we kind of get deeper into those
19 details, let's tell the Court a little bit
20 about yourself. And if we could pull up
21 Roper's Exhibit 6 on the screen.

22 (RSF Exhibit 6 was referenced at this time.)

23 Q: And, Mr. Bosse, can you tell us what that
24 document is?

25 A: This is my CV.

1 Q: All right. And ---

2 OBJECTION:

3 MS. JONES: Your Honor, a CV is hearsay. The
4 witness is in the courtroom, and I object.

5 THE COURT: Well, it hasn't been admitted, number
6 one. I mean, or even offered.

7 MS. JONES: Well, I know, but he's testifying from
8 it and it's up on the screen. So I ---

9 THE COURT: Well, if that's the objection, then we
10 would -- do you -- what's your response to
11 that?

12 MS. HOLLINGSWORTH: Your Honor, I'm happy to go
13 ahead and prove it through him. The point of
14 the document is his testimony will be
15 consistent with his knowledge, skills and
16 experience, and it would move us along.

17 THE COURT: Yes.

18 MS. HOLLINGSWORTH: But I'm happy to have him
19 authenticate it ---

20 THE COURT: Okay.

21 MS. HOLLINGSWORTH: --- and describe it, if that
22 would work for the Court.

23 THE COURT: Okay.

24 MS. JONES: It's still hearsay under 803.

25 MS. HOLLINGSWORTH: Your Honor, I think the document

1 is -- this client -- this is his document, he
2 wrote it, it's consistent with his testimony.
3 He prepared it. I mean, that's like saying his
4 words are hearsay. I mean, this is ---

5 THE COURT: Well, I mean, he can't ---

6 MS. HOLLINGSWORTH: He is in the courtroom to
7 testify ---

8 THE COURT: I get it.

9 MS. HOLLINGSWORTH: --- about the document.

10 THE COURT: I get it. That's the first time someone
11 has ever objected to that, but on the other
12 hand, she does have a point. I mean, is that
13 -- to say that it's his words would mean that
14 you can just take anything you wish to testify
15 to and present an exhibit. I think the
16 response would be -- well, I'm not gonna give
17 you that.

18 MS. HOLLINGSWORTH: Well, Your Honor, the equivalent
19 of, we can sit here and read this whole thing
20 in and it's his testimony. I mean, this is a
21 document that's not dissimilar from a business
22 record. He prepared this document, it's his
23 historical information, this is his testimony.
24 And, you know, certainly he's here in the
25 courtroom, it's not an out-of-court statement.

1 He is here to testify about the document, so I
2 would submit, Your Honor, this is consistent
3 with ---

4 THE COURT: Go ahead.

5 MS. JONES: That's my point. He gets to testify as
6 to his qualifications. He can't put his CV in.
7 The CV itself is an out-of-court statement that
8 is not admissible because it's hearsay under
9 803. The witness can tell the Court what his
10 qualifications are but the CV is not admissible
11 -- admissible.

12 MS. HOLLINGSWORTH: But, Your Honor, it's not an
13 out-of-court statement. He is the declarant.
14 He is here in the courtroom testifying. He's
15 not an expert. This is just to get us through
16 his education and his work experience.

17 THE COURT: Well.

18 MS. HOLLINGSWORTH: But, you know, it just seems to
19 me that we're already kind of starting off on
20 a rough foot, but I -- the declarant is here,
21 it's not an out ---

22 THE COURT: Well, I'm gonna, at this point in time,
23 having not researched it further, I'm gonna
24 sustain the objection.

25 MS. HOLLINGSWORTH: That's fine, Your Honor.

1 THE COURT: You can go into it in depth.

2 MS. HOLLINGSWORTH: Your Honor, I think where we are
3 speaks for the process that we'll use, that's
4 fine.

5 Q: Mr. Bosse, if you would, where did you go to
6 college?

7 A: Villanova University.

8 Q: Okay. And tell us, what did you study at
9 Villanova?

10 A: So, I received a -- my major was in political
11 science with a minor in business. I graduated
12 in 2006.

13 Q: Okay. And do you have any other education
14 after that?

15 A: I do. After I graduated from -- finished
16 undergrad, I went to MUSC to receive my
17 masters, my MHA, masters in healthcare
18 administration.

19 Q: Okay. When did you graduate with your masters
20 degree?

21 A: 2008.

22 Q: And what did you study as part of that program?

23 A: Essentially the administrative aspect of
24 healthcare.

25 Q: And what did you do after that?

1 **A:** After I finished my masters, I went to -- I
2 moved to Charlotte and did a residency at
3 Carolinas Healthcare System. I was -- I did
4 that for a year. I was located out of the main
5 hospital of the system, Carolinas Medical
6 Center, which is a large, I think its about
7 800-bed facility. It's a level I trauma center
8 and is their -- their hub.

9 **Q:** Okay. Make sure you speak up enough so the ---

10 **A:** I'm sorry.

11 **Q:** --- court reporter can hear you.

12 **A:** Sorry.

13 **Q:** All right.

14 THE COURT: And me.

15 **A:** Sorry.

16 MS. HOLLINGSWORTH: Yes.

17 **Q:** A fellowship at, you said, Carolinas Medical
18 Center?

19 **A:** Correct.

20 **Q:** What did that entail? Just describe, what was
21 the fellowship for?

22 **A:** So, as a fellow you're part of the -- like a
23 junior member of the administrative team. So
24 you sit in, you work with the senior leadership
25 team and you're present with them for strategic

1 planning, all things regarding the
2 administration of the hospital. You're given
3 projects for that year throughout various
4 departments of the hospital and the healthcare
5 system to kind of expand knowledge and breadth
6 and understanding of what you're doing within
7 healthcare.

8 Q: Okay. And how long did you do that fellowship
9 for?

10 A: It's a one-year fellowship. When I completed
11 that, I remained at Carolinas Medical Center.
12 I was hired as the business manager of
13 perioperative services.

14 Q: Okay. And what is that?

15 A: So, perioperative services is a department that
16 essentially the operating rooms fall under.
17 So, everything that touches the operating room:
18 anesthesia; operating room; pre-op; PACU;
19 materials management for the operating room;
20 pre-op services, all fall under perioperative
21 services.

22 Q: Okay. And this was at the Carolinas Medical
23 Center?

24 A: Yes, at the flagship, yes.

25 Q: All right. And what were your responsibilities

1 as a business manager of the perioperative
2 services?

3 A: So, my responsibilities included management of
4 the revenue cycle, cost containment projects
5 and working with my director on materials,
6 processes, in terms of bringing in various
7 supplies into the system.

8 Q: Okay. And then did you change roles at some
9 point?

10 A: I did. So I was promoted to director of
11 business operations for perioperative services.
12 And so my role expanded to include not only
13 just the revenue cycle like I had prior, but
14 also the materials management and functions of
15 the OR, scheduling, budget development,
16 strategic planning for the department, and
17 tasked with a focus on deficiencies.

18 Q: Okay. And approximate how long did you work in
19 that kind of role with Carolinas?

20 A: So, I was at Carolinas for, I think, seven
21 years. Six of them in perioperative services
22 and, I believe, as the director for two or --
23 I think two years.

24 Q: All right. And any specific projects that you
25 recall that you worked on during that time?

1 **A:** The biggest focal point was, like I mentioned,
2 efficiencies and utilization. We had a very
3 busy OR. They were on that -- on the main
4 site. We had an outpatient and inpatient
5 operating rooms. I think they totaled over 30
6 with them on that campus. And we had high
7 volumes, doing over 30,000 surgeries a year in
8 those two settings. So there was a lot of, a
9 lot of volume coming through and a need to
10 create efficiencies because we were -- you're
11 not always able to grow your volume just by
12 purchasing order, so we had to figure out how
13 to do things most efficiently with what we had.

14 **Q:** Okay. And what about did you have occasion to
15 work on construction or renovation projects?

16 **A:** Yes. We did do -- shortly after I got there we
17 did do a renovation and minor expansion project
18 of our ORs.

19 **Q:** Okay. And so what did you do after you --
20 after that role with Carolinas?

21 **A:** So, after I left Carolinas, that's when I came
22 to Roper St. Francis. I arrived in, I believe
23 it was 2015. And I came to the system as the
24 service line director of neurosciences.

25 **Q:** Okay. And so just tell us what is

1 neurosciences?

2 A: Sure. So, neurosciences has responsibilities
3 over neurosurgery, the neuro-hospitalists,
4 which are our stroke team, and pain management.
5 So, as the service line director, it's
6 outpatient responsibilities. So, essentially
7 helping to grow their practices and -- through
8 strategic, strategic planning, budget --
9 budget processing and things like that.

10 Q: Okay. How many folks were you responsible for?

11 A: I don't recall the exact number but physician-
12 wise, physician and I'll say provider, the
13 physicians and the APPs, it was probably over
14 40.

15 Q: Okay.

16 A: Within that service.

17 Q: And you said you were the service line director
18 for neurosciences, is that right?

19 A: Yes, it is.

20 Q: And did you add any other responsibilities?

21 A: I did. So about a year into my tenure at Roper
22 St. Francis, I was also given the
23 responsibility of our surgery service line. So
24 the responsibilities were -- were the same as
25 what I was doing with the neurosciences, it

1 just also now included all the departments that
2 roll up under surgery, which would include
3 general surgery, urology, bariatrics,
4 cardiothoracic, urology, etcetera.

5 Q: Okay. And you described four hospitals when
6 you first introduced the system to us. Were
7 you at one particular hospital?

8 A: So, it's a -- service line director is a system
9 roll within our organization, so you're
10 responsible for the oversight of that service
11 throughout the system, not just at one
12 facility.

13 Q: And how did your, kind of, leadership reporting
14 chain work?

15 A: So, I reported to -- when I arrived I reported
16 to the CEO of St. Francis which was Allen
17 Carroll. He left and then I started reporting
18 to Steve Porter, who was also CEO.

19 Q: And did you transition to another roll?

20 A: I did. So I think it was 2018 I transitioned
21 to the director of Berkeley Hospital
22 development.

23 Q: Okay. And what did that mean?

24 A: So, when I took on that responsibility the
25 Berkeley Hospital site had just come out of the

1 ground, so steel was up. And so my
2 responsibilities were essentially management of
3 the project. Very simply put, it can be
4 paralleled to like a project management
5 position where I had responsibility of working
6 with: our contractors, our construction teams;
7 our IS group to ensure, you know, that we're
8 building the infrastructure for the facility;
9 our nursing teams to make sure that we're
10 staffing -- getting ready, staffing in a timely
11 manner and appropriately; our physicians, make
12 sure we've got a medical staff when the doors
13 open. So really my responsibilities include
14 anything and everything to make sure the
15 hospital opened on time and successfully.

16 Q: And this role was specific to Berkeley
17 Hospital?

18 A: It was, yes.

19 Q: And, so tell us, is that still the title you
20 have today?

21 A: It is not. My current title is chief
22 administrative officer of Berkeley Hospital.

23 Q: And what has changed?

24 A: So, the director of development position was
25 more of a getting ready, making sure we're

1 going to open the hospital, and the chief
2 administrative officer is more responsibility
3 and oversight of the success of the
4 operationalization of the hospital.

5 Q: Okay. And who do you report to in your role as
6 chief administrative officer?

7 A: I report to Anthony Jackson. He's the vice
8 president and CEO of the acute care divisions
9 for Roper St. Francis. And the acute care
10 divisions are essentially at four hospitals, so
11 he's got oversight over all four hospitals.

12 Q: Okay. Let's take a look at Roper's Exhibit 5,
13 please.

14 (RSF Exhibit 5 was referenced at this time.)

15 Q: Yeah. And, there's notebooks behind you, Mr.
16 Bosse. I don't know if you -- it might be
17 helpful. It should be tab five.

18 A: Okay.

19 Q: If you could, just review those documents and
20 identify them.

21 A: So, these would be our updates that we provide
22 to DHEC on a project.

23 Q: And are you familiar with these documents?

24 A: I am, yes. They would be prepared by Shannon
25 Cantwell, who is our regulatory affairs

1 specialist and submitted by her. She would
2 work with -- she'd seek input on the documents
3 to appropriately update DHEC, which would
4 include feedback from me.

5 MOTION TO ADMIT:

6 MS. HOLLINGSWORTH: Your Honor, we would move to
7 admit Roper St. Francis Exhibit 5 into
8 evidence.

9 MS. JONES: I don't have any objection to the
10 authenticity, but I don't know the relevance of
11 it. It's about their Roper Hospital, not what
12 we're here about.

13 THE COURT: I'll overrule your objection.

14 (RSF Exhibit 5 was admitted into evidence.)

15 Q: Mr. Bosse, are you familiar with the project
16 cost for the Berkeley Hospital project?

17 A: I am. We came in at about 117 million dollars.

18 Q: And, as part of your work both during the time
19 as director of it's development and now chief
20 administrative officer, did you have any
21 familiarity with what the project costs were
22 estimated to be to the Department?

23 A: My understanding is 117 million dollars. We
24 had a CON budget that we had to stay on and
25 under, and that's why we -- 117 was our target

1 the entire time.

2 Q: Okay. And describe for us where, where is
3 Roper's Berkeley hospital located?

4 A: It is -- I guess very easily put, it's near the
5 intersection of 17A and 176, which is kind of
6 the Carnes Crossroads, Nexton community.

7 Q: And what are those; what is Carnes Crossroad,
8 Cane Bay and Nexton?

9 A: So, Carnes Crossroad, Cane Bay and Nexton are
10 the large neighborhood development center that
11 are going up in and around our site.

12 Q: Okay.

13 A: That we closely associate with.

14 Q: Okay. How far is your hospital from, say, Cane
15 Bay?

16 A: Probably three miles up the street.

17 Q: And what about -- how far is your hospital from
18 Nexton?

19 A: From the edge of our property line to the edge
20 of the Nexton property line, less than a mile.

21 Q: Okay.

22 A: Yeah.

23 Q: All right. Are you familiar with where the
24 proposed location is for the Medical
25 University's community hospital?

1 **A:** I am. It's about less than probably about four
2 miles from our site, less than a ten minute
3 drive.

4 **Q:** Okay. And for you, what is the significance of
5 the Roper Berkeley Hospital to the Roper St.
6 Francis system?

7 **A:** So, I know that this is -- this project started
8 well before I arrived at Roper St. France, but
9 -- over 11 years ago. This project's been in
10 it works. It was considered a large strategic
11 initiative for Roper St. Francis and I think
12 there's been a lot of investment in time and
13 energy into getting the doors open, which we
14 successfully did a month ago. And the finances
15 of it, I would defer that to our CFO, Mr.
16 Johnson.

17 **Q:** Okay. Tell me about the -- you said it opened
18 about a month ago; tell me about that.

19 **A:** So, October 4th, we opened our doors at
20 midnight, 0001 in the morning, it was a -- like
21 I said, 11 years in the making so there was a
22 lot of excitement around it. And I think it
23 was less than eight hours after opening our
24 door we delivered the first baby in the
25 hospital. And that was the first baby born

1 with a birth certificate in Berkeley County in
2 over 45 years cause it's been about 45 years
3 since Berkeley County had a hospital in that
4 community. 45 years ago the hospital shut it's
5 doors, so it's been a community that has not
6 had that access.

7 Q: Okay. And now, so tell us what services does
8 your hospital offer?

9 A: So, we are a community hospital with a full
10 service emergency department open 24/7. We
11 have perioperative services; ORs, we've got
12 four of them; we've got in patient laboratory;
13 inpatient and outpatient lab services;
14 pharmacy; and 50 beds, 20 of them are on our
15 second floor for women's services delivering
16 babies, and 30 of them are on our third floor.
17 22 are med/surg, six ICU and 2 step-down beds.

18 Q: Okay. And in terms of the types of care, the
19 types of physician specialties that are there,
20 can you tell us some of what those are?

21 A: We've got a complement of physicians that are
22 capable of taking care of a community hospital.
23 We've got orthopedic surgeons, urologists,
24 hospitalists to staff the inpatient side. ED
25 physicians, radiologists. And on our site we

1 have a medical office building with
2 subspecialty outpatient offices for physicians
3 as well.

4 **Q:** Okay. And the emergency department, can you
5 describe that for us?

6 **A:** So, our emergencies department has -- we have
7 14 bays, one of which is within that complement
8 of 14, one is our resuscitation bay. So it's
9 a -- like I said, open 24/7, fully capable of
10 caring for the community.

11 **Q:** Okay. And you mentioned it briefly, what about
12 outpatient services?

13 **A:** So outpatient services in our hospital,
14 surgery, radiology. We have our radiology
15 department has a 1.5 T MRI, 128 slice CT
16 scanner, nuclear medicine, two x-ray machines,
17 3D mammo, ultrasound, so we're fully capable of
18 taking care of the community from an outpatient
19 perspective imaging-wise. And then the
20 outpatient services that are there in our
21 medical office building as well.

22 **Q:** Okay. And tell us a little bit about the
23 medical staff.

24 **A:** So, our medical staff is specific to Berkeley
25 Hospital. We do -- Roper St. Francis does have

1 a centralized medical staff office that's
2 responsible for working the credentialing
3 process for all physicians. They do go through
4 our consolidated medical executive committee
5 and credentials committee, but in terms of
6 approving the medical staff, each individual
7 hospital board is responsible for approving the
8 medical staff for their specific hospitals. So
9 it is not a given that one physician who would
10 be on our medical staff would also be on
11 another medical staff. They are all individual
12 appointments, but certainly many of them do
13 have appointments on multiple medical staffs.

14 Q: Okay. And can you tell us roughly how many
15 physicians have privileges at Roper's Berkeley
16 Hospital?

17 A: I believe it's about 450 at this point in time.

18 Q: Okay. And are some of the Roper St. Francis
19 physicians employed?

20 A: Yes. There are -- of the 450, I believe about
21 just 10 percent of our medical staff are
22 employed by Roper St. Francis, which is our --
23 which would be physician partners, what we call
24 them.

25 Q: Okay. So, what about then, what's the other 90

1 percent?

2 A: They would be community positions, private
3 practice physicians.

4 Q: Okay. And that 10 percent number, is that
5 similar to the other hospitals in the Roper St.
6 Francis system?

7 A: It's not. I think at other hospitals within
8 the system probably have a -- looking at their
9 medical staff, and I can't quote it, but I'm
10 certain that their medical staff has a higher
11 comp of physician partners considering that
12 within Mount Pleasant, downtown Roper and West
13 Ashley, that's where the bulk of the physician
14 offices are located.

15 Q: All right. And what about telemedicine, does
16 Roper St. Francis Berkeley offer telemedicine?

17 A: We do. We have virtual critical care for our
18 ICU patients through a company called AICU
19 which is in partnership with the Medicine
20 University of South Carolina. We also do
21 virtual consults for patients who are in a bed
22 that might need a specific subspecialty consult
23 like infectious disease or neurology where
24 because of the size of our facility we don't
25 have all subspecialties on campus at all times.

1 Q: And, so is the administrator for Roper St.
2 Francis Berkeley, what do you consider the area
3 where you draw the majority of your patients?

4 A: The area that I consider our patient draw would
5 be our immediate surrounding communities. You
6 know, roughly put, the most approximate 10 zip
7 codes around there, around our facility, which
8 would include Carnes Crossing, Cane Bay and
9 Nexton.

10 Q: Okay. And how many zip Codes did you say?

11 A: Ten.

12 Q: And can you estimate roughly sort of how large
13 is that in size of an area?

14 A: Estimated, probably a 15 mile radius.

15 Q: And why do you feel that 10 immediate zip codes
16 are ---

17 A: Cause I think within a community hospital like
18 ours that's where the primary patient
19 population you're gonna serve is going to be
20 coming from.

21 Q: And, you've already heard some discussion about
22 population growth here this morning. What are
23 your thoughts about the population in the area?

24 OBJECTION:

25 MS. JONES: Objection, Your Honor.

1 THE COURT: Yeah, I figured you were going to ---

2 MS. JONES: --- talk about population growth.

3 THE COURT: What did you say?

4 MS. JONES: I was objecting to the question about
5 his thoughts about the population.

6 THE COURT: I thought you were going to stand up on
7 that. Any response?

8 MS. HOLLINGSWORTH: Well, Your Honor, I think he's
9 the chief administrative officer of the
10 hospital we're discussing here and he's not
11 offering as an expert, he can give just his
12 personal factual knowledge about the population
13 in the area.

14 THE COURT: Well, if he has specific knowledge of
15 the population in the area, he can testify to
16 that. I think you'd have to lay a foundation
17 for that.

18 MS. JONES: Right.

19 MS. HOLLINGSWORTH: Sure.

20 **Q:** Mr. Bosse, when you looked -- did you review
21 data when you looked at those zip codes that
22 you described?

23 **A:** We reviewed data in terms of where our patients
24 were coming from within those zip codes
25 already. There was a large portion of our

1 patient population that existed within those
2 zip codes, yes.

3 Q: Okay. And when you were looking at that
4 information, have you looked at any metrics in
5 terms of whether or how it's growing or not
6 growing?

7 A: There was consideration for the growth,
8 obviously. I think anyone would give
9 consideration to growth when they're going down
10 a new venture, but I'm not a health service
11 planner, so I would -- I think the majority of
12 that work or conversation, I'd defer to Mr.
13 Richardson, who was our health service planner
14 for the project.

15 Q: You're not a health planning expert?

16 A: Certain -- correct, yes.

17 Q: All right. And in terms of the services you
18 provide and your goal with Roper St. Francis
19 Berkeley Hospital, do you monitor or stay
20 abreast of projects of other providers in your
21 community?

22 A: Naturally, yes. So, you know, I'm familiar
23 that Summerville Hospital had an expansion
24 project. Trident has done renovation and
25 expansion. I'm aware that Trident or HCA is

1 putting a freestanding ED just down the street
2 from the hospital on 17A, right at the -- on
3 17A right by the entrance of Nexton. And I
4 know that HCA also has CON in hand for a 50-bed
5 facility in Berkeley County and obviously MUSC
6 is requesting the 128 beds in the community as
7 well.

8 Q: Okay. And as you were working on the
9 development of this project did you interact
10 with members of the community at all about the
11 Roper St. Francis Berkeley Hospital?

12 A: Yes. So, as part of the opening aspect of the
13 hospital, in order to, you know, let the
14 community know who you were and what we were
15 going to be doing there, and kind of asking,
16 you know, what they expected from us and to
17 make sure we met their needs, we would go out
18 into the community and meet frequently, maybe
19 a different group each month for a period of
20 time with HOAs or rotary clubs.

21 Q: And can -- what are some of the -- can you give
22 us the names of some groups or areas that you
23 spoke with?

24 A: We've spoken with Carnes Crossroads HOA. We've
25 spoken with Berkeley County Rotary Club,

1 Summerville Rotary Club, to name a few.

2 Q: All right. Can we please pull up DHEC's
3 Exhibit 1.

4 (DHEC Exhibit 1 was referenced at this time.)

5 Q: And this is the -- DHEC Exhibit 1 which has
6 been already stipulated into evidence. Page
7 405 of the DHEC record. And, Mr. Bosse, you
8 should have DHEC's Exhibits.

9 And, Mr. Bosse, you had your deposition taken
10 in this case, is that right?

11 A: That's correct.

12 Q: And are you familiar with the application
13 that's at issue in this case?

14 A: Yes, I'm familiar with it. I did not read it
15 but I am familiar with it, yes.

16 Q: And are you familiar with this document that's
17 in the application?

18 A: I've seen it, yes.

19 Q: Turn if you will -- well, what is it?

20 A: So, this is a brochure from Nexton Community
21 for -- telling people about what the community
22 -- telling what the community is about.

23 Q: And turn to page 407 of that record.

24 A: Okay.

25 Q: And, if you could, where is your hospital in

1 relation to the Nexton community?

2 A: So, if you look at the center of the page where
3 it says Nexton, go three o'clock, couple inches
4 over, it says Roper St. Francis Hospital. So
5 we are right there on the border of it.

6 Q: Okay. And Carnes Crossroads, is that the
7 community you were mentioning earlier?

8 A: It is, yes.

9 Q: So this is the brochure that's in the
10 application, is that right?

11 A: Correct.

12 Q: Do you consider those areas in that map out
13 there to be the communities you serve?

14 A: Absolutely.

15 Q: All right. Let's take a look at Roper St.
16 Francis 114.

17 COURT REPORTER: I'm sorry, what? Roper St. Francis
18 ---

19 MS. HOLLINGSWORTH: 114.

20 COURT REPORTER: 114, thank you.

21 (RSF Exhibit 114 was referenced at this time.)

22 Q: Have you seen this document?

23 A: I have.

24 Q: Ans can you describe what's on this document?

25 A: So, this document appears to be a radius model

1 of -- with MUSC's proposed site and the
2 distance of 10, 15, 20 miles outside of the
3 center of their proposed site, which I'm not
4 sure if that's the exact proposed site. I
5 think it's more towards where it says 17 on the
6 page, which is, again, right next to our
7 location.

8 Q: Okay. Can you just describe for the Court and
9 the record, where is your -- where is the Roper
10 St. Francis Berkeley Hospital?

11 A: So, looking at this map where it says Alt 17,
12 that should be the intersection of 17A and 176,
13 and so we are right there where it says Alt 17.

14 Q: Okay. What concerns, if any, do you have about
15 the proposed project?

16 A: I have significant concerns about the project.
17 Obviously it's just down the street from our
18 hospital. We opened up a month ago and I think
19 that to say that it would not have an impact on
20 our hospital, I think is -- it's not realistic.
21 One of the most challenging things about
22 opening up a hospital is staffing. And I think
23 there's a staffing crunch that's felt through
24 all the hospitals within the lowcountry, MUSC
25 included, currently. And so opening up a new

1 hospital for us, we did have challenges
2 staffing. I would say we're in about a 90
3 percent staffed right now. The most
4 challenging areas to staff in a hospital are
5 typically your procedural areas, like labor and
6 delivery and the OR, and those are two areas
7 that we're still not at 100 percent staffing.
8 So, to say that you're gonna put a hospital
9 just down the street from ours is not gonna
10 have an impact on our facility, I don't think
11 is -- an inaccurate statement. I think you do
12 have the ability to pull staffing from our
13 hospital which can negatively impact us and our
14 ability to care for patients. I also think
15 that, you know, it's -- it has the possibility
16 of hurting both sites. MUSC might have issues
17 staffing their hospitals as well when the -- if
18 the site opens up because we've got the staff
19 and vice versa. So, if volume gets pulled out
20 of my facility and I still have staff, then I'm
21 talking about cutting staff, they're going to
22 unemployment. So, those are real concerns that
23 this project brings to our staffing.

24 MOTION TO STRIKE:

25 MS. JONES: Your Honor, I have a contemporaneous

1 objection to that testimony and I move to
2 strike it on two grounds. First of all, 702.
3 And secondly, on judicial estoppel based to the
4 direct contrary testimony that Roper submitted
5 to this Court and to the Court of Appeals when
6 they made their application for their 50-bed
7 hospital. And on that basis, that testimony
8 should be stricken.

9 THE COURT: All right, let's see. You started with
10 -- on the judicial estoppel ---

11 MS. JONES: Yes.

12 THE COURT: --- it has five elements, so you haven't
13 established those five elements.

14 MS. JONES: Yes, Your Honor.

15 THE COURT: You have -- no, I said you haven't
16 established those five elements, because I have
17 -- it's my understanding, I think it's all
18 five. So I overrule that objection.

19 Now, what was the 702 objection?

20 MS. JONES: That he's offered an opinion.

21 THE COURT: Okay.

22 MS. JONES: And he hasn't been qualified.

23 THE COURT: All right. Do you wish to respond?

24 MS. HOLLINGSWORTH: Your Honor, I submit that it's
25 not in violation of 702 because it's testimony

1 that falls under Rue 701. He is a lay witness,
2 I've not offered him as an expert, he doesn't
3 purport to be an expert, but he's just
4 providing his opinion based on his perception;
5 that he's uniquely qualified, as he is running
6 a hospital in that chosen site. And so he's
7 simply offering his opinion testimony, it is
8 not expert testimony.

9 MS. JONES: 701 and 702, if he's offering an opinion
10 about the operation of the hospital, that's not
11 a lay opinion. She can't have it both ways.
12 It can't be admissible under 701 and be an
13 opinion about the operation of a healthcare
14 facility.

15 THE COURT: All right. You can't -- 701 requires
16 rationally based on perception, or are helpful
17 for a clear understanding of the evidence, and
18 then the third one is, not based on specialized
19 knowledge. So, if you could -- I think you've
20 got (a) and (b).

21 MS. HOLLINGSWORTH: Yes, Your Honor.

22 THE COURT: So, tell me about (c).

23 MS. HOLLINGSWORTH: Your Honor, I think he's
24 speaking -- well, all he has spoken to is the
25 staffing concerns that he in fact experienced

1 and that he believes if there were additional
2 pulls on those resources this is what would
3 happen. That is based on his actual experience
4 in staffing a hospital contemporaneous with
5 where we are, and I don't think you need
6 specialized knowledge or skill in order to
7 describe the -- sort of the functions in a
8 hospital of staffing.

9 MS. JONES: Well, the testimony that I heard from
10 the witness was a question that was posed to
11 him about what effect the Medical University
12 Berkeley hospital would have, what he believes
13 it might have to Roper Berkeley Hospital. And
14 he offered -- she asked him about the impact on
15 the hospital, how it might impact them.

16 THE COURT: His hospital?

17 MS. JONES: His hospital.

18 THE COURT: Yeah.

19 MS. JONES: How it might impact his hospital and he
20 talked about the staffing concerns and he's
21 talked about the location and he talked about
22 the service to the population there. Those are
23 the three things that he talked about.

24 THE COURT: Okay.

25 MS. JONES: And I think for all three of those

1 things, you're looking at that third element
2 and you're looking at a specialized knowledge.

3 THE COURT: Well ---

4 MS. JONES: And she asked for his opinion.

5 THE COURT: --- I love your approach of I am asking
6 a contemporary -- gosh, I can't even say it.
7 contemporaneous objection. So you declared
8 that it was contemporaneous but it occurred
9 after he testified. But I'll just drop that
10 one.

11 I think I'm -- I'm gonna overrule that one.
12 You got close, but I just think that fits
13 within whether he's even offering an opinion.
14 He's just testifying about the operation of his
15 hospital, so.

16 MS. JONES: I understand what you're saying, Your
17 Honor, and I will -- maybe I'll go a little
18 further into it on cross.

19 THE COURT: Yeah. Go ahead.

20 MS. HOLLINGSWORTH: Thank you, Your Honor.

21 **Q: Mr. Bosse, I think you mentioned you're about**
22 **90 percent staffed ---**

23 **A: Yes.**

24 **Q: --- is that right? So how are you handling**
25 **vacancies?**

1 **A:** So, vacancies in our hospital, we try very hard
2 not to use travelers which is a common
3 utilization of staff resources that many
4 organizations do. And we try not to use
5 travelers within Berkeley Hospital specifically
6 because we're opening up a new hospital, so we
7 wanted our team in there to create our culture
8 and our experience. With that said, we did
9 hire travelers related to this project by
10 putting them in other hospitals so that we
11 could pull resources into ours to fill those
12 staffing vacancies while we still worked to
13 hire ourselves up to full staff. So, while we
14 tried very hard not to put staffing within
15 Berkeley Hospital, as a result, we did have to
16 hire traveling nurses within the system because
17 of us pulling resources elsewhere.

18 **Q:** Okay. And could you give us a little bit more.
19 What is a traveling nurse?

20 **A:** So, a traveling nurse is essentially a
21 contracted nurse that comes in from out of your
22 location, out of your city, that we pay much
23 higher rates for their services. And they come
24 for a period of time to help you through
25 staffing shortages. They're not designed to

1 cover PTO or sick days, they're designed to
2 cover vacancies.

3 Q: Okay. And why is it -- why do you not want to
4 use traveling nurses at your hospital?

5 A: One, the expense. Like I mentioned, travelers
6 are very expensive. And two, opening up a new
7 hospital we wanted to have our Roper St.
8 Francis culture in there. So when you bring in
9 traveling nurses, while they're obviously
10 qualified to do the job, some places might have
11 different processes and protocols, and those
12 are things that when you come in for a short
13 period of time, which can be three to six
14 months, you know, you only spend maybe a week
15 orienting on your unit before you're given your
16 own assignments. And so it's not really enough
17 time to understand how we do work in our
18 system. So, it can create a different
19 experience for the patient.

20 Q: And does Roper St. Francis, the system, have
21 nurse vacancies in addition to at your
22 hospital?

23 A: It does, yes. There are -- we have nurse
24 vacancies throughout the organization. And
25 actually, I think it's next week that our HR

1 team is hosting a recruitment event for
2 nursing.

3 Q: When you were evaluating an area that your
4 patients -- what you expect your patient draw
5 to be in, were you looking at areas down in
6 Mount Pleasant or the peninsula?

7 A: No.

8 Q: Why not?

9 A: Because those patients aren't going to come to
10 Berkeley Hospital. There's much closer
11 hospitals, whether they're Roper St. Francis,
12 MUSC or HCA hospitals, than driving up to
13 Berkeley Hospital.

14 Q: Okay. And are there any services that you're
15 aware of that are proposed for the MUHA
16 Berkeley Hospital that your hospital doesn't
17 provide?

18 A: Not that I'm aware of. My understanding is
19 that everything that MUHA is proposing to
20 provide at their site we cover at our site as
21 well.

22 Q: And does your hospital comply with EMTALA?

23 A: Absolutely.

24 THE COURT: Comply with what?

25 MS. HOLLINGSWORTH: EMTALA.

1 THE COURT: Okay.

2 Q: And do you restrict admissions to your
3 hospital?

4 A: We do not.

5 Q: And are you aware of any problems or issues
6 with access in your communities that you serve
7 with getting acute care services?

8 A: Not that I'm aware of.

9 MS. HOLLINGSWORTH: One moment, Your Honor.

10 Q: My fault for using acronyms. Can you -- what
11 is EMTALA?

12 A: EMTALA, I can't spell out the -- each of the
13 letters there, but essentially it's having --
14 treating all patients that come through your
15 emergency room, that you're not turning anybody
16 away.

17 Q: And your emergency department does that?

18 A: Yes. We comply with EMTALA.

19 Q: Do the other Roper St. Francis hospitals do
20 that as well?

21 A: Yes, they do.

22 Q: I have no further questions. Thank you, Mr.
23 Bosse.

24 MS. HOLLINGSWORTH: Thank you, Your Honor.

25 THE COURT: Do y'all wish to cross?

1 MR. THOMAS: No, Your Honor.

2 MR. WICEVIC: No questions from the Department,
3 thank you.

4 MS. JONES: I just have a few.

5 THE COURT: Really?

6 MS. JONES: Well, I'll do the best I can, Judge.

7 MR. BOSSE - CROSS-EXAMINATION BY MS. JONES:

8 **Q: Mr. Bosse, my name's Celeste Jones and I'm a**
9 **lawyer at Burr Foreman McNair and I represent**
10 **the Medical University. I haven't met you**
11 **before, so.**

12 MS. JONES: If you will just bear with me a moment
13 to introduce myself to the witness please, Your
14 Honor.

15 **Q: I want to ask you about a couple of things that**
16 **you testified to in your deposition and you**
17 **just went over in your direct examination.**
18 **It's true, isn't it, that the Berkeley County**
19 **area is growing dramatically, isn't it?**

20 **A: It is true the Berkeley County area is growing,**
21 **yes.**

22 **Q: And isn't it true that you get asked about that**
23 **frequently by the press and by other people?**

24 **A: We do, yes.**

25 **Q: And there is -- the reason that Roper -- are**

1 you familiar with why Roper built the Berkeley
2 Hospital?

3 A: So, I have secondhand knowledge of it, but the
4 project started before my tenure at Roper, yes.

5 Q: But you took it on in April of 2018 to finish
6 the construction?

7 A: I believe so, yes.

8 Q: And as a part of that ---

9 A: Yes.

10 Q: --- did you look at the CON or did you look at
11 any of the decisions?

12 A: I did not look at the CON, no.

13 Q: Okay. Did you -- what did you review then to
14 familiarize yourself with the purpose for the
15 hospital?

16 A: Well, my charge at the time was to make sure
17 that we opened up a hospital, not to defend it
18 or prove its need.

19 Q: And the hospital opened October the 4th?

20 A: It did, yes.

21 Q: Okay. And how many patients did you treat on
22 October the 4th?

23 A: I can't say with certainty but our ER probably
24 saw about 30 patients that day.

25 Q: 30 patients that day?

1 **A:** Approximately, yes.

2 **Q:** And you had a couple of guideposts you were
3 trying to meet when you first opened, didn't
4 you?

5 **A:** I'm sorry?

6 **Q:** You had a couple of goals and guideposts that
7 you had to meet for your JCAHO accreditation --
8 -

9 **A:** Correct.

10 **Q:** --- and then for -- to be able to bill and
11 collect under Medicare, right?

12 **A:** That's correct.

13 **Q:** All right. And what were those?

14 **A:** So, you have ---

15 THE COURT: Well, can I understand the question
16 because you transitioned, you went from a
17 couple of guideposts you were trying to meet
18 and then you said ---

19 MS. JONES: When you open.

20 THE COURT: --- and then you said a couple of
21 guideposts you had to meet. And so which one
22 is it so I'll know.

23 MS. JONES: They were trying to meet them because
24 they had to meet them for accreditation and
25 billing purposes.

1 THE COURT: Okay.

2 MS. JONES: I'm sorry, I'll ---

3 THE COURT: Well, if you have to meet if, you're
4 gonna try to meet it, I do believe.

5 MS. JONES: Yeah, that was -- okay, thank you.

6 Q: So, could you explain to the Court what goals
7 or number of patients you had to treat in order
8 to qualify for the Joint Commission
9 Accreditation?

10 A: Yes. You have to -- as a new hospital, you
11 have to have 20 inpatient discharges before you
12 can qualify for a Joint Commission visit. And
13 Joint Commission comes in to work on behalf of
14 the CMS to provide you deemed status for
15 Medicare/Medicaid.

16 Q: And you had a plan as to how to meet that,
17 didn't you?

18 A: We had a plan to open the doors and serve the
19 patients of the community.

20 Q: Was your plan for those 20, first 20, did you
21 think at the time or plan at the time that you
22 thought they would come through the emergency
23 department?

24 A: Yes.

25 Q: And did they?

1 A: We had patients come through the emergency
2 department that were discharged, yes.

3 Q: And how long did it take you to reach that 20
4 goal?

5 A: We probably reached 20 within the first week.

6 Q: And then, the second metric that you needed to
7 meet for Medicare billing purposes, that was to
8 get the JCAHO accreditation right?

9 A: I'm sorry the second one, what ---

10 Q: The second one, what did you have to do in
11 order to be able to bill for Medicare?

12 A: We had to have Joint Commission come in and
13 credential us.

14 Q: So, you had to meet the 20 discharges under
15 JCAHO and then get the Joint Commission?

16 A: Correct.

17 Q: And you did that within the first week?

18 A: No. We had our 20 discharges within the first
19 week, I think it was actually seven days. And
20 then you inform Joint Commission that you've
21 met your discharge quota and then they do not
22 schedule a visit, they arrive. They give you
23 a phone call at 7:30 in the morning and say
24 we're gonna be there. And actually we had our
25 visit last week.

1 Q: Okay. And the medical staff there, you said
2 there are 450 on your medical staff?

3 A: I believe so.

4 Q: All right. And you say that there's a
5 consolidated MEC?

6 A: Yes.

7 Q: Would you tell the Judge what the MEC is.

8 A: So, the medical executive committee is ---

9 Q: And what do you mean when you say it's
10 consolidated?

11 A: So, it is -- we just have one for the entire
12 system, so representatives of the medical staff
13 from each of the four facilities sit on the
14 consolidated medical staff.

15 Q: All four Roper Hospitals, the medical staffs on
16 those four hospitals, all go through the same
17 medical executive committee for credentialing
18 purposes?

19 A: That's -- they go through a credentials
20 committee and then they go, after they're
21 approved through the credentialing committee
22 then they go to MEC for approval, the medical
23 executive committee. And then those, after
24 they pass that hurdle, then they get passed
25 back to the respective boards at each of the

1 facilities and each board, each hospital board
2 has the responsibility of ultimately approve
3 the medical staff.

4 Q: And to date, after being open -- how many days
5 have you been opened now, 40?

6 A: Since October 4th. So, yeah, just over a
7 month.

8 Q: Just over a month you have 450 providers on
9 your medical staff at the Berkeley Roper
10 Hospital?

11 A: That's correct.

12 Q: That's like eight doctors per bed.

13 A: So, the way the medical staff works is you can
14 apply for active privileges, you can apply for
15 consulting privileges. There's different
16 levels of privileges. We have
17 anesthesiologists, the entire group gets
18 credentialed because they serve all the
19 hospitals in the system. So, obviously, if
20 they've got an anesthesia group of, I don't
21 know the number, but let's say 30, they all
22 need to be credentialed on each of the sites so
23 they can practice in each of the hospitals.
24 Same way with radiology, emergency department
25 and other services.

1 **Q:** Yes, sir. But for the 50 beds that are at
2 Roper Berkeley ---

3 **A:** Uh-huh.

4 **Q:** --- that you're trying to cover, you have 450
5 doctors credentialed and on staff to tend to
6 those patients?

7 OBJECTION:

8 MS. HOLLINGSWORTH: Your Honor, I object to that.

9 That's not been his testimony ---

10 COURT REPORTER: I'm sorry, I couldn't hear you.

11 That's not been what?

12 MS. HOLLINGSWORTH: That was not his testimony.

13 That's a misstatement of his testimony.

14 MS. JONES: Your Honor, I've got him on cross
15 examination. He can clear up anything, that's
16 not a proper objection. I get to cross examine
17 him. And that is what he testified to.

18 THE COURT: I'm going to overrule that and allow you
19 to redirect if you wish.

20 MS. HOLLINGSWORTH: Thank you, Your Honor.

21 **Q:** Let's clear it up. How many physicians are on
22 the medical staff at Roper Berkeley?

23 **A:** About 450.

24 **Q:** 450. And there are 50 beds there, correct?

25 **A:** That's correct.

1 Q: So, if you do the math, 450 divided by 50, you
2 come up with eight, right?

3 A: Yes.

4 Q: Now, I want to ask you about, a few questions
5 about -- a few more questions about the
6 doctors. How many of the physicians, of the
7 450 physicians that are on staff at Roper
8 Berkeley came from -- are also on staff at
9 other Berkeley hospitals?

10 A: I do not have ---

11 Q: I mean other Roper hospitals?

12 A: I don't have an exact number, but I would say
13 probably 90 percent are on medical staff at
14 other hospitals in our system.

15 Q: So basically the physicians that were already
16 on staff at the other three Roper hospitals
17 applied for privileges at the new hospital in
18 Berkeley County and were granted privileges
19 there?

20 A: Correct.

21 Q: 90 percent?

22 A: Essentially, yes.

23 Q: And did any of the doctors at your new Berkeley
24 Hospital come from MUSC?

25 A: No. Well, I believe a -- maybe neonatology.

1 We got coverage from there. We also use
2 Telestroke coverage, so physicians within the
3 Telestroke network who can be MUSC physicians
4 would also get credentialed through that as
5 well.

6 Q: And, that's the situation at Roper downtown and
7 the other two Roper hospitals as well, for the
8 NICU physicians from the Medical University to
9 come and provide coverage at those other -- at
10 Roper hospitals?

11 A: Yes.

12 Q: And for the stroke patients, the Medical
13 University provides that coverage through their
14 physicians, don't they?

15 A: Not completely, no. But -- so they are part of
16 our stroke team. We have our own stroke
17 physicians within the organization.

18 Q: Now, none of the Berkeley -- none of the Roper
19 hospitals have a level I trauma center, do
20 they?

21 A: That's correct, we do not.

22 Q: The Medical University is the only facility in
23 the greater Charleston area that has a level I
24 trauma center, isn't that right?

25 A: That's correct.

1 Q: And they're the only one that has a level IV
2 NICU?

3 A: That's correct.

4 Q: And, if you would please, would you tell the
5 Judge what a level I trauma center is and what
6 a level IV NICU is.

7 A: So, essentially they're getting the sickest of
8 the patients, the sickest of the babies and the
9 train wreck of patients that are, you know, at
10 -- casualties and accidents.

11 Q: Another question about the physicians, did any
12 of your physicians, to your knowledge, that
13 applied for and got privileges at Roper
14 Berkeley come from Trident?

15 A: Yes. We have physicians on our staff that
16 practice at Trident.

17 Q: They practice both places?

18 A: Yes, they do.

19 Q: So they still have their privileges at Trident
20 to your knowledge ---

21 A: That's correct.

22 Q: --- they're just practicing at both locations
23 now?

24 A: That's correct.

25 Q: And about how many people is that?

1 A: I did not know the answer to that.

2 Q: Okay. Is it less than 10?

3 A: It's not less than 10, no.

4 Q: Is it less than 20?

5 A: Probably not.

6 Q: How many is it then?

7 A: I don't -- so, it's -- you know, when we look
8 at the practices that might be practicing at
9 both locations, orthopedics, women services,
10 urology. So, it's ---

11 Q: So it's group practices?

12 A: Group practice, yes.

13 Q: Do you know what group practices are at both
14 facilities?

15 A: LowCountry Women's Specialists; Lowcountry
16 Orthopedics; Palmetto's Urology; South
17 Carolina Sports, to name a few.

18 Q: I want to ask you a few questions about the zip
19 codes that you were testifying about, the 10
20 zip codes. Are any of those 10 zip codes in
21 Dorchester County?

22 A: I believe so.

23 Q: Do they include the CHS areas? Charleston and
24 Dorchester?

25 A: I'm sorry, what do you mean by the CHS areas?

1 Q: I meant Charleston. I -- the zip codes that --
2 the 10 zip codes that you testified about on
3 direct ---

4 A: Yes.

5 Q: --- reach into Dorchester County and Charleston
6 County, right?

7 A: I believe so.

8 Q: And did you identify those 10 zip codes based
9 on patient discharges at Roper Berkeley?

10 A: So, identified those -- nonscientific approach
11 to identifying those zip codes of the proximate
12 location to our site. And then looking at our
13 ED discharge data of where patients were coming
14 from within our system currently. Because they
15 don't like these -- I commented earlier we have
16 a Northwoods ED, we've got the Moncks Corner
17 Medical Plaza ED, and so those were EDs that
18 were -- draw on some of those patients already.

19 Q: What does nonscientific identification of the
20 zip codes mean?

21 A: It means I looked at a map and said this zip
22 code is close to our hospital.

23 Q: That's how you picked the 10?

24 A: Yes. And they're in our community.

25 Q: Okay.

1 A: I did not use any ---

2 Q: And those are the 10 you were testifying to on
3 direct examination?

4 A: That's correct.

5 Q: Did you identify the zip codes or did you do it
6 -- you said we did; who is we?

7 A: In my analysis I identified the zip codes.
8 Like I said, by looking at the map and saying
9 which ones are proximate to our hospital.

10 Q: So you didn't do it with someone else, is that
11 your testimony?

12 A: My analysis, I did it by myself.

13 Q: What did you mean when you said we?

14 A: I must have misspoke.

15 Q: Okay, all right.

16 A: I did my analysis.

17 Q: That's fine.

18 A: Yeah.

19 Q: Where do you live?

20 A: I live on Daniel Island.

21 Q: And you drive from Daniel Island to the Roper
22 Berkeley Hospital every day?

23 A: I do.

24 Q: How long does it take you to get there?

25 A: About 35 to 40 minutes.

1 Q: Is that with or without traffic?

2 A: That's without traffic.

3 Q: Okay. Do you have occasion to go back downtown
4 to the Roper facility downtown?

5 A: I do.

6 Q: How long does it take you to get there?

7 A: About 30 to 35 minutes.

8 THE COURT: is that -- well now, where is that from?

9 A: I'm sorry.

10 Q: From the Roper Berkeley Hospital or from Daniel
11 Island?

12 A: Oh, from Daniel Island.

13 THE COURT: Okay.

14 Q: How long does it take you to get from Roper
15 Berkeley to downtown?

16 A: About an hour without traffic. With traffic,
17 much more than an hour.

18 Q: And the service area that you were serving in
19 your 10 zip codes, it includes three different
20 counties, right?

21 A: I believe so.

22 Q: Berkeley, Dorchester and Charleston?

23 A: Correct.

24 Q: So that's your service area?

25 A: (Nods head.)

1 Q: And how long have you lived in Charleston now?

2 A: Since I started Roper St. Francis, so about --
3 just over four years.

4 Q: And have you lived at Daniel Island the whole
5 time?

6 A: I have.

7 Q: Is traffic getting better or worse going
8 downtown?

9 A: Traffic going downtown from Daniel Island, I
10 take 526 to 17 and it hasn't changed.

11 Q: It hasn't changed. How about the traffic going
12 the other way to Berkeley County?

13 A: That is not an issues getting from Daniel
14 Island to Berkeley County.

15 Q: Okay. How about going from Berkeley County to
16 downtown?

17 A: It is problematic at certain times of day,
18 especially during rush-hour.

19 Q: So it hasn't improved?

20 A: No.

21 Q: Are you familiar with the Roper proposal to
22 build the hospital in Berkeley County?

23 A: The Roper proposal to build which ---

24 Q: The 50-bed hospital that you just opened. Are
25 you familiar with that proposal, what they put

1 in the proposal?

2 A: Like I said, I've not read the CON application,
3 but yes, I'm familiar with it.

4 Q: Did you know that Roper based it's application
5 for this 50-bed hospital on the premise that
6 they would -- that Roper would be servicing
7 it's own patients?

8 OBJECTION:

9 MS. HOLLINGSWORTH: Your Honor, I would object.
10 He's just testified that he hasn't read the
11 application, isn't familiar with it and it
12 should -- you know, facts that aren't in
13 evidence yet. She's testifying.

14 THE COURT: Well, she asked did you know.

15 MS. HOLLINGSWORTH: And she's giving him a
16 characterization of facts and I dispute the
17 characterization that she's provided. It's not
18 in evidence and he hasn't read the application.
19 He's already testified to that.

20 MS. JONES: I thought he testified he was familiar
21 with it; that he hadn't read it, but he was
22 familiar with it.

23 Q: Now, if I heard you wrong, you correct me.

24 THE COURT: Whoa, whoa.

25 MS. JONES: Yeah, I mean ---

1 THE COURT: I've gotta make the ruling first.

2 MS. JONES: Yes, sir. But I can respond to the
3 objection as well.

4 THE COURT: Yeah, go ahead.

5 MS. JONES: Well, my response to the objection is,
6 I've got this witness on cross-examination and
7 I get to ask him these questions. I can ask
8 him if he's familiar with it. I thought he
9 said he was familiar with it. And if he's
10 familiar with it, then I can ask him the
11 questions.

12 THE COURT: I overrule the objection.

13 MS. HOLLINGSWORTH: Thank you, Your Honor.

14 **A: I'm familiar with the application to the point**
15 **we're allowed to build a 50-bed hospital, what**
16 **I've put in there. In terms of the analysis**
17 **that was done to determine why we built a 50-**
18 **bed and in what locations, as I said earlier,**
19 **I was not involved in that process. So, our**
20 **health planning expert was the -- is probably**
21 **the most able to answer to that.**

22 **Q: So you don't know, is that what you're telling**
23 **me?**

24 **A: I'm telling you -- yes, I'm telling you I don't**
25 **know.**

1 Q: Okay, all right. If you don't know, that's
2 fine. So, the summation of your knowledge of
3 Roper Berkeley is just the work that you've
4 done in the last year and a half?

5 A: That's correct.

6 MS. JONES: Give me just a minute, Your Honor.

7 Q: I do need to ask you another question about the
8 medical staff. The 450 members of the medical
9 staff at your new hospital in Berkeley, how
10 many of those have admitting privileges?

11 A: I believe on our active status, which has
12 admitting privileges, the number's in the 200s.

13 Q: And of the acting staff in the 200s, where were
14 -- are the majority, if not all of those
15 physicians, also credentialed at another Roper
16 Hospital?

17 A: Likely, yes.

18 Q: Do you know of any that are not?

19 A: Yes. Some of the subspecialties that might --
20 like women's services that may have practiced
21 at Trident before have -- were not on staff at
22 the Roper facilities prior.

23 Q: And correct me if I'm wrong, I think you said
24 earlier that 90 percent of the 450 were also on
25 other Roper hospital staffs?

1 **A:** Yeah, I did say that.

2 **Q:** All right. Of those with admitting privileges,
3 would it still be 90 percent or higher?

4 **A:** Of the -- of the ones with admitting
5 privileges, how many are on other ---

6 **Q:** Roper staffs, yeah. What percentage ---

7 **A:** I ---

8 **Q:** --- of ---

9 **A:** --- yeah, I'd say it's still 90 if -- 90
10 percent plus.

11 **Q:** 90 percent plus?

12 **A:** Yes.

13 **Q:** That's all the questions I have.

14 MS. JONES: Tender the witness, Your Honor.

15 THE COURT: All right. Any redirect.

16 MS. HOLLINGSWORTH: If I may, Your Honor, briefly.

17 MR. BOSSE - REDIRECT EXAMINATION BY MS.

18 HOLLINGSWORTH:

19 **Q:** Mr. Bosse, just a few questions. Could you
20 explain for us what -- what is the difference
21 between, I think you described them as
22 consulting privileges versus active privileges;
23 what is the difference?

24 **A:** So, consulting privileges, you have to have --
25 and I don't want to butcher the definitions of

1 them, but there are -- for consultants, there
2 are certain -- or for active status, there are
3 a certain number of patient touches a year that
4 you have to have within a hospital in order to
5 -- once you hit that number, you are -- you
6 have to become active status. Consulting
7 privileges are essentially a -- you are called
8 up to provide consultation on a patient that
9 might be in the hospital.

10 Q: So if you are -- if you have privileges, does
11 that mean you're at the hospital all the time?

12 A: It does not, no.

13 Q: And I'm trying to understand some of the
14 percentages that you were asked about. 90
15 percent of your medical, the credentialed
16 medical staff, is -- also has credentials at
17 other Roper facilities, is that what -- is that
18 what you testified to?

19 A: Yeah, I believe that would be accurate.

20 Q: And then how does that interrelate with -- are
21 they all employed then?

22 A: Absolutely not, no. They're not all employed.

23 Q: How much of your -- of these 450 credentialed
24 physicians, how many are employed by Roper St.
25 Francis?

1 A: On our staff, of the 450, about 10 percent are
2 physician partners.

3 Q: So does that mean that they're -- those -- that
4 it's only 10 percent that has an employment
5 relationship with Roper St. Francis?

6 A: That's correct.

7 Q: Okay. And you were asked about a trauma
8 designation. To your knowledge, did you see in
9 the application, is the hospital proposed to go
10 in Nexton by Medical University going to have
11 a trauma designation?

12 A: Is MUSC's hospital gonna have a trauma
13 designation?

14 Q: Yes.

15 A: I do not believe so.

16 Q: Okay.

17 A: That's not my understanding.

18 Q: Is there a trauma center near your hospital
19 right now?

20 A: Trident is a trauma center.

21 Q: All right. And then can you just look quickly
22 at a document. This is the Roper St. Francis
23 Exhibit 114.

24 (RSF Exhibit 114 was referenced at this time.)

25 Q: If we could kind of zoom in a little bit more.

1 **OBJECTION:**

2 **MS. JONES:** Your Honor, I'm gonna object. This is
3 outside of the scope of the cross. It's
4 improper redirect.

5 **MS. HOLLINGSWORTH:** I didn't get to ask a question
6 yet, Your Honor, if I could ---

7 **THE COURT:** Yeah.

8 **MS. HOLLINGSWORTH:** --- ask the question.

9 **THE COURT:** Let her ask the question first.

10 **MS. JONES:** Ask the questions.

11 **MS. HOLLINGSWORTH:** Thank you.

12 **Q:** **Mr. Bosse, you were asked about whether the 10**
13 **zip codes, proximate area, where they fell**
14 **within the counties. Do recall that testimony**
15 **on cross examination?**

16 **A:** **I do recall.**

17 **Q:** **Okay. And if you could, looking at this map,**
18 **could you describe within those three circles,**
19 **where do those 10 zip codes fall?**

20 **A:** **They would all fall within that 10 miles**
21 **radius, the inner circle.**

22 **Q:** **Okay. You were asked about Dorchester and**
23 **Charleston County zip codes. The zip code --**
24 **I can't read that far away. You were asked**
25 **about Charleston County zip codes. And looking**

1 -- this zip code in North Charleston, 29406,
2 are you familiar with the North Charleston area
3 in 29406?

4 A: 29406, I am familiar with that.

5 Q: Is that the zip code where you Northwoods
6 facility is?

7 A: I believe it is.

8 Q: And was that zip code within the immediate
9 proximate area that you looked to for your
10 service area?

11 A: I believe it was.

12 Q: And then what about zip codes with Mount
13 Pleasant or East Cooper, any of those areas?

14 A: No, we did not look in that area.

15 Q: Okay.

16 A: And actually, if I can just clarify the
17 statement I made. The -- looking at this, I
18 think the -- not all of them fell within that
19 10 miles radius, like 29469, which is up top in
20 that 15 mile radius, would've also been my
21 analysis.

22 Q: Okay.

23 A: And 29461.

24 Q: And you described it as being nonscientific?

25 A: Correct.

1 MS. HOLLINGSWORTH: Those are my questions, Your
2 Honor, thank you very much.

3 **Q: Thank you, Ms. Bosse.**

4 THE COURT: Re-cross on what she has asked?

5 MS. JONES: How about leave that back up.

6 MS. HOLLINGSWORTH: Your Honor, is it your
7 preference to have re-cross with the witnesses
8 in the case?

9 THE COURT: If it's on new matter.

10 MS. HOLLINGSWORTH: Okay.

11 MS. JONES: Could you put it up? Okay. Well, if
12 you don't want to do it for me, that's okay.
13 That's all right. I can live with it.

14 MR. BOSSE - RECROSS-EXAMINATION BY MS. JONES:

15 **Q: All right. What you just testified to on**
16 **redirect, in the 10 miles radius, there's only**
17 **four zip codes.**

18 **A: I amended my statement, and I believe I said**
19 **that there were additional zip codes outside of**
20 **that 10 mile radius that I identified, like**
21 **29469 and 29461, which are beyond the 10 mile**
22 **radius.**

23 **Q: And, in fact, on your nonscientific circles**
24 **here, the zip codes are written and you can --**
25 **anybody who's looking at it can count them up,**

1 **right?**

2 **A:** **That's -- yes, that's accurate.**

3 **Q:** **All right. Thank you.**

4 THE COURT: Well, I think you can step down now.

5 So, we're through for today?

6 CONCLUDING MATTERS:

7 MS. HOLLINGSWORTH: We are, Your Honor. We would

8 start in the morning with Mr. Johnson.

9 THE COURT: Okay. I do want to say, I found the
10 question interesting, Ms. Jones, you asked him
11 if that was with or without traffic. How can
12 you be on the road and there be no traffic?

13 MS. JONES: I think everybody knows what it means to
14 have traffic in Charleston.

15 THE COURT: I'm just picking. All right, thank
16 y'all. We're adjourned.

17 MS. HOLLINGSWORTH: Thank you, Your Honor.

18 MS. JONES: Thank you.

19 MS. HOLLINGSWORTH: Your Honor, what time would you
20 like to start in the morning, at ten o'clock?

21 THE COURT: I'll start whenever. I'm starting to
22 feel a little better so.

23 MS. CRUM: 10:00 is fine.

24 THE COURT: 10:00 is fine?

25 MS. CRUM: If it suits Your Honor.

1 THE COURT: Okay. See you at ten o'clock.

2 MS. HOLLINGSWORTH: Thank you, Your Honor.

3 (The hearing adjourned at 2:11 p.m.)

4 DAY TWO - THURSDAY, NOVEMBER 7, 2019

5 CALL TO ORDER:

6 COURT REPORTER: All rise.

7 THE COURT: Y'all be seated. Who's up?

8 MS. HOLLINGSWORTH: That would be me, Your Honor.

9 Good morning.

10 THE COURT: Good morning to all of y'all. I'm

11 actually starting to feel alive again.

12 (Off the record discussion)

13 MS. HOLLINGSWORTH: Thank you, Your Honor.

14 Wonderful introduction. Your Honor, Roper St.

15 Francis would like to call Brett Johnson to the

16 stand.

17 COURT REPORTER: Brett, B-R-E-T-T?

18 MR. JOHNSON: Yes, ma'am. One T.

19 COURT REPORTER: One T. B-R-E-T.

20 MR. JOHNSON: Yes, ma'am.

21 COURT REPORTER: Raise your right hand, please. Do

22 you solemnly swear the testimony you're about

23 to give in this matter is the truth, the whole

24 truth, and nothing but the truth, so help you

25 God?

1 MR. JOHNSON: I do.

2 COURT REPORTER: Thank you.

3 MR. JOHNSON - DIRECT EXAMINATION BY MS.

4 HOLLINGSWORTH:

5 Q: Good morning.

6 A: Good morning.

7 Q: If you could, introduce yourself to the Court.
8 What's your full name?

9 A: Bret, with one T, David Johnson.

10 Q: And, Mr. Johnson, before we dig into the meat
11 of this, if you don't mind, tell the Court a
12 little bit about your background.

13 A: Okay. My professional background started in
14 1989 with a firm called Arthur Andersen. At
15 the time, it was one of the big eight
16 accounting firms. And before that, I was an
17 experienced audit manager with that firm. I
18 stayed with them for eight years conducting
19 audits predominately and consulting,
20 predominantly in healthcare, but also some real
21 estate as well. And that was after receiving
22 a BS degree in accounting from the University
23 of Iowa.

24 Q: Okay. When did you -- do you remember when you
25 graduated from the University of Iowa?

1 **A:** May of 1989.

2 **Q:** Okay. And so, did you go directly to Arthur
3 Andersen?

4 **A:** I did.

5 **Q:** All right. And other than your Bachelor's
6 degree in -- in Accounting, do you have any
7 other educational licenses or certifications?

8 **A:** I am a certified public accountant in the state
9 of South Carolina.

10 **Q:** Okay. And when were you first licensed as a
11 CPA?

12 **A:** In South Carolina, it would have been around
13 '96, but I believe I had reciprocity from Iowa,
14 but I don't think I'm licensed -- I don't think
15 I'm licensed anymore in Iowa. I think just
16 South Carolina.

17 **Q:** And when were you first licensed in Iowa?

18 **A:** I think it was immediately before getting
19 licensed in South Carolina.

20 **Q:** Okay. And since you've got -- since you were
21 first licensed as a certified public
22 accountant, have you always maintained a
23 license?

24 **A:** Yes.

25 **Q:** And has your licensed every lapsed anywhere?

1 A: No.

2 Q: Okay. All right. And now -- so, what did you
3 do after Arthur Andersen?

4 A: So, in 1997, I took a job as Director of
5 Finance with the former Roper CareAlliance,
6 which is now Roper St. Francis Healthcare
7 today.

8 Q: Okay. And do you have a CV?

9 A: I -- I do not. I have not interviewed for a
10 job in 30 years, so I -- embarrassed to say, I
11 don't have a resume.

12 THE COURT: --- out an objection.

13 MS. HOLLINGSWORTH: Well, that will make this a
14 little quicker.

15 (Laughter.)

16 Q: All right. Let's touch back for a moment on
17 your CPA licensure. Are there requirements or
18 what are the requirements to maintain that
19 license?

20 A: Well, just two major ones. You have to be in
21 the profession of accounting and finance to
22 maintain a license and also, there are 40 hours
23 a year of required continuing professional
24 education.

25 Q: Okay. And what -- what are some examples of

1 the ways in which you meet that 40 hours a
2 year?

3 A: So, there -- a number of organizations offer
4 CPE. The things I like to -- to attend are any
5 accounting pronouncement updates. Hitting a
6 couple of those annually is always good. And
7 then, anything industry specific. There's a
8 lot of CPE on population health and billing and
9 compliance, and things like that. So, those
10 are what I tend to focus on when I attend CPE.

11 Q: Okay. And so, you mentioned the 40 hours a
12 year of continuing education, maintaining a
13 practice. Are there any other significant
14 requirements or obligations?

15 A: No. I would just say staying out of trouble.
16 Not committing any acts discreditable, that are
17 called in the CPA profession.

18 Q: Okay. Okay. Are there periodicals or
19 published materials that you regularly review
20 as -- to stay current in that field?

21 A: Yeah. I do receive the Journal of Accountancy,
22 which is a monthly publication. I -- you know,
23 in healthcare, you start everyday it seems
24 with lots of reading. And I get lots of daily
25 updates from the advisory -- they're called the

1 Advisory Board from another outfit called
2 Becker's, Becker's Healthcare. They -- they
3 give you a lot of what's happening or updates
4 on regulatory matters and other things
5 happening in the industry. So, I would --
6 there's also the Federal Register, publishes
7 proposed changes from Medicare, Medicare --
8 Medicare and Medicaid and their rules as well.
9 So reading is a big part of just staying
10 abreast of what's going on in healthcare.

11 Q: Okay. And do you still do that today?

12 A: Yes.

13 Q: All right. Do you belong to any professional
14 organizations or groups that focus on
15 healthcare finance?

16 A: Uh-huh. I'm a member of the American Institute
17 of Certified Public Accountants. I'm a member
18 of the South Carolina -- SCCPAs, South Carolina
19 Association of CPAs. I'm a member of the HFMA.
20 I'm pretty sure -- I hope my assistant had sent
21 my -- my dues in. And then, I sit on a couple
22 of task forces for the South Carolina Hospital
23 Association.

24 Q: All right. And so, let's go back to your work
25 experience with Arthur Andersen. What were

1 your titles during your time there?

2 **A:** As an experienced audit manager, I guess by the
3 time I left, I focused mostly on audits of
4 healthcare organizations. I also did some real
5 estate. But I also participated in a number of
6 consulting projects with health systems around
7 projections, budgeting, feasibility studies. I
8 would assist when those organizations did bond
9 issuances. An interesting project I
10 participated in in Asheville in the mid-90s was
11 a -- was a COPA study, which is a Certificate
12 of Public Advantage. And that is a study to
13 determine -- at that time, Memorial Mission and
14 St. Joseph's Hospitals wanted to merge, but
15 they were the only two hospitals in that area.
16 So, the study was to determine if the benefits
17 or the savings to the community for merging
18 offset the loss of competition in that
19 community. And I spent four or five months in
20 the summer of probably '95 or '96 doing that
21 work.

22 **Q:** Okay. And who were some of the clients that
23 you did work for when you were with Arthur
24 Andersen?

25 **A:** My largest client was Carolinas Healthcare

1 System, which is now Atrium Health. They're
2 about a nine -- today a nine million dollar
3 health system. They weren't quite that big
4 when I served them a number of years ago, but
5 I spent a lot of my time on Atrium. But
6 Chester County Hospital was a client. Haywood
7 Medical Center -- or Haywood County Hospital
8 was a client. Richland Memorial, I did work
9 there. I did work in Asheville. I had clients
10 in Texas, Atlanta that I did some projects for.

11 Q: Okay.

12 A: But primarily the Carolinas.

13 Q: Okay. And recognizing it was a while ago, but
14 can -- kind of explain to us what did you do;
15 what was the work that you did that involved
16 feasability studies?

17 A: Uh-huh. So, you know, the feasibility studies
18 are really done to determine is a project or is
19 a strategic plan, you know, feasible in terms
20 of is it -- can it be funded and typically, is
21 it accretive to the organization in terms of
22 income.

23 Q: Accretive; what is that?

24 A: Is it -- does it produce positive income.

25 Q: Okay.

1 **A:** And is it going to promote the health of the
2 organization.

3 **Q:** All right. And you mentioned that the COPA
4 that you worked on, can you tell us just a
5 little bit of what you were evaluated and what
6 you completed?

7 **A:** Yeah. So the -- again, the COPA application
8 was -- you know, because Mission and St.
9 Joseph's were competing, when they got
10 together, then that community lost the
11 competition. So, the COPA application, or the
12 Certificate of Public Advantage was to make
13 sure -- it was really a commitment on the part
14 of the health system to say, we're going to
15 deliver this level of savings to the community,
16 so there's an advantage to us affiliating. To,
17 you know, the -- the additional leverage we
18 garner by affiliating is not -- we're not going
19 to use that to -- to increase cost to the
20 community, we're actually going to use this to
21 promote savings in the community.

22 **Q:** And were there any changes in the facilities or
23 the structures ---

24 **A:** You know, one interesting -- one interesting
25 savings that we came across that I was involved

1 in is the -- is that Mission and St. Joseph's
2 had two full service ERs across the street from
3 each other and that was very expensive. So,
4 some of the savings that I recall -- this was
5 years ago, but I recall that the volume going
6 through those ERs was enough to where they only
7 needed one ER for the higher acuity patients
8 and one urgent care center for the lower
9 acuity. So, Mission kept their ER, but St.
10 Joe's across the street, closed their full-
11 service ER, but used that space for urgent
12 care.

13 Q: Okay. And now, when did you leave Arthur
14 Andersen?

15 A: July of 1997.

16 Q: Okay. And tell us how you came to join Roper?

17 A: So, Roper CareAlliance was a consulting client
18 of mine with Arthur Andersen and I was in town
19 in Charleston pitch hitting as their director
20 of finance two days a week. That position was
21 vacant and I was coming down two days a week
22 just to -- just to pitch hit while they sought
23 another con- -- director of finance. At that
24 time or around that time, my largest client,
25 Carolinas Healthcare Systems signed a one-year

1 management contract with the Roper
2 CareAlliance. And I was -- I had a child at
3 that time, I was looking to get off the road
4 and that was a good fit.

5 Q: Okay. And so, what position did you take?

6 A: Director of finance.

7 Q: All right. And tell us a little bit -- what
8 were you duties and responsibilities ---

9 A: Okay.

10 Q: --- as director of finance?

11 A: So, I would've been responsible for all the
12 financial reporting in accordance with
13 generally accepted accounting principles and
14 maintaining an internal control structure that
15 allowed for accurate reporting in accordance
16 with generally accepted accounting principles.
17 I was over things like payroll and AP that
18 would be fairly typical for that role. The
19 budgeting process, I was responsible for. I
20 ran our decision -- or I oversaw our decision
21 support systems, which is mainly our -- like
22 our cost accounting systems. I was also over
23 supply chain or materials and I was over re --
24 the reimbursement areas too, which oversee our
25 Medicare and Medicaid reimbursement.

1 Q: Okay. And who did you report to?

2 A: The CFO.

3 Q: Okay. And then, when did that -- when did your
4 position change?

5 A: I was promoted to CFO in March of 2005.

6 Q: Okay. And so, to what position?

7 A: I was promoted to chief financial officer.

8 Q: And is that what you are today?

9 A: Yes.

10 Q: Okay. All right. So, tell us a little bit
11 about how it went from Roper CareAlliance to
12 Roper St. Francis.

13 A: Okay. So, in 1998, in Charleston Roper St. --
14 or Roper CareAlliance, which was a two-hospital
15 system competed with Bon Secours-St. Francis
16 Hospital. And for years, those two
17 organizations had talked about affiliating and
18 in August of 1998, they did successfully enter
19 into an affiliation whereby the former Roper
20 CareAlliance contributed its assets to a new
21 co; Bon Secours Health System out of Baltimore,
22 which was the sole member of St. Francis
23 Hospital, contributed that hospital to a new
24 co; and then, Carolinas Healthcare System
25 bought into that new co at a 10 percent

1 membership interest. And ---

2 THE COURT: You say new co?

3 A: So, with the affiliation, a new company was
4 formed.

5 THE COURT: Oh, new company.

6 A: And then three parties contributed assets to
7 that company. And that company was called
8 CareAlliance Health Services, and that was a
9 name that just never stuck in Charleston.
10 Everybody knew who Roper was and everybody knew
11 who St. Francis was; nobody knew who
12 CareAlliance Health Services was. So because
13 we could never brand that name, shortly after,
14 maybe a year or two after we adopted that name,
15 we changed it to Roper St. Francis Healthcare.

16 Q: And how long had Roper Hospital been downtown?

17 A: Roper was formed in, I think, 1829.

18 Q: Okay.

19 A: And has been serving the downtown Charleston
20 community since that time.

21 Q: All right. And then, tell us about -- because
22 we heard a bit yesterday. Tell us, was St.
23 Francis Hospital always where it's located
24 today?

25 A: Well, St. Francis isn't really -- has always

1 been kind of a community hospital and they were
2 on the peninsula of Charleston for years and
3 years. St. Francis started serving Charleston,
4 I think, 1882. And they were located downtown
5 approximate to both MUSC and Roper's Roper
6 Hospital facility. Around -- and, you know,
7 they were not doing well financially on the
8 peninsula. In approximately 1996, they
9 relocated west of the Ashley to a new facility
10 on Tecklenburg Boulevard.

11 Q: Okay. And so, was that before the affiliation
12 took place?

13 A: They -- they would have moved about two years
14 before the affiliation.

15 Q: Okay. And going back to that period of time
16 when Roper St. Francis became the brand, were
17 there any other hospitals in the system?

18 A: Yeah. There was a small hospital not far from
19 downtown that was -- a Roper North facility and
20 we -- it was a underutilized facility. It was
21 already close to downtown and we did, because
22 it was underutilized, shut that facility down.
23 In doing so, we did work closely with the --
24 with the mayor of North Charleston and the
25 residents of North Charleston and to supplement

1 for shutting the hospital down, we did open up
2 an emergency room and a diagnostic center in
3 the Northwoods area of North Charleston.

4 **Q:** Is that the Roper Northwoods freestanding ED?

5 **A:** Correct.

6 **Q:** Okay. All right. If you could, tell us what
7 does your job as CFO for Roper St. Francis
8 entail?

9 **A:** So, it's -- it's everything I went through as
10 director of finance, although now a director of
11 finance reports to me. I've also got revenue
12 cycle, which is billing and collecting. I
13 administer to our finance committee of our
14 board and our investment committee of our
15 board. I'm over managed care contracting and,
16 you know, the -- I mentioned revenue cycle.
17 You know, probably one of the most different
18 things about being director of finance versus
19 CFO though is, as a senior leader I'm part of
20 the senior team that really sets the strategic
21 direction of the organization and then is
22 responsible for achieving that strategy and the
23 goals established as part of that strategy.

24 **Q:** All right. As CFO, do you have any
25 responsibilities related to budgeting?

1 **A:** Yes. I -- yes. I'm -- just like I was over
2 budgeting process as director of finance and
3 then, I'm obviously over that as well as CFO.

4 **Q:** How many -- you mentioned senior leadership
5 position. How many senior leadership positions
6 are there are Roper St. Francis?

7 **A:** It's -- I think there are ten vice presidents.

8 **Q:** Okay. All right. And you mentioned managed
9 care contracting. What is your role with
10 regard to managed care contracting?

11 **A:** So, you know, governmental payers -- it really
12 applies to predominantly commercial payers like
13 Blue Cross, Cigna, United, Aetna. It's not,
14 you know, the government -- the governmental
15 payers pretty much inform you what they're
16 going to pay you, so there's really no
17 negotiation with Medicare and Medicaid. There
18 are what are called Medicare and Medicaid
19 Advantage programs where -- where some Medicare
20 and Medicaid volume is being insured through
21 private sector insurance companies, and we do
22 contract with those. But most of my job with
23 -- well, we probably have 60 managed care
24 contracts, but the -- most of my job in managed
25 care is dealing with Blue Cross, Cigna, United

1 and Aetna. And -- and working to stay in
2 network with those companies at fair
3 reimbursement rates.

4 Q: Okay. And -- so, do you participate in the
5 government insurance programs?

6 A: Yep, we do.

7 Q: Okay. And what about sort of -- what is --
8 what is your role when it comes to the
9 budgeting or the financials for Roper St.
10 Francis?

11 A: So, you know, the process really starts with
12 strategic planning. And, you know, the
13 financial planning has to be closely linked
14 with strategic planning. And, you know, it
15 seems like strategic planning is an ongoing
16 process all the time, so financial planning is
17 ongoing as well. But with our financial
18 planning and budgeting, we seek to be able to
19 support our mission in the community, but also
20 fund our strategic plan along with the daily
21 operations of the company and maintain our
22 fiscal health in -- in doing so.

23 Q: Okay. And is Roper St. Francis -- well, first
24 let me ask you, as CFO, the responsibilities
25 are they to any specific hospital or to the

1 system?

2 A: I'm -- I'm responsible for the -- for the
3 system.

4 Q: So, that would be all of the hospitals and
5 facilities.

6 A: All the hospitals. And I would tell you that,
7 you know, the budget is everyone's
8 responsibility. You know, it's not just the
9 CFO's budget or finance's budget. In any
10 organization, the budget has to be owned
11 predominantly by the operators ---

12 Q: Okay.

13 A: --- of a company.

14 Q: That was definitely the CFO hat right there.
15 You wanted that in the record, I think, didn't
16 you?

17 A: (No audible response.)

18 Q: Is Roper St. Francis professionally audited?

19 A: We are required, because we have -- through our
20 debt covenants, to obtain an independent
21 external audit. And Dixon Hughes Goodman is
22 the firm that currently provides that work.

23 Q: And you're right, that was poor wording. Do
24 you have an independent -- you have independent
25 audits of your financials; is that right?

1 **A:** That is correct.

2 **Q:** Okay. And you said, Dixon Hughes does that
3 work?

4 **A:** Yeah, Dixon Hughes Goodman ---

5 **Q:** Okay.

6 **A:** --- does that work.

7 **Q:** All right. And what is your role in the
8 preparation or development of those financials?

9 **A:** So, I am responsible overall for preparing
10 financial statements in accordance with
11 generally accepted accounting principles. And
12 for us, that's -- those are the Financial
13 Accounting Standards Board, or FASB rules. I'm
14 also responsible for maintaining internal
15 control environment to safeguard the assets of
16 Roper CareAlliance, and also make sure that the
17 internal controls allow us to produce accurate
18 financial statements in accordance with GAAP or
19 generally accepted accounting principles.

20 **Q:** Okay. So, tell us -- kind of give us a little
21 more detail about what you mean with internal
22 controls?

23 **A:** You know, the capture of revenue and the
24 completeness of our expenses and the
25 safeguarding of our assets. You know, I

1 mentioned I was over supply chain. You know
2 there's hundreds of millions of dollars of
3 supplies that come through an organization
4 every year; making sure those -- those are
5 safeguarded and are used appropriately for
6 patient care. We handle a lot of cash in the
7 organization, and what our controls over that
8 cash and making sure it gets to Roper St.
9 Francis' bank account on a timely basis, when
10 it's collected.

11 Q: Okay. And you mentioned GAAP, generally
12 acceptable accounting principles. What are
13 those?

14 A: Those are the rules that we have to follow in
15 preparing our financial statements. The same
16 financial statements that are externally
17 audited.

18 Q: Okay. And then, you use the -- the terminology
19 FASB. Tell us what that is.

20 A: Okay. So, the Financial Account Standards
21 Boards sets the standards under which we report
22 under generally accepted accounting principles.
23 And that -- that applies to predominantly
24 public companies and private companies, non-
25 governmental companies. Governmental companies

1 like -- like MUHA, for instance, use -- use
2 governmental accounting standards or GASB, it's
3 called. And there's a tremendous amount of
4 overlap between FASB and GASB, but there are
5 some differences between the two.

6 Q: Okay. And what -- what type of organization is
7 Roper St. Francis?

8 A: We're a 501(c)(3), not-for-profit organization,
9 which means effectively, that we're a community
10 asset and that -- that the income and assets of
11 our organization have to be used for the
12 community and cannot enter into the private
13 benefit of an individual.

14 Q: Okay. And does Roper St. Francis have a
15 mission, a mission statement?

16 A: Our mission statement is healing all people
17 with compassion, faith and excellence.

18 Q: Okay. And so, what are some ways in which you
19 can describe that -- how that mission is met?

20 A: Yeah. I mentioned that Roper St. Francis has
21 been in the community since the 1800s and I,
22 you know, I've been in Charleston about 22
23 years, but it's amazing how many people you run
24 into that were born either in Roper or St.
25 Francis. And, you know, I think -- you know,

1 primarily, we're there to promote the health of
2 the community.

3 Q: Okay. And what about -- what are some other
4 initiatives that are important to the Roper St.
5 Francis mission?

6 A: Well, we do provide a significant amount of
7 community benefit. As a non-profit, we -- we
8 pay a lot of taxes. We pay a lot of property
9 taxes and other types of taxes including sales
10 tax, but we -- we don't pay federal and state
11 income tax. But in lieu of doing that, then we
12 have to demonstrate to the IRS that we're
13 providing -- you know, an appropriate amount of
14 community benefit. And that is included -- we
15 file a Form 990 every year to demonstrate to
16 the IRS, among other things, that we're meeting
17 our obligations. But the predom- -- we --
18 predominantly, two things with regard to
19 charity care, we provided care at no cost to
20 patients that can't afford to pay and that's
21 the biggest component and community benefit.
22 And then we also fund a number of organizations
23 in town, who we're not affiliated with, but
24 their mission is similar to ours and we fund
25 them to promote their mission, which we think

1 complements ours.

2 Q: Okay. And you had mentioned one of the topics
3 you are interested in in some of your
4 continuing education was population health. Is
5 that an example of population health?

6 A: No. Population health is more geared toward
7 cost savings and healthcare and it's -- it's --
8 even after 10 or so years, it's very much in
9 it's infancy yet. But population health is
10 really about, you know, how do we -- how do we
11 not react to people being sick, how do we use
12 data and other things to keep people well. You
13 know, how do we intervene before the patient --
14 you know, how do we promote healthy living and
15 also intervene before the patient gets sick and
16 that's -- and through that fundamental shift in
17 healthcare, that is supposed to lower costs.

18 Q: Okay. And so, you mentioned you're responsible
19 for the overall system budget. How does that
20 interface with the strategic planning process?

21 A: So, you -- you have to have a strategic
22 planning process and a budgeting process that
23 are tightly linked because the -- the strategic
24 plan has to be funded. And the strategic plan
25 also has to promote the -- the going concern of

1 the organization. I mean, so -- you know, each
2 year we look at our strategic plan and, you
3 know, do -- are we gen- -- you know, we have to
4 generate the margins to cover our strategic
5 plan, while also meeting our mission
6 objectives. And then the strategic plan needs
7 to promote -- promote growth of the
8 organization and the long-term financial
9 stability of Roper St. Francis.

10 Q: Okay. As CFO, how many people report to you?

11 A: I have 10 direct reports, but on the board
12 chart, I have just over 600, I believe, that
13 report through the CFO's office.

14 Q: Okay. And who do you report to?

15 A: The CEO, who's name -- who's Lorraine Lutton,
16 our CEO.

17 Q: The C -- is she CEO of the system?

18 A: Of the system. Yes.

19 Q: And we heard Mr. Bosse yesterday mention
20 Anthony Jackson. Can you -- who is Anthony
21 Jackson? How does his role relate to yours?

22 A: Yeah. Anthony is a vice president. I'm a vice
23 president. He's a vice president of the
24 operating side, not the finance side. And he
25 is over our acute care division, which consists

1 of the four hospitals that have been talked
2 about yesterday and today. And so, I would
3 call Anthony a peer.

4 Q: Okay. Is he one of the 10 that you mentioned?

5 A: Yes.

6 Q: All right. As CFO for Roper St. Francis, how
7 do you evaluate capital projects?

8 A: So, we -- we put things in two buckets, and we
9 have a discipline around this: that routine and
10 -- we have a bucket called routine and minor
11 strategic. And routine is really replaceable.
12 You know, as things wear out, as OR
13 instrumentation and other capital items wear
14 out, we -- we -- those have to be funded or
15 replaced. We call that routine capital. We
16 also have minor strategic, which would -- which
17 are smaller strategic projects. And our
18 discipline is we fund that with cash flows from
19 operations. So, if that budget is limited
20 every year to the -- what's available through
21 cash flows from operations. We have another
22 bucket called -- called major strategic and it
23 -- the major strategic is generally things like
24 Berkeley Hospital, Mount Pleasant Hospital,
25 that we fund using debt capacity of the health

1 system.

2 Q: Okay. And is there -- is there a definition or
3 a threshold for a major strategic project?

4 A: No. There's not a dollar threshold. It's one
5 of those things you know it when you see it.
6 And, you know, again, it's generally been the
7 really big stuff, like new hospitals or new
8 towers on existing hospitals.

9 Q: Okay. And what metrics are you evaluating when
10 you're considering a major strategic project?

11 A: So -- so because major strategic projects are
12 debt financed, you know, our -- that starts to
13 bring in our credit rating. And Roper St.
14 Francis is the only investment grade rated
15 health system in the lowcountry. But our
16 access to capital -- access to capital and
17 affordable capital, is pretty much determined
18 by that credit rating.

19 Q: Okay. And so, explain this credit rating.

20 A: So, it works similar to a person's -- an
21 individual's credit score. You know, your
22 access to debt, whether you're trying to get a
23 mortgage or a credit card, as an individual,
24 your access to debt is largely determined by
25 your credit score. You know, how much debt you

1 can get and at what rates is covered by -- or
2 determine by your credit score. Health --
3 healthcare works the same way. I mean, Roper
4 Francis is a billion dollar company, but our
5 access to capital is really dictated by that
6 credit score or that credit rating that we
7 received from a company called Moody's Investor
8 Service. And they updated us at least annually
9 in issuing that rating.

10 Q: Okay. And who is -- tell us more of -- what is
11 Moody's?

12 A: Moody's is one of the large rating agencies
13 that rate healthcare systems. I think they
14 rate over 500 healthcare systems nationally and
15 they rate municipalities, other companies, but
16 they also have a big healthcare practice.

17 Q: Okay.

18 A: And they're independent of Roper St. Francis.
19 They're similar to like a Standard and Poor's
20 or a Fitch, who are also common -- large
21 healthcare rating agencies.

22 Q: Okay. All right. And so, is -- is the rating
23 process an important one for Roper St. Francis?

24 A: It -- it is. And the question you asked a
25 couple of questions ago was -- was how do --

1 was what do you start to consider when you --
2 when you think about major strategic. And, you
3 know, credit rating is very important because
4 we would not want to take on anything strategic
5 that would push our risk profile to the point
6 where our credit rating was -- was in jeopardy,
7 where our access to future funding would be in
8 jeopardy.

9 Q: Okay. And you mentioned investment grade.
10 What does that mean?

11 A: It -- so, ratings, there's a scale of ratings
12 and they're different from the different rating
13 agencies, but I think the more common ratings
14 that maybe folks -- folks in the Court you may
15 have heard, you have like AAA. You know, the
16 government is rated AAA. It's considered risk
17 free. You have AA, A, and then you get down
18 into, you know, BBB, BB. And when you get
19 really below BBB, then you're getting into non-
20 investment grade kind of junk bond status.

21 Q: Okay. All right. And is it just letters or
22 are there an other markers?

23 A: No. There can be -- S -- Standard and Poor's
24 uses a plus/minus system and Moody's uses like
25 a 1, 2, 3. So, if you're an A- with S&P, that

1 is commensurate with an A3 for Moody's. If
2 you're an A+ with -- I might have got it mixed
3 up. If you're an A+ with S&P, that is
4 commensurate with an A1 of Moody's. If you're
5 an A3 with Moody's, that's like an A- with S&P.

6 Q: So it's not complicated at all?

7 A: It's a little different.

8 Q: All right. Well, how is Roper St. Francis
9 rated?

10 A: We -- we are rated Baa1, which is really one
11 notch under A-.

12 Q: Okay.

13 A: But still well into the investment grade
14 category.

15 Q: Okay. All right. And so, as a CFO and in
16 maintaining your professional CPA, are there
17 metrics or thresholds that you regularly
18 monitor that are indicators of financial
19 health?

20 A: Well, the rating agencies when they -- and when
21 you're looked at from a -- from a fiscal health
22 perspective, when the rating agencies are
23 looking at the market you're in; they're
24 looking at the quality of management; they're
25 looking at the quality of the strategic plan;

1 they're looking at your -- your historical and
2 projected performance, but -- but some of the
3 biggest things that affect rating, and that we
4 look at very carefully, to dial in on your
5 question, is there are some ballot sheet
6 strength metrics that are extremely important
7 and then there are some margin or investments
8 -- investment or income performance metrics
9 that are extremely important. And just walking
10 through a few of the more important ones, you
11 know, days cash on hand is probably the most
12 important balance sheet metric the rating
13 agencies look at.

14 Q: And what does that mean?

15 A: And that is -- it's your unrestricted cash
16 investments divided by your average daily
17 expenditures. Okay. So, you know, Roper St.
18 Francis every day sends out the door to pay its
19 bills about 2.6 million. 2.5 to 2.6 million.
20 So, if you take our unrestricted cash
21 investments, divide it by that 2.6, it reflects
22 the number of days we could stay in business if
23 revenue stopped coming in.

24 Q: Okay.

25 A: And that's probably the number one balance

1 sheet strength metric that is looked at. The
2 other thing the rating agencies look at on
3 balance sheets, there's two more that are
4 critically important, the relationship of your
5 cash to debt. You know, so there's a ratio of
6 cash to debt that they look at. How much --
7 how much in cash do you have versus debt. And
8 you know, an A rated facility probably has a
9 \$1.70 in cash for every dollar of debt.

10 Q: Okay.

11 A: And then the third metric is -- is the debt to
12 capitalization ratio, which is really like a
13 debt to equity ratio. It's your -- it's your
14 debt divided by your debt plus your
15 unrestricted net assets or your equity. And
16 really what that tells you is, you know, your
17 debt to equity ratio tells you how much of the
18 company do we own and how much does the bank
19 own.

20 Q: And is that expressed as a ---

21 A: As a ---

22 Q: --- how is that expressed?

23 A: --- percentage.

24 Q: A percentage, okay. And what are -- what is a
25 threshold ---

1 **A:** An A rated facility would be in the -- around
2 33, 34 percent, meaning that -- in my previous
3 analogy it means kind of the -- the debt
4 holders own, you know, using this term loosely,
5 own 33 percent of the company and the company
6 owns 67 percent of itself. That's kind of --
7 that's kind of how you would explain the debt
8 equity -- debt to cash ratio.

9 **Q:** And those are metrics you said on the balance
10 sheet strength?

11 **A:** Those are important balance sheet strength
12 metrics, yes.

13 **Q:** Okay. And then, I think you mentioned there's
14 some income performance.

15 **A:** Uh-huh. So, that's -- those are generally
16 expressed in terms of margins. And there are
17 two that the rating agencies focus heavily on.
18 There's operating cash flow margin, and that is
19 -- that is defined as income from serving
20 patients, less the cost of serving patients.
21 Before those costs include depreciation and
22 interest expense. And what the important of
23 that margin metric is, you know, it's your
24 revenue for serving patients less the cost of
25 serving patients before depreciation interest.

1 It really looks at what cash flow from
2 operations do you have available for debt and
3 for capital expenditures or to apply back into
4 your balance sheet to build your cash reserves.

5 Q: Okay.

6 A: And then, operating margin is the same
7 calculation except you add depreciation and
8 interest into the expenses. And that is -- and
9 then, if you take the result of that and divide
10 it into revenue, you come up with a percent.
11 And what that percent is indicative of is how
12 many -- in healthcare -- other industries, it's
13 dollars on dollars, but healthcare pays on the
14 dollar. You know, how many pennies on the
15 dollar is Roper St. -- is a health -- is a
16 company earning.

17 Q: Okay.

18 A: Two operations.

19 Q: How often do you monitor metrics like this for
20 Roper St. Francis?

21 A: At least monthly.

22 Q: Okay. And is that unique to the Roper St.
23 Francis or a non-profit healthcare system?

24 A: I would -- no. I would -- any -- any company
25 that relies on -- on requiring debt is going to

1 have to maintain the fiscal strength to be able
2 to access debt on an affordable basis.

3 **Q:** Okay.

4 **A:** So, I think all companies are looking hard at
5 those metrics.

6 **Q:** Okay. And do you follow the financial health
7 or performance of other hospitals?

8 **A:** I do. To the extent it's publically available,
9 which any hospital with public debt is pretty
10 much gonna have to produce their financials to
11 the public. I do look at trends in South
12 Carolina for, you know, ten large health sys-
13 -- non-profit health systems in South Carolina.

14 **Q:** All right.

15 OFFER AS EXPERT:

16 MS. HOLLINGSWORTH: And, Your Honor, we offer Mr.
17 Johnson as an expert in healthcare finance.

18 MS. CRUM: No objection, Your Honor.

19 MR. WICEVIC: No objection, Your Honor.

20 MR. THOMAS: No objection.

21 MR. SUMMER: No objection.

22 THE COURT: He is so qualified.

23 MS. HOLLINGSWORTH: Thank you, Your Honor.

24 **Q:** Mr. Johnson, if you would, tell us a little bit
25 about -- let's talk some more about the

1 organizational structure and sort of sizing up
2 your system.

3 A: Uh-huh. So, we are about 1.2 billion in assets
4 and projecting it to hit in fiscal year 2019,
5 950 million of revenues.

6 Q: Okay. And in terms of -- tell us a little bit
7 about --

8 A: Sure.

9 Q: --- the hospitals, where they're located and
10 how they're sized?

11 A: So, we have Roper Hospital in downtown
12 Charleston. It's a -- it's a tertiary -- it's
13 our highest acuity tertiary hospital. I
14 believe it has 266 licensed beds. We have our
15 St. Francis Hospital west of the Ashley, which
16 has 204 beds. We have our Mount Pleasant --
17 our Mount Pleasant Hospital, which opened in
18 November of 2010, that resulted from a transfer
19 of beds from the downtown Roper Hospital to
20 North Mount Pleasant, and that's 85 beds. And
21 then we have -- of course, have our Berkeley
22 50-bed hospital. Again, a transfer of beds
23 from -- from the peninsula to -- to the
24 Berkeley County area. That's 50-bed and that
25 opened on October 4th. And I would say in

1 addition to our acute division, we have a large
2 employed physician network, approximately 230
3 employed physicians, both primary care and
4 specialists. We have a number of what are
5 called mid-levels, about 80 advanced
6 practitioners and nurse practitioners in that
7 physician division to support the physicians.
8 We also have the bells and whistles you'd
9 expect on a health system our size. We have a
10 large home health. We have physical, a large
11 physical therapy division, hospice, inpatient
12 rehab, just a lot of the other -- and then, a
13 lot of the post -- what are called post-acute,
14 which are services offered after someone is
15 discharged from the hospital. We've got a lot
16 -- large presence of those as well.

17 Q: Okay. And you mentioned that Roper Hospital is
18 a tertiary or highest acuity hospital. Can you
19 give us descriptions of the other three?

20 A: Yeah. Roper is our -- our highest acuity
21 hospital and it has the largest IC -- intensive
22 care units. It does open heart surgery and
23 thoracic surgery that our other hospitals don't
24 do. So, it maintains a higher level of acuity.
25 Our St. Francis Hospital is a community

1 hospital, but it also has a tertiary program,
2 which is a large neuro-spine practice.

3 Q: Okay.

4 A: Mount Pleasant is a community hospital, but
5 it's been open 10 years. It is starting to see
6 more and more joint replacements. We have some
7 of our joint surgeons that live in Mount
8 Pleasant that wanted to use that facility. So,
9 it is -- it is becoming more acute as time goes
10 by, but still a community hospital.

11 Q: Okay. And you gave me some of those financial
12 metrics on the sizing of the system. How does
13 that compare within South Carolina?

14 A: So, I mentioned that we were a billion-two in
15 revenues and appropriate a billion -- excuse
16 me, a billion-two in assets, approaching a
17 billion in revenues. You know, MUHA is 2.1
18 million -- billion in assets and about a
19 million-six to a million-seven in revenues in
20 their 2019 audited financials. Prisma, which
21 is here in Columbia, is closer to five billion
22 in assets and that's probably the largest
23 health system in South Carolina.

24 Q: Five billion?

25 A: Five billion. There are a number of other --

1 you know, you have McLeod, you have -- you have
2 AnMed, you have Spartanburg and Self, and, you
3 know, they're all large health systems, either
4 a little bit larger than Roper St. Francis or
5 a little bit smaller depending on who it is,
6 but you -- you have a -- between 750 million
7 and a billion and a half. There's quite a few
8 hospitals in -- systems in South Carolina that
9 are that size.

10 Q: Okay. And I -- I won't tie you to the exact
11 bed, but do you know roughly the total beds
12 that your system has, the acute care beds?

13 A: 6 -- let me see. 605, I believe.

14 Q: Okay. All right. Let's go -- let's talk some
15 more about capital projects and what goes into
16 your analysis. Are all capital projects
17 intended or planned in order to generate
18 additional revenue?

19 A: No. There are projects that pertain to patient
20 safety that get approved that I have no ROI and
21 a good one recently that was very expensive is
22 -- is -- and a lot of hospitals along the coast
23 are doing this. It's related to shelter in
24 place, which is -- which is just -- you know,
25 we do have storms and in those named storms, we

1 just make sure -- when you have a mandatory
2 evac because a storm is coming, there are
3 patients on life support that you can't
4 evacuate, you know. So, you have to hunker
5 down and take care of those patients. And
6 shelter in place is a project to take our
7 generators and electrical switches and -- and
8 move them up, you know, out of the way. So,
9 that they were just more reliable. So, that we
10 kind of hardened the facility against --
11 against named storms.

12 Q: Okay. And you -- you said ROI; can you tell us
13 what that is?

14 A: I'm sorry. Return on investment. So, having
15 a project that would -- that simply -- and it's
16 an expensive bricks and mortar project to -- to
17 lift your generators higher up or lift your
18 electrical switches higher up is certainly
19 nothing that is going to produce income for
20 Roper St. Francis. But you do it because it's
21 -- of patient safety.

22 Q: Okay. Are there other -- any other types of
23 projects that might be considered capital
24 project, but aren't adding revenue?

25 A: Uh-huh. So, the new tower at Roper Hospital

1 back in the early 2000s is a good example. You
2 know, we -- our heart and vascular program was
3 operating in space, I think, that dated back to
4 the '60s and we built a new heart and vascular
5 tower that opened in 2003 or 2004. There was
6 no incremental revenue or volume associated
7 with that. We just needed to update the space
8 they were practicing in.

9 Q: Okay. What is incremental?

10 A: So, incremental revenue would pertain to -- as
11 it pertains to a project would be -- would be
12 new patients you would expect because of
13 introducing that project.

14 Q: Okay. All right. So, what are -- what are
15 some examples of projects that would have
16 incremental revenue?

17 A: Well, our Berkeley Hospital for example, you
18 know, in our CON, we noted that, you know,
19 within Berkeley County we thought, you know, 50
20 -- the patients that we serve in Berkeley
21 County, about 50 percent, would redirect from
22 our other hospitals to that hospital, but then
23 50 percent of the volume would also be patients
24 new to us either -- either through market share
25 growth or through just the growth in that

1 community. So -- so, a component of Berkeley
2 Hospital was redirect, but a component was
3 also, this is going to create new business for
4 Roper St. Francis Healthcare.

5 Q: Okay. How as the tower not incremental?

6 A: Because we didn't increase the number of
7 surgeons. We didn't increase our footprint in
8 heart and vascular, other than the new square
9 footage. So, we did not think we would
10 increase the number of open hearts or caths or
11 anything just by virtue of -- of building that
12 new tower.

13 Q: And are there -- are there special or different
14 considerations when you have a major strategic
15 project that doesn't have incremental ---

16 A: So, you're going to -- you know, like with the
17 heart tower, you know, we -- we wanted to build
18 that in the least expensive way possible
19 because it was not going to provide incremental
20 revenues. So, cost becomes a major factor if
21 you're not expecting the project to create
22 additional revenues.

23 Q: And how long has -- you mentioned the west of
24 the Ashley is when the hospital out -- the
25 current Bon Secours-St. Francis -- Roper

1 Hospital downtown, how old is that facility?

2 A: The original tower -- now, Roper's been
3 downtown in various locations since the early
4 1800s, but that tower started, I believe, in
5 1940. And then, there were additions made in
6 the '60s and there were additions made in the
7 '80s, which we still occupy. And then, there's
8 the new -- or I say new. The heart and
9 vascular tower, which is the 2004,
10 approximately.

11 Q: Okay. So, and you might have touched on this,
12 but how are these major strategic projects
13 funded?

14 A: At Roper St. Francis, we will fund them
15 predominantly with debt. And I mentioned our
16 -- our -- our owners or member companies
17 earlier a bit. They may also provide a cash
18 contribution to Roper St. Francis to help fund
19 major strategic, but it's predominantly through
20 the issuing of not -- a tax exempt bond debt.

21 Q: Okay. And is this where that credit rating is
22 important?

23 A: Absolutely.

24 Q: Okay. And how frequently do you have major
25 strategic projects; do you keep a list of them?

1 **A:** Uh-huh. Well, major strategic for us happens
2 about every five years since I've been involved
3 in Roper St. Francis. And the reason is, you
4 know, you do something from a major strategic
5 perspective, you increase your -- your debt,
6 which lowers your debt capacity. And to afford
7 to be able to do the next strategic thing, you
8 have to -- you have to bring your balance sheet
9 back to -- to where you have the debt capacity
10 for the next major strategic item. If we were
11 to just put strategic project after strategic
12 project, that would create a risk profile that
13 would not allow us to create -- it'd create a
14 financial and a risk profile that would not
15 allow us to keep our investment rate credit
16 rating.

17 **Q:** Okay.

18 **A:** So, we -- we build a Mount Pleasant Hospital
19 and then we're outta the -- we're out of
20 strategic, major strategic for a few years
21 until we recover the balance sheet and have the
22 capacity for that next major strategic thing.

23 **Q:** Okay. And very generally, but what were the
24 circumstances and timing for the strategic
25 planning of the Mount Pleasant and then,

1 Berkeley Hospitals?

2 A: In terms of timing, the Mount Pleasant, we
3 would have filed the CON in the 2005-2006 time
4 frame. We would have issued debt after it was
5 a clean CON and we were able to move forward.
6 The -- the facility I mentioned opened in -- in
7 November of 2010. I think it wasn't too long
8 after that that we actually filed the CON for
9 Berkeley, but knew that would not be a short
10 process to ultimately get to an open facility
11 in Berkeley County. We knew we had enough
12 runway to get the balance sheet where it needed
13 to be.

14 Q: What are reasons that you as a CFO might not
15 recommend pursuing a major strategic project?

16 A: If it were not -- for a major strategic
17 project, I mentioned earlier, you know, major
18 strategic projects have to promote the going
19 concern of the organization, so I would not
20 want to spend a 100 million dollars on
21 something that did not -- that was not added to
22 -- to margin of the health system. That would
23 be very important to the CFO. Also, if it --
24 if it were to create stress on the balance
25 sheet that put the organization's credit rating

1 at risk, I would -- I would want to work with
2 our board and valued members to say, okay, how
3 do we do this in a way that preserves that
4 credit rating. So, I would, you know -- and in
5 addition to that and where -- probably where
6 you would start is, first of all, does this
7 project support our mission and -- and
8 strategic direction of the organization. But
9 once that was determined to be a yes, then my
10 job is, okay, how are going to pay for it and
11 maintain our access through affordable capital.

12 Q: And if your credit rating drops, then how easy
13 it to bounce back?

14 A: You know, it's easy to lose your credit rating;
15 it's much harder to get it back. We -- you
16 know, if you were to get downgraded, you know,
17 you'd have to demonstrate several years of
18 improved performance before you're gonna --
19 you're gonna get your credit rating back. The
20 rating agencies are not just, okay, you bounce
21 back a little bit the year after your
22 downgraded, here's your rating back. It
23 doesn't work that way. You've got to have
24 several years of sustained performance at that
25 higher category level before they're going to

1 bring you back up.

2 Q: Okay. The Roper Berkeley CON application, were
3 you involved in -- well, even before the
4 application, were you involved in the planning
5 for that project?

6 A: Yes.

7 Q: Okay. And in what way?

8 A: I was, as just discussed, I -- you know, I
9 would have been involved in the financial
10 feasibility of that -- that project.

11 Q: And what -- in the -- in the planning for that,
12 what was the reasoning or the rationale behind
13 the project generally?

14 A: As I mentioned in this chair, I think 10 or 12
15 years ago -- or 10 years ago, it was to move
16 our -- it was move beds to an area to -- an
17 area where our patients existed. Move -- move
18 our services to our -- the population we
19 served.

20 Q: Okay. And is that similar to the Mount
21 Pleasant ---

22 A: We did ---

23 Q: --- Hospital plan?

24 A: That as the same strategy for Mount Peasant,
25 correct.

1 Q: Okay. If we could, Roper St. Francis 25. And
2 let's make sure ... All right. It should be
3 tab 25.

4 (RSF Exhibit 25 was referenced at this time.)

5 Q: And what was your -- what was your title at the
6 time this application was filed?

7 A: This was December of 2008, so I would have been
8 chief financial officer.

9 Q: Okay. And December of 2008, is that the date
10 of the application filing?

11 A: Yes.

12 Q: Who's Shannon Cantwell?

13 A: She oversees all of our Certificate of Need
14 activity for Roper St. Francis.

15 Q: Okay. And let's see. And are you familiar
16 with the application?

17 A: I am. It's been a number of years since I've
18 studied it carefully, but -- but I am familiar
19 with it.

20 Q: Take a look at page 18 of that Exhibit. So in
21 the top right it would save 25-018. And what
22 was the -- what was the service area that was
23 proposed for the Roper St. Francis Berkeley
24 Hospital?

25 A: It was -- it was predominantly Berkeley County

1 and as this states, we expected to generate 90
2 percent of our -- of our volume from the
3 hospital from Berkeley County, but then another
4 10 percent of the volume for that hospital
5 would come from contiguous counties.

6 Q: Okay. And did you do the -- the planning or
7 forecasting on the utilization piece of this?

8 A: I did not.

9 Q: Do you recall who did?

10 A: A firm called Richardson Knapp of which Mark is
11 -- Mark Richardson's here today.

12 Q: Okay. All right. And let me ask you this --
13 let's see. Go to page 24. It might be on page
14 -- I'm sorry, page 25 of the Exhibit. And at
15 the -- the application's December 2008. Have
16 things changed in the last 10 years, 11 years?

17 A: Well, there's been an awful lot of change in
18 healthcare. You know, it's interesting
19 nationally and in South Carolina as well, you
20 know, healthcare is -- health systems were very
21 healthy financially 10 years ago. High
22 margins. Margins have steadily declined in
23 more recent years to the point where Moody's
24 Investor Service actually has a negative
25 outlook on the hospital or health system

1 industry. And that's because of -- margins
2 have fallen below levels nationally that
3 Moody's considers to be sustainable.

4 Q: Okay. At the type of the application, what was
5 the average length of stay that was used in
6 forecasting the utilization ---

7 A: I think it was in the neighborhood of 4.25 and
8 as you talk about change in the industry, I
9 mean, you know, that's something that has
10 changed a lot as well. I -- we're in the midst
11 of budgeting now for -- for our health system,
12 and our anticipated -- and budgets aren't final
13 yet, but our anticipated length of stay for the
14 Berkeley Hospital for 2020 is in the
15 neighborhood of 3.0. So, a fairly significant
16 drop.

17 Q: The average length of stay for Roper Berkeley's
18 Hospital?

19 A: That's correct.

20 Q: Okay. All right. Let's look at Roper St.
21 Francis Exhibit 4, please.

22 (RSF Exhibit 4 was referenced at this time.)

23 Q: And can you tell us what this is?

24 A: This is a schedule showing length of stay
25 trends for Roper St. Francis -- three of Roper

1 **St. Francis' hospitals.**

2 **Q: Okay. And is this the type of data that you**
3 **regularly monitor?**

4 **A: Every month.**

5 **MOTION TO ADMIT:**

6 **MS. HOLLINGSWORTH: Your Honor, I would move to**
7 **admit Roper St. Francis Exhibit 4?**

8 **MS. CRUM: No objection.**

9 **MR. WICEVIC: No objection.**

10 **MR. THOMAS: No objection.**

11 **THE COURT: It's admitted.**

12 **MS. HOLLINGSWORTH: Thank you, Your Honor.**

13 **Q: So, can you describe whether or how this trend,**
14 **as you called it, is reflective of industry**
15 **changes?**

16 **A: Yeah. And I'd probably isolate two of our**
17 **community hospitals on a -- you know, St.**
18 **Francis and Mount Pleasant and, you know,**
19 **noting that Mount Pleasant's length of stay is**
20 **very -- it's very similar to what I commented**
21 **on projecting for Berkeley, right around 3.0.**
22 **Roper Hospital, which is designated by the RH,**
23 **is our tertiary hospital where our most acute**
24 **patients are gonna be cared for and you can see**
25 **a higher length of stay, as you would expect.**

1 It's above 4 percent approaching 5 in 2018.

2 **Q:** Okay. And when you're doing your financial
3 planning ---

4 THE COURT: You say 4 percent.

5 **A:** I'm sorry.

6 THE COURT: You mean 4, 4 days?

7 **A:** Yes, Your Honor. Four days.

8 **Q:** When you're doing your financial planning and
9 forecasting for the new Roper St. Francis
10 Berkeley Hospital, do you use any of your -- or
11 more of your facilities as more comparable?

12 **A:** Yeah. The Mount Pleasant facility would be
13 probably most comparable to Berkeley. But when
14 we're -- when we're -- also, when we're
15 calculating length of stay, I mean, we would
16 look at the service mix for that hospital and
17 we could determine, you know, through --
18 through history what our expected length of
19 stay would be based on that service mix.

20 **Q:** Okay. And if we could go back to Exhibit 25 --
21 Roper St. Francis 25.

22 THE COURT: If I could stop -- when you say service
23 mix, you mean the higher the acuity ---

24 **A:** Yes. That's correct. It's -- you know, and it
25 can be a little beyond that. Are we doing

1 joint replacement? Are we doing oncology? Are
2 we doing, you know, urology and then, what
3 level of service are we providing within each
4 of those service lines that will -- you know,
5 the further you move up the -- the sicker your
6 patients are, the higher the acuity of care and
7 then the -- typically, the longer the lengths
8 of stay is going to be as well.

9 Q: Exhibit 25. I believe it's Page 72.

10 (RSF Exhibit 25 was referenced at this time.)

11 Q: So, we're looking back at the application for
12 the Roper St. Francis Berkeley Hospital. Do
13 you recall this document, Mr. Johnson?

14 A: Yes.

15 Q: And what is this?

16 A: This is a -- I guess a certification from me
17 back in 2008 that Roper St. Francis is capable
18 of funding the Berkeley Hospital.

19 Q: Okay. And what was the date of your letter?

20 A: November 19th, 2008.

21 Q: And turn to the next page, page 74 in the
22 exhibit. And what is this document?

23 A: This is a letter to me dated December 4th, 2008
24 from a representative of Wachovia, and the
25 letter states that -- that they have conducted

1 a debt capacity study for Roper St. Francis
2 Healthcare and based on that debt capacity
3 study, Roper St. Francis has a debt capacity to
4 fund the new Berkeley Hospital.

5 Q: And would you have assisted Wachovia Securities
6 with looking at information to do that?

7 A: Yes. And I -- again, I go beyond just the
8 letter to -- to make -- I would have been
9 making sure also that we would do it with our
10 current ratings level.

11 Q: Okay. And did you have concerns about Roper
12 St. Francis' ability to afford the hospital
13 project?

14 A: I did not.

15 Q: What were you -- how did you come to not have
16 that concern? What analysis had you done?

17 A: We would have done projection -- projections of
18 that -- of the expected performance of that
19 facility along with the rest of the healthcare
20 system. We would have put together a debt
21 structure and then, forecasted the payments and
22 principle interest and interest on that debt
23 structure and we would have made sure that it
24 -- that it was within the funding capacity of
25 Roper St. Francis Healthcare.

1 Q: Okay. And you had mentioned that you paid
2 close attention to your rating, your credit
3 rating. Would you have done anything in
4 advance of the project with regard to your
5 credit rating?

6 A: Yes. Yeah. We -- it's important to -- to keep
7 an open line of communication with your rating
8 agencies and we would definitely have discussed
9 any major strategic initiatives with the rating
10 agencies and how we were going to fund those
11 strategic initiatives early in the game. I
12 can't swear it was before this letter, but it
13 would -- we would never be in a situation where
14 the rating agencies would read something in the
15 Post and Courier and call us to find out what
16 was going on. We would -- we would be very
17 proactive about communicating with our rating
18 agencies.

19 Q: If -- if you had reason to believe that a
20 project would negatively impact your credit
21 rating or cause a downgrade, what would go into
22 your -- what impact would that have on your
23 analysis?

24 A: I -- I think it would -- if the project created
25 that kind of risk for the organization, I think

1 -- first of all, I wouldn't support it, but I
2 -- I wouldn't -- it would not get past our
3 finance committee or our board either.

4 Q: All right. If we could look at Page, I
5 believe, 65 of the exhibit.

6 MS. CRUM: I'm sorry, you said 65?

7 MS. HOLLINGSWORTH: Yes, ma'am. Same Exhibit 25.

8 Q: And you can -- you have the notebook, you can
9 flip a few pages, but you can identify the
10 series of documents for us?

11 A: Yes. It's a -- it's a forecast prepared by
12 Richardson Knapp of the incremental performance
13 of our proposed Berkeley Hospital.

14 Q: Okay. And so, explain for us incremental
15 performance.

16 A: So, I mentioned earlier that incremental volume
17 is the volume that you expect to be new to your
18 health system because of the project. So, it
19 -- it's not redirected volume. It's not volume
20 you already have that you're just redirecting.
21 It would be that new volume that you would
22 expect by virtue of implementing a project; in
23 this case, a new hospital.

24 Q: Okay. So, looking at that -- those top two
25 lines on this exhibit, tell us, what is patient

1 days incremental and what does that mean to be
2 incremental patient day?

3 A: So, that would be the incremental inpatient
4 activity, that would be a metric of inpatient
5 incremental activity that was projected for
6 this facility.

7 Q: Okay. And so, the overall revenues, are they
8 based only on these incremental patient days or
9 volumes?

10 A: That's correct.

11 Q: All right. And then can you -- what is
12 adjusted patient days?

13 A: So -- so, I mentioned that patient days apply
14 to inpatient volume. You also seek a volume
15 metric that accounts for both inpatient and
16 outpatient volumes and this is common in the
17 industry. So, what adjusted patient days are,
18 it's a global unit of volume measure to include
19 both your inpatient and your outpatient
20 activity. And it's a fairly standard
21 calculated -- common calculation in our
22 industry. But you're seeking that global
23 volume measure that includes both your
24 inpatient and your outpatient activity.

25 Q: Okay. All right. And then, looking at -- let

1 me see if I can try to get to --just to kind of
2 finish up with this record. I think in the
3 Exhibit, it might be at page 75. So, Exhibit
4 25, page 75. And there's a few documents. Can
5 you identify these for us, Mr. Johnson?

6 A: These are the requests from the Department and
7 I believe we received at least two, seeking
8 additional information about our project.

9 Q: And what are some examples -- and you're
10 welcome to flip through it. What are some
11 examples ---

12 A: Sure.

13 Q: --- of the information the Department asked for
14 ---

15 A: They were seeking additional information about
16 the average daily census and census rates.
17 They wanted more information about surgical
18 volumes, about our space program, occupancy
19 rates.

20 Q: Okay. So, did Roper St. Francis provide
21 outpatient volumes and projections?

22 A: Yes.

23 Q: And did you participate in the contested case
24 hearing for this application?

25 A: Yes.

1 Q: And what is your understanding of why you had
2 to participate in that contested case hearing?

3 A: HCA or Trident opposed the approval of two
4 hospitals in Berkeley County, if I remember
5 correctly.

6 Q: Okay. And you -- what do you recall about
7 their proposal for a hospital?

8 A: They were proposing to build a 50-bed hospital
9 in Monck's Corner.

10 Q: All right. And what did the Department decide?

11 A: The Department decided to approve both, which
12 is also something Roper St. Francis supported.
13 We felt at -- we felt that the two 50-bed
14 hospitals, that community could support -- or
15 that county could support two 50-bed hospitals,
16 so we were supportive of the -- of the decision
17 from the Department.

18 Q: Okay. And as you sit here today, what is your
19 position?

20 A: It hasn't changed.

21 Q: What is your understanding of the status of the
22 Monck's Corner hospital?

23 A: That they intend to still build it. And they
24 are experiencing wetland issues that are
25 delaying the project. And interestingly

1 enough, we experienced wetland issues on our
2 campus that delayed the project.

3 Q: All right. Let's -- we'll talk about, a little
4 bit more about feasibility. When you're
5 reviewing the feasibility of a project from a
6 financial perspective, what are you looking at;
7 what elements are you considering?

8 A: Well, first of all, I want to make sure the
9 project supports our mission and our strategic
10 direction of the organization and meeting those
11 two objectives, then I would get into, okay, is
12 this going to promote the going concern of
13 Roper St. Francis Healthcare. Is it going to
14 -- you know, is it going to, you know, be an
15 additive to Roper St. Francis, both from an
16 operational perspective and a financial
17 perspective.

18 Q: And how do you do that? How do you evaluate
19 that?

20 A: In -- you know, looking at -- looking at volume
21 that that -- or looking at the patients that
22 that project is going to serve, then also the
23 financial outcome of that as well.

24 Q: Okay. So, how does -- how do you translate
25 volume into ---

1 **A:** **So ---**

2 **Q:** **--- financial performance?**

3 **A:** **Every -- everything in a healthcare projection**
4 **starts with volume and then, you know, once you**
5 **-- once finance and operations work to**
6 **establish what volumes are, then the rest of**
7 **the pro forma, revenues and expenses, can**
8 **cascade down from that. And when we've got --**
9 **just based on a mix of services like we**
10 **discussed earlier, Roper St. Francis has**
11 **decision support systems that will tell us what**
12 **expected revenues and expenses are for that**
13 **service mix.**

14 **Q:** **Okay. Let's look at the CON application for**
15 **the proposed Berkeley Hospital. It's Joint**
16 **Exhibit 1.**

17 MS. CRUM: It's a DHEC Exhibit.

18 MS. HOLLINGSWORTH: I'm sorry, yeah; DHEC Exhibit 1.
19 Sorry, Your Honor. Just looking for the
20 witness copies in the notebook.

21 **A:** **Thank you.**

22 **(DHEC Exhibit 1 was referenced at this time.)**

23 **Q:** **Get this one out of your way. We are looking**
24 **at the application for the project that the**
25 **Medical University proposes in Berkeley County.**

1 Have you -- are you familiar with this
2 document?

3 A: Some portions of it, yes.

4 Q: Okay. Let's go to Page 590 -- let's go to Page
5 595 of the Joint -- DHEC Exhibit 1. And this,
6 this series of documents, can you explain to us
7 what these are that start at 595?

8 A: Yep. So, these -- well, 595 is an attestation
9 from my counterpart at MUHA certifying to
10 these, following the schedules. And these
11 following schedules are projections for MUHA
12 inclusive of the project and exclusive of the
13 project and then a discreet presentation on 598
14 of the actual project.

15 Q: Okay. So, let's -- let's walk through that a
16 little slower. What is on DHEC CON 596?

17 A: This is a projection for Medical University
18 Hospital Authority from projected fiscal year
19 2020 through 2025 and this projection would
20 include the activities of the proposed -- of
21 their proposed Berkeley Hospital.

22 Q: Okay. And then, tell us what is on DHEC CON
23 597?

24 A: It would be the same analysis or the same
25 projection exclusive of the proposed Berkeley

1 Hospital project.

2 Q: Okay. So, is that the Medical University
3 without the project?

4 A: That's correct.

5 Q: Okay. And then, what is on DHEC CON 598?

6 A: 598 includes a discreet presentation of the
7 projected performance of the MUHA Berkeley
8 Hospital.

9 Q: Okay. And these pages within the application
10 that we just walked through, are you familiar
11 with these pages?

12 A: That we just walked through, yes.

13 Q: Okay. And you mentioned that everything starts
14 with volume. What -- what analysis or what had
15 you done when you reviewed this application
16 looking at the pro forma for the project?

17 A: I think I noted in my recent deposition, it was
18 really difficult -- you know, I could see the
19 numbers; the revenue and expense numbers, but
20 it was really difficult for me to ascertain any
21 -- a lot of meaningful metrics because volume
22 wasn't really presented in detail in the CON
23 application.

24 Q: Okay. So, look at the bottom of the project
25 pro forma, the assumptions. In that first

1 assumption, what -- did you have volume
2 schedules with the pro forma?

3 A: In my deposition, I think I noted some -- that
4 I had come -- somewhere I'd come across 3,900
5 discharges, but -- but in terms of a -- of a
6 discreet schedule that shows volume by year,
7 both inpatient and key outpatient volumes, I
8 don't believe any such was included in the
9 application.

10 Q: Okay. And in preparing for the hearing, have
11 you been able to review a volume schedule?

12 A: I was. And that was very recently, I guess,
13 able to be given to me.

14 Q: Okay. Let's look at Trident's Exhibit 74,
15 please.

16 (Trident's Exhibit 74 was referenced at this time.)

17 Q: And can you identify what this document is, Mr.
18 Johnson? This is Trident's 74.

19 A: Yes. It -- it appears to -- it appears to be
20 what also is a page 596 of the schedules that
21 we just went over.

22 Q: Okay. So, do the numbers on the first three
23 pages of Exhibit 74, do they tie to the pro
24 formas that we just went over in the
25 application?

1 **A:** I will answer that, I guess, just based on a
2 few check totals.

3 **Q:** Okay.

4 **A:** It's appears to be the same.

5 **Q:** Okay.

6 **A:** In both documents.

7 **Q:** And look at page 4 of that document. Do you
8 have it?

9 **A:** Yes.

10 **Q:** And what is that information appear to be?

11 **A:** This is volume information that pertains to the
12 proposed MUHA Berkeley Hospital project for the
13 projected years 2023 through 2025. And that
14 includes some -- both discharges and then some
15 -- some length of stay and also some occupancy
16 information and a couple of key outpatient
17 volumes.

18 **Q:** Okay. And so, what are your thoughts about
19 this?

20 **A:** Well, the first thing, you know, it's a 325
21 million dollar project and one of the first
22 things that -- that hit me was, you know, how
23 are -- these are very modest levels of volume.
24 And the question is ---

25 **THE COURT:** Modest levels of what?

1 **A:** **Very -- these aren't not large volumes. These**
2 **are fairly small volumes. How does such small**
3 **volume support a 325 million dollar project.**
4 **That was my first reaction as CFO.**

5 **Q:** **Okay. And looking at some of the assumptions,**
6 **I think there are -- we've got discharge**
7 **information; is that right?**

8 **A:** **We do. So, in -- for instance in year 2023**
9 **they're -- they're proposing 3,135 discharges.**

10 **Q:** **Okay. And then, the length of stay information**
11 **is presented?**

12 **A:** **Yes. For -- and it is consistent throughout**
13 **the projected years at 4.7 overall.**

14 **Q:** **Okay. And what are your thoughts about the**
15 **length of stay ---**

16 **A:** **Um ---**

17 **OBJECTION:**

18 **MS. CRUM:** **Your Honor, I'm just going to object.**

19 **I'm sure if she's gonna ask him about thoughts**
20 **or his opinions because see, thoughts are a lot**
21 **different than an opinion.**

22 **THE COURT:** **Okay. Rephrase.**

23 **MS. HOLLINGSWORTH:** **Yes, Your Honor.**

24 **Q:** **Mr. Johnson, what is your opinion about the**
25 **assumptions as to the length of stay for the**

1 project?

2 A: For a community hospital, 4.7 would be a very
3 high length of stay.

4 Q: Okay.

5 A: I would expect something more similar to -- to
6 3.0, which is our projection for Berkeley
7 Hospital or our 2020 budget for our Berkeley
8 Hospital.

9 Q: Okay. And over the last five years, have
10 length of stays been increasing or declining?

11 MS. CRUM: I ---

12 A: I would ---

13 OBJECTION:

14 MS. CRUM: I'm going to object to the form. I don't
15 know if we're talking about nationally ---

16 THE COURT: Yeah. It -- rephrase that.

17 MS. HOLLINGSWORTH: Yes, Your Honor.

18 Q: Mr. Johnson, in the lowcountry area, in the
19 tri-county area, where you have your hospitals
20 in the system, have length of stays been
21 increasing, staying flat or decreasing?

22 A: Generally, decreasing.

23 Q: Okay. And it -- now, on a national --
24 nationally, what would -- the same question.

25 OBJECTION:

1 MS. CRUM: Your Honor, I'm going to also object to
2 that. He's not been qualified as an expert in
3 health planning and healthcare finance nor have
4 they laid a foundation that he knows what the
5 ALOS is, average length of stay, I'm sorry,
6 nationally.

7 MS. HOLLINGSWORTH: Your Honor, he is qualified.
8 He's been accepted by the Court as an expert in
9 healthcare ---

10 THE COURT: Well, in this area he's really not
11 giving an opinion. You're asking him state
12 based on his knowledge what the average length
13 of stay. So, if you rephrase the question
14 based upon his knowledge if he knows it.

15 MS. HOLLINGSWORTH: Sure.

16 THE COURT: Then we can move right along.

17 MS. HOLLINGSWORTH: I will. Thank you, Your Honor.

18 **Q: Mr. Johnson, in the reviewing and the -- and**
19 **the information you monitor regularly in your**
20 **job as CFO, do you review information about**
21 **length of stay nationally?**

22 **A: I review our length of stay monthly, if not**
23 **more often. But I also as, you know, the --**
24 **there are reports released by the rating**
25 **agencies with -- that have metrics that I spoke**

1 to before. Length of stay is a metric that
2 they also release and length of stay nationally
3 has -- has been dropping. I will say though
4 that, this is a caveat, there -- so, the -- a
5 lot of things that you'd be -- that used to be
6 inpatient have now moved to outpatient. You
7 know, for instance, knee -- you know, a knee --
8 knee replacements used to be a couple -- two or
9 three length day -- lengths of stay. We're
10 doing knees on an outpatient basis. So, while
11 just in terms of the macro of math, while yes,
12 length of stay is coming down nationally, a lot
13 of those short stays are converting to
14 outpatient. And then, of course, if you're
15 taking the short stays out of the calculation,
16 that can tend to increase the calculation. But
17 -- but if -- but if you looked at length of
18 stay by service line, things like that,
19 generally, you're going to decreases in length
20 of stay.

21 Q: And length of stay, is that a metric tied to
22 inpatient volume?

23 A: It is. It's how many days on average a patient
24 stays in your facility.

25 Q: And -- and is that -- that a metric that you

1 pay attention to for your system?

2 A: Absolutely.

3 Q: Okay. All right. All right. And reviewing
4 the -- now, the volume assumptions that you
5 see, what other opinions do you have on the pro
6 formas for the proposed project?

7 A: Well -- you know, I mentioned as a CFO I looked
8 at this and you know, a 325 million dollar
9 project and fairly small volumes, so how is
10 this thing -- because the -- the pro forma
11 shows a profit in year three. How -- how is
12 small volume getting to a profit on such a
13 large investment? And so, I -- that took me to
14 look at some revenue numbers for this pro forma
15 and do -- and now with volume available, do
16 some metric analysis around revenue.

17 Q: Okay. And when you say -- what are some
18 metrics that you would look at?

19 A: Two, two in particular. One is I wanted to
20 know what gross revenue per discharge was. So,
21 on average every -- on average, as patients are
22 discharged from that facility, what is their
23 bill going to look like. You know, how many
24 thousand dollars is their bill going to be;
25 that's what that metric is. And I also looked

1 at net revenue per adjusted discharge, which is
2 the collections MUHA is expecting on -- on
3 their -- on their -- per adjusted discharge.

4 Q: Okay. And did you do some of those
5 calculations on this pro forma?

6 A: I did.

7 Q: Will you pull up Demonstrative 1 please?
8 (Demonstrative 1 was referenced at this time.)

9 Q: Can you walk us through what you have
10 calculated here?

11 A: And these numbers should tie to -- to pages, on
12 the Trident Exhibit, 66 and 67. But this is a
13 very simple calculation. It simply takes your
14 gross inpatient revenue, which for the 2023
15 fiscal year is projected by MUHA and
16 206,355,000. And you'd simply divide it by the
17 number of discharges that they offer on page 67
18 of 3,135.

19 Q: Okay.

20 A: And that results in a charge per discharge of
21 over 65,000 dollars. And, you know, that was
22 -- I guess, eye opening for me because in Roper
23 St. Francis Healthcare, our community hospitals
24 are roughly 35 -- 34-35,000, not 65,000.

25 Q: Okay. And now, break it down just a little bit

1 more. What do you mean -- what is gross revenue
2 per inpatient ---

3 A: It's what is billed. So, the -- what this pro
4 forma says is the average patient that is
5 discharged from this Berkeley Hospital, when
6 they get their bill and they're at their
7 kitchen table opening it up, they're going to
8 see, for that four-day length of stay, they're
9 going to see a bill for almost 66,000 dollars
10 on average.

11 Q: Okay. All right. And I think you mentioned
12 it, but what is that you see in your systems
13 for a similar metric?

14 A: Our community hospitals are running in the mid-
15 30s. 34-35,000 per discharge in charges.

16 Q: And so what was the other metric that you said
17 you calculated?

18 A: So, the other thing I wanted to look at, you
19 know, in fairness patients don't necessarily
20 pay charges in healthcare, so what I wanted to
21 also look at was the net revenue per adjusted
22 discharge that was projected for this facility
23 because that, that is cash. That is what MUHA
24 is expecting to collect on this book of
25 business.

1 Q: And remind us what's an adjusted ---

2 A: So ---

3 Q: --- discharge.

4 A: An adjusted discharge is -- it's discharges
5 plus a calculated outpatient equivalent. And
6 if you add those two numbers, you get adjusted
7 discharge, which again is a global unit of
8 volume measure common in the healthcare
9 industry.

10 Q: Okay. Let's look at Demonstrative 2, please.

11 (Demonstrative 2 was referenced at this time.)

12 Q: And is this the math that you just described?

13 A: Yes. And all this is calculable from the two
14 pages that I used to calculate the previous
15 slide.

16 Q: Okay. And if you would, walk us through ---

17 A: Sure.

18 Q: --- the calculations.

19 A: So, we've already seen -- already seen that
20 discharges total 3,135. And then, to compute
21 adjusted discharges, you have to calculate that
22 outpatient equivalent. So, that outpatient
23 equivalent is simply the gross outpatient
24 revenue, which is -- which is on -- it's on
25 line -- it's on the second line, outpatient

1 revenue of schedule 66, and that's 116,613,000.

2 Q: And for the record, let me note; this is the
3 DHEC CON page 598. Okay.

4 A: And then, you would divide that by a number
5 that appeared on a previous slide, which is
6 your gross revenue for discharge. And by
7 dividing outpatient revenue by your gross
8 revenue for discharge, that converts the
9 outpatient revenue into a kind of discharge
10 equivalent for the outpatient side, if that
11 makes sense.

12 Q: Okay. And then, what do you do from there?

13 A: Then, you simply add the two numbers up, the
14 3,135 and the 1,772 outpatient equivalents, and
15 that gives you total adjusted discharges of
16 4,907.

17 Q: Okay.

18 A: And then, I simply took net patient service
19 revenue off of the 2023 projected year of --
20 and this number -- the 92 million 896, does not
21 appear on the face of the -- of the schedule.
22 You have to -- it was not provided as a
23 subtotal on the schedule, so what I did was I
24 took net operating revenue presented at
25 94,755,000 and reduced that by the other income

1 of 1 million 859 to come up with net patient
2 service revenue of 92,896,000.

3 Q: Why did -- why did you take out the other
4 income line?

5 A: Because that's not net patient service revenue.
6 It's revenue from their cafeteria and other
7 places in the hospital that does not
8 necessarily result from a patient bill.

9 Q: Okay. And so, you got net patient service
10 revenue of 92,896,000 and what did you do with
11 that?

12 A: I simply divide that into adjusted discharges
13 to get a net revenue per adjusted discharge
14 number.

15 Q: All right. And what is that?

16 A: And it's 18,931 dollars.

17 Q: So, what does that metric mean?

18 A: That is -- that is cash. That is what MUHA is
19 projecting to collect from the community on a
20 per adjusted discharge basis.

21 Q: All right. And then, you've got some numbers
22 in the bottom right of the screen. What are
23 those?

24 A: Again, just comparing this to a -- to a -- you
25 know, to community hospitals that are in our

1 health system, we're less than 10,000 versus
2 what they're projecting at almost 19,000 per
3 adjusted discharge. Our tertiary hospital,
4 Roper Hospital, is -- net revenue per adjusted
5 discharge is between 14 and 15,000 per adjusted
6 discharge. So -- and then, I also looked at,
7 well, where it the -- the quaternary/tertiary
8 care hospital downtown from MUHA, where are
9 they running? And I was able to calculate that
10 for 2018 at 21,808 dollars per adjusted
11 discharge. So, it's a little surprising to me
12 to see that their community hospital is -- is
13 only about a 15 percent discount from their
14 quaternary facility located downtown.

15 Q: And -- so, how does that net revenue per
16 adjusted discharge calculation translate to
17 sort of acuity of the patients?

18 A: You would expect more like -- like I said, our
19 Roper Hospital downtown is doing open heart
20 surgeries and treating our sickest ICU
21 patients, is running between 14 and 15,000 per
22 adjusted discharge. So, you would expect a
23 facility in the 18 to 19,000 range per adjusted
24 discharge to really be a very high acuity, you
25 know, tertiary/quaternary medicine facility.

1 Q: Okay. And in your -- as the CFO of the system
2 and in your experience, do you -- are you
3 familiar with what CMI is?

4 A: Yes, I am. It is -- it is case mix index. And
5 with -- there is a -- it's a weight, really.
6 And there -- for each DRG. Every inpatient
7 gets classified into a diagnostic resource
8 category or a DRG. And each DRG carries a --
9 a weight, which is also described as this case
10 mix. And then, if you aggregate all of your
11 inpatient volume, all your DRGs, that average
12 weight is your CMI, case mix index.

13 Q: Okay. And what is the numbering system, one to
14 ten, 100?

15 A: Generally, it goes below -- below one up to --
16 up to -- I don't know where the cap is. There
17 are some procedures that I think are 10. But
18 generally, a -- a very acute -- a very busy
19 quaternary/tertiary facility would be above a
20 two, maybe two and a half overall. Our Roper
21 Hospital is a -- right at a 2.0.

22 Q: Okay. What about -- do you know the overall
23 CMI for St. Francis Hospital?

24 A: Our -- both of our community hospitals, St.
25 Francis and Mount Pleasant, run right around a

1 1.3 overall.

2 Q: Okay. And so -- so, what is that a -- again,
3 a overall CMI of 2.5 or greater tell you about
4 the patient acuity?

5 A: That they would be extremely sick patients.

6 Q: Okay. And let's look back at the pro forma for
7 the project. When will the project be
8 profitable according to the pro forma?

9 A: In -- well, essentially break even in 2024 and
10 then, profitable in 2025.

11 Q: All right. And so, do you have any opinions
12 about the -- this pro forma?

13 A: There is no way this facility is going to
14 generate over 18,000 dollars in reimbursement
15 on per adjusted discharge basis.

16 Q: Okay. Why do ---

17 A: And ---

18 Q: Why do you think that?

19 A: Because governmental payers dictate to you what
20 they pay. There's not a lot of difference
21 between what they're going to pay a MUHA
22 community hospital and a Roper St. Francis
23 community hospital. So, 70 percent,
24 approximately, of your payments are going to be
25 dictated to you by the payers and are not going

1 to be much different. The differential can
2 really only come from the commercially insured
3 market, that Blue Cross, Aenta, United, Cigna,
4 companies like that. It would require an
5 incredible increase in commercial
6 reimbursement, which is paid for by the
7 employers and employees in the community, and
8 would require an enormous increase in the rates
9 contracted by this new Berkeley Hospital to
10 achieve this kind of net revenue. And I am
11 confident that there's no way that's going to
12 -- that they're gonna get that. And I feel
13 strongly that this facility will not produce
14 anywhere near 18,000 per adjusted discharge in
15 that revenue.

16 Q: Based on -- in your opinion, based on that
17 average net revenue per patient discharge, are
18 the proposed charges for this project
19 comparable to other community hospitals in the
20 area?

21 A: No, they are not.

22 Q: So, based on your analysis and in your opinion,
23 are the projected collection and reimbursement
24 assumptions consistent with other community
25 hospitals in the area?

1 A: They are not.

2 Q: All right. Do you have an opinion on what a
3 more reasonable assumption -- a pro forma based
4 on more reasonable assumptions would look like?

5 A: I think that this community hospital will
6 generate net review per adjusted discharged,
7 probably not far off of where Roper St.
8 Francis' community hospitals are currently
9 running.

10 Q: Have you calculated that?

11 A: I did.

12 Q: Demonstrative 3, please.

13 (Demonstrative 3 was referenced at this time.)

14 Q: While he pulls that up, what is the projected
15 -- that projected metric for the Roper St.
16 Francis Berkeley Hospital?

17 A: As discussed earlier, it's less than 10,000 on
18 a per adjusted discharge basis for our
19 community hospitals.

20 Q: And this number, is this one that you just
21 developed for this hearing, the number for
22 Roper St. Francis Berkeley?

23 A: No. That is -- it's still been in draft form,
24 but that is -- because our budget is not board
25 approved, but that's our current net revenue

1 per adjusted discharge for 2020 for our
2 Berkeley Hospital.

3 Q: So, this is the net revenue per adjusted
4 discharged that you are forecasting for your
5 Roper St. Francis Berkeley Hospital?

6 A: For 2020, correct.

7 Q: Okay. And so, if you could, tell us what is on
8 the screen here?

9 A: Well, because -- I believe -- first of all, I
10 think 18,000 dollars or north of that for a
11 reimbursement on per adjusted discharge basis,
12 I just don't think that is -- is rational at
13 all. I think this community hospital will
14 generate rates similar to Roper St. Francis.
15 So, I simply -- I took the -- and I did
16 capsulize the numbers to -- for presentation
17 purposes, but the -- I wanted to restate MUHA's
18 pro forma with what I think is a more rational
19 net revenue per adjusted discharge number. And
20 so, the numeric column on the left is exactly
21 what -- in the capsulized version is exactly
22 what MUHA put forth in the pro forma we've been
23 discussing on -- in the Trident Exhibit, it's
24 page 66. And then, all I did was took the
25 number of adjusted discharges that this

1 facility is expected to have and instead of
2 multiplying adjusted discharges by an 18,000
3 dollar reimbursement rate, I used Berkeley
4 Hospital's number of 9857 and came back with a
5 restated net revenue number of 48,368,000. And
6 then, I left everything else on the pro forma
7 the same in terms of other income and expenses.

8 Q: What was your conclusion?

9 A: That this facility would lose a lot of money if
10 you restated that revenue to a more reasonable
11 number. And I wasn't surprised. I think when
12 you -- you know, community hospitals serve --
13 as Mr. Bosse commented yesterday, you know,
14 seven to ten mile radius around the hospital,
15 if you put a half a billion dollars in assets,
16 it's going to serve a seven-mile radius. This
17 is not unexpected for a CFO. This does not
18 surprise me.

19 Q: And so, for your -- what is the calculation
20 that you reached for the restated pro forma;
21 what is that number, just so you can ---

22 A: A loss of ---

23 Q: --- read it in the record?

24 A: A loss of 55,970,000.

25 Q: Okay. Now, you mentioned -- what did you do

1 with the expenses proposed by the applicant?

2 A: I didn't have a basis for changing the
3 expenses.

4 Q: Okay.

5 A: They -- they look high but I didn't have a
6 basis for changing them.

7 Q: Okay. All right. And did you -- did you look
8 to see how this would calculate out to year
9 three?

10 A: Well, I thought that maybe over time the -- if
11 you substituted the revenue -- with the
12 substituted revenue, I still thought that over
13 time, maybe this projection improves and it did
14 not. The losses actually increased. Taking
15 this format and moving it forward to 2024 and
16 2025, you did not see a recovery in the P&L.
17 In fact, year three lost more money than year
18 one.

19 Q: Okay. And so, this -- this loss that you -- as
20 you've restated the pro forma, is that the only
21 negative impact that you concluded from this
22 pro forma MUHA did?

23 A: No. I -- I think, you know, MUHA is setting
24 themselves up for a double whammy here because
25 presumably this volume that's going to redirect

1 is profitable in their downtown facility. So,
2 they are taking volumes they're making money
3 on in their downtown facility and they're
4 moving it, which is going to reduce the
5 profitability of the downtown facility because
6 that volume will not be there and they're
7 moving into an environment where they're going
8 to lose a substantial amount of money. So, I'd
9 say this is a double whammy to -- to MUHA.

10 Q: What do you mean by they're moving volume?

11 A: Well, they -- in their CON application, they've
12 said that 100 percent of this volume is going
13 to redirect from their downtown facility. So,
14 that's what I mean by -- by that.

15 Q: Okay. And if we look at the CON application
16 and the three pro formas, so the application
17 there, DHEC pages 596, 597 and 598. In
18 reviewing these pro formas, how -- how do these
19 pro formas show you the impact of the 100
20 percent redirection?

21 A: Okay. So, I'll just -- make a reminder here
22 that -- so, 596 and all I'm focused on here is
23 the total revenue line item, which is the third
24 line item down for -- from the -- what I'm
25 going to talk about here. So, you would -- so,

1 these statements have MUHA with the project on
2 596, MUHA without the project on 597. And what
3 you would expect if volume is just going to
4 simply redirect and if there's no incremental
5 volume, you would expect the revenue totals
6 between the two scenarios to equal each other
7 because you have no incremental volume. And --
8 and what is demonstrated here clearly on this
9 -- on these two schedules, 596 and 597, is that
10 there is more revenue or incremental revenue to
11 MUHA in the years the hospital projects goes
12 live. And in fact, if you add up the pro forma
13 -- or you add the projection for the hospital,
14 the project hospital with the MUHA revenues in
15 the pro forma without the project, they equal
16 MUHA with the project. So, what this is
17 telling me is that while they say there's 100
18 percent redirection in the CON application,
19 they're pro formas illustrate zero redirection
20 and that 100 percent of this volume will be
21 incremental.

22 Q: Did you make a slide that puts that information
23 together?

24 A: I believe I did.

25 Q: And it's Demonstrative 4.

1 (Demonstrative 4 was referenced at this time.)

2 A: Yeah. So to, I guess, better illustrate what
3 I'm saying is, is that if all of the volume is
4 simply going to redirect, line 1, the numbers
5 on line 1 and the numbers on line 3 ought to
6 equal each other.

7 Q: And how do these numbers ---

8 A: And they ---

9 Q: --- go together?

10 A: So, if you take the first line and add it to
11 the second line, you get -- it sums to the
12 third line. So, you know, MUHA without the
13 project plus the project equals MUHA with the
14 project. And -- and if truly you were
15 expecting 100 percent redirection, lines 1 and
16 lines 3 would equal each other.

17 Q: Do you have any opinions on the -- that the
18 mathematical calculation is one plus two equals
19 three? That the first line -- let me say it
20 differently. MUHA without the proposed project
21 plus the proposed project equals MUHA -- what
22 is your -- what is your ---

23 A: I can ---

24 Q: --- conclusion when you see that?

25 A: That -- that this pro forma is saying that zero

1 of the volume in the new project hospital is
2 going to redirect -- be redirection.

3 Q: Okay. And if -- if indeed this pro forma is
4 reflective of the revenues that would be
5 associated with the MUHA Berkeley County
6 Hospital, what are your opinions on what that
7 would mean for Roper St. Francis and Roper's
8 Berkeley facility?

9 A: Well, given these hospitals are going to serve
10 a seven to ten mile radius around the hospital,
11 whether it's ---

12 **OBJECTION - MOTION TO STRIKE:**

13 MS. CRUM: Object to the form. I'm sorry. Let's
14 strike the statement. There's no foundation
15 laid that that's what the application has
16 suggested is going to be the MUHA Berkeley
17 service area.

18 MS. HOLLINGSWORTH: Your Honor, his testimony has
19 been that he -- in his opinion, it's -- seven
20 to ten is a reasonable service area for the
21 hospital. He certainly didn't say that that's
22 what MUHA said it would be.

23 MS. CRUM: He just said given that these hospitals
24 and these is more than one. If he's -- and he
25 is talking about the MUHA Berkeley hospital.

1 THE COURT: I kind of consider that as a
2 hypothetical. Just so the record will be
3 clear, rephrase it.

4 MS. HOLLINGSWORTH: Sure, Your Honor. I'll lead
5 into it a little better, Your Honor, if that
6 suits.

7 THE COURT: Yeah.

8 Q: Mr. Johnson, in your opinion, what do you
9 expect the draw area or the area from which
10 patients would come for a community hospital
11 like MUHA's proposed hospital?

12 OBJECTION:

13 MS. CRUM: Your Honor, I'm going -- further going to
14 object. He has not been qualified as an expert
15 in health planning. And the draw of where
16 hospitals would be -- bring patients from is a
17 health planning concept, not a health finance
18 concept, Your Honor.

19 THE COURT: Okay. It may or may not be depending on
20 his knowledge.

21 Q: Mr. Johnson, in your work that you do as CFO,
22 do you -- who do you rely on to give you
23 information about the patients and populations
24 that you serve?

25 A: Well, I mentioned in the beginning of this

1 testimony that I'm -- I'm over our decision
2 support systems, which are not only our cost
3 accounting systems, but also maintain a lot of
4 demographic information about our patients.
5 And, you know, a lot of times, when we go to do
6 a pro forma, we will have to -- have to -- you
7 know, when you're projecting volume for a pro
8 forma, which I do often, you have to understand
9 where that volume's coming from and what your
10 distribution channels are for that volume.

11 Q: And were you here for Mr. Bosse's testimony
12 about the Roper St. Francis Berkeley Hospital's
13 ---

14 A: Yes.

15 Q: --- patient area?

16 A: Yes.

17 Q: And in your work with the system as CFO and in
18 your experience, was his testimony consistent
19 with what you believe the area would be for a
20 community hospital's ---

21 A: Yes.

22 Q: --- draw area?

23 A: Yes.

24 Q: So, if you could -- if indeed, hypothetically,
25 if MUHA's pro forma was reflective of the

1 business it would generate from the area
2 proximate to its hospital, what are your
3 opinions on what that means for Roper St.
4 Francis and Roper's Berkeley hospital?

5 A: So, whether the revenue capture from MUHA is
6 their number or my number, you're still talking
7 about a sizeable capture from that same service
8 area. It would have a very detrimental impact
9 on your Berkeley hospital.

10 Q: Okay. And let's -- let's change gears a little
11 bit and talk ---

12 THE COURT: It would have a sizeable impact if it
13 was incremental revenue?

14 A: If a 128-bed hospital, you know, right near our
15 St. Francis hospital were constructed or right
16 near our Berkeley hospital were constructed,
17 those -- both those hospitals are going to
18 serve -- in my opinion, are going to serve the
19 same seven to ten mile radius around the --
20 around the hospital. It would have a
21 significant negative effect on our Berkeley
22 facility.

23 THE COURT: Okay. And what was asking is I presume
24 that it encapsulates the idea of it being
25 incremental revenue.

1 **A:** **Um.**

2 **THE COURT:** Because you said incremental revenue was
3 revenue that was not redirected; it's revenue
4 the hospital ---

5 **A:** **Yeah.**

6 **THE COURT:** --- generates for its own service area.

7 **A:** **That -- yeah. You are correct. So, this pro**
8 **forma is telling me that not only does MUHA**
9 **intend to maintain -- maintain all their**
10 **current Berkeley book of business, then they're**
11 **going to add to it by the amounts reflected in**
12 **this pro forma, which would have a very**
13 **detrimental impact on our Berkeley Hospital.**

14 **Q:** **Mr. Johnson, in looking at some of the changes,**
15 **let's, if would could, talk a little bit about**
16 **the changes in your industry over the last 10**
17 **years.**

18 **A:** **So, I alluded to that a little bit earlier.**
19 **You know, margins nationally have gone from**
20 **healthy to unhealthy you know to the point**
21 **where Moody's Investor Services has a negative**
22 **outlook on our industry. And the main reason**
23 **they have a negative outlook is because margins**
24 **have fallen below what Moody's considers to be**
25 **sustainable.**

1 Q: Okay.

2 A: And that problem exists very much in the state
3 of South Carolina. You know, I mentioned
4 earlier that we -- and we monitor margins for
5 ten large health systems in South Carolina.
6 Back in 2015, you know, operating cash flow
7 margins are almost twice what they're running
8 today and I will tell you that if you aggregate
9 those ten hospitals and look at operating cash
10 flow margins, we are not in a sustainable place
11 for health systems in South Carolina.

12 Q: And I think we've talked about this morning,
13 went through a number of definitions, but can
14 you -- what are -- what do you mean when you're
15 talking about the margins and what that's
16 representing?

17 A: Yep. So, I mentioned operating cash flow
18 margin. And that again, is the revenue for
19 serving patients less the cost of serving
20 patients before factoring in depreciation and
21 interest. So, that gives you how much cash
22 flow you have available to fund capital, to
23 fund debt or to plow back into your balance
24 sheet in your cash reserves.

25 Q: Okay. And do you monitor any metrics in terms

1 of benchmarks for some of those lines?

2 A: Yeah. So, if you look at Moody's Investor
3 Services, who produces annually medias,
4 operating cash flow margin has gone from above
5 10 percent, five or six years ago, for A-rated
6 hospitals. The mean is now 7.8. In South
7 Carolina, those ten hospitals I talked about
8 have gone from above 10 percent in 2015 to 6.1
9 percent as of the -- using 2018 financial
10 statements for those entities.

11 Q: Okay. And do you have an opinion on what the
12 overall trend is margins in your industry?

13 A: Down.

14 Q: And sort of from a historical perspective,
15 where does the current environment stand from
16 the last ---

17 A: You know---

18 Q: --- 10 to 20 years?

19 A: --- the -- in my opinion, the biggest challenge
20 in healthcare, and we see this during our
21 annual budget process, our revenue on a per
22 unit of service basis goes up around one
23 percent a year and you know, Medicare for the
24 last five or six years, has given us about one
25 percent a year rate increase. Medicaid in the

1 state of South Carolina has cut significantly
2 since 2011 to the non-profits. If you sit down
3 with Cigna or Blue Cross, the first thing they
4 tell you, every hospital, you're overpaid, our
5 employers are mad, we've got to pay you less.
6 And -- but you know, somewhere one to two
7 percent, maybe three or four is a good increase
8 these days from a managed care payer. So, when
9 you blend all that together, we get about a one
10 percent increase each year in rate. Okay. Our
11 expenses go up, because of inflation and other
12 things, around 4 to 5 percent a year. So,
13 every year we sit down and do budget on a 900
14 million dollar base, I've got one percent
15 revenue growth; I've got 4 to 5 percent
16 inflation growth. You know, Charleston's a
17 highly competitive market from an employee
18 perspective, and you know, you gotta pay your
19 employees to keep them on the payroll and keep
20 them happy. So, that difference between that
21 1 and 4 percent on a -- on a 900 million dollar
22 base is about 30 million dollars a year, 27
23 million dollars a year. So, every year, we sit
24 down and do budget, we're 27 million behind and
25 we got to make that up just to sustain margin.

1 And that's the biggest challenge in healthcare
2 as I see it.

3 Q: Okay.

4 A: And so -- well, I'll stop there.

5 Q: Okay. So, in the strategic planning process
6 and in your evaluations on how to afford major
7 capital projects for Roper St. Francis, have
8 you -- have you considered or pursued HUD
9 backed financing?

10 A: We have not. We've -- we've always had access
11 to affordable rates without -- you know, HUD is
12 a costly way to issue debt and they put a lot
13 of operating restrictions on you. So, it's
14 never been an attractive source of financing
15 for Roper St. Francis.

16 Q: What do you mean by re- -- what are the
17 restrictions?

18 A: They -- they put covenants that ---

19 OBJECTION:

20 MS. CRUM: Your Honor, I'm gonna to object to that.

21 He has just testified that he has not even
22 gotten - hasn't done HUD financing. There's no
23 foundation or basis for any testimony about
24 restrictions that HUD may put on -- on a
25 project.

1 MS. HOLLINGSWORTH: I'll rephrase the question, Your
2 Honor.

3 THE COURT: Yep.

4 Q: In financing for major capital projects,
5 including bond financing, are there such things
6 as restrictions or covenants on the debt
7 obligations?

8 A: Yeah. You're lender -- yeah. You have
9 covenants that you submit to as part of bond
10 financings.

11 Q: Okay. What -- what is a covenant?

12 A: A covenant might mean you have to maintain a
13 certain level of day's cash on hand. It might
14 mean that you're -- that something called a
15 debt service coverage ratio, which is, you
16 know, it has to be maintained. That you
17 maintain your tax exempt status. Those are
18 examples of covenants.

19 Q: Okay. And in terms of financing or lending
20 generally, do you have any familiarity with
21 what restrictions might be imposed by lenders?

22 A: Well, I just went through some. I wouldn't
23 call them restrictions; I'd call them
24 covenants.

25 Q: Okay.

1 **A:** But they -- the covenants can restrict
2 certainly.

3 **Q:** Okay.

4 **A:** What about with regard to restricting or for
5 example, setting aside moneys or restricting
6 access to certain cash for example?

7 **A:** Well, if you have a liquidity covenant, you
8 know, Roper St. Francis has a liquidity
9 covenant -- covenant that we can't drop below,
10 I believe, 75 days cash on hand. That would --
11 so, if we -- for each measurement period, which
12 is twice a year, if we fell below 75 days, we'd
13 have to cure that within a certain period of
14 time or we would be in default on our bonds.

15 **Q:** All right. So, let's look Trident's Exhibit 1,
16 please.

17 **MOTION TO ADMIT TRIDENT 74:**

18 MS. HOLLINGSWORTH: And actually, Your Honor, while
19 we pull that up, I should have -- we would move
20 Trident's Exhibit 74 into evidence.

21 MS. CRUM: Your Honor, I don't see how they can move
22 Trident's Exhibits into evidence. He didn't
23 say that he's created it. There's been no
24 basis or anything else. This is Roper not
25 Trident.

1 THE COURT: I recognize that. I was thinking about
2 it while you were ...

3 MS. HOLLINGSWORTH: Yeah. Well, Your Honor, it --
4 it's a discovery document. It's actually the
5 Medical University's document and as part of
6 the exhibit list identifications, Roper, rather
7 than have duplication, there are exhibits that
8 are on Trident's list that we pulled off our
9 list so that the Court wouldn't have a Roper
10 version of the same document that would lead to
11 duplication. So, that was in our
12 communications even, we said, we're going to
13 reduce the duplication and identifications.

14 MS. CRUM: And that's not a problem, Your Honor. I
15 couldn't see what it was from ---

16 THE COURT: Okay.

17 MS. CRUM: --- this screen. But it's our audited
18 June 30, '19 financials from KPMG. I don't
19 object.

20 THE COURT: Clarification noted.

21 MS. CRUM: Yes, sir. Thank you.

22 MS. HOLLINGSWORTH: Ms. Crum, because I don't want
23 you -- to pull one over on you, I was going
24 back to Trident's 74, which was the pro forma
25 from the discovery production.

1 MS. CRUM: Sorry. That's not what was on my screen.

2 I do object to their using a Trident Exhibit.

3 There's been no foundation from where it came

4 from, when it was produced, how long it's --

5 they've had it. So, I object to their putting

6 in a Trident Exhibit at this point.

7 THE COURT: I guess that would be an authenticity

8 objection?

9 MS. CRUM: Yes, sir. It would be.

10 THE COURT: Okay.

11 MS. HOLLINGSWORTH: Your Honor, with respect, we had

12 deadlines to address objections to evidence and

13 designations of exhibits. As I just explained,

14 it's not a Trident-only exhibit. Roper St.

15 Francis also identified documents in the

16 exhibit. We then reduced our list to avoid

17 duplication, which we explained. So, it's a --

18 it's a document produced by MUHA in Discovery

19 that my -- Mr. Johnson has reviewed and

20 supports his analysis of these issues as an

21 expert.

22 THE COURT: So, this ---

23 MS. HOLLINGSWORTH: It's the University's document.

24 THE COURT: The Trident document that you're seeking

25 to introduce is a document that was produced by

1 MUHA?

2 MS. HOLLINGSWORTH: That's right, Your Honor. It
3 just has a Trident label on it. It could have
4 said Petitioner's 74, I mean we just -- for
5 purposes of who -- who was identifying and
6 making copies, there's a list that was provided
7 among counsel that has a Trident label on it as
8 petitioner. There's a list that has Roper St.
9 Francis as petitioner. Where there was
10 duplication, we ---

11 THE COURT: I can't ---

12 MS. HOLLINGSWORTH: --- pulled out duplications,
13 Your Honor.

14 MS. CRUM: Is that 2906?

15 MS. HOLLINGSWORTH: It's MUHA RFP 29064.

16 THE COURT: So, you would ultimately be objecting to
17 the authenticity of MUHA ---

18 MS. CRUM: Now, that I can see the MUHA designation,
19 I withdraw the objection.

20 THE COURT: Okay. So, any ---

21 MR. WICEVIC: No objection.

22 MR. THOMAS: No objection.

23 THE COURT: It's admitted.

24 (Trident's Exhibit 74 was admitted into evidence.)

25 MS. HOLLINGSWORTH: Thank you, Your Honor. And my

1 apologies for not doing that earlier.

2 **Q:** Let's go back to what was marked as Trident's
3 Exhibit 1, which is the audited financial --
4 well, I'll let -- Mr. Johnson, can you tell us
5 what this is at Trident's Exhibit 1?

6 (Trident's Exhibit 1 was referenced at this time.)

7 **A:** Yes. These are the audited financial
8 statements of Medical University Hospital
9 Authority for their fiscal year ending June
10 30th, 2019.

11 **Q:** Okay. And did you review these documents
12 before the hearing?

13 **A:** Yes.

14 **Q:** All right.

15 **MOTION TO ADMIT TRIDENT 1:**

16 MS. HOLLINGSWORTH: All right. I'm going to move
17 Trident's Exhibit 1 into evidence. It is the
18 audited financials produced by the Medical
19 University in the case.

20 MS. CRUM: No objection.

21 MR. WICEVIC: No objection.

22 MR. SUMMER: No objection.

23 MR. THOMAS: No objection.

24 THE COURT: It's admitted.

25 (Trident's Exhibit 1 was admitted into evidence.)

1 MS. HOLLINGSWORTH: Thank you, Your Honor.

2 Q: If we could turn to page 17 in the Exhibit.
3 And you might have the Trident notebook in
4 front of you.

5 COURT REPORTER: I'm sorry. Which exhibit did you
6 just say?

7 MS. HOLLINGSWORTH: This is Trident's Exhibit 1.

8 COURT REPORTER: Thank you.

9 MS. HOLLINGSWORTH: Yes, ma'am.

10 Q: Mr. Johnson, we are at page 17 of Trident's
11 Exhibit 1, the 2019 audited financials. Can
12 you tell the Court what this document is?

13 A: It is a statement of net position, which is
14 almost a balance sheet as of June 30th, 2019
15 for Medical University Hospital Authority.

16 Q: Okay. And what -- what do you use a balance
17 sheet for?

18 A: It -- it states your -- your -- your financial
19 position. It includes what your total assets
20 are, your total liabilities and then what your
21 equity then is, which is usually your assets
22 minus your liabilities.

23 Q: Okay.

24 A: As of a specific point in time, it's a
25 snapshot.

1 Q: Okay. And what opinions do you have about this
2 document?

3 A: Well, the first -- I guess, several. When I
4 look at this document, I -- I see -- you know,
5 it's a very weak balance sheet from a credit
6 perspective. There are, you know, 2.1 million,
7 you know, halfway down the page around 2.1
8 million -- excuse me, billion, of total assets,
9 but there are 2.7 billion of liabilities. And
10 as -- and that's what's leads to, as was noted
11 in the opening comments earlier in this trial,
12 because liabilities exceed assets, there is a
13 623 million -- 623 million dollar deficit in
14 equity or net position for -- for MUHA. And,
15 you know -- you look at that 2.7 million in
16 liabilities, liabilities generally have to be -
17 - have to be satisfied with cash or assets.
18 So, if MUHA has 100s of millions more in
19 liabilities that are -- ultimately have to get
20 satisfied with cash or assets than they have
21 currently in assets.

22 Q: Okay. So, what does this -- what other
23 conclusions do you draw?

24 A: That -- just the magnitude of debt currently on
25 this balance sheet. If you look at -- in the

1 bottom half of the page, they have, you know,
2 their current installments on long-term debt
3 are 33.6 million, they have short-term debt
4 that's coming due in a few months of 120
5 million, and then they have long-term debt
6 further down of 752 million. If you add all
7 that up, it's around 900 million of debt. And
8 in the footnotes to the financial statements,
9 it's also noted that there's about 88 million,
10 I believe, of debt associated with Shawn
11 Jenkins, the new children's hospital that's net
12 yet on this balance sheet. So, you add all
13 that up, there's a billion dollars worth of
14 debt sitting on this balance sheet in addition
15 to some very sizeable net pension and OPEB
16 liabilities. And ---

17 THE COURT: What type of ---

18 A: So, the -- since Medical University
19 participates in the State Pension Plan, which
20 is I think 48 billion underfunded, under the
21 GASB rules, MUHA and other state organizations
22 have to carry their share of that deficit.

23 THE COURT: Okay.

24 A: That pension deficit on their financial
25 statements. And it's -- ultimately, that will

1 have to be satisfied with cash or assets over
2 time. So, it's -- it's real. It's not a --
3 it's not a book number.

4 Q: Okay. What is that -- where is that line item
5 or items on this balance sheet?

6 A: It's about two-thirds of the way down. It's
7 call net patient liability and that's 794.6
8 million and then, below that is another
9 liability, consumer liability, OPEB liability
10 that's 676 million.

11 Q: Okay. And did you analyze how this balance
12 sheet compares with the investment grading
13 metrics that you monitor?

14 OBJECTION:

15 MS. CRUM: Your Honor, I'm going to object to the
16 form -- I'm going to object to that question.
17 It's not relevant to this case. MUHA is not
18 using Moody's -- I'm sorry. It's not using
19 bonds. So, any -- any comparison to MUHA's
20 balance sheets to bond balance sheets and bond
21 ratings, is immaterial. It's irrelevant.

22 MS. HOLLINGSWORTH: Well, Your Honor, I disagree on
23 the relevance. We've repeatedly talking about
24 financial feasibility and financial issues and
25 this information, what -- of what I was laying

1 the foundation for was an update to a chart
2 that was actually provided the Department staff
3 during review. So, it's simply additional
4 evidence of the same issue presented to DHEC
5 during review.

6 MS. CRUM: Your Honor, I didn't say that it wasn't
7 an issue raised below. I said it's not
8 relevant to this issue. We are not doing bonds;
9 that's clear. We're going to do HUD financing
10 or potentially, even pay for it ourselves. But
11 our -- how we would stack up in a bond, Moody's
12 rating it not relevant.

13 MS. HOLLINGSWORTH: Your Honor, I think my expert
14 can given an opinion on -- it goes to why HUD
15 financing is the financing that would have to
16 be pursued and any opinion he has on whether or
17 not other financing would have been available
18 based on their financial metrics.

19 THE COURT: All right. I'm going to overrule it as
20 long as you pursue that line of questioning.

21 MS. CRUM: I'm sorry, Your Honor?

22 THE COURT: I'm overruling your objection based on
23 her assertion of the line -- the purpose about
24 for which she is asking these questions. I
25 would find that relevant whether I, you know --

1 ultimately, at the end of this case, I'll have
2 to decide how pertinent it is, but ---

3 MS. CRUM: All right, sir.

4 THE COURT: --- it is what it is.

5 MS. CRUM: Thank you. Could I just have a
6 continuing objection?

7 THE COURT: Yes, ma'am.

8 Q: Mr. Johnson, during the -- did you assist with
9 the opposition presented by Roper St. Francis
10 during the Department staff review of the
11 project?

12 A: Yes.

13 Q: Okay. And did you provide some information as
14 part of that opposition?

15 A: Yes. I did.

16 Q: Okay. Let's first look at -- if we could look
17 first at DHEC 1, page 742.

18 THE COURT: And while -- while we're here. How much
19 longer are you going to be on this witness?
20 Just to know.

21 MS. HOLLINGSWORTH: Yes, Your Honor.

22 THE COURT: So, I know how to regulate today.

23 MS. HOLLINGSWORTH: Your Honor, I would think 30
24 minutes perhaps.

25 THE COURT: Okay.

1 MS. HOLLINGSWORTH: 30 to 45 minutes on direct and I
2 would sit down.

3 THE COURT: Well ---

4 MS. HOLLINGSWORTH: If you would -- if the Court
5 would like to take a break before we do the
6 kind of last ---

7 THE COURT: How are we doing over there? Need a
8 break?

9 (No audible response.)

10 THE COURT: Okay. All right.

11 MS. CRUM: Your Honor, I would appreciate a five
12 minute break.

13 THE COURT: Well, then, let's take a five minute
14 break.

15 (A break was taken from 12:06 p.m. until 12:16 p.m.)

16 COURT REPORTER: All rise.

17 THE COURT: Y'all be seated.

18 **Q: Mr. Johnson, we were about to ---**

19 THE COURT: You want to object all the way from the
20 back?

21 MS. JONES: No, just standing up.

22 THE COURT: She was standing.

23 (Laughter.)

24 MS. JONES: Just stretching my legs. I'll sit down.

25 (DHEC Exhibit 1 was referenced at this time.)

1 Q: Could we look at DHEC Exhibit 1, page 752. And
2 Mr. Johnson, right before we took that quick
3 break, we were -- we were discussing input you
4 had into the opposition materials that were
5 provided to DHEC; is that right?

6 A: Yes.

7 Q: What is this here -- this -- in the DHEC
8 record?

9 A: Earlier in my testimony, I went through some
10 key balance sheet strength metrics that were
11 important to the rating agencies in terms of
12 converting your balance sheet into -- into
13 strength metrics to determine how credit worthy
14 that balance sheet was. And two -- two of
15 those metrics appear in here and then, there's
16 also a third one here that I didn't discuss
17 earlier, which is debt service coverage or
18 maximum debt service coverage, which would be
19 a calculation of your income to debt service
20 divided by your highest year's annual debt
21 service.

22 Q: and if we could look at the next Demonstrative.
23 Is that number 5?

24 COURT REPORTER: Demo 4 was our last one, so it
25 would be Demo 5.

1 MS. HOLLINGSWORTH: It would be 5?

2 THE COURT: The Court Reporter is excellent at math.

3 MS. HOLLINGSWORTH: She's keeping us straight.

4 Q: Mr. Johnson, what is -- what have you prepared
5 here on Demonstrative 5?

6 (Demonstrative 5 was referenced at this time.)

7 A: It's a bit of an update. So, I was able to use
8 MUHA's 2019 audited financials to update their
9 metrics for the three key balance sheet
10 strength metrics I mentioned earlier and
11 compare that to, on the far right, Moody's A
12 category, which is a strong investment grade
13 category of performance, but also the B --
14 Moody's Baa3, which represents the lowest
15 investment grade rating that Moody's offer.
16 So, below Baa3, you're going to be in junk bond
17 status.

18 Q: Okay. And so, let's -- when you are looking at
19 the balance sheet that we looked at earlier,
20 did -- was the Nexton -- was Berkeley hospital
21 project, MUHA's Berkeley hospital project on
22 there?

23 A: It was not. So, there was -- as I mentioned
24 earlier, about a billion dollars in debt either
25 on that balance sheet or coming onto that

1 balance sheet because there was still 88
2 million of Shawn Jenkins Hospital debt that's
3 not reflected on that balance sheet. So,
4 they're pretty much at a billion dollars and
5 another presumably 325 million coming from this
6 proposed project.

7 Q: Okay. If we could go back to DHEC 1.

8 (DHEC Exhibit 1 was referenced at this time.)

9 Q: And the next page of DHEC Exhibit 1, and the
10 record, it's 753. In the materials provided to
11 the Department staff during review, did you
12 assist with providing information about
13 projects under development by Medical
14 University Hospital Authority?

15 A: You know, I've certainly seen this. I don't
16 know that it came from my office, but I'm
17 certainly familiar with it.

18 Q: Okay. And do you keep -- kept tract of other
19 developments and capital commitments made by
20 MUHA?

21 A: I think recently there's been announcements
22 that they plan on building a hospital in -- is
23 it Indian Land or is it ---

24 MS. JONES: Hearsay.

25 A: Indian Land in North Carolina. I believe

1 there's release that they plan on building a
2 replacement facility in Lake City. So, in
3 addition, you know, they've got a billion in
4 debt. There's -- they're trying to convince --
5 they're trying to get a project for another 300
6 million, but they've got at least two more
7 hospitals plus additional projects as reflected
8 here. So, they're currently unfunded.

9 Q: Okay. And are you -- are you familiar with any
10 other projects or acquisitions that -- well,
11 that -- that have been talked about even so far
12 in this trial?

13 A: Would you -- can you repeat the question?

14 Q: Yeah. Are you familiar with any other
15 acquisitions or projects that have taken place
16 since this application that the Medical
17 University has ---

18 A: Yeah. They ---

19 OBJECTION:

20 MS. CRUM: I'm going to object to the form of the
21 question. Projects that have taken place since
22 this application.

23 THE COURT: It's undefinitive.

24 MS. HOLLINGSWORTH: I'm sorry, Your Honor. I didn't
25 hear what you said.

1 THE COURT: It wasn't definite.

2 MS. HOLLINGSWORTH: Okay. I apologize. Let me try
3 to do a better job, Your Honor.

4 Q: Mr. Johnson, are you familiar with any other --
5 do you have any understanding of the
6 relationship between the CHS hospitals and
7 Medical University?

8 A: I do. They were, my understanding, four
9 hospitals that MUHA purchased from -- from CHS
10 and then, it's not Carolinas Healthcare Systems
11 in Charlotte. This would CHS based out of
12 Tennessee, I believe. They purchased hospitals
13 in Florence, Lancaster, Chester, and maybe
14 Marion, South Carolina. I think the purchase
15 price was in the neighborhood of 137 million,
16 which they financed most, if not all of.

17 Q: Okay. And let's look at -- well, let me ask
18 you this. What are your thoughts about the --
19 you keep mentioning a billion -- what is your
20 opinion about the billion dollars in debt? You
21 keep mentioning that metric or that number.

22 A: You know, I think the HUD expert -- and I'm not
23 commenting HUD here, I'm commenting about debt
24 capacity, but the HUD expert testified that he
25 felt that there were maybe a billion-six ---

1 OBJECTION:

2 MS. CRUM: Your Honor ---

3 **A: --- in debt capacity.**

4 MS. CRUM: I'm going to object to his giving any
5 opinion about what a HUD expert testified to.
6 He has said he's not going to testify about
7 HUD. He hadn't identified the expert. But she
8 hasn't laid a foundation as to how he knows any
9 of this allegedly.

10 MS. HOLLINGSWORTH: Your Honor, he didn't given --
11 he was laying -- the discussion that he has
12 listened to the deposition or he's read the
13 deposition of their expert ---

14 THE COURT: Yeah, but that's not in evidence, so how
15 do you want to approach it?

16 MS. HOLLINGSWORTH: Well, sure, Your Honor, he's --
17 he has been qualified to give expert opinions
18 on healthcare finance and he has prepared to
19 give an opinion on debt capacity of the Medical
20 University and he's providing the Court with
21 information of -- information about what he
22 reviewed in considering that capacity.

23 MS. CRUM: Your Honor, he might -- he's already
24 given his opinion as far as I can tell with
25 regard to Moody's and the ability to get bond

1 financing. HUD is a totally different method
2 of financing. She has not laid any foundation
3 that he has any expertise whatsoever in HUD or
4 can make any opinions based on HUD financing.

5 THE COURT: I sustain the objection at this point.

6 MS. HOLLINGSWORTH: Thank you, Your Honor. Though I
7 would point out, I didn't ask -- he's not
8 offering nor have I solicited an opinion about
9 HUD. I'm discussing with him debt capacity
10 unrelated to HUD, Your Honor. But I will ---

11 THE COURT: Okay. I ---

12 MS. HOLLINGSWORTH: I will try to ask him questions
13 ---

14 THE COURT: Well -- yeah. Rephrase it. Maybe I
15 missed the point myself, but I ---

16 MS. HOLLINGSWORTH: Sure. Your Honor, I -- I will
17 try to do a better job.

18 **Q: Mr. Johnson, do you have any knowledge about**
19 **the debt capacity that the Medical University**
20 **believes they have?**

21 **A: Well, whether it's -- and when you issue HUD**
22 **debt, you are issuing bonds. Those bonds are**
23 **just insured by HUD. So, HUD is a form of**
24 **credit enhancement. It's not the bank.**

25 MOTION TO STRIKE:

1 MS. CRUM: Your Honor, I'm going to move to strike
2 that. We have no foundation that he knows what
3 HUD is. He hasn't -- she hasn't laid a
4 foundation. He's just espousing opinions
5 without any knowledge or a basis that he has
6 any expertise in that area.

7 THE COURT: I will sustain that objection. I got a
8 feeling he's going to explain it, but, you
9 know.

10 **Q: Let's take a look, Mr. Johnson ---**

11 THE COURT: Yeah. Lay a foundation of his knowledge
12 about ---

13 MS. HOLLINGSWORTH: Sure, Your Honor.

14 **Q: Can we pull up Roper St. Francis 117.**

15 **(RSF Exhibit 117 was referenced at this time.)**

16 **Q: If we could go to page 24 of Roper St. Francis**
17 **Exhibit 117. Mr. Johnson, have you reviewed**
18 **these document -- well, actually, you might**
19 **want to -- let's look at -- we might start on**
20 **page 16 or 17 of the Exhibit, you have it in**
21 **front of you.**

22 **A: I'm there.**

23 **Q: Have you reviewed this document?**

24 **A: Yes.**

25 **Q: And what is this document?**

1 **A:** **It is a feasibility study done by an outside**
2 **party that, I believe was used as a feasibility**
3 **-- self-feasibility projections pertaining to**
4 **the HUD financing that MUHA is seeking for the**
5 **four hospitals they purchased from CHS.**

6 **Q:** **Okay. Turn to page 19 in that Exhibit. Roper**
7 **St. Francis 117, page 19. And who performed**
8 **this -- whose -- who -- whose document is this?**

9 **A:** **It's a ---**

10 **OBJECTION:**

11 **MS. CRUM:** Your Honor, I'm going to object to the
12 relevance of this. This is the CH -- CHS
13 hospitals, the hospital purchases in Lancaster,
14 Chesterfield, Florence, and Mullins. It
15 doesn't have anything to do with the financing
16 for Roper Berkeley.

17 **THE COURT:** Well, he's testifying as to the amount
18 of debt that is occurring as a result of those
19 purchases and the impact that that will have
20 upon MUHA. So, if that is what he's going to
21 testify to, so you're now saying that all of
22 that was irrelevant?

23 **MS. CRUM:** Your Honor, I think -- I withdraw my
24 objection.

25 **THE COURT:** Okay.

1 Q: Mr. Johnson, if you could, take us to where in
2 this document that the information is that
3 you've reviewed recently.

4 A: 117-024.

5 Q: Okay. Can you tell us, what is that?

6 A: Well, this is a projected or forecasted
7 statement of operations or forecasted income
8 statement for MUHA.

9 Q: Okay. And are you familiar with these types of
10 documents?

11 A: Yes.

12 Q: Is -- this feasibility study, is that the types
13 of study you did in your -- with your time at
14 Arthur Andersen?

15 A: Yes.

16 Q: Okay. And so, tell us what your opinions are
17 about this document at Roper St. Francis 117-
18 024?

19 A: Well, more from a macro perspective, you know,
20 MUHA is at a billion dollars in debt and
21 they're looking to -- based on the projects in
22 the pipeline, get to a -- get to a billion and
23 a half or a billion-six of debt. Clearly,
24 based on the projects they've got in the
25 pipeline that they're looking at continued well

1 above the billion they've currently got. And
2 whether debt is HUD debt or any other type of
3 debt, you've got to be able to make the debt
4 service payments on that debt. And if you --
5 you know, a billion and a half of debt at four
6 percent interest rate over 30 years is about
7 125 million dollars a year in annual debt
8 service. So, as the strategic appetite of MUHA
9 increases, if there's connectivity between
10 strategic planning and financial planning,
11 you're going to see the financial projections
12 increase to fund that additional appetite. And
13 there's got to be cash flow projected to cover
14 the debt service. And one of the things that
15 jumped out at me in this pro forma is earnings
16 are not projected to increase as the strategic
17 appetite increases. Earnings are projecting to
18 decrease . And, in fact, if by 20 -- you know,
19 by 20 -- you know, income available for debt
20 service by 2022 on this income statement is
21 around 92 million. I mean, that doesn't cover
22 debt service on a billion and a half of debt.
23 And -- and remember that income available for
24 debt service or the that operating cash flow --
25 you use that to not only to cover your debt

1 service, but MUHA has millions of square feet
2 of space and they have millions of dollars,
3 tens of millions of dollars in equipment. You
4 know, that operating cash flow has to pay for
5 drills in the OR when they break and chillers
6 when they quit working in the summertime and
7 things like that. If they're spending all
8 their money on debt service, how do they
9 maintain millions of square feet of existing
10 planning.

11 Q: Okay. Did you review any other documents that
12 include projections or forecasting for Medical
13 University?

14 A: I did. I think I reviewed -- because I wanted
15 to see a progression. You know, as strategic
16 appetite goes up, again, do the projections go
17 up to meet the demands of that increased
18 spending. And so, I did look at several CON --
19 pro formas contained in CON applications, I
20 think two in '17 and one in 2019.

21 Q: Okay. Will you pull up Demonstrative 7,
22 please?

23 (Demonstrative 7 was referenced at this time.)

24 Q: And if you could, walk us through -- what is
25 here on Demonstrative 7?

1 **A:** Okay. So, the important thing to note is that
2 for each column, each column pertains to 2022.

3 **Q:** Okay.

4 **A:** So -- so, this isn't 2022, 2023, 2024. This is
5 2022 as it was presented in three different CON
6 applications. So, you have a stand alone ED for
7 Berkeley County. This was certified in June of
8 2017. Six months later in December of '17, you
9 have projections that are certified pertaining
10 to the proposed Berkeley hospital. And then,
11 18 months later approximately, in June of '19
12 for the 29-bed addition, you have projections
13 for MUHA presented. And again, as the
14 strategic appetite increases and as the
15 spending increases, you would expect their to
16 be an improved cash flow to pay for that and
17 cover all that debt service. And you can see
18 some -- and I'm going down to the net income
19 line at the very bottom. You know, between
20 June of 2017 and December of 2017, there is an
21 improvement in -- in earnings, and then they
22 revise that down in the follow-up pro forma in
23 June of '17. So, you know, this either -- you
24 know, with the WIPFLi study we just looked at
25 or this, either two things are happening here,

1 one of two things. Either they can't afford
2 all this debt, and that's evident in the
3 projections or there's just a disconnect
4 between financial planning and strategic
5 planning. And if that disconnect exist, that
6 certainly should be important to the Department
7 and to this Court because those two have to be
8 synced.

9 Q: Okay. And let's see -- I do think we recently
10 got another pro forma. Were you able to review
11 one more since that, the date of the 29-bed
12 application?

13 A: I think -- yeah. I think this pro forma came
14 out within days of today or it's -- it's very
15 fresh, I guess.

16 Q: Okay. And put that on he screen. All right.
17 And so, this morning, were you able to review
18 an additional pro forma that you received from
19 DHEC?

20 A: Yes.

21 Q: Okay. And I know it's hard to see on the
22 screen. What is the date of that letter?

23 A: November 5th, 2019.

24 Q: And are you familiar generally with an
25 application for a freestanding emergency

1 department filed by Medical University in the
2 Sea Islands?

3 A: I know it's out there. I have not reviewed the
4 CON, but I did look at this document with the
5 projections.

6 Q: Have you tried to look at the projections
7 before this morning?

8 A: No.

9 Q: Okay.

10 A: They weren't available to me.

11 Q: Okay.

12 MS. HOLLINGSWORTH: Let's turn to the page that has
13 -- I'm sorry. All right.

14 (RSF Exhibit 135 was referenced at this time.)

15 Q: And looking at that pro forma that you received
16 this morning, what -- what did you -- what ---

17 A: Yes.

18 Q: What opinions did you have on this?

19 A: So, this has what I was looking for. I mean,
20 this -- this has -- if you add -- add up
21 operating income -- like for 2022, if you had
22 up operating income plus depreciation and
23 interest, you're going to see over 300 million
24 dollars of cash flow that would be available
25 for -- for debt service and available for

1 capital improvement, things like that. So,
2 this -- this is what I was looking for all
3 along, you know, is a pro forma that would
4 allow MUHA to fund their strategic plan.

5 Q: And does this look -- how is this different
6 than the one ---

7 A: Well ---

8 Q: --- the most recent one that you had?

9 A: Well, what concerns about this pro forma is if
10 you look at the ---

11 THE COURT: Well, she asked one question and you're
12 answering another.

13 A: My apologies.

14 THE COURT: All right.

15 Q: How did this one compare with the most recent
16 one that you saw that's on your comparison
17 slide?

18 A: The most recent one from six months ago, I
19 guess -- or the one from six months ago, had
20 around 93 million of operating cash flow. This
21 projection has over 300 million of operating
22 cash flow.

23 Q: Okay. And so, what are your opinions on this
24 pro forma?

25 A: So, if you look at the audited financial

1 statements of MUHA for 2019, they had -- I
2 believe 103 million dollars of operating cash
3 flow. And so, what this pro forma suggests is
4 that they were going to triple the amount of
5 operating cash flow starting a very short time
6 from now by 2022. The other thing that I know
7 just from a metric perspective, the average --
8 MUHA finished 2019 with a 6 percent operating
9 cash flow margin. They're projecting 14.8
10 percent as an operating cash flow margin, which
11 would -- which would put them -- you know, the
12 average in non-profits across the state right
13 now, I testified, was 6.1 percent. That would
14 put them well over two times the average. It
15 would put them well over two times what they're
16 currently running and would make them easily --
17 you know, I would say, if -- if not -- it'd be
18 well above any other -- you know, the McLeods
19 and the -- you know, Lexington finished last
20 year at 7 percent OCFM. I mean, this is a --
21 in a challenging environment like we're in
22 today, I mean, a 14 percent OCFM, I -- that
23 would be an incredible lift in earnings in a
24 very short period of time. I mean, again,
25 they're looking -- this pro forma says, MUHA is

1 going to triple their cash flow, their
2 operating cash flow between the 103 million
3 they finished '19 -- 2019 with and a very short
4 time later in 2022. And if these are
5 replacement projects, where does that
6 additional cash flow come from?

7 Q: Okay. And so, what is your opinion about the
8 14 percent OCFM assumption in the most recent
9 pro forma?

10 A: That is -- again, that's -- you know, that's
11 double the -- almost double the national
12 average, OCFM for A-rated hospitals. It's more
13 than double the six percent they finished 2019
14 with. In a challenging environment like we're
15 in, expecting to hit those levels of OCFM, I
16 just -- it would be an incredible feat to -- I
17 mean, to get there. I mean, for the good of
18 healthcare, I hope they get there, but that --
19 it would be -- just -- I don't think it's
20 reasonable to budget those level of margin or
21 forecast those levels of margin.

22 Q: And let's go back very quickly to ---

23 MOTION TO ADMIT:

24 MS. HOLLINGSWORTH: Well, before I leave this, I
25 would offer that we add a number to it. So,

1 Your Honor, for clarity in the record and --
2 the application itself was identified as an
3 Exhibit but the documents were not available
4 until they were provided to us this morning.
5 So, we would ask that they be admitted as
6 Exhibit 135.

7 MS. CRUM: We have no objection, Your Honor.

8 MR. WICEVIC: No objection.

9 MR. THOMAS: No objection.

10 MS. CRUM: This would be added ---

11 THE COURT: It's admitted.

12 MS. CRUM: I'm sorry, Your Honor. This would be
13 added to that Exhibit?

14 THE COURT: No.

15 MS. HOLLINGSWORTH: No. We'll just use the sticker
16 number that we have.

17 MS. CRUM: Okay.

18 MS. HOLLINGSWORTH: We'll ---

19 THE COURT: Okay. It's 135?

20 MS. HOLLINGSWORTH: Yeah. Yes, Your Honor, Roper
21 St. Francis 135.

22 THE COURT: Okay.

23 (Off the record discussion)

24 THE COURT: What are we waiting upon?

25 MS. HOLLINGSWORTH: We were trying to find another

1 number, Your Honor. But we'll move on.

2 MS. CRUM: And I was waiting to get a copy of the
3 Exhibit because we don't have a copy of the
4 Exhibit.

5 MS. CRUM: We'll get it emailed. I don't have a
6 copy either. It was -- that's why -- I got this
7 morning ---

8 MS. JONES: We can't agree to the admissibility of
9 it if we can't see a copy.

10 MS. CRUM: We've got to see a copy, Your Honor. Is
11 there somewhere we can't print it or ---

12 MS. JONES: If they don't have a copy, then we can't
13 ---

14 THE COURT: Email it to ---

15 MS. HOLLINGSWORTH: Your Honor, I will email it and
16 perhaps after lunch if we need to bring this up
17 again, we can do so.

18 THE COURT: I tell you what, I'm going to admit it
19 pending a copy being made available and if none
20 is made available within a time frame of which
21 you need to utilize it, it will not be ---

22 MS. CRUM: Your Honor.

23 THE COURT: --- the condition of its admission will
24 not be complied with.

25 MS. CRUM: Your Honor, I just want to make sure that

1 it has everything in it that was submitted to
2 DHEC, also.

3 THE COURT: Okay.

4 MR. SUMMER: Your Honor, I just want to get
5 something straight for the record. This is
6 their budget that they did not put into a CON
7 application filed with the Department. And
8 once again, we didn't get it until this morning
9 because we've been begging the Department to
10 produce it to us. So, it is their document.
11 So, the irony of the fact that they're
12 screaming for a copy is not lost on me, but
13 we'll make sure at the lunch break, we get them
14 one.

15 MS. CRUM: Your Honor, it was filed at DHEC noon
16 yesterday and I don't have a copy. That's all
17 I can say.

18 MS. JONES: Well, and we don't know what they put in
19 the Exhibit.

20 THE COURT: Whoa, whoa, whoa. Okay. It's your
21 filing. I get one aspect of that and that is
22 you want to make sure it's what you filed. And
23 that I'm okay with. The rest of it is irony.
24 Okay.

25 (Laughter.)

1 THE COURT: Okay.

2 Q: Mr. Johnson, in your role as CFO for Roper St.
3 Francis, are you familiar with the services
4 that are offered at Roper's Hospital in
5 Berkeley?

6 A: Yes.

7 Q: Okay. And are there any services that are
8 proposed for the -- MUHA's community hospital
9 in Berkeley County that Roper Berkeley is not
10 already providing?

11 A: Not that I'm aware of, which leads to my
12 conclusion that it's unnecessarily duplicative
13 for that community.

14 Q: And ---

15 MOTION TO STRIKE:

16 MS. CRUM: Your Honor, I'm sorry. He just offered a
17 legal conclusion and he interpreted the law and
18 I would move that the unnecessary -- not an
19 unnecessary -- not an unnecessary duplication
20 answer be struck. It was also not an answer --
21 wasn't an answer to his -- her question.

22 THE COURT: Response?

23 MS. HOLLINGSWORTH: Your Honor, I wasn't - that
24 wasn't an expert opinion. He's the CFO. He's
25 also a fact witness, which we've made very

1 clear. He's simply giving his -- his thoughts
2 on an impact ---

3 THE COURT: Well, he said I would also add. And
4 when he did the I would also add, he was moving
5 beyond your question; was he not? I'm asking.

6 MS. HOLLINGSWORTH: Your Honor, I think his answer
7 was responsive to my question. I'm asking
8 about ---

9 THE COURT: What was the question again?

10 MS. HOLLINGSWORTH: I asked him are there any
11 services that the Medical University is
12 proposing to offer that Roper St. Francis
13 Berkeley Hospital doesn't offer. I think his
14 response that no and that that means
15 duplication is just a word generally known and
16 understood. It's not ---

17 THE COURT: Yeah. I didn't take that as a legal
18 term. I just -- my only concern was whether it
19 was asked of him.

20 So, I'm going to -- I'm going to respectfully
21 overrule that and just tell you, I, for the
22 record, do not take that at all as a comment on
23 the law. I take it as a general reference to
24 the duplication of services for which he had
25 already elicit- -- or stated in his first part

1 of his answer. In other words, it was
2 redundant.

3 MS. HOLLINGSWORTH: Thank you, Your Honor.

4 **Q: Mr. Johnson, what is your understanding of the**
5 **-- the beds to be used by Medical University**
6 **for the hospital in Berkeley County?**

7 OBJECTION:

8 MS. CRUM: Your Honor, I'm going to object. There's
9 been no foundation laid for that at all.

10 MS. HOLLINGSWORTH: Your Honor, he has -- he's
11 familiar with the project. He said he's
12 reviewed parts of the application. He's aware
13 of the application. He's been preparing. He's
14 been deposed in this case. He's been asked a
15 significant amount of questions. So, he is
16 more than able to talk about how they propose
17 to establish their hospital through beds. It's
18 all consistent with his testimony.

19 MS. CRUM: Your Honor, he's been offered as an
20 expert in healthcare finance, not in healthcare
21 planning.

22 MS. HOLLINGSWORTH: He's ---

23 MS. CRUM: And how MUSC is going to use the beds is
24 -- that doesn't have anything to do with
25 healthcare planning, Your Honor. I'm sorry --

1 finance.

2 MS. HOLLINGSWORTH: Well, I disagree with whether or
3 not it's relevant to healthcare finance, but,
4 Your Honor, he is also a fact witness. The
5 fact that when he gives information about
6 finance, that it rises to the level of expert
7 opinion. We are -- he's not -- we're not
8 offering him to give planning opinions. And,
9 in fact, we made that clear earlier. He's not
10 expert in healthcare planning, but as a CFO of
11 a health system in this same area he's familiar
12 with, he's testified about how his hospitals
13 were established and ---

14 THE COURT: All right. Give me the question again.

15 MS. HOLLINGSWORTH: Your Honor, I just asked if --
16 what was his understanding of how the Medical
17 University proposed to establish the hospital
18 with beds.

19 THE COURT: But you would have to -- you're asking
20 him if he can testify to his understanding of
21 how the Medical University intends to
22 accomplish that. If you have knowledge of,
23 specific knowledge to answer that, then I'll
24 allow you to answer it. Not a speculative
25 response. You want to her to ask the question

1 again?

2 **A:** **Yes. Please.**

3 **Q:** **Mr. Johnson, are you aware of how in the**
4 **application Medical University proposes to use**
5 **beds to establish the Berkeley County Hospital?**

6 **A:** **In the ---**

7 **OBJECTION:**

8 **MS. CRUM:** Your Honor, I'm going to object to that.

9 The application speaks for itself and how the
10 Medical University is going to use the beds.

11 **THE COURT:** I overrule that.

12 **A:** **In the application the -- the bed need is**
13 **institution specific, not county or community**
14 **specific. So, they -- they ---**

15 **Q:** **All right. And when you -- the Roper St.**
16 **Francis Berkeley Hospital, how did those -- how**
17 **were those beds -- where did those beds come**
18 **from or how were those beds used?**

19 **A:** **They were -- they were transferred from our**
20 **Roper hospital on the peninsula to Berkeley.**

21 **Q:** **Okay. And in your work with Roper St. Francis,**
22 **do you -- are you at times presented with**
23 **concerns or issues related to -- that involve**
24 **capacity constraints?**

25 **A:** **Yes.**

1 Q: And have you -- do you -- what, if any,
2 strategic planning are you involved in where
3 capacity constraints are an issue?

4 A: Can you repeat the question?

5 Q: Sure.

6 A: Sorry.

7 Q: Sure. When you have capacity constraints as an
8 issue, as you've identified and for purposes of
9 planning strategic projects, what are you
10 considering as a CFO on how to address that?

11 A: Well, I would look at -- you know, in terms of
12 the service line, you know, if we are at
13 capacity, how do we expand that capacity and
14 what is the best way to expand that capacity.

15 Q: Okay. And in terms of -- okay. And we touched
16 on this earlier, but again, just as the CFO for
17 Roper St. Francis, what concerns do you have
18 about the proposed community hospital that
19 Medical University asked to establish?

20 A: Well, just recapping, the bed -- I mean, it's
21 a very expensive project. It is -- it is --
22 the fact that two hospitals are being put so
23 close in proximity in Berkeley County, it's not
24 just gonna be bad for Roper St. Francis, as
25 I've illustrated, I think it's going to be bad

1 for MUHA as well. And when you're looking to
2 simply redirect your -- your volumes, you know,
3 as I testified to in the -- our heart tower at
4 Roper Hospital, that you're going to do in the
5 most cost effective way possible. And I'm not
6 a construction expert, but I do know that the
7 tower that they're vacating in the children's
8 hospital was built in 1986, I believe. And
9 that's not old from a healthcare perspective.
10 If I were CFO, I'd look really hard at that --
11 that tower that's being vacated when the --
12 when the move is made to the children's
13 hospital and see if that's a more cost
14 effective answer than the hospital in Nexton.

15 Q: Okay. And if Medical University already had
16 their hospital in the Summerville area and we
17 did not have ours, would you support
18 establishing our hospital where it is today?

19 A: No. So, I would to say things. I'd say one,
20 absolutely not. And two, when we built our
21 Mount Pleasant hospital, there were plenty of
22 land options in close proximity to the tenant
23 owned East Cooper Hospital, and we
24 intentionally rejected any land within a few
25 mile of the tenant hospital to make sure we

1 **were in a discreet more of a -- more of a**
2 **separate market in that northern Mount Pleasant**
3 **area.**

4 MS. HOLLINGSWORTH: One -- I beg your indulgence.
5 Luckily, she only has housekeeping issues, Your
6 Honor.

7 MOTION TO ADMIT RSF 25:

8 MS. HOLLINGSWORTH: There were two exhibits we
9 talked about that I would ask that we put in
10 evidence. One is Roper St. Francis 25, which
11 is the Roper St. Francis Berkeley application
12 that we walked through earlier.

13 MS. CRUM: I believe that that is already DHEC
14 Exhibit Number 7 and we put the entire DHEC
15 Exhibit in.

16 MS. HOLLINGSWORTH: Okay. I'll take the whole
17 entire Exhibit ---

18 MS. CRUM: Yeah.

19 MS. HOLLINGSWORTH: That's great. And then, if we
20 could pull up that Demonstrative -- the last
21 one we walked through, 7.

22 (Demonstrative 7 was referenced at this time.)

23 **Q: And, Mr. Johnson, you -- you have sources for**
24 **these numbers there on your Demonstrative. I**
25 **know it's hard to read on the slide. The Bates**

1 numbers there at the bottom of the
2 Demonstrative, if you could read those into the
3 record so that we have that information later?

4 A: Okay. RSF26-086, CON 0597, and then RSF 23-
5 097.

6 Q: All right. And zoom back out. This is -- the
7 Demonstrative with those three pro formas that
8 you walked through earlier. And again, could
9 you just read in the record, what are the --
10 the net income numbers for those three
11 iterations ---

12 A: Okay.

13 Q: --- of the pro formas that you just talked
14 about?

15 A: For the Berkeley County freestanding ED,
16 certified in June of 2017, net income is
17 21,649,244 dollars. For the Berkeley Community
18 Hospital, pro forma certified in December of
19 2107, the net income is 59,487,000 dollars.
20 And then for the 29-bed addition, Certificate
21 of Need application certified in June of 2019,
22 net income is 20,271,000.

23 Q: Okay.

24 MOTION TO ADMIT RSF 136:

25 MS. HOLLINGSWORTH: Your Honor, I just want to -- I

1 beg your indulgence. Your Honor, I have no
2 further questions.

3 MS. CRUM: I thought you -- did you move that into
4 evidence? I thought you had said you ---

5 THE COURT: Called it a Demonstrative exhibit.

6 MS. CRUM: Oh, I'm sorry. I thought I heard her say
7 she was going to move it into exhibit --
8 evidence.

9 MS. HOLLINGSWORTH: I would love to, but I wasn't
10 going to attempt to.

11 MS. CRUM: We won't object.

12 MS. HOLLINGSWORTH: Oh, well, I -- yes. If the
13 Court would accept them, then we would ---

14 THE COURT: That ---

15 MS. HOLLINGSWORTH: Demonstrative Exhibit 7.

16 THE COURT: Well, we'd have to get it marked as an
17 Exhibit.

18 MS. HOLLINGSWORTH: We'll put it as the next Roper
19 St. Francis number.

20 THE COURT: Which would be? 1,558.

21 (Laughter.)

22 MS. CRUM: 136, maybe.

23 MS. HOLLINGSWORTH: 136.

24 THE COURT: All right. It's admitted as 1 -- well,
25 any objections?

1 MR. THOMAS: No objections.

2 MR. WICEVIC: No, Your Honor.

3 THE COURT: It's admitted.

4 MS. HOLLINGSWORTH: Thank you, Your Honor.

5 THE COURT: And we are going to break for lunch now.

6 When do y'all suggest being back? 2:00 or

7 thereafter?

8 MS. HOLLINGSWORTH: Mr. Johnson is the only witness

9 that -- based on his cross, it's ---

10 MR. SUMMER: 2:00 o'clock is fine with me.

11 MS. HOLLINGSWORTH: Ms. Crum?

12 MS. CRUM: About 2:15, Your Honor?

13 THE COURT: 2:15 it is. Okay. Sold.

14 (A break was taken from 12:56 p.m. until 2:18 p.m.)

15 COURT REPORTER: All rise.

16 THE COURT: Hey, y'all. Y'all be seated.

17 Well, which one?

18 MR. SUMMER: No questions, Your Honor.

19 THE COURT: No questions?

20 MR. WICEVIC: No questions.

21 THE COURT: Okay.

22 MS. CRUM: Your Honor, if you don't mind, I'm gonna

23 scoot just a little closer so that I can reach

24 my notebooks there.

25 THE COURT: Okay.

1 MS. CRUM: That's easier said than done. Okay.

2 THE COURT: Well, the closer you get to Ms. Jones,
3 the more apt she's going to be able to grab
4 you.

5 MS. CRUM: She would do that anyway, Your Honor.

6 (Laughter.)

7 MS. CRUM: You know, we do need to get the computer
8 switched so that we can put screen shots up.

9 THE COURT: Okay.

10 MS. CRUM: That's quick. This new technology's --
11 this is the old dog. Mr. Johnson ---

12 THE COURT: The next thing I want to come up with --
13 I saw something in a magazine. I want to get
14 it where we start doing almost all of our
15 exhibits digitally and then we can even start
16 marking them admitted. So, I'm working toward
17 that end.

18 MS. CRUM: Do we need an appropriation for that?

19 THE COURT: I think we're about there. I think we
20 could even -- you know how you -- we've got, I
21 think they're called annotated screens that you
22 can draw on, we could start even admitting the
23 annotations digitally down the road, but I'm
24 just working on stuff like that.

25 MS. CRUM: It's all exciting.

1 MR. JOHNSON - CROSS-EXAMINATION BY MS. CRUM:

2 Q: Mr. Johnson, I'm Liz Crum. We met at your
3 deposition on September the 19th, wasn't it?

4 A: Yes.

5 Q: Okay. And as I told you then, if one of my
6 brilliant questions makes no sense, tell me
7 that and I'll try to ask it again. Okay?

8 A: Thank you.

9 Q: All right. You're not an expert in health
10 planning, are you?

11 A: No.

12 Q: The last -- when was the last time that Roper
13 Hospital showed an institutional bed need in a
14 South Carolina State Health Plan?

15 A: I don't recall that we -- that we have.

16 Q: Okay. And in fact, the CON applications that
17 you did -- when I say you, I'm talking about
18 Roper St. Francis did, with Roper St. Francis
19 Mount Pleasant and Roper St. Francis Berkeley,
20 were all transfers of beds, licensed beds, from
21 downtown to either Mount Pleasant or to Roper
22 Berkeley, right?

23 A: Yes.

24 Q: The last time you worked with GASB was before
25 you left Arthur Andersen, is that right?

1 **A:** Yes. It would have -- it would have been 1997
2 or before.

3 **Q:** Okay. All right.

4 **A:** I've sat through some GASB updates as part of
5 my CPE, but I ---

6 **Q:** And when was that?

7 **A:** Usually, annually they'll give updates. Well,
8 to be honest, I don't pay a lot of attention to
9 GASB ---

10 **Q:** Okay.

11 **A:** --- during those updates.

12 **Q:** And you have never worked in a hospital or
13 healthcare enterprise that was a governmental
14 enterprise that used GASB, have you?

15 **A:** I never worked for one, but I've audited some
16 in public accounting.

17 **Q:** And that was when you were with Arthur
18 Andersen, correct?

19 **A:** That's correct.

20 **Q:** Okay. Roper St. Francis Hospital system, is
21 that the only healthcare system that you have
22 worked with, have been employed by?

23 **A:** From -- technically, no. We -- so, when I was
24 director of finance, I was employed by Roper
25 CareAlliance. When I got promoted to CFO,

1 technically, I moved over to the management
2 company's payroll which was Carolinas
3 Healthcare System out of Charlotte. When that
4 con- -- when that management contract ended at
5 the end of 8- -- 2018, I transferred back to
6 Roper St. Francis's payroll. So I sat in the
7 same chair, but on three different payrolls.

8 Q: Three different payrolls, but the -- the system
9 that you were working for was the same?

10 A: Effectively, yes.

11 Q: Okay. I think you said that you chose, that
12 Roper St. Francis chose the Mount Pleasant site
13 to put its -- transfer its 86 beds because it
14 was far enough away from East Cooper. Did I
15 misunderstand that?

16 A: No, that was a -- that was definitely a
17 consideration when we were looking for sites
18 for that hospital. We wanted to be well into
19 the northern area of Mount Pleasant and not,
20 not in proximity to East Cooper Hospital.

21 Q: How far -- as you drive, how many miles is it
22 between East Cooper and Roper Mount Pleasant?

23 A: I believe in miles it's, it's seven. Minutes
24 are a different story.

25 Q: No, I'm just asking in miles.

1 A: Yes.

2 Q: All right, sir. So you think it's seven miles
3 or seven point one or two miles?

4 A: Approximately seven is what I recall.

5 Q: Okay. And how far is the current Roper
6 Berkeley Hospital from the proposed Roper --
7 I'm sorry, the proposed MUSC site in Nexton?

8 A: I understand it's, by driving, four miles; as
9 the crow flies, probably less.

10 Q: What is the basis of your understanding, Mr.
11 Johnson?

12 A: I have not -- I've obviously been many times to
13 our Berkeley site, I have not driven personally
14 to the -- to the site where the Nexton -- the
15 new -- proposing their hospital. I believe in
16 the -- in getting ready for this case, I've
17 read that they're four miles apart.

18 Q: And where did you read that?

19 A: I don't recall the specific document.

20 Q: Okay. You said Roper St. Francis system is a
21 Baa1 rating by Moody's, is that right?

22 A: Correct.

23 Q: Okay. Now, is it still CareAlliance or is it
24 got a new Inc. now?

25 A: Technically, we are still CareAlliance Health

1 Services and then d/b/a Roper St. Francis
2 Healthcare. There are -- I do believe our
3 founding members intend to change that soon to
4 just Roper St. Francis Healthcare.

5 Q: Well, and you testified earlier that
6 CareAlliance didn't stick, so you went back to
7 Roper St. Francis, is that correct?

8 A: Correct.

9 Q: Okay. And brand is important, isn't it?

10 A: Yes.

11 Q: And with brand, that's how people know to find
12 the hospital they're looking for, right?

13 A: I'm not sure I understand the question.

14 Q: Okay. If somebody's driving past and they want
15 to go to an MUSC facility and they see MUSC or
16 MUHA on that, they know it's a facility that
17 they're looking for, right?

18 A: Yes.

19 Q: And that's why you use Roper St. Francis,
20 right?

21 A: Correct.

22 Q: Okay. Now, what is the Medical Society of
23 South Carolina?

24 A: They are, I believe, the fourth oldest medical
25 society in the country, founded in the 1700s,

1 and it is -- it is a membership of physicians.

2 Q: And what does it have to do -- let me strike
3 that. Roper St. Francis -- I'm sorry, the
4 Medical University -- let me get that right.
5 The Medical Society actually founded Roper
6 Hospital, didn't it?

7 A: That's my understanding, correct.

8 Q: Okay. That's what you testified to in the 2012
9 case, isn't it?

10 A: If I was asked that question, yes, I would have
11 ---

12 Q: Okay. All right.

13 A: --- responded that way.

14 Q: Now, you talk with Ms. Hollingsworth this
15 morning about your testimony in the 2012 Roper
16 St. Francis and Trident 50-bed hospital cases,
17 didn't you?

18 A: Yes.

19 Q: Okay. You talked a lot of Moody's this
20 morning. Moody's -- do you have to annually
21 update to Moody's -- I think you were talking
22 about covenants?

23 A: Yes. They perform surveillance, what they call
24 surveillance, at least annually.

25 Q: Okay. And y'all have disclosed to them that

1 MUHA has gotten a CON -- a CON has been,
2 regulatoryily approved for one, in Berkeley
3 County, haven't you?

4 A: I'm -- I want to say that Moody's surveils MUHA
5 as well, or MUSC, but, but we would have
6 certainly disclosed that.

7 Q: My question is, have you, on behalf of Roper
8 St. Francis, disclosed the existence of the
9 DHEC approval of our CON application?

10 A: That, I don't know. I -- I would have expected
11 Moody's to have garnered that from MUSC.

12 Q: Now, let me -- I didn't mean to interrupt you.
13 Go ahead if you have something else to say.

14 A: I don't -- I want to say yes, but I don't
15 specifically recall me telling our analyst that
16 that's the -- that indeed exists.

17 Q: Well, isn't it one of your responsibilities to
18 tell the analysts of significant risks to your
19 hospital?

20 A: Yes, that would be.

21 Q: And do you not consider MUHA to be a --
22 Berkeley to be a significant risk?

23 A: Yes.

24 Q: So, you should have told MUHA -- you should
25 have told Moody's about that, shouldn't you?

1 A: Yes, that would ---

2 Q: Okay. Now, how many days cash on hand does
3 Roper St. Francis system have?

4 A: Approximately 90.

5 Q: Mr. Johnson, you have to -- you get an update
6 from Moody's, don't you, on an annual basis as
7 to what they're going to say about your credit
8 rating and strengths and weaknesses?

9 A: At least annually, yes.

10 Q: And before they publish that, don't they give
11 it to you to give you the opportunity to take
12 exception to some of the doc- -- to some of
13 their conclusions?

14 A: We are limited to, to correcting errors, but,
15 yes, they do let us review it, but --
16 immediately before it gets published.

17 Q: Okay. And so, it -- they let you correct any
18 errors.

19 A: If there are errors, they'll let us correct.
20 Other than that, our opinion doesn't matter to
21 that, to Moody's.

22 Q: And you have the ability to point out to them
23 where you think they might be wrong?

24 A: That's correct.

25 Q: Okay. Now, you have a -- would you please,

1 **sir, put up MUHA Exhibit 17?**

2 MS. CRUM: I think we're getting our notebook
3 here, Your Honor.

4 (Off the record discussion)

5 (MUHA's Exhibit 17 was referenced at this time.)

6 **Q: Would you turn to Exhibit 17?**

7 **A: (Witness complies.)**

8 **Q: Now you recognize that as your -- as**
9 **CareAlliance Health Services, Inc.'s update to**
10 **credit analysis, dated June 26, 2019, right?**

11 **A: Yes.**

12 **Q: Okay. And that ---**

13 MS. HOLLINGSWORTH: Your Honor, I apologize for
14 interrupting. Could we -- this is the first
15 time we're seeing this document. Could we make
16 sure that we're laying the foundation for the
17 document?

18 MS. CRUM: I was just ---

19 MS. HOLLINGSWORTH: This isn't our document.

20 MS. CRUM: I was asking him if he recognized it. I
21 was ---

22 MS. HOLLINGSWORTH: Well, I understand, but you were
23 -- you were telling him what it was, I was --
24 we asked that the witness be able to identify
25 it and establish it.

1 MS. CRUM: Sure.

2 Q: Mr. Johnson, do you recognize this document?

3 A: I do. This is our most recent analyst report
4 from Moody's Investor -- Investor Service,
5 dated June 26, 2019.

6 Q: Is this something that you looked at and rely
7 on in your financial forecasting and planning?

8 A: I would -- I would say no. This is really a
9 report made to our bondholders. I do react to
10 things that Moody's thinks are credit positives
11 and credit negatives. That certainly shapes
12 some of our financial planning.

13 Q: It shapes some of your financial planning.
14 What part of it doesn't it shape?

15 A: You know, I'm trying -- you know, just because
16 a rating agency thinks something -- for
17 instance, bonds are different than equity.
18 Like when we get approval of a new hospital,
19 you know, if we were -- if we were a for-profit
20 company with stock, that might mean an
21 improvement to our stock price; you know,
22 having that franchise might be an improvement
23 to our stock price. Rating agency's look at
24 bonds and say, well, that's risk to Roper St.
25 Francis Healthcare until that facility gets

1 established. So every time we go to build a
2 new facility, that generally has a little bit
3 of credit negative to it, but it doesn't stop
4 us from, from moving forward.

5 Q: Okay. Let me ask my question again. What part
6 of your financial planning doesn't your credit
7 -- the credit opinion shape?

8 A: Well, so our financial planning is really
9 connected to our strategic planning. Moody's
10 doesn't work with us on strategic planning and
11 things like that. So, you know, maintaining
12 our credit rating is an important part of, of
13 our financial environment, but they're not at
14 the table with the board and management shaping
15 our strategy or anything.

16 Q: Maybe I misunderstood what you said this
17 morning. But I thought you had testified this
18 morning that your credit rating was integral
19 and completely important to your ability to do
20 strategic planning and to maintain debt.

21 A: It is critically important. So strategic
22 planning goes way beyond major capital
23 projects, and maybe that's where we're not
24 connecting here. So, but for -- to the extent
25 that we have a major strategic capital project

1 that's gonna require debt financing, yes,
2 Moody's opinion will be very important.

3 Q: Now, when was the last time you issued bonds?
4 Was that when you got ready to build Roper St.
5 Francis?

6 A: We technically -- yeah, Roper St. Francis,
7 we've been out of the public debt markets
8 since, I believe, 2014, and all of our debt now
9 is private -- privately placed with banks.

10 Q: What interest rate do you have?

11 A: Our blended -- our overall blended rate is in
12 the -- it's slightly over 4 percent.

13 Q: What is a blended rate?

14 A: Well, we have different tranches of debt issued
15 at different times. And the markets do go up
16 and down in terms of interest rates, so we
17 would have -- so depending on what interest
18 rates were at the time we issue those bonds,
19 they would be different. And we also have some
20 variable rate debt that fluctuates as well. So
21 if you aggregate all that together, I think
22 we're a little above 4 percent aggregate cost
23 of capital.

24 Q: So for my pea brain, that's basically, it costs
25 you 4 percent to borrow any kind of capital

1 money?

2 A: Approximately, yes.

3 Q: Okay. All right, sir. Now, I think you also
4 testified this morning that your board wouldn't
5 approve a hospital project that wasn't
6 financially feasible, is that correct?

7 A: Correct.

8 Q: Okay. What information do you have that the
9 MUHA board would abrogate its fiduciary
10 responsibility and approve a project that was
11 not financially feasible?

12 A: I don't know that we -- just because you --
13 now, a CON is a -- is not a commitment. So I
14 don't know what the MUHA board has approved or
15 the MUSC board has approved in terms of -- in
16 terms of the actual construction contracts and
17 debt where those truly are commitments. So I
18 just have no knowledge of what, specifically,
19 has been approved.

20 Q: So would it then be your testimony that the
21 DHEC -- that the MUHA board would approve this
22 project in writing per the CON Regs and then at
23 a later date come back and say, no, we didn't
24 approve it?

25 A: Well, I think boards do know that CONs are not

1 commitments. I can't speculate as to what the
2 board was thinking, but I do know that boards
3 understand that CONs are not firm legal commit-
4 -- not legal commitments; it's not a contract.

5 Q: So you don't know what DHEC -- the MUHA board
6 would do, do you?

7 A: No.

8 Q: Now let me go back here to MUHA 17.

9 (MUHA Exhibit 17 was referenced at this time.)

10 Q: The MUHA credit analysis and summary says that
11 it believes that -- and I'm gonna say Roper St.
12 Francis instead of CareAlliance, is that okay?

13 A: Yes.

14 Q: Okay. That Roper St. Francis will have a
15 higher cash margin in 2019 than it's had in the
16 last several years, doesn't it?

17 A: That's correct.

18 Q: And it also says that it will have stronger
19 cash flow, coupled with the suspension of cash
20 distribution payments which would allow Roper
21 St. Francis to improve key liquidity metrics
22 modestly, right?

23 OBJECTION:

24 MS. HOLLINGSWORTH: Your Honor, I would object to
25 reading the hearsay into the record.

1 MS. CRUM: I'm not reading it.

2 THE COURT: Well, let's ---

3 MS. HOLLINGSWORTH: He's highlighting what ---

4 THE COURT: --- but I don't ---

5 MS. HOLLINGSWORTH: He's highlighting the document as
6 she's reading from it.

7 THE COURT: Well.

8 MS. CRUM: I'm not reading from it, Your Honor. I'm
9 reading from my notes, which aren't a verbatim
10 copy.

11 THE COURT: Well, he's highlighting the Exhibit. Is
12 this Exhibit in evidence, though?

13 MS. HOLLINGSWORTH: No, Your Honor.

14 THE COURT: Oh.

15 MS. CRUM: No, I haven't moved it in yet, Your
16 Honor.

17 THE COURT: Well ---

18 MS. CRUM: Okay.

19 THE COURT: --- arguably it's demonstrative, but
20 then on the other hand, the way you're
21 approaching it, I -- if it's not in, I don't
22 think he should be highlighting it.

23 MS. CRUM: I'm going to go ahead and move it in
24 then, Your Honor.

25 THE COURT: Okay.

1 **Q:** Is this a document, Mr. Johnson, that you
2 received in the ordinary course of your
3 business?

4 **A:** Yes.

5 **Q:** And is it a document that you rely on as CF0?

6 **A:** Yes.

7 **Q:** Is it a document that you recognize and have it
8 in your files?

9 **A:** Yes.

10 **MOTION TO ADMIT MUHA 17:**

11 MS. CRUM: Your Honor, at this point, I'm going to
12 move in MUHA Exhibit 17.

13 THE COURT: Let's ...

14 MR. WICEVIC: No objection.

15 MS. HOLLINGSWORTH: Your Honor, I object. It's
16 hearsay. This isn't a document that Roper St.
17 Francis prepared. He testified earlier he
18 didn't rely on this in any of the opinions he's
19 used here, so this is a document created by
20 another entity. He's aware of it, he knows it,
21 it's not his document, so it's simply hearsay
22 and it can't come in.

23 MS. CRUM: Your Honor, I asked him if he kept it in
24 the ordinary course of business ---

25 THE COURT: Well, that's ---

1 MS. CRUM: --- it's an exception to the hearsay
2 under Rule 803(3).

3 THE COURT: Well, ordinary course of business. I
4 think you would start first with the definition
5 of hearsay which is a statement other than the
6 one made by a declarant while testifying at a
7 trial or hearing or offered into evidence to
8 prove the proof of the matter asserted. So, I
9 don't know that this is -- what is this being
10 offered for?

11 MS. CRUM: Your Honor, I'm offering it to show that
12 MUHA -- I'm sorry, I gonna do that a lot, I
13 mean, sorry -- that Roper St. Francis,
14 actually, is in good condition, that it has
15 strengths, that it has -- and I'll be happy
16 just to question him from it.

17 THE COURT: Well you ---

18 MS. CRUM: Do it as a demonstrative.

19 THE COURT: Well, you can do it.

20 MS. CRUM: Happy to do that.

21 THE COURT: You can impeach him with it.

22 (Off the record discussion)

23 MS. CRUM: Ms. Jones reminded me that he is also an
24 expert, and as an expert, he can rely on
25 hearsay.

1 THE COURT: Correct.

2 MS. HOLLINGSWORTH: Yes, Your Honor, but he already
3 testified that he did not rely on this document
4 for purposes of his analysis or planning, so.

5 THE COURT: That is also correct.

6 MS. CRUM: I'm sorry ---

7 MS. HOLLINGSWORTH: This is not his document.

8 MS. CRUM: I couldn't hear the last purposes and
9 analysis of and I couldn't hear that.

10 MS. HOLLINGSWORTH: He testified in response to your
11 question earlier, he did not rely on this
12 document for purposes of his expert opinions
13 that he's offered.

14 THE COURT: Here's how that rule works, is, you
15 know, Roper could have offered or allowed him
16 to testify as to hearsay. On cross-
17 examination, you can illicit that hearsay if
18 that hearsay is -- was used in him formulating
19 his opinion. Now where we are now is, there's
20 no evidence that this hearsay document was
21 utilized in formulating his opinion. It
22 appears to me that you're -- what we're doing
23 at this point in time, is you're attempting to
24 impeach him with this Exhibit.

25 MS. CRUM: I'm just going to use it as a

1 demonstrative, Your Honor.

2 THE COURT: Okay.

3 Q: Now, Mr. Johnson, are your interim financials
4 better this year than they were last year?

5 A: Yes.

6 Q: And you have stronger margins?

7 A: We do. I would say we are not at sustainable
8 margins. We've got improvement to go before
9 it's sustainable margins, but '19 is better
10 than '18, correct.

11 Q: And so, you have a better margin this year than
12 you did last year?

13 A: Yes.

14 Q: And you're going to have a better market
15 position as a result of that, correct?

16 A: Well, our rating was affirmed, it wasn't
17 improved, it wasn't upgraded. But, I guess I
18 need a definition of market position.

19 Q: You define it for me, please, sir.

20 A: I -- I don't understand the context, so it
21 would be a struggle.

22 Q: What is your definition of market position,
23 vis-a-vis, Roper St. Francis and the other
24 healthcare systems in the tri-county area?

25 A: Generally speaking, that would be your market

1 share and the distribution of your facilities.

2 Q: Okay. Thank you. And isn't it true that in
3 2019, Roper had a -- the highest percentage
4 market share of any of the three healthcare
5 systems ---

6 A: The ---

7 Q: --- in the tri-county area?

8 A: I'm sorry for interrupting you, but the answer,
9 market share information that's available is
10 only inpatient and we, I believe, we're
11 slightly ahead of the other two major systems.

12 Q: For inpatient?

13 A: For inpatient volume, correct.

14 Q: Okay. Right. And isn't it true that there
15 have been some -- that -- well, let me stop.
16 Don't you have strong -- when I say you, I'm
17 sorry, I mean Roper St. Francis. Don't you
18 have a strong physician alignment throughout
19 the medical -- through the Medical Society of
20 South Carolina?

21 A: Oh, that's certainly a positive for our
22 organization. I will say a lot of Medical
23 Society physicians split their volume between
24 Roper St. Francis and the HCA facilities and
25 make a lot of referrals to MUHA as well.

1 **Q:** **So is it your position that Roper St. Francis**
2 **does not have a strong physician alliance**
3 **through the Medical Society of South Carolina?**

4 **A:** **I believe that we do.**

5 **Q:** **Do you believe or is it your opinion that**
6 **Berkeley -- the new hospital in Berkeley County**
7 **will provide a good opportunity for Roper St.**
8 **Francis to grow its market share?**

9 **OBJECTION:**

10 **MS. HOLLINGSWORTH:** Your Honor, I would object to
11 the question. She's asking his opinion in a
12 health planning context and market share and
13 they were very clear that that wasn't an area
14 that he should testify to on direct.

15 **MS. CRUM:** I'll rephrase that question, Your Honor.

16 **THE COURT:** Okay.

17 **Q:** **Isn't it true, Mr. Johnson, that the new**
18 **hospital in Berkeley County will help increase**
19 **the bottom line for Roper St. Francis?**

20 **A:** **I would certainly hope so. Yes. Or allow ---**

21 **Q:** **Now ---**

22 **A:** **--- us to -- allow us to continue our journey**
23 **to sustainable margins. I hope it's positive.**

24 **Q:** **But that would be increasing the bottom line,**
25 **wouldn't it?**

1 **A:** From where it is today, yes.

2 **Q:** Okay, thank you. Now, who were the founding
3 members?

4 **A:** We have three. We have the Medical Society of
5 South Carolina, which you've recently
6 mentioned; we also have, it used to be Bon
7 Secours Health System. They have merged with
8 -- they have merged and now are Bon Secours
9 Mercy Health. They're based out of Cincinnati
10 now. And then we have Carolinas Healthcare
11 System, or Atrium Health. Those would round
12 out the three.

13 **Q:** And how large is the new merged Bon Secours
14 system?

15 **A:** It is 8 or 9 billion dollars in total assets.

16 **Q:** And how many hospitals does it have?

17 **A:** It's -- you know, I'm fairly new to them, but
18 I would say -- I want to say, like, 37. Or
19 it's 30 or 40 hospitals. Between the --
20 between the east coast and their midwestern
21 operations, I want to say 37, but I could be
22 wrong. I'm really new to them.

23 **Q:** Capital contributions, what kind of capital
24 contributions does -- do the founding members
25 make to Roper St. Francis?

1 **A:** So, when we do a major strategic project,
2 historically, there are times when founding
3 members have made contributions. For instance,
4 I believe they committed -- or contributed 25
5 million to our Mount Pleasant hospital, and I
6 think they contributed 20 million to our
7 Berkeley hospital, and the Medical Society will
8 -- they haven't done this recently, but it was
9 a number of years ago, they had funded some
10 routine capital needs we had as well.

11 **Q:** Well, a number of years ago, like in 2012 --
12 I'm sorry. Back in August -- February of 2008,
13 the Medical Society bought the property at
14 Carnes Crossroads in Berkeley County, didn't
15 they?

16 **A:** That's correct.

17 **Q:** Okay. And they bought that in February of
18 2008, correct?

19 **A:** Correct.

20 **Q:** And the CON application for the Berkeley
21 Hospital was filed in August of 2008, right?

22 **A:** That sounds correct.

23 **Q:** Okay. So any other capital contributions that
24 any of the founding members, other than the
25 Medical Society, have made?

1 **A:** Yeah, I'm forgetting a larger recent one. Last
2 -- or in 2018 and 2019, the founding members
3 committed 50 million to Roper St. Francis
4 Healthcare to fund some -- to pay -- to reduce
5 debt and to fund some capital needs.

6 **Q:** Okay. So would it be fair to say that Roper
7 St. Francis has access to capital that it does
8 not have to go through conventional financing
9 or through bond financing?

10 **A:** Well, the way our model works, is for years --
11 it's been suspended recently because of our
12 poor financial performance, but for years, we
13 made a distribution each year to our founding
14 members. And we've distributed over 300
15 million to our founding members over the last
16 20 years. And that model was set up to where
17 money would come back in for major strategic or
18 at times when we needed an infusion, so.

19 **Q:** I'm sorry. Can I ask you to speak just a
20 little bit louder?

21 **A:** Yes.

22 **Q:** Thank you, sir. Would it be fair to say that
23 the Roper St. -- that the Medical Society of
24 South Carolina is in the nature of a support
25 organization for your not-for-profit

1 corporation?

2 A: That's correct.

3 Q: Okay. One of the challenges that you have
4 today is a weather-related challenge. Is that
5 a fair assessment?

6 A: The storms have certainly interrupted
7 operations, yes.

8 Q: Okay. And, in fact, in the 2012 case, you
9 testified that Roper St. Francis had to move
10 its data center from the, I think you said, sea
11 level at the Roper parking garage north because
12 of flooding?

13 A: Well, it was a host of reasons. Certainly the
14 risk of flooding played into that. The other
15 problem with being downtown Charleston is, you
16 can't get the power you need, the redundant
17 power you need for a data center and you can't
18 get the redundant fiber that you need for a
19 data center. So, it just -- as our health
20 system became more and more wired, so to speak,
21 we relied more and more on our data center to
22 keep us operational. And the risk profile of
23 being on a peninsula, for many reasons,
24 electricity, you know, storms and electricity,
25 and also fiber, you know, it just wasn't good

1 enough there anymore. We really, for business
2 continuity, we needed to relocate it and that's
3 why we moved it to Ladson.

4 Q: Okay. And MUHA has the same, if not greater
5 because it's a larger hospital, data needs that
6 y'all have, don't they?

7 A: Yes.

8 Q: Mr. Johnson, you would agree with me that THS,
9 Roper St. Francis and MUHA are the top three
10 health systems in the tri-county area?

11 A: Yes.

12 Q: You would also agree with me, wouldn't you,
13 that Moody's sees MUSC and Trident as your
14 major competitors?

15 A: Yes.

16 Q: You're not -- when your staff prepares a pro
17 forma, and I'm assuming it's your staff that
18 does it, for a CON application, are you
19 conservative in preparing the revenue
20 projections?

21 A: We certainly like to think they're reasonable.
22 You know, I think accurate is probably the
23 mantra that we go with in, again, finance.

24 Q: Are you aware that under the CON Regs, the pro
25 forma only has to show financial feasibility at

1 the end of three years for a healthcare system?
2 I'm sorry. Let me strike that. Are you aware
3 that the CON Regs require or suggest that a
4 hospital show a performance that is in the
5 positive neighborhood at the end of three
6 years?

7 A: Um ...

8 OBJECTION:

9 MS. HOLLINGSWORTH: I would object to that question,
10 it's -- there's no foundation for him answering
11 a question about the Regulations at all.

12 MS. CRUM: I'll go back and re-question.

13 THE COURT: All right.

14 Q: Mr. Johnson, when you -- make a -- do a pro
15 forma for your system, what is your objective
16 regarding -- regarding performance at the end
17 of three years?

18 A: I wouldn't, you know, I -- I wouldn't say there
19 is one I mean, you know, we do projections --
20 it depends on the life of the asset and things
21 like that. I mean, projection -- we don't have
22 any rules about how things we -- how things are
23 supposed to look. We try and project
24 accurately, and there are pro formas that come
25 forward that don't make money, period. And,

1 you know, every strategic idea that comes
2 forward or capital idea that comes forward, we
3 generally do a pro forma for, but a lot of them
4 don't look good and that just gets taken into
5 account as we evaluate and prioritize those
6 projects.

7 Q: And, Mr. Johnson, would you agree that when you
8 are doing a pro forma, when you start, it's a
9 work in progress?

10 A: Yes.

11 Q: And that it might change from the beginning to
12 what you finally submit?

13 A: Well, I want to be clear. Yes, I mean,
14 projections are -- projections change as
15 assumptions change, and assumptions are
16 expected to change over time. So as you do pro
17 formas, I would expect that my forecast of
18 Roper St. Francis Healthcare for -- that I
19 prepared this year will probably look a little
20 different next year.

21 Q: Okay. Have you ever done any work in an
22 academic medical center?

23 A: uh ...

24 Q: A financial position?

25 A: I'm sure somewhere back in my Arthur Andersen

1 days, I did. I don't recall.

2 Q: Let me rephrase that. Have you ever been
3 employed by an academic medical center in a
4 financial position?

5 A: You know, I -- I'm trying to think of whether
6 Atrium Health is technically a academic -- I
7 guess they're probably not. So my answer would
8 be no.

9 Q: Okay. Roper St. Francis has a number of access
10 points with physician offices and outpatient
11 services, doesn't it?

12 A: Yes.

13 Q: Approximately about 90 in the tri-county area,
14 aren't there?

15 A: I think that's correct.

16 Q: Okay. And you have a new medical office
17 building up in the Roper Berkeley area, don't
18 you?

19 A: Yes, we do.

20 Q: How many medical offices are up there?

21 A: It's a -- I know it's an 80,000 square foot
22 building. I don't know how many offices that
23 has been carved up into.

24 Q: Do you know how many physicians have offices up
25 in the Berkeley County area?

1 **A:** **I do not.**

2 **Q:** **Mr. Johnson, were you aware that in the -- at**
3 **the MUHA 2019 audit, that it had income or had**
4 **money in the bank, 450 million dollars**
5 **restricted and unrestricted funds?**

6 **A:** **I know it has a 400-plus million dollar number**
7 **on the cash line on their balance sheet.**

8 **Q:** **Okay.**

9 **A:** **I don't know about unrestricted and restricted.**

10 **Q:** **Okay. Do you know that at the end of the 2019**
11 **audit, MUHA had an operating income of 35**
12 **million dollars?**

13 **A:** **I did see that.**

14 **Q:** **Okay. And did you also see that at the end of**
15 **the 2019 audit, MUHA had free cash flow of 150**
16 **million dollars?**

17 **A:** **I computed operating cash flow of 103, not 150.**

18 **Q:** **Okay. All right. You have a -- Roper Berkeley**
19 **just got a CON to build a rehab hospital,**
20 **didn't they?**

21 **A:** **I understand that's correct, yes.**

22 **Q:** **Okay. And you took those beds and you put them**
23 **in Berkeley County, aren't you, the hospital**
24 **there?**

25 **A:** **That I don't know.**

- 1 Q: Okay.
- 2 A: I -- I'm not exactly sure of that.
- 3 Q: Who can I ask to find that out?
- 4 A: Troy Powell is our vice president ---
- 5 Q: Okay.
- 6 A: --- in that post-acute services.
- 7 Q: Can we just look at the CON application? I'm
- 8 not talking about right now, is that another
- 9 way to find out?
- 10 A: Yeah, I would assume so. I've not ---
- 11 Q: Okay.
- 12 A: --- read the document.
- 13 Q: All right, sir. Well, Roper St. -- or Roper
- 14 Hospital provides rehab bed -- rehab services
- 15 and beds downtown, don't they?
- 16 A: Yes.
- 17 Q: Okay. Do you know why Roper put the hospital
- 18 bed -- the new rehab hospital in Berkeley
- 19 County and didn't just add the beds downtown?
- 20 A: Yes. And some of this -- some of this gets to
- 21 discussion in a paper. I think it was in the
- 22 paper about the potential for ---
- 23 Q: Mr. Johnson, I'm asking what you know, now
- 24 about what's in the paper.
- 25 A: Then can you please repeat your question?

1 **Q: Do you know why Roper Hospital put the rehab**
2 **beds in a hospital in Berkeley County instead**
3 **of adding them with the existing rehab beds at**
4 **the downtown hospital?**

5 **OBJECTION:**

6 **MS. HOLLINGSWORTH:** Your Honor, I object. The
7 witness has already said he doesn't know
8 anything about the application and that
9 question just assumed facts that are not in
10 evidence and I ---

11 **MS. CRUM:** I'll ask it another way, Your Honor.

12 **THE COURT:** Okay.

13 **Q: Do you know whether or not Roper gave any**
14 **consideration to adding additional rehab beds**
15 **in its downtown hospital?**

16 **A: I would have to defer that to Troy Powell. I'm**
17 **not sure.**

18 **Q: And we could also -- that's fine. But to the**
19 **best of your knowledge, the new beds aren't**
20 **being added downtown, are they, to the best of**
21 **your knowledge?**

22 **A: To the best of my knowledge, correct.**

23 **Q: Okay, thanks. Let's go back here. You talked**
24 **-- you're not providing any testimony regarding**
25 **MUHA's ability to finance this project through**

1 HUD, are you?

2 A: I'm sorry, can you repeat the question?

3 Q: You're not providing any testimony regarding
4 MUHA's ability to finance its project using HUD
5 financing, are you?

6 A: I can't opine on whether it's going to be
7 approved by HUD, no.

8 Q: Okay. And I think you've already testified
9 that you've never done a HUD project, was that
10 correct?

11 A: Correct.

12 Q: Tell me the basis of your knowledge about
13 MUHA's financing, other than the audits.

14 A: Well, I think we went -- when you say
15 financing, are you just speaking ---

16 Q: Finances. You talked about how terrible the
17 finances were, it was a very weak balance
18 sheet. Tell me the basis of your knowledge,
19 other than your review of the KPMG audits.

20 A: Well, I would have reviewed that audit and
21 then, you know, their fiscal health would also
22 be evident in their -- well, their future
23 fiscal health would also be evident in their
24 projection models, and I testified to some of
25 that as well.

1 Q: So, and that's all you've looked at?

2 A: Their -- that's all I recall.

3 Q: Okay. You gave, I think, some testimony about
4 the CHS hospitals, to the hospitals in
5 Lancaster, Chesterfield, Florence, and Marion -
6 - Mullins, right?

7 A: I mentioned those this morning, yes.

8 Q: Okay. All right. What do you know about their
9 finances?

10 A: Nothing recently. I audited Chester County
11 Hospital 25 years ago, but that was a long time
12 ago. I don't know anything currently about
13 their finances.

14 Q: As they would say in the fairy tales, that
15 would have been long ago and far away, wouldn't
16 it?

17 A: That's -- that's true.

18 Q: Do you have any information as to how those
19 hospitals are performing now?

20 A: I -- I don't. I mean, as a CFO in South
21 Carolina, I would not think they would be high-
22 margin facilities.

23 Q: Okay. What do you base that on?

24 A: Just the -- I mentioned I was on a -- a
25 Medicaid task force as part of the hospital,

1 South Carolina Hospital Association and one of
2 the most common topics during those meetings is
3 how the rural hospitals are struggling
4 financially, so I'd put the Lancaster and the
5 Chester facility in that bucket of rural
6 hospitals, maybe Mullins. And Florence -- the
7 Florence hospital, I think, is probably in a
8 better market. They have a lot of competition
9 from McLeod, so.

10 Q: Tell me what you know about the Lancaster
11 market.

12 A: That it's in South Carolina, south of
13 Charlotte, and that it's more of a rural
14 market.

15 Q: Okay. What is -- where is Indian Land?

16 A: North of that close to the border, North
17 Carolina, South Carolina border.

18 Q: So this morning when you said it was in North
19 Carolina, you just mis-spoke?

20 A: Oh, I did. Yes, I mis-spoke.

21 Q: Now, do you know whether or not Charlotte and
22 the whole Charlotte area is moving south into
23 the Lancaster area and there's a population
24 explosion?

25 A: I don't know how you define explosion, but

1 Charlotte, for many years, has been moving
2 south, yes.

3 Q: Let's look at DHEC Exhibit 7, page 471.

4 (DHEC's Exhibit 7 was referenced at this time.)

5 MS. CRUM: Can you blow up that second paragraph,
6 please, sir? I'm gonna have to get closer to
7 read it here.

8 Q: Can you read that from there?

9 A: Yes, I can.

10 Q: Okay. Now, that's the letter from Mr. Marvin
11 of Wachovia to you, correct?

12 A: Yes.

13 Q: And this is the letter that Roper St. Francis
14 put in and gave to DHEC to show the ability to
15 finance the project for the 50-bed hospital,
16 correct?

17 A: It's -- as I recall it, yes.

18 Q: And that's what you testified this morning ---

19 A: Yes.

20 Q: --- right?

21 A: Yes.

22 Q: Now, this isn't a guarantee to finance, is it?

23 A: No, it's not.

24 Q: Okay. And they've specifically said it was
25 subject to their subsequent review of revenue

1 and expense projections, right?

2 A: Yes.

3 Q: Okay. How many physicians are on staff at the
4 consolidated CME?

5 A: I -- you mean for Roper St. Francis in total?

6 Q: Yes, sir; in total.

7 A: I think it's over 800.

8 Q: Okay. And the hospital's been open since
9 October the 4th and you're already -- I think
10 you testified, you had 450 physicians on staff?

11 A: Well, I think Mr. Bosse testified ---

12 Q: Mr. Bosse, I'm sorry, you're right.

13 A: --- yesterday. Correct.

14 Q: Okay. Now, the telemedicine, he testifies
15 about the telemedicine physicians? Are those
16 consulting physicians?

17 A: What he -- what I recall from his testimony is,
18 he was trying to note that a number of those
19 physicians were a part of groups that are a
20 part of, what are called, hospital-based
21 physicians, and he mentioned anesthesiology,
22 ED, pathology. Typically, those groups,
23 everyone in that group would go ahead and apply
24 for privileges, whether they were really gonna
25 be staffed there or not just in case they

1 needed to be there.

2 Q: Let me go back to my question.

3 A: Yeah.

4 Q: I asked you about the telemedicine program that
5 he testified about. Do you remember that
6 testimony?

7 A: Not really.

8 Q: Okay. Do you remember whether or not he
9 testified that MUSC assisted with the
10 telemedicine program and provided specialists
11 for y'all?

12 A: I guess.

13 Q: If you don't remember, that's fine.

14 A: I honestly don't recall that testimony from
15 yesterday.

16 Q: Okay. Well, do you have any knowledge as to
17 whether specialists who provide services to
18 Roper St. Francis through telemedicine, are
19 actually on active staff and admit patients to
20 Roper St. Francis?

21 A: You know, that's a credentialing question. I'm
22 not exactly sure of ---

23 Q: Okay.

24 A: --- the answer of, yes.

25 Q: And I think you also said that the Roper

1 Hospital downtown was built in 1940 and there
2 were some towers added in the early '60s, the
3 Pettit Tower, I think?

4 A: I think Pettit was the '80s, but yes ---

5 Q: Okay.

6 A: --- there were towers in the '60s.

7 Q: Petties -- Pettit was in the early '80s and
8 then the heart and vascular in the 2000s?

9 A: Yes.

10 Q: Okay. Isn't it true, Mr. Johnson, that in the
11 2012 case, you testified that if Roper downtown
12 keeps expanding within the Roper Hospital, at
13 some point it would have to renovate the
14 buildings and towers that were built in the
15 '40s, '60s, and '80s?

16 A: That's -- I'll take your word for that. That
17 sound -- I don't recall the exact testimony.

18 Q: Well, I'll be glad to pull it up and let you
19 look at it if you'd like to. It's up to you.

20 A: It sounds -- it sounds accurate.

21 Q: All right, sir. Now, isn't it true, Mr.
22 Johnson, that you also testified it is
23 significantly more expensive to bring those
24 older buildings up to today's standards than it
25 is to go do a green fill product -- project.

1 **A:** I did -- I did, but that was a green fill
2 project much less expensive than we're talking
3 about here today.

4 **Q:** Sure. But you testified that it's more
5 expensive to bring the old plants up to today's
6 standards than it is to do a green fill
7 project?

8 **A:** Correct. And what I was referring to was 1940s
9 and 1960s towers, not a tower that was being
10 vacated that was built in 1986, so I think --
11 I think the two would be different.

12 **Q:** When was University Hospital built?

13 **A:** Well, I think -- well, the -- I think the space
14 being vacated in the children's hospital was
15 1986.

16 **Q:** And what's the space being vacated in the
17 children's hospital?

18 **A:** To -- to move over to the new Shawn Jenkins
19 Hospital.

20 **Q:** Sure. I understand that and I wasn't clear on
21 my question. What -- is it bassinets that are
22 being vacated in the children's hospital?

23 **A:** My understanding is there's -- there's 200
24 rooms in the Shawn -- new Shawn Jenkins
25 Hospital, so there's also -- it's more than

1 bassinets, I would certainly think.

2 Q: From the children's hospital.

3 A: From the space that operations are currently
4 conducted in the children's hospital. I would
5 think that would be more than just bassinets.

6 Q: All right, sir. Do you know how many beds more
7 than bassinets?

8 A: I do not.

9 Q: Do you know how many bassinets are being
10 transferred?

11 A: I do not.

12 Q: Would 66 sound right to you?

13 A: I'd have no way to gauge that.

14 Q: All right, sir. Do you know how MUSC proposes
15 to use the space from the Children's Hospital
16 that's being vacated when Shawn Jenkins opens?

17 A: I do not.

18 Q: Do you know whether or not they might be using
19 it for organ transplant?

20 A: I do not.

21 Q: Mr. Johnson, Roper-reliant patients, are those
22 patients that see physicians that can admit
23 them to Roper Hospital, is that correct?

24 A: Well, I would assume -- I'm gonna try to agree
25 with you and I assume when you say Roper-

1 reliant patients, they are patients that are --
2 that seek services routinely at Roper St.
3 Francis Healthcare?

4 Q: Yes.

5 A: Yes.

6 Q: Okay. Mr. Johnson, would you pull up Roper St.
7 Francis Exhibit 6, please, sir?

8 MR. BUPP: 7?

9 MS. CRUM: 6.

10 MS. CRUM: It's 7, I'm sorry, 7.

11 (RSF Exhibit 7 was referenced at this time.)

12 Q: You remember, Mr. Johnson, when I took your
13 deposition I asked you whether or not you had
14 done any quantification of adverse impact that
15 MUHA Berkeley would have on Roper Berkeley. Do
16 you remember that?

17 A: Yes.

18 Q: And at that point, you told me that your
19 recollection was that you had done a test or an
20 analysis back in 2017 for purposes -- may I
21 finish my question, please, sir -- for purposes
22 of the strategic planning for 2018. And you
23 said you'd look for it for me, didn't you?

24 A: I think I testified that Mr. Reinhardt with
25 Carolinas Healthcare System had done some

1 volume analysis.

2 Q: And didn't you testify that he assisted you
3 with it? I'll be glad to get your deposition
4 out and let you read it.

5 A: I don't think I testified that he assisted me
6 with, with the volume analysis.

7 (Off the record discussion)

8 MS. CRUM: I'm gonna show him a four-pager. It's
9 four to a page, I'm sorry. It's a deposition
10 that's four to the page.

11 Q: It's a little hard to read and it starts on
12 page 92 through 94.

13 MS. HOLLINGSWORTH: Could you -- is that the
14 original transcript?

15 MS. CRUM: No, I'll be glad to get the original
16 transcript out.

17 MS. HOLLINGSWORTH: Can you tell me the page again?

18 MS. CRUM: I did, 92.

19 MS. HOLLINGSWORTH: Yep. The second page.

20 Q: Okay. It starts on line 4 and it goes through
21 -- you can look through -- 93, line 25, you're
22 welcome to read on if you want. Just take a
23 look at that. Start at line 4. And I
24 apologize for the small writing. I have to
25 take my glasses off too.

1 A: So I'm sorry, you said page 93, line 24?

2 Q: 92.

3 A: 92, okay.

4 Q: On 92, line 4.

5 A: Oh, okay. Okay.

6 Q: You did testify that you had Mr. Reinhardt
7 assist you with the projections, right? You
8 did the study and he assisted you with the
9 projections.

10 A: Well, your question here is, who assisted you
11 in developing.

12 Q: That's right.

13 A: And I said, I used some impact projections that
14 came from Atrium, a representative of Atrium.
15 And then you asked who that was and I said,
16 Scott Reinhardt.

17 Q: Okay.

18 A: So I didn't say that he assisted me.

19 Q: Okay. Sorry about that. I don't mean to
20 quibble with words with you. But so, you
21 utilized Mr. Reinhardt's projections, correct?

22 A: They were presented at that -- they were
23 prepared and presented for board -- for two
24 purposes, yes, as an impact analysis, yes.

25 Q: And so, yes, you utilized his projections?

1 **A:** **I'm certainly knowledgeable of them.**

2 **Q:** **Okay. All right. Now, you didn't produce that**
3 **to us during your deposition or before your**
4 **deposition, did you?**

5 **A:** **I did not.**

6 **Q:** **Okay. Let me just see -- let's look at Bates**
7 **page -- Roper St. Francis 248, page 7. For**
8 **your strategic planning purposes, this was**
9 **developed to show a potential MUHA hospital in**
10 **the Berkeley market, is that correct?**

11 **A:** **Yes.**

12 **Q:** **Okay. Next page. And it was -- the purpose**
13 **would show how potential MUSC acute hospital**
14 **impact on the Berkeley market dynamics, right?**

15 **A:** **Yes.**

16 **Q:** **Okay. Look at page 250. The total impact of**
17 **potential MUSC acute hospital going forward on**
18 **the core Berkeley market. Is this gonna show**
19 **-- is the purpose of this PowerPoint to show**
20 **how MUHAS hospital, if there were one, would**
21 **affect the core Berkeley market, total market?**

22 **OBJECTION:**

23 **MS. HOLLINGSWORTH:** **Your Honor, I would object to**
24 **the question. This document is not in evidence**
25 **and hasn't been offered into evidence, so**

1 there's nothing about this that this witness
2 has said it shows anything. I mean, he's
3 answering her questions, but this document is
4 not in evidence.

5 MS. CRUM: Mis- ---

6 THE COURT: Well, go ahead.

7 MS. CRUM: Mister -- my recollection, and maybe I
8 misheard him, is that Mr. Johnson testified
9 that he gave this to -- I can't remember if you
10 said the board -- but you gave it to members of
11 the Roper St. Francis management for purposes
12 of determining what would happen if MUSC came
13 into the market, Your Honor. He has testified
14 at length as to what he thought MUHA would do
15 to -- MUHA Berkeley would do to Roper St.
16 Francis. I think it's a perfectly legitimate
17 ---

18 THE COURT: Well, she's impeaching him with it. So
19 what's in error about impeaching him with this
20 document which he recognizes, that's prepared
21 and utilized by Roper?

22 MS. HOLLINGSWORTH: Well, Your Honor, she's asking
23 about a -- him about a document prepared prior
24 to the CON application being filed. She's not
25 impeaching him with anything. He hasn't said

1 anything inconsistent that -- that this could
2 be used for impeachment. And she's also just
3 mischaracterized where it was presented or to
4 whom it was presented. She's classifying --
5 just named the categories of people. That's
6 not what he said.

7 MS. CRUM: I'll be happy to ask him again. I maybe
8 misunderstood who he said it was presented to.

9 THE COURT: Let's clear all that up.

10 Q: Who did you say that you presented this to, Mr.
11 Johnson?

12 A: Well, this -- yeah, and I may have mis-spoken.
13 So this was prepared by Scott Reinhardt of
14 Atrium Health, who -- or Carolinas Healthcare
15 System at the time. He would have presented
16 this to that planning committee.

17 Q: Yet in your deposition, you told me that you
18 had done this.

19 A: It's possible, but maybe -- I did not create
20 this. It was created by Mr. Reinhardt and
21 presented by Mr. Reinhardt.

22 Q: Do you know what this is?

23 A: It -- it was an impact analysis, yes.

24 Q: Okay. And you know how it was used by Roper
25 St. Francis.

1 A: I would say it was informational.

2 Q: Informational. Okay.

3 A: To our -- yeah, to ...

4 Q: And it was informational to show the market
5 impact of Roper St. Francis Berkeley to MUHA,
6 what if MUHA came in, right?

7 A: That's correct.

8 Q: Okay. Do you still have a copy of the
9 deposition up there? Do you have one up there
10 or did I ---

11 A: It's ---

12 Q: It's just the little four pager thing that was
13 hard to read.

14 A: I don't see it.

15 Q: Mr. Johnson, would you just please go ahead and
16 open that. Tell the Court what it is.

17 A: It's the deposition of me on September 19th.

18 Q: All right. Turn to page 92, please, sir.

19 A: Did you say page 19?

20 Q: 92.

21 A: 92. Thank you.

22 Q: All right. I'm just going to start at line 4.
23 This is me questioning you. "Have you done any
24 projections as to how your operating cash flow
25 would be affected, if at all, if the 128-bed

1 MUHA came online?" And you asked, "From a
2 system -- from a Roper St. Francis system ..."
3 And I said, "Yes. And you said, "No ..." Then
4 I said, "What about from a Roper Berkeley
5 perspective?" And I had asked if you had done
6 any projection. And you said, "A. I believe
7 the answer to that is yes." And I said, well
8 what does it show. And you said, it had been
9 a while -- and I'm paraphrasing here. "And
10 what is that negative impact?" And you said,
11 "... I -- I can't state it as I sit here ..."
12 "How long ago did you run that" assessment --
13 "that document" to "make that -- create that
14 document?" And if you go on down, who -- I
15 asked, "Who assisted you in developing that
16 study regarding the effect that a MUHA hospital
17 might have on you?" And you said, "I used some
18 impact projections that came from Atrium, a
19 representative of Atrium." "And who was that?"
20 "Scott Reinhardt was his name." "And what was
21 his position ..." He was with the planning
22 division. "Do you still have a copy of that
23 study?" "I would have to look. I didn't --
24 I'd have to look."

25 A: Yes, that was my testimony.

1 **Q:** You testified that you did the document, didn't
2 you?

3 **A:** I ...

4 **Q:** I asked you if you had "done any projections as
5 to how your operating cash flow would be
6 affected ..." And you said, "No, I have not,
7 not from a system perspective." "What about
8 from a Roper Berkeley perspective?" Answer, "I
9 believe the answer to that is yes." Which time
10 were you wrong in your testimony?

11 **OBJECTION:**

12 **MS. HOLLINGSWORTH:** Your Honor, I would object. The
13 witness has answered all the questions. This
14 isn't even actually an impeachment. He's
15 already said this isn't his document, this is
16 the Scott Reinhardt volume document and he's
17 answering these questions about it, but I don't
18 see where he's being impeached with something
19 yet.

20 **MS. CRUM:** Your Honor, in his deposition, he told me
21 he created this document. I started off with
22 ---

23 **THE COURT:** I don't know if he said he created it,
24 but he used it, utilized it.

25 **MS. CRUM:** Your Honor, let me read it again, if I

1 might, and I'll be glad to put the deposition
2 transcripts into evidence.

3 THE COURT: Okay. Well, let me -- read it to me
4 again.

5 MS. CRUM: All right, sir. Are you going to testify
6 in any form -- oh, I'm sorry, I skipped to the
7 wrong place, it's little pages. "Have you done
8 any projections as to" your operating cash flow
9 -- "as to how your operating cash flow would be
10 affected, if at all, if the 128-bed MUHA
11 hospital came online?" He answers, "From a
12 system -- from a Roper ... system perspective?"
13 "Yes." And he says, "No, I have not, not from
14 a system perspective." Then I asked, "Q. What
15 about from a Roper Berkeley perspective?" The
16 answer is, "I believe the answer to that is
17 yes." And I had asked him if he had done any
18 projections.

19 THE COURT: Okay. You say I had asked him if he had
20 done any projections.

21 MS. CRUM: I was just ...

22 THE COURT: Well, read ---

23 MS. CRUM: Here, here's what I said. "Have you done
24 any projections as to how your operating cash
25 flow would be affected ..." And you was Mr.

1 Richard- -- Mr. Johnson. And then he said, "I
2 believe the answer is yes." Is -- "the answer
3 to that is yes." And the question was, "What
4 about a Roper Berkeley perspective." This is
5 the Roper Berkeley perspective. And then, he
6 goes on. Let's see, yes. On line 14 on page
7 93. "Okay. Who assisted you in developing
8 that study ..." "... assisted you in
9 developing that study regarding the effect that
10 a MUHA hospital might have on you?" He
11 answers, "I used some ..." "I used some impact
12 projections that came from Atrium, a
13 representative of Atrium." "... who was that?"
14 "Scott Reinhardt was his name."

15 THE COURT: Well, that's why I said I didn't think
16 he said he prepared them, he used them.

17 MS. CRUM: He -- what he said was, who assisted you
18 in developing that study. He said he had done
19 a study. I don't know -- I don't know how else
20 one takes that is when they say, I have done
21 the study and you got some assistance, that
22 doesn't mean he didn't develop it, Your Honor.

23 MS. HOLLINGSWORTH: Your Honor, what Ms. Crum is
24 saying is actually not the words she just read
25 on the paper. He didn't say he performed the

1 study, she's making assumptions from his
2 testimony. We didn't have a document. This
3 testimony, there was no document in front of
4 everyone. He testified to the best of his
5 recollection. We produced the document when he
6 went back looking for it, here is the Scott
7 Reinhardt information, I mean, I -- he's not --
8 -

9 THE COURT: Well, I really don't get why we're going
10 back and forth so much about this anyway. You
11 don't have to sit down. Whether he prepared
12 them himself or used them, is that -- is
13 something that is a part of his analysis. I
14 don't -- you're beating a horse I don't think
15 you need to beat. That -- what I'll need to
16 understand is what purpose now are you
17 questioning him about this report?

18 MS. CRUM: Your Honor ---

19 THE COURT: That I just ---

20 MS. CRUM: --- he has done -- he has testified at
21 great length about how badly this going -- the
22 MUHA Berkeley Hospital is going to hurt Roper
23 Berkeley. This analysis just simply doesn't
24 show that.

25 THE COURT: Okay. Ms. Hollingsworth keeps saying

1 you haven't impeached him yet, so at this point
2 in time, I'm going to let her go forward.
3 Okay, but if you wish to object down the road,
4 you certainly are open to do that.

5 MS. HOLLINGSWORTH: Okay.

6 **Q:** **Could you just put up the very first page**
7 **again? Just flip through. Let's get to the**
8 **next -- go on to the next -- okay, we looked at**
9 **that page.**

10 **Q:** **Now -- you redacted, when this was produced, a**
11 **lot was redacted, right?**

12 **A:** **Yes.**

13 **Q:** **Okay. Now, let's go on over to page 252. At**
14 **the top it says, "Berkeley Analysis: MUSC What**
15 **If?" You see the "Key Assumption: Of the**
16 **market shift, a 70/30 split is assumed from**
17 **Trident/" Roper St. Francis "respectively."**
18 **Explain what you mean by that.**

19 **A:** **So of the -- of the volume of the market share**
20 **shift to the new MUHA facility, if I recall**
21 **correctly, this was 70 percent of that market**
22 **share was gonna come from the HCA facilities**
23 **and 30 percent from Roper St. Francis.**

24 **Q:** **Okay. So, what this is showing is if that --**
25 **from Roper's perspective, one of the**

1 assumptions would be, if MUHA -- if MUSC -- or
2 MUHA Berkeley happened, they would take 70
3 percent of any patients they took from Trident
4 and 30 percent from Roper St. Francis.

5 A: Correct.

6 Q: Okay. Down here on the bottom, it's the
7 volumes. Those are just the projected patient
8 days, is that right?

9 A: Those, I believe, are discharges.

10 Q: Are discharges. Okay, discharges. All right.
11 And then, the next page, page 253. This is the
12 market impact of Roper St. Francis and MUSC and
13 the difference here is that there's a 50/50
14 split. The assumption is 50 percent comes from
15 Roper and 50 percent comes from HCA?

16 A: That's correct.

17 Q: Okay. And this is discharges still down on the
18 bottom?

19 A: That's correct.

20 Q: All right. Now flip on over ---

21 THE COURT: So, where I can understand this, is this
22 a projection of what will happen or is this
23 just simply a market analysis of what would
24 happen if it did happen?

25 A: So I would characterize this as what would

1 happen to volume. It's two scenarios that look
2 at what could happen to volume in Berkeley
3 County if MUHA puts a facility there and -- and
4 we did one 70/30 split, but because of the
5 close proximity for that hospital to ours, we
6 also did a 50/50.

7 THE COURT: Okay.

8 Q: And you just said close proximity. Oh, no, we
9 -- I asked you that. Skip that one. Sorry.
10 The take away, next page, please, sir. It is
11 imperative for Roper St. Francis to capitalize
12 on its first-to-market advantage against a
13 potential MUSC hospital. What do you mean by
14 that?

15 A: That -- so the discussion back then, and this
16 is from memory, was that, you know, the
17 Berkeley Hospital was a big project for Roper
18 St. Francis Healthcare, it was imperative that
19 management be successful launching that
20 project.

21 Q: And that the person who gets to the market
22 first, gets an advantage, is that correct?

23 A: That's correct, yes.

24 Q: And the person who gets to the market first,
25 gets its patient base established, correct?

1 **A:** Yeah, and we outlined some of that -- or that
2 in our CON in terms of what our expected market
3 share growth was.

4 **Q:** You talking about your 2000- -- the Berkeley
5 County 50-bed CON hospital?

6 **A:** Yes.

7 **Q:** Okay. And you said you looked at the MUHA
8 Berkeley CON application?

9 **A:** Yes.

10 **Q:** Would you agree with me that the soonest we
11 could get our hospital built, if we started
12 building in, say, April of 2020, we could get
13 it built and operational would be October or
14 November of 2023?

15 **A:** It -- in my deposition I said I wasn't going to
16 testify to construction matters, but based on
17 my experience, it takes a year to do the
18 architectural work and two years to do the
19 building. So, approximately three years would
20 be reasonable.

21 **Q:** Okay. I was just basically talking about the
22 time line in the CON application. Do you know
23 whether the time line in MUHA Berkeley CON
24 application would mandate that we wouldn't be
25 open until 202- -- well, November --

1 **October/November 2023?**

2 **A:** **I believe that the projections associated with**
3 **that facility start in 2023, correct.**

4 **Q:** **And that sounds reasonable to you, doesn't it?**

5 **A:** **If -- yes. Around three years, yes.**

6 **Q:** **How could you determine impact on Roper**
7 **Berkeley if MUSC Ber- -- MUHA Berkeley would**
8 **have?**

9 **A:** **Well, I think it's in the -- could you be a**
10 **little more specific with your question?**

11 **Q:** **Yes, sir. What method did you use to determine**
12 **impact that MUHA Berkeley would have on Roper**
13 **Berkeley?**

14 **A:** **Well, I think we looked at volume in this**
15 **analysis just as an informational item on that**
16 **and included at the bottom of that slide all**
17 **scenarios, you know, the 70/30 and the 50/50**
18 **would create a material impact to our facility**
19 **in Berkeley County.**

20 **Q:** **Okay. And you're talking about the -- what has**
21 **been marked as Berkeley Exhibit 7?**

22 **A:** **Yes.**

23 **MOTION TO ADMIT RSF 7:**

24 **MS. CRUM:** **Your Honor, I'm going to move admission**
25 **of Berkeley Exhibit 7.**

1 MS. HOLLINGSWORTH: No objection.

2 MR. THOMAS: No objection.

3 MR. WICEVIC: No objection.

4 THE COURT: It's admitted.

5 (RSF Exhibit 7 was admitted into evidence.)

6 MS. CRUM: Thank you, sir.

7 COURT REPORTER: When you say Berkeley 7, I just
8 want to make sure you're talking about Roper
9 St. Francis 7.

10 MS. CRUM: Yes, ma'am. I'm sorry.

11 COURT REPORTER: Thank you.

12 MS. CRUM: Roper St. Francis.

13 COURT REPORTER: Thank you.

14 MS. CRUM: I apologize. We have way too many
15 Berkeleys and Ropers and MUHAS and we will HCAs
16 and Tridents.

17 **Q: Mr. Johnson, you consider Berkeley County to be**
18 **a growing market, don't you?**

19 **A: Yes.**

20 **Q: And you consider the I-20 corridor going**
21 **northwest from the Charleston peninsula up**
22 **through Berkeley County to be a growing**
23 **corridor, don't you?**

24 **A: Generally, yes.**

25 **Q: Okay. Are you familiar with Berkeley County's**

1 topography?

2 A: Not too much.

3 Q: Do you know that they have Francis Marion
4 National Forest in Berkeley County?

5 A: Yes.

6 Q: Do you know that they have Lake Marion in
7 Berkeley County?

8 A: Yes.

9 Q: And part of Lake Moultrie?

10 A: Yes.

11 Q: Do you know whether or not Berkeley County has
12 county-wide zoning?

13 A: I am not too familiar with the Berkeley zoning
14 rules.

15 Q: Mr. Johnson, you would agree with me, wouldn't
16 you, that to restrict a hospital provider to a
17 certain geographic area when it has a
18 significant patient population in a growing
19 market, would unfairly penalize the provider?

20 A: Generally speaking, yes, and that's one of the
21 reasons we supported two 50-bed hospitals in
22 Berkeley County.

23 Q: And, in fact, that's what you testified to in
24 the 2012 case, isn't it?

25 A: Yeah, probably.

1 Q: Yeah. MUHA is not proposing to finance this
2 project with traditional bond financing, is it?

3 A: Well, I do think they issue public debt. I do
4 believe that you hire an investment banker and
5 you go to the public bond markets and issue
6 bonds, it's just that HUD is the insurance
7 company, so to speak, that insures those bonds
8 get paid. That's my understanding.

9 Q: And if HUD insures those bonds get paid and
10 with the HUD insurance, MUHA has a AAA credit
11 rating, doesn't it?

12 A: MUHA does not, the bonds do.

13 Q: The bonds do. Well, it amounts to a lower
14 interest rate, doesn't it?

15 A: The higher the credit rating on the bonds, the
16 lower the interest rate.

17 Q: Correct. So let me say it again. A AAA credit
18 rating amounts to a lower interest rate on
19 bonds, doesn't it?

20 A: Then lesser credit ratings, yes.

21 Q: Yes, sir. Okay. Do you what interest rate
22 MUHA was getting on the CHS financing?

23 A: I don't think they've completed that financing
24 yet. Long-term financing; they have short-
25 term financing in place, my understanding is.

1 Q: Okay. Do you know what short-term financing
2 rate they got?

3 A: I would assume very low because short-term
4 rates are very low right now.

5 Q: Do you know that?

6 A: Yes.

7 Q: Oh, I'm sorry. You know that the rates are low
8 now. I was saying that do you know that MUHA
9 got a very low rate.

10 A: I would assume so.

11 Q: Okay.

12 A: In a bridge loan, I would assume that to be
13 very low.

14 Q: And what would you consider to be a very low
15 rate?

16 A: You know, it was approximately a year, I think,
17 it would be between one and two percent, or
18 maybe around one percent, one-and-a-half
19 percent.

20 Q: In the -- in your testimony during the 2012
21 trial, didn't you and the other witnesses for
22 Roper consistently testify that the Roper
23 Berkeley Hospital would be financially feasible
24 based on the redirection or repositioning of
25 patients from downtown and market growth?

1 **A:** I don't believe that's -- what our CON said was
2 that that hospital would be 50 percent of our
3 Berkeley Hospital patients would be redirected
4 in that -- into that facility. I don't think
5 we, in our CON, expected downtown patients to
6 come out to Berkeley County.

7 **Q:** Mr. Johnson, I asked you about the testimony in
8 the trial, not about what the CON said. Do you
9 want me to repeat the question?

10 **A:** Please.

11 **Q:** Okay. Isn't it true that you -- that you and
12 others testified that the -- that Roper
13 Berkeley Hospital would be financially feasible
14 based on a repurposing of your -- of 50 percent
15 of your patients, 60 percent of your patients
16 to the Roper Berkeley Hospital and plain growth
17 from the service area?

18 OBJECTION:

19 MS. HOLLINGSWORTH: Your Honor, I would just object.
20 That's not the same question. I think maybe
21 there was a word in there that was not what was
22 meant in repurposing.

23 MS. JONES: You said repurpose instead of redirect.

24 MS. CRUM: Okay. I'm sorry. Redirecting.

25 **Q:** Do you want me to try to repeat that again?

1 A: If you would, I thought those were -- I didn't
2 think they were the same question, same as the
3 first one.

4 Q: I thought it was, but in the CON application,
5 Roper Berkeley, alternately used redirect and
6 repurpose, didn't they?

7 A: I don't recall, but I'll accept that it means
8 the same thing.

9 Q: Okay. So my question. At the 2012 hearing,
10 didn't the Roper Berkeley witnesses
11 consistently testify that the project would be
12 financially feasible based only on the
13 redirection or repurposing of its own patients
14 and the growth in the marketplace?

15 A: I don't -- I just don't specifically recall
16 that. I'll ---

17 Q: all right, sir. That's fine. You talked about
18 a number of projects that you say MUHA is
19 getting ready to undertake, and you talked
20 about the Williamsburg Hospital. What is the
21 basis of your knowledge that MUHA is going to
22 do a hospital, new hospital in Williamsburg
23 County?

24 A: I think there was some media disclosure on
25 that.

1 Q: So it's what you read in the newspapers?

2 A: Yes.

3 Q: Okay. Do you know how that's going to be
4 funded?

5 A: I do not.

6 Q: Okay. So you don't know whether that will add
7 to the debt or not, do you?

8 A: I do not.

9 Q: Okay. You talked about, I think maybe two CON
10 applications in Lancaster County or Lancaster?

11 A: There, I believe, I recall mentioning one.

12 Q: All right.

13 A: Which was the Indian Land.

14 Q: All right, sir. Well, how did you find out
15 about that?

16 A: I was told that by someone within MUSC.

17 Q: Who told you?

18 A: I think it's public information, but a
19 gentleman, Matt Severance, who is a friend of
20 mine, mentioned that to me.

21 Q: And Mr. Severance used to work at Berkeley?

22 A: He did.

23 Q: Okay. So did he tell you how it was going to
24 be financed?

25 A: No.

1 Q: Did he tell you how much the project was going
2 to cost?

3 A: He did not.

4 Q: Did he tell you when they were going to file
5 the application?

6 A: No.

7 Q: What else do you not know about it?

8 A: Pretty much what I testified to is what I know.

9 Q: All right, sir. Florence. What's going to
10 happen in Florence?

11 A: I think they've applied for a freestanding ED,
12 but I don't know beyond that what's going to
13 happen.

14 Q: Okay. Do you know whether or not that was the
15 freestanding ED that had been approved for
16 Carolinas prior to the time of the acquisition?

17 A: I believe I did hear that.

18 Q: Okay. And you do know that when a CON has not
19 been implemented, if there's a change of
20 ownership, it voids the CON. You know that,
21 don't you?

22 A: I did know that, yes.

23 Q: All right, sir. The Sea Island FSED that was
24 talked about, we talked about this morning.
25 What's the -- I guess you saw the CON

1 application, didn't you?

2 A: I saw the projections contained in there, yes.
3 I wouldn't say I've reviewed the CON
4 application.

5 Q: Okay. And you saw those projections this
6 morning?

7 A: Yes.

8 Q: Did you do that Exhibit that was put up on the
9 screen?

10 A: Counsel would have done that at my -- I don't
11 think it was a -- I think it was a page out of
12 the projections. I don't think we had to
13 prepare anything, I think we just put up the
14 actual page out of the projections.

15 Q: Oh, well I was talking about -- I guess I was
16 talking about Exhibit 137, which was a
17 comparison of the ---136, sorry, comparison of
18 the net income. Did you do that Exhibit?

19 (RSF Exhibit 136 was referenced at this time.)

20 A: Well ---

21 Q: 136?

22 A: --- technically, I mean, counsel actually
23 prepared it on Excel, but I had asked for it.

24 Q: All right, sir. Now you talked about the
25 amount of debt that MUSC has. Shawn Jenkins

1 Children's Hospital. How much debt does MUSC
2 actually have for Shawn Jenkins?

3 A: It's -- I want to say in the 280 million range,
4 if I'm recalling correctly, but all the debt it
5 not yet on the books of MUHA for that project.
6 My understanding is there's another 88 million
7 or so that needs to come on the books.

8 Q: Okay.

9 A: As the project finishes up.

10 Q: Okay. Do you know how much money was given in
11 gifts to MUHA for Shawn Jenkins?

12 A: I think around 35 million, if I recall
13 correctly.

14 Q: Okay. Do you know if it was more?

15 A: No. I wouldn't know if it was more.

16 Q: Did you subtract that from the amount of the
17 billion dollar debt that you added?

18 A: Well, I don't think you would do that. I mean
19 ---

20 Q: Okay.

21 A: --- the debt's the debt, so.

22 Q: So, how did you get the cost -- are you talking
23 about the debt of MUHA or -- of Shawn Jenkins
24 or the cost of the hospital?

25 A: When I -- I think there's 288 million in

1 existing debt, and I think there's another 88
2 million that needs to come on the balance sheet
3 as that project gets finished up.

4 Q: Okay. All right, sir. But that's -- where did
5 you get that information?

6 A: From their audited financials.

7 Q: All right. For ...

8 (Off the record discussion)

9 Q: For any of the MUHA projects that y'all have on
10 the debt -- I mean have on the books that
11 you've said goes to the billion dollars, do you
12 know the source of funding for each of those?

13 A: Just to clarify. I mean, there's currently a
14 billion dollars on -- of debt on the MUHA
15 balance sheet, not including the pension
16 liabilities. When you add in the additional
17 Shawn Jenkins debt, there's right at a billion.
18 There -- what we discussed this morning was,
19 yeah, there is strategic appetite and those
20 projects have to get funded. And debt -- I
21 would presume debt would be the vehicle for
22 funding those.

23 Q: Okay. I think you and I might be speaking
24 apples and oranges and you're speaking
25 accounting and I'm speaking legalese. So let

1 me try this again. of the -- when you're
2 saying debt, what you're saying is all of these
3 projects that you've listed and you had an
4 Exhibit up there, MUHA has incurred debt that
5 they are still having to pay off for those
6 projects. Is that accurate?

7 A: Yes. Some of those projects were debt financed
8 and that debt is on the balance sheet. A
9 number of those projects have not been started
10 yet, so they -- it is not clear how they're
11 going to be funded. I would assume debt
12 financing would be used for a lot of them.

13 Q: Okay. Do you know whether any of those
14 projects were paid from operating cash?

15 A: I would find that unlikely given the level of
16 operating cash that they have.

17 Q: All right, sir.

18 (Off the record discussion)

19 Q: I think just one last thing. The analysis that
20 you gave to Ms. ... Hollingsworth ---

21 MS. CRUM: I'm sorry. I'm semi brain dead, Your
22 Honor.

23 Q: The analysis you gave to Ms. Hollingsworth this
24 morning, your analysis was based on the seven
25 mile area that you testified that patients

1 **would be drawn from, right?**

2 **A: Which ...**

3 **OBJECTION:**

4 **MS. HOLLINGSWORTH:** Your Honor, I object. That's a
5 mischaracterization of his testimony. There
6 was no analysis that he gave based on the seven
7 miles radius.

8 **THE COURT:** Any response?

9 **MS. CRUM:** No, sir. I just misunderstood what he
10 said, then.

11 **THE COURT:** Okay.

12 **MS. CRUM:** I'll try something else.

13 **Q: Mr. Hollingsworth [sic], what was the service**
14 **area that you used when you were doing your**
15 **analysis this morning?**

16 **A: I put up several different demonstrative**
17 **slides, so which one are we referring to, if I**
18 **might ask?**

19 **Q: I'm just talking about every one of them that**
20 **you did your analysis this morning, what --**
21 **sir, let me say this. What do you think the**
22 **services area is for the MUHA Berkeley**
23 **application?**

24 **A: This morning I did testify I think the service**
25 **of a community hospital is going to be 7 to 10**

1 miles ---

2 Q: Okay.

3 A: --- around the hospital.

4 Q: And you said that, and you were including MUHA
5 Berkeley in that, correct?

6 A: That's correct.

7 Q: All right, sir. Do you know whether or not
8 more than approximately half of MUHA's patients
9 originate from outside of the tri-county area?

10 A: I know they have a strong secondary market
11 pull; I don't know the percentages.

12 Q: Okay. Thank you, sir. And if you would answer
13 any questions that anyone else may have.

14 THE COURT: Re-direct?

15 MS. HOLLINGSWORTH: I have a few, Your Honor. I
16 don't know if you want a five-minute break or
17 you want to keep going.

18 THE COURT: Everyone's good over there?

19 (No audible response.)

20 THE COURT: Okay. If everybody else is fine, we
21 are. If y'all need one, though.

22 MS. HOLLINGSWORTH: No. I'm good, Your Honor, thank
23 you.

24 MR. JOHNSON - REDIRECT EXAMINATION BY MS.

25 HOLLINGSWORTH:

1 Q: Mr. Johnson, just a few follow-up and I do it
2 in reverse order, so, this will be fresh to
3 start with. Do you -- you were asked about
4 some of the recent projects that MUHA has
5 pursuing like the Indian Land Hospital. Do you
6 recall being asked about that ---

7 A: Yes.

8 Q: --- from Ms. Crum? And you mentioned having
9 read it in a release, do you recall that?

10 A: I believe that's -- yeah, I mentioned I heard
11 about it from Mr. Severance and I read about it
12 somewhere, and then I believe even during a
13 Roper St. Francis board meeting it was -- there
14 was mention of that at one point.

15 Q: Okay. And -- where you read about it somewhere
16 published, could that have been the media
17 release that MUSC put on their website on
18 October 11th?

19 A: That's probably where that came from.

20 Q: Okay. And you were asked about the Roper
21 Berkeley application and redirection and
22 repurpose. I want to ask you, do you recall
23 whether there was any element to that analysis
24 other than redirection of Berkeley County Roper
25 St. Francis aligned and market growth. Was

1 there any other component to the analysis?

2 A: In our original CON?

3 Q: Right.

4 A: There was the expectation that the 10 percent
5 market share shift would occur, but there was
6 also, I believe, you know, 90 percent of the
7 volume would come from inside the county, 10
8 percent of the volume would come from outside
9 the county.

10 Q: Okay. And you were shown that PowerPoint
11 presentation. I don't think we need to pull it
12 up. You were asked bullet points there at the
13 end about capitalize on the first-to-market.
14 Do you recall that testimony?

15 A: I do.

16 Q: Okay. And I think I understood you say that
17 that presentation would have been in 2017?

18 A: Yes.

19 Q: Okay.

20 A: Yes, 'cause it was for our 2018 strategic
21 planning cycle, so that would have occurred in
22 '17.

23 Q: Okay. And when was the CON application filed,
24 do you recall?

25 A: I do not.

1 Q: Okay. And by 2017, was -- were you already
2 constructing the hospital?

3 A: I can't remember if we had broken ground yet,
4 but we certainly would have been busy on the
5 architectural aspects of it.

6 Q: Okay. 'Cause you've been asked a good bit
7 about a hearing here in this Court, was there
8 litigation surrounding our approval for that
9 Berkeley Hospital?

10 A: There was.

11 Q: Okay. And in terms of the investment, has
12 Roper St. Francis invested more than just the
13 total project costs for that CON that was in
14 the CON application?

15 A: There has been. It's significant. We've, you
16 know, the hospital costs in there, obviously,
17 we also -- there was a medical office building
18 constructed, which we have a master lease on
19 that medical office building. So we kind of
20 own the financial risk of that building. There
21 is a master campus plan, you know, 5 or 6
22 million, which has been funded toward ... And,
23 you know, we have also made medical staff
24 investments in that market as well.

25 Q: Okay. And so, in your world as a CFO and when

1 you are evaluating projects, major strategic
2 projects, what does it mean to capitalize on an
3 investment?

4 A: I would say that it would meet the objectives
5 of, of why you did it. You know, you
6 capitalize would mean that you -- that it was
7 financially successful, if that were the pro
8 forma, and that you would garner the volume and
9 serve the patients you expected to serve.

10 Q: Okay. And the litigation and the contested
11 case process surrounding that application, was
12 that an additional cost associated with that
13 project?

14 A: It was.

15 Q: Was it significant?

16 A: I don't recall. I'm sure it was, 'cause it was
17 a very lengthy process with a lengthy trial.

18 Q: Okay. And I think we saw the bullet at the
19 bottom, but what was the conclusion that -- at
20 the bottom of that slide regarding the
21 potential impact if there was an additional
22 hospital in Berkeley County?

23 A: That under either scenario, the 70/30 scenario
24 or the 50/50 scenario, that each would have a
25 material impact on the Berkeley Hospital.

1 Q: Okay. And do -- you were asked about the space
2 being vacated from the Children's Hospital, do
3 you recall that?

4 A: Yes.

5 Q: Okay. And you were asked about the bassinets,
6 is that right?

7 A: Yes.

8 Q: Okay. And do you recall whether the
9 application for that project also addressed 158
10 beds that were being transferred to the new
11 hospital in the CON application?

12 A: 158?

13 Q: The -- you were asked about the 66 bassinets,
14 do you recall that?

15 A: Yes.

16 Q: Okay. And do you recall if the CON application
17 also addressed the 158 beds that were being
18 transferred to Shawn Jenkins?

19 A: To Shawn Jenkins, okay. I would assume that's
20 correct, I don't recall that specific number.

21 Q: Okay. And Wachovia Securities, what do they
22 do?

23 A: Well, they're no longer Wachovia Securities.
24 They are now part of -- Wachovia is now part of
25 Wells Fargo, but they were investment bankers,

1 which means they -- Mr. Marvin was an
2 investment banker, which means he works with
3 health systems to issue public debt.

4 Q: Okay. And you were asked about information
5 that you reviewed or relied on in evaluating
6 the financials for MUHA in this case. Did you
7 also review documents that had been produced in
8 discovery by MUHA?

9 A: Yes; some, yes.

10 Q: Okay. And the slides that we went through this
11 morning, you had source information about what
12 information that the data came from, didn't
13 you?

14 A: Yes.

15 Q: You were asked about, in the 2019 and audited
16 financials, Ms. Crum was asking you about cash
17 availability and she mentioned restricted cash
18 versus unrestricted cash. Do you remember
19 that?

20 A: I do.

21 Q: Can you -- what is that?

22 A: Well, so -- unrestricted cash means the
23 organization can spend it any way they see fit.
24 Restricted cash could be a contribution that
25 came in from a donor that was -- that had a

1 restriction on it, you know, this can only be
2 used for a certain purpose. I'm assuming that
3 the 25 million that Shawn Jenkins gave was
4 restricted to the construction of that
5 hospital, so that would be restricted cash
6 until it was spent.

7 Q: Okay.

8 A: And, you know, bond proceeds when they're put
9 in escrow prior to being spent, are restricted.
10 You can't tap into those funds for general
11 operating purposes.

12 Q: Okay. And back at the beginning, you were
13 asked about the distance between Roper Hospital
14 and Mount Pleasant and East Cooper, and you
15 mentioned both minutes and miles. And how many
16 minutes is that travel distance between Roper's
17 hospital and Mount Pleasant and East Cooper?

18 A: Well, it can, when it's busy, it can easily be
19 45 minutes to an hour.

20 Q: All right.

21 MS. HOLLINGSWORTH: I beg your indulgence, Your
22 Honor.

23 (Off the record discussion)

24 MS. HOLLINGSWORTH: Your Honor, I have no other
25 questions. Thank you, Mr. Johnson.

1 THE COURT: Any re-cross on a new matter raised?

2 MS. CRUM: Your Honor, yes, sir.

3 MR. JOHNSON - RE-CROSS-EXAMINATION BY MS. CRUM:

4 **Q: Ms. Hollingsworth just asked you if you had**
5 **reviewed any documents produced by MUHA in**
6 **developing your opinions and you said you had.**
7 **Identify the documents for me.**

8 OBJECTION:

9 MS. HOLLINGSWORTH: Your Honor, I object. What I
10 asked him, I asked him if he reviewed. I
11 didn't ask him specific documents and they're
12 noted on his slides. I think it's unfair to
13 make him -- there's over 30,000 Bates labels of
14 documents that have -- we've produced in this
15 case. I would -- that is simply not a good
16 cross question and it's impossible to answer.
17 30,000 Bates labels.

18 MS. CRUM: Your Honor, you just can't have it both
19 ways. She came up and asked him, did you
20 review financial documents. I can assure you
21 there were not over 30,000 financial documents
22 in the production. And either he reviewed them
23 and he can tell us whether he relied on them or
24 not. And if he doesn't remember, he doesn't
25 remember.

1 THE COURT: And how is this new?

2 MS. CRUM: He had never been asked before about
3 whether he had reviewed any documents in giving
4 his opinions.

5 MS. HOLLINGSWORTH: Your Honor, on cross, she asked
6 him about him reviewing audited financials.
7 And, one other thing, all I did was ask him if
8 he reviewed discovery documents. That was the
9 extent of it.

10 THE COURT: Yeah.

11 MS. HOLLINGSWORTH: That's not new material.

12 MS. CRUM: Yes, Your Honor, she said, didn't you
13 review documents other than the financials.
14 That's what she asked about, that's all I'm
15 asking about now, is what they were.

16 THE COURT: Go ahead. I'll let him answer or let
17 her ask.

18 **A: Can you please repeat the question?**

19 **Q: Yes, sir. Could you tell me what documents,**
20 **other than the MUHA financials that were**
21 **produced by MUHA, you reviewed in forming your**
22 **opinions regarding the financial status of**
23 **MUHA?**

24 **A: I think just to -- I've reviewed the financial-**
25 **related documents. I don't recall anything**

1 non-financial. I certainly reviewed the, you
2 know, flipped through the CON, and I'm trying
3 to think of what else other than -- the audited
4 financial statements, the CON, the pro forma
5 doc- -- the documents that the pro formas were
6 in that I discussed this morning. I'm trying
7 to think of what else. I can't think beyond
8 that or recall beyond that.

9 Q: Thank you, sir.

10 CONCLUDING MATTERS:

11 THE COURT: All right. You may step down. Where
12 are we?

13 MS. HOLLINGSWORTH: Your Honor, that would be --
14 tomorrow we'd have Mr. Richardson testify as
15 the last witness for Roper St. Francis's case
16 in chief.

17 THE COURT: Okay. Well then, are we start at 10:00
18 or ...

19 MS. HOLLINGSWORTH: Mr. Richardson does have a
20 flight to catch. Could we start at 9:00 or
21 9:30 if that's ---

22 THE COURT: Either one's fine with me. Are you
23 okay?

24 (No audible response.)

25 MS. CRUM: Your Honor, 9:30 would be better. We've

1 got folks coming up from Charleston, so.

2 THE COURT: 9:30 it shall be.

3 MS. HOLLINGSWORTH: And, Your Honor, Mr. Johnson

4 would he be excused to return back to

5 Charleston until next time?

6 THE COURT: Oh, yes.

7 (The hearing adjourned at 3:59 p.m.)

8 DAY THREE - FRIDAY, NOVEMBER 8, 2019

9 CALL TO ORDER:

10 COURT REPORTER: All rise.

11 THE COURT: Y'all be seated. Thank you.

12 MS. SHOUN: All right.

13 THE COURT: So, y'all're gonna switch back on this

14 witnesses.

15 MR. SUMMER: Musical chairs, Your Honor.

16 MS. HOLLINGSWORTH: Just this one, Your Honor.

17 THE COURT: Just messing with you. So, today is

18 health planning from the Roper perspective, I

19 guess.

20 MS. SHOUN: Yes, sir.

21 THE COURT: Okay.

22 MS. SHOUN: We are ready to proceed, if it ---

23 THE COURT: All right.

24 MS. SHOUN: Petitioner would call Mark Richardson to

25 the stand.

1 COURT REPORTER: Raise your right hand, please. Do
2 you solemnly swear that the testimony you're
3 about to give in this matter is the truth, the
4 whole truth, and nothing but the truth, so help
5 you God?

6 MR. RICHARDSON: I do.

7 COURT REPORTER: And would you please state your
8 name for the record?

9 MR. RICHARDSON: Mark, M-A-R-K, Richardson.

10 COURT REPORTER: Thank you.

11 MR. RICHARDSON - DIRECT EXAMINATION BY MS. SHOUN:

12 **Q: Good morning.**

13 **A: Good morning.**

14 **Q: Mr. Richardson, you've already given your name**
15 **to the Court -- to the Court Reporter. Can you**
16 **tell us a little bit about yourself?**

17 **A: Sure. I'm a healthcare planner. I have been**
18 **since the late '70s and still now, that's the**
19 **-- that's been my career. That's what I do.**
20 **From an educational perspective, the -- I**
21 **received a bachelor's degree -- post-high**
22 **school, received a bachelor's degree from Colby**
23 **College in Waterville, Maine back in 1997. As**
24 **part of that, I had a chance for a year to --**
25 **to spend a year over in Saint Andrews in**

1 Scotland studying marine science. It was a
2 wonderful thing. Following undergraduate
3 graduation, I moved to Cornell University,
4 where I received a master's in business
5 administration in 1979, which was a general MBA
6 course of study. Concurrent with that ---

7 THE COURT: I'm going to stop you. So, you go from
8 Marine Science to an MBA. How -- what was the
9 transition there? I'm just curious.

10 A: The -- the reality was is that I was trying to
11 find a ---

12 THE COURT: A way to make money.
13 (Laughter.)

14 A: Right. Yeah. This is before the big loans,
15 but yes. That's true.

16 MS. SHOUN: I tried law school for that, Your Honor,
17 it didn't work.

18 THE COURT: Yeah.

19 A: I was actually trying to find a -- a -- like a
20 research science management track, so to be the
21 guy that would like manage the labs ---

22 THE COURT: Oh, okay.

23 A: --- and stuff. And there weren't any. You
24 know, there's none of that there. So, I ended
25 up going to Cornell Business and Healthcare

1 that I -- I did the healthcare track as well.
2 Was about the closest I could get to -- to
3 managing research stuff, was managing
4 healthcare.

5 THE COURT: Oh, okay.

6 A: So. And -- and I thought, you know, I'd
7 consult for a couple of years and 40 years
8 later, here I am.

9 THE COURT: So, under your theory, then, I guess by
10 moving into healthcare you could still deal
11 with crustaceans?

12 (Laughter.)

13 A: Yeah. I'm not going to say crabby people.

14 THE COURT: Okay.

15 MS. SHOUN: I can step down, if you ---

16 THE COURT: I'll stop.

17 MS. SHOUN: No, this is far more entertaining than
18 what I'm going to do.

19 THE COURT: Well, I have to do something to make it
20 interesting.

21 MS. SHOUN: We appreciate that. Thank you.

22 Q: Mr. Richardson, you were telling us. You got
23 your MBA from Cornell in 1979 and at the same
24 time ---

25 A: At the same time, the -- the -- a parallel

1 track with that degree, I received
2 certification from Cornell's program in -- the
3 Sloan program in healthcare management. The --
4 back at that point, there was not a masters of
5 hospital administration track. So, basically,
6 the healthcare management focus at -- at
7 Cornell Business was in the Sloan Management
8 Program.

9 Q: Okay.

10 A: And so the MBA and certification at the same
11 time.

12 Q: So ---

13 A: And they were both finished in '79.

14 Q: It was a dual certification?

15 A: That is correct.

16 Q: Okay. Where -- where did you go after grad
17 school?

18 A: After grad school, I went -- went right to
19 consulting with a company by the name of Kurt
20 Solomon and Associates, which is an Atlanta-
21 based multi-industry, multi-national consulting
22 firm, where I started as a consultant in the
23 health services division.

24 Q: What did that entail?

25 A: Clients were primarily healthcare providers,

1 pretty much throughout the southeast and the
2 east coast. The work that I was doing
3 primarily was healthcare planning, which back
4 in the '70s really was trying to do some
5 healthcare forecasting in terms of what you'd
6 expect in -- into the future, strategic
7 planning in terms of helping hospitals and
8 folks figure out where they ought to be going
9 in terms of services, or the programs, or
10 expansion/need development. But basically,
11 it's -- it's healthcare planning, the same
12 thing I'm doing today, but really the start of
13 that emphasis or -- or specialty, there wasn't
14 a lot of healthcare planning really before mid
15 to late '70s.

16 Q: Different now?

17 A: Yes, it is; very much.

18 Q: How long were you with Kurt Solomon?

19 A: I was with Kurt Solomon for four years. Stayed
20 with them, multiple clients. Started as a
21 consultant, ended as a senior consultant with
22 them. And then, in 1983, I left Kurt Solomon
23 with a couple of the other folks that were at
24 Kurt Solomon and helped started up the firm of
25 FL -- FLR Health Resources, which was Flood,

1 Follower, Lamb, Luntrell and Richardson (ph).
2 That's the FLR. Atlanta based. The -- this
3 was pure just healthcare. Kurt Solomon had
4 multiple industries. This was the just the
5 health -- this was the healthcare speciality
6 group. Worked, very similar to before with
7 Kurt Solomon. A lot of the same clients.
8 Where the firm did healthcare work ranging from
9 engineering to systems to finance to planning,
10 and I was still in -- and was still involved
11 with the healthcare planning side of business.

12 Q: Okay. And where were you primarily located
13 with that -- the next firm? And let me -- let
14 me back up and ask you. The R for Richardson
15 is you?

16 A: Yes, it is.

17 Q: Okay. All right.

18 A: And there was only one R. The others were
19 dual. So -- so, it's Flood, Follower, Lamb,
20 Luntrell (ph). The FLR started in Atlanta.
21 And that's where -- that's where we started.
22 We opened an office in Dallas a couple of years
23 in. I remained living and based in Atlanta,
24 but I managed the Dallas office.

25 Q: From Atlanta?

1 A: Yes.

2 Q: You did it remotely?

3 A: Yes.

4 Q: And what -- if you can characterize the types
5 of healthcare work that you did there, would
6 you do that for the Court, please?

7 A: Sure. The -- really, it's a continuum of what
8 I've done all along. Clients are primarily
9 healthcare providers, hospitals, ambulatory
10 surgery, ambulatory care, home health, hospice.
11 Geography was east coast and the Dallas office,
12 it moved into -- into the South Central U.S. as
13 well. The work that I did really was
14 healthcare planning in terms of looking at
15 markets for market potential, looking at
16 markets for growth for potential opportunities
17 for my clients. Working with -- with some of
18 my clients in terms of opposing folks down the
19 road that were trying to -- to develop a
20 competing service. So, it was -- start to
21 finish has always been healthcare planning.
22 Just, you know, very similar all along.

23 Q: Is there a -- a group or a type of client that
24 you -- on which your primary focus was?

25 A: The ---

1 Q: At FLR?

2 A: Focus at FLR really had been pretty
3 consistently throughout my career, even through
4 today, has been primarily working with not-for-
5 profit organizations. And, you know, though
6 it's a mix of them, probably more of the higher
7 size -- bigger sized healthcare not-for-profit
8 systems. It would be the folks that -- I do a
9 broad amount of stuff. But that's -- if
10 there's a larger group, that's probably what it
11 is.

12 Q: Okay. And what did you do when you left FLR?

13 A: I left FLR and spent one year in the Accounting
14 firm of Laventhall Horwath (ph) where I
15 basically worked -- started in their Atlanta
16 office, and then moved to Boston where I was
17 the -- in charge of the healthcare planning
18 practice in their Boston office.

19 Q: You went home?

20 A: Yes.

21 Q: Okay. And then after that, what did you do?
22 After that one year.

23 A: After one year, the -- the -- I found that the
24 accounting environment was not -- didn't fit me
25 very well. So, I started a firm of -- of

1 Richardson Knapp and Associates with Mr. Rick
2 Knapp, which was basically, Mr. Knapp and I, a
3 couple of other folks, as I've stated as with
4 HA, basically, same time of work, a lot of the
5 same clients. Really just a continuation of
6 the practice that -- that I've had over the --
7 over the past 20 or 30 years. The ---

8 Q: Okay. I'm sorry. Didn't mean to interrupt
9 you.

10 A: No. It -- the -- that firm started in Atlanta.
11 We started there and after a year or so, I
12 ended moving -- moving to Bo- -- back to -- in
13 Laventaller Horwath (ph), I started in Atlanta,
14 moved to the Boston office, the -- when that --
15 from that, I left there; I came back to Atlanta
16 ---

17 Q: Okay.

18 A: --- to start Richardson Knapp. Then moved --
19 about a year or so after this, moved up to
20 Boston, basically to help with family.
21 However, the majority of my practice still
22 remains -- remained in the southern --
23 southeastern part of the country. The -- you
24 know, people joke in terms of well, you live --
25 you live in Boston, how much New England work

1 do you have? Very little. The -- you know,
2 really it's the -- the work that I do tends to
3 be with existing relationships and existing
4 clients, which is the southeast.

5 Q: What you started building early on?

6 A: Yes.

7 Q: Okay. And you helped out Delta, I'm sure.

8 A: The -- I'm good to them and they're sometimes
9 good to me.

10 Q: Sometimes. What kind of work do you do with
11 your healthcare clients at Richardson Knapp?

12 A: Basically, I -- I do healthcare planning. And
13 what that is is market assessment work in terms
14 of what size is a market, is it growing, is it
15 contracting other opportunities in the market
16 for -- for my client or for the development of
17 new services or programs. In situations where
18 there is a regulation required to either --
19 either develop or to contest a project, that
20 goes to Certificate of Need, such as we are
21 here today. The -- you know, everything
22 doesn't get a CON, but -- but some does and in
23 some parts of my career, a lot it has. So,
24 basically, it's market assessment, planning,
25 competitive strategies, forecasting, but it's -

1 - it's all of that same sort of healthcare
2 planning and -- and assessment activity.

3 Q: Let me ask you this; even if you're not dealing
4 with a CON application or opposition, would you
5 be looking at basically the same elements ---

6 A: Yes.

7 Q: --- as far as strategy and volumes and
8 projections?

9 A: The -- basically to -- to do healthcare
10 planning, the -- you need to define what
11 geography you're looking at. You need to
12 define what population and the population
13 dynamics in that service area may be. You need
14 to look in terms of the dynamics of what's
15 happening. If I'm looking at a given service,
16 service A, you know, what's happening with
17 service A within that -- within that geography.
18 And are there expected changes. The example
19 I'll give is that, you know, 20 years ago
20 ambulatory surgery, you know, really was a
21 pretty unique type issue. But we started with
22 folks that were developing ambulatory surgery
23 centers and, you know, the what-if there in
24 terms of how far can they really flex in terms
25 of going forward for -- how much -- how much

1 surgery can shift over to the ambulatory side,
2 so. It's -- geography, population dynamics,
3 utilization, existing, forecast, trends, and
4 competitive analysis in terms of -- of who's
5 doing what within the marketplace.

6 Q: And in the years since you started with Kurt
7 Solomon, you mentioned ambulatory surgery.

8 A: Yes.

9 Q: Have there been other, I don't know if trends
10 is the right word, but developments in
11 healthcare? You ment- -- such as ambulatory
12 surgery.

13 A: Sure. Ambulatory care is -- is a major one in
14 terms of -- there is -- there has been and
15 continues to be a shift in terms of, you know,
16 trying to get as many folks out of the higher
17 costs, typically inpatient settings, as
18 possible to outpatient settings. So, that has
19 occurred and continues to occur. There's been
20 a distribution of technology. For example,
21 cardiac cath in terms of more interventional
22 cath. Used to be, you know, reserved for just
23 the -- you know, the -- the largest, the
24 biggest and the best. You know, interventional
25 cardiology right now tends to be distributing

1 much more than it was back 10, 15 years ago.
2 Cancer care today, you know the -- the whole
3 new technology with -- with some of my clients
4 with looking at the bone marrow transplant,
5 emerging field. You know the -- that is having
6 a major impact on the -- on the cancer
7 marketplace.

8 Q: What about urgent or emergent care, that too?

9 A: The -- the -- I talk about -- I'm an old guy,
10 so old days. Yeah, old days basically, you
11 went to the doctor's office or you went to the
12 emergency room. And now, basically, there's a
13 continuum of care that's -- that's been
14 established in terms of -- you've still got the
15 physicians who have geared up what they can and
16 will do, you know, in there little office
17 operations. Then, you have sort of the minor
18 emergency or the urgent care, which basically
19 is that -- you know, if it's 8:00 o'clock at
20 night and your doctor's there, you can go and
21 get your test for your -- for your strep throat
22 or for your ear or your kids, whatever it may
23 be. The there's freestanding emergency rooms,
24 which basically brings out of the -- sort of
25 unbundles from the hospital location. You

1 know, pretty aggressive emergency room services
2 in terms of typically board qualified, board
3 certified emergency room doctors. You know, a
4 pretty good mix of -- of diagnostic and
5 treatment capabilities. So, yeah. That's
6 another one where there's, you know -- most of
7 it was based in the hospital or the hospital
8 operation and it's now been -- been distributed
9 out.

10 Q: And these changes have essentially taken place
11 since your -- your dual certification from
12 Cornell?

13 A: Yes.

14 Q: You've seen these happening in the -- happen in
15 that period of time?

16 A: Yes. They have.

17 Q: Okay. And the dynamics around the changes in
18 the ---

19 A: Right.

20 Q: --- healthcare industry?

21 A: Right.

22 Q: And I think you mentioned this earlier in
23 describing for the Court what you do, do you
24 assist with Certificates of Need.

25 A: Yes, I do.

1 Q: And tell me, is there a geographic area in
2 which most of your practice exist related to
3 CONS.

4 A: Most of the southeast U.S.

5 Q: Okay. Just as you indicated, that's your main
6 client base.

7 A: Yes.

8 Q: Okay. What is your role, generally speaking,
9 as it relates to CONS? And lets start first,
10 if you would, if you're supporting an
11 application.

12 A: The -- the -- my role with -- with supporting
13 an application really can range from the
14 clients doing the vast majority of the work and
15 I'm doing some oversights and review and -- and
16 providing direction. But really the -- the
17 burden stays with the client. Two, a situation
18 where I'll be responsible for the -- for the
19 CON itself. Now, I'm not responsible for the
20 operational forecast or the facility design,
21 those type things, but I'm actually in charge
22 of putting the document together, gathering and
23 coordinating all of the required pieces of
24 whatever application may be and -- in that
25 situation, I'm typically responsible 100

1 percent for the need and planning forecast in
2 the application, basically defining the need
3 for the proposed project.

4 Q: And do you oppose Certificates of Need ---

5 A: Yes, I do.

6 Q: --- for your clients? And generally, tell us
7 what's involved in that.

8 A: That tends to be more of a hands-on type
9 approach, where I'll work with a client to
10 basically provide a -- a unbiased assessment of
11 the proposal or the project that's being --
12 being submitted by the opposition. It might
13 surprise you that folks get a little emotional.
14 They -- you know, it's sort of an -- you know,
15 the local folks, so they try to get, you know,
16 a real life take on -- on what's happening.
17 And what I'll then do is work with them in
18 terms of trying to assess, in terms of whether
19 it meets or does not meet whatever the -- the
20 absolute criteria for review are within an area
21 within South Carolina or Florida or Georgia.
22 And I will also look in terms of just trying to
23 see the -- the -- sort of the so what question
24 in terms of, if they do this, you know, is
25 there an adverse impact. So, that's typically

1 the opposition part of it.

2 Q: Are you familiar with South Carolina's
3 Certificate of Need Act?

4 A: Yes.

5 Q: Okay. In looking, for instance, at South
6 Carolina's Certificate of Need Act, are you
7 familiar in particular with B(11)?

8 A: Yes, I am. In terms of -- B(11) basically is
9 the component of the South Carolina CON that --
10 that -- it's where you put your need analysis
11 basically in terms of -- it's an assessment of
12 is there a need for this proposed project, is
13 there adverse impact, does it make sense from
14 a community perspective.

15 Q: Do you recall generally what kind of things
16 B(11) needs to include?

17 A: Well, the -- the -- B(11) needs to include a
18 reasonable definition of geography. It has to
19 -- needs to include a analysis and profile of
20 demo -- population and demographics. It needs
21 to include a, a review and assessment of
22 utilization, historical utilization trends,
23 utilization forecasts. It needs to basically
24 talk about are there alternatives that are
25 available for the project. It needs to look in

1 terms of adverse impact. All of the pieces
2 really go to -- really is pretty much as I've
3 said before in terms of you need to make an
4 argument in B(11) as -- as to why you should be
5 approved.

6 THE COURT: So, when you say it needs to include, you
7 mean the application ---

8 A: Yes.

9 THE COURT: --- needs to include?

10 A: Yeah. Yeah. Which -- which typically is what
11 you do anyway, but you just want to make sure
12 you get it on paper so that the folks here in
13 Columbia or the folks in Tallahassee or Atlanta
14 can -- can see where you are in terms of -- the
15 regulators can see basis, rationale, reasoning.

16 Q: Mr. Richardson, we've put on the screen DHEC's
17 Exhibit 1, Page 21.

18 (DHEC Exhibit 1 was referenced at this time.)

19 Q: And if you'll just take a quick at B(11) there
20 and just to make sure you that you hit the
21 points because I asked you generally your
22 recollection, so.

23 A: Right. Okay. I see that and whoever made it
24 bigger, thank you. The -- basically, the --
25 the -- the defined requirements of B(11) are to

1 demonstrate, and to me that means that, you
2 know, your burden to -- to document that the
3 proposed project is needed or projected as
4 necessary to meet an identified need of the
5 public and there are some -- some requirement
6 minimums there. Identification of target
7 population, degree of unmet need, projected
8 utilization, utilization of existing services,
9 past utilization of existing services,
10 justification of the project will not
11 unnecessary duplicate existing entities, and I
12 think -- I just talked a little bit about the
13 applicant must all show all assumptions, data,
14 sources, and methodologies. So, basically,
15 it's -- you need to show what's happening, what
16 you're going to do, what the impact of it is
17 and provide enough documentation so that a
18 reviewer can -- can see where all the pieces
19 came from.

20 Q: What about when you're opposing a CON
21 application? How do you address B(11)?

22 A: Well, basically, you know, I assess in my
23 opinion whether the proposal meets -- meets
24 these issues. If -- it's a similar thing.

25 Q: The balance of the same issues basically. Can

1 you give the Court an overview of the CON
2 projects you've worked on in the state of South
3 Carolina whether those are assisting one of
4 your clients in submission to the CON or
5 opposing a CON?

6 **A:** **Sure. There's these Roper Berkeley projects.**
7 **There's the original one and this one.**

8 MS. CRUM: Excuse me, Your Honor. Could I ask you
9 to speak just a little bit louder because when
10 you turn towards Your Honor, I can't quite hear
11 you.

12 MS. SHOUN: He is soft spoken, so.

13 MS. CRUM: Yeah.

14 THE COURT: If you can turn and get the microphone
15 closer to you.

16 **A:** **I'll try not to hit, which is always an issue.**
17 **Thank you. I'll try to go louder. The Roper**
18 **projects, in terms of this project and the**
19 **prior.**

20 **Q:** **And when you say prior, just so we're clear for**
21 **the Court because you talked about a lot.**

22 **A:** **Yeah. I'm talking about he prior Roper St.**
23 **Francis Berkeley County CON project.**

24 **Q:** **Yes, sir.**

25 **A:** **I was actively involved in that. I had some**

1 input in the Roper St. Francis Mount Pleasant
2 project as well.

3 Q: Okay.

4 A: Right now, I'm working in, you know, 10, 12
5 counties in the state of South Carolina on home
6 healthcare CON activities in terms of trying to
7 get expanded counties or -- or shifting the
8 location of -- of counties for Amedisys
9 Healthcare. I've just completed a project here
10 -- here -- in the lowcountry, basically with
11 Palmetto Lowcountry with development of a
12 freestanding psychiatric facility in Ladson.
13 Working with Lexington Medical Center on --
14 worked with them with bed adds and -- and
15 surgery changes. I've worked with psychiatric
16 work here in Columbia at Three Rivers. I've
17 worked with Carolina Center for Behavioral
18 Health up in Greenville-Spartanburg, Grand
19 Strand up in Myrtle Beach in terms of -- of
20 beds and hospitals and services. It -- pretty
21 much across the board in terms of sizes and
22 types of facilities here in the state.

23 Q: Okay. Anything in the state upstate?

24 A: No. Well, actually, the Spartanburg Carolina
25 Center is up in spartan- -- Greenville-

1 Spartanburg. And I actually did work -- did do
2 some work up in Springs Memorial over the years
3 in terms of helping with -- with planning a CON
4 work as well.

5 Q: In ones of which you've worked with St. Francis
6 in the past and you mentioned Mount Pleasant,
7 you mentioned the -- and we have this one of
8 course. And then, you mentioned the other CON
9 when Roper St. Francis submitted its CON for
10 what is not the Roper Berkeley Hospital. Was
11 there litigation?

12 A: Yes, there was.

13 Q: Okay. Was there as to Mount Pleasant?

14 A: Mount Pleasant did not -- I'm using a planning
15 term, did not get a clean approval. I think
16 there was -- there was challenge of litigation.
17 It did not -- it did not go to trial.

18 Q: Okay. And the other one did; is that ---

19 A: Yes, it did.

20 Q: --- Roper CONs? Okay.

21 A: Yes, it did.

22 Q: All right. Did you testify in the Roper CON
23 application case?

24 A: Yes, I did.

25 Q: Are you a member of any professional

1 associations or hold any certificates or
2 designations in the healthcare industry?

3 A: No. The -- in the healthcare planning area,
4 there really is, you know, one general --
5 American Hospital Association Society is the
6 society of healthcare planning and marketing,
7 which basically, I was one of the founding
8 members of that. It's changed more and more in
9 my perspective to a public relation sales
10 contact type of focus. So, I left -- I've left
11 -- let that lapse.

12 Q: You talked about testifying in the -- in the
13 litigation that was incident to Roper St.
14 Francis application for what is now its
15 Berkeley Hospital, correct?

16 A: That is correct.

17 Q: Were you qualified as an expert in that case?

18 A: Yes, I was.

19 Q: Besides that, how many times have you been
20 qualified as an expert in general, in your
21 work?

22 A: 30, 40, 50 times in multiples venues.

23 Q: Can you tell us how many in South Carolina?

24 A: I was trying to -- to do that that -- that
25 inventory last night and -- and I was having

1 problems just identifying them all. It would
2 be five to ten, somewhere in there.

3 **Q:** Okay. And in what areas have you been
4 qualified?

5 **A:** The healthcare -- healthcare plan in terms of
6 the -- the -- there are some attorneys that
7 will try to say healthcare planning for
8 ambulatory surgery, you know, if it's an
9 ambulatory surgery case. But basically, it's
10 healthcare planning in -- in -- every instance.

11 **Q:** And those elements that compromise it that you
12 enumerated for us earlier.

13 **A:** Yes.

14 **Q:** Have you ever been offered as an expert, but
15 the Court has declined to qualify you?

16 **A:** I have not.

17 OFFER AS EXPERT:

18 MS. SHOUN: Your Honor, at this moment, we would
19 move to have Mr. Richardson qualified as an
20 expert in healthcare planning based on his
21 education, experience and his background.

22 MR. SUMMER: No objection.

23 THE COURT: There you go.

24 MS. CRUM: I didn't think so, but I was just
25 checking.

1 MR. WICEVIC: No objection from the Department.

2 MS. CRUM: I just have a couple of voir dire
3 questions, Your Honor.

4 THE COURT: Proceed.

5 MR. RICHARDSON VOIR DIRE EXAMINATION BY MS. CRUM:

6 Q: Mr. Richardson, as I understand it, you're
7 going to testify in healthcare planning, but
8 that does not include giving an opinion in
9 healthcare finance, does it?

10 A: In terms of dollar -- anything with dollar
11 signs, no. In terms of the required component
12 of financial forecast, which is volume
13 planning, I do do that and ---

14 Q: That's part of planning.

15 A: Planning. But in terms of, you know,
16 dollarization, in terms of reimbursement, those
17 type issues, no.

18 Q: And you're not going to give an opinion, are
19 you, on the ability to complete the project in
20 this case?

21 A: The -- I may reference the information that was
22 provided by Mr. Johnson yesterday, but the - -
23 the -- I have done no independent debt capacity
24 analysis or margins or -- or -- or comparables.

25 OBJECTION:

1 MS. SHOUN: Your Honor, if might just object. I'm
2 not sure this is proper voir dire of the
3 proposed expert. I mean, I think it might be
4 some cross-examination questions, but I'm not
5 sure it goes to his qualifications, his
6 education and his background in the field.

7 THE COURT: I get -- I'd have to disagree with you
8 on that. It appears to be going to setting the
9 perimeters for what -- for what he would be
10 qualified to testify ---

11 MS. SHOUN: I ---

12 THE COURT: --- about.

13 MS. SHOUN: Yes, sir.

14 MS. CRUM: Yes, sir. You're exactly right, Your
15 Honor.

16 THE COURT: So.

17 MS. CRUM: Thank you.

18 **Q:** And you are not going to -- with the ability to
19 complete the project, you're not going to give
20 any kind of opinion regarding MUS -- MUHA's
21 ability to complete the project, are you?

22 **A:** Like I said, I -- I've -- I've heard and I've
23 discussed with Mr. Johnson his opinions, but I
24 -- I think I have, you know, nothing in
25 addition to that. The -- the -- he talked

1 about his concerns in terms of -- of
2 weaknesses, in terms of the vast magnitude of
3 services. I'm not going to do anything unique
4 in addition -- unique and in addition to that.

5 Q: And from a healthcare planning perspective,
6 you're not going to give any opinions, are you,
7 regarding cost containment?

8 A: Well, I think cost containment is a -- is a
9 part of healthcare planning.

10 Q: All right, sir. But I asked if you were going
11 to give any opinions about that.

12 A: I don't know what my attorney may ask, but in
13 terms of the -- you know, in terms of -- of --
14 if -- if a -- if a competing project is a
15 higher charge, higher net revenue program, I
16 think that has an impact on -- on community
17 need and community benefit.

18 Q: I asked you about cost containment. This is
19 not a competing project, is it?

20 A: The -- I don't think it is ---

21 Q: All right, sir.

22 A: --- in terms of -- in terms of the legal
23 perspective, but in terms of looking at
24 alternatives and impact on community, it ---

25 MS. CRUM: I'm just -- I'm not going to object. I

1 am going -- I'll have a lot cross-examination
2 for him.

3 THE COURT: Okay. All right. He's so qualified.

4 MS. SHOUN: Thank you, Your Honor.

5 MR. RICHARDSON DIRECT EXAMINATION BY MS. SHOUN CONT.:

6 **Q: Mr. Richardson, are you familiar with the**
7 **purposes as you understand them to be of the**
8 **Certificate of Need Program in this state?**

9 **A: Yes, ma'am, I am.**

10 **Q: Could you summarize those for the Court?**

11 **A: Sure. And I'm going to use as a reference the**
12 **-- the CON regulation 61-15 because they do a**
13 **better job than I do. You know, their purpose**
14 **is -- is defined there.**

15 **Q: Okay.**

16 **A: And basically, and I'm reading regulation 61-15**
17 **Section 101, purpose. The purpose is to**
18 **promote -- promote cost containment, to prevent**
19 **unnecessary duplication of healthcare**
20 **facilities and services, guide the**
21 **establishment of health facilities and services**
22 **which will best meet public needs, and show**
23 **that high quality services are provided in**
24 **health facilities in the state.**

25 **Q: Okay. Keeping that there in your mind and**

1 present before the Court then, what is the role
2 of the South Carolina Health Plan in the CON
3 application process? Because we've talked
4 about some different things here as you
5 understand that.

6 OBJECTION:

7 MS. CRUM: Your Honor, I think he is -- she's asking
8 for a legal conclusion. The role of the Health
9 Plan is set out specifically in the CON Act and
10 it's not up to him to testify ---

11 THE COURT: Well, the question is inartfully asked
12 because there -- she could be asking what is
13 the role under the law or she could be asking
14 what his perspective of the role. So, I would
15 ask you to rephrase it.

16 MS. SHOUN: I would be happy, Your Honor.

17 Q: Mr. Richardson, what is your perspective of
18 the role of the South Carolina Health Plan in
19 the CON application process?

20 A: The -- the -- I see the Health Plan and I use
21 the Health Plan as basically a -- a operational
22 framework that takes the -- the 61-15
23 regulations and brings it down to -- to sort of
24 real life issues and real life evaluatives for
25 giving -- for giving services within the sates.

1 For example, the acute care beds, there's a
2 chapter and a section that talks about, you
3 know, the general -- you know, the bed analysis
4 and bed assessment. And so, basically it takes
5 the overall regulations and brings it down to
6 a focused approach.

7 Q: And I think I heard you say, and you please
8 correct me if I'm wrong, but you use it in the
9 course of your healthcare planning
10 consultation?

11 A: Sure. If -- if I'm doing -- doing work in
12 South Carolina, then -- you know, I use and
13 I'll make sure my clients understand, you know,
14 the framework of the regulations and the
15 framework of the state, the applicable State
16 Health Plan.

17 Q: So, do -- is the Health Plan revised from time
18 to time?

19 A: Typically, yearly. Occasionally, bi-annually.
20 But, yes. It's -- it's -- it's brought current
21 over time.

22 Q: So, given that it's revised from time to time,
23 then how is it determined which one may apply
24 to a particular application, a particular CON
25 application as you understand that to be?

1 OBJECTION:

2 MS. CRUM: Your Honor, that -- that is set out in
3 the CON Act. There's a very specific section
4 in the CON Act. She's asking for a legal
5 conclusion yet again.

6 MS. SHOUN: I asked for his understanding of it,
7 Your Honor. He says he uses the Plan in his
8 consultation and advisement of his client. And
9 all I'm asking is if he does that, he must have
10 some way to determine which one is applicable.

11 MS. CRUM: Your Honor, it doesn't matter I
12 understand -- his -- what his understanding of
13 the law is. The law is what it is.

14 MS. SHOUN: Didn't ask him for a legal conclusion,
15 Your Honor, or a legal opinion.

16 MR. SUMMER: Your Honor, might I be heard?

17 THE COURT: Yes, sir.

18 MR. SUMMER: Because this issue is going -- has been
19 raised against my client's expert as well, I
20 think two things here. One is we -- we can do
21 -- we can do this the way that Judge McLeod
22 used to do it and say, you know what, I'm
23 letting this come in for whatever it's worth;
24 I'll decide what weight to give it at the end
25 of the case. But we can also look at the rule

1 and the rules say -- if you look at Rule 704,
2 opinion on ultimate issue, testimony in the
3 form of opinion or on -- or inference otherwise
4 admissible it not objectionable because it
5 embraces an ultimate issue to be decided by the
6 trier of fact. The notation gives, as a great
7 example, Your Honor, the notion that you have
8 to let the psychiatrist testify in a criminal
9 case about whether or not that psychiatrist
10 believes the defendant is insane before the
11 Court can weigh the evidence and determine from
12 a legal basis whether or not the defendant is
13 insane. In a very similar fashion, what we're
14 dealing with here is really ---

15 THE COURT: Well, what we're de- -- I get what
16 you're saying and I -- and his point is well
17 taken, but it's not the right -- we're not
18 quite there yet. But still we -- we have to
19 lead up to that. If he is entitled to testify,
20 to give an opinion on the ultimate conclusion,
21 then would he not also be entitled to explain
22 his understanding of the law so as to work
23 toward making that opinion?

24 MS. CRUM: Your Honor, I think that ---

25 THE COURT: I guess that's where you're trying to

1 go.

2 MR. SUMMER: Well, and it is. And it's 20 years of
3 jurisprudence in this court because this
4 witness testified in Marlboro Park and his
5 decision on each one of those issues, okay, was
6 adopted by Judge Geathers and followed by the
7 Court of Appeals. Similar fashion in CRCC; we
8 had Mr. Sullivan testifying on each of those
9 issues of healthcare planning. And so, when
10 you testify about what this means as a
11 healthcare planner, all you're doing is saying
12 this is how the law is applied in my field.
13 You're not saying that in this case here's the
14 decision, Judge; you have to adopt it. All it
15 is is evidence and you get to weight that
16 evidence, Your Honor, and you get to juxtapose
17 it against their expert as well as our expert
18 in weighing that evidence and deciding what
19 value to give it, if any at all.

20 THE COURT: I get it.

21 MS. SHOUN: Additionally, Your Honor, I think South
22 Carolina jurisprudence provides that once the
23 Court has vetted this expert and qualified him
24 as an expert, any objections at that point goes
25 to the weight ---

1 THE COURT: weight.

2 MS. SHOUN: --- not to the admissibility of his
3 testimony.

4 THE COURT: Okay.

5 MS. CRUM: All right. Your Honor, first, I would
6 say that what he's testifying about is his
7 reading and understanding of the law and his
8 conclusions from that. That's your job, Your
9 Honor. The ---

10 THE COURT: No. Well, if he has got to take that
11 law and apply it in healthcare planning, then
12 he has to have somewhat of an understanding of
13 the law to apply; does he not? How else could
14 he -- how else could your witness or any other
15 witness come in here and ---

16 MS. CRUM: All right, sir.

17 THE COURT: --- testify about CON planning if they
18 don't understand the law for which is sets
19 forth the requisites for doing that planning?

20 MS. CRUM: Your Honor, first -- let me -- I'm going
21 to come right back to that.

22 THE COURT: Okay.

23 MS. CRUM: But -- we're not objecting to his
24 testimony regarding the ultimate conclusion in
25 this case, what -- what he determines. We're

1 objecting to his reading the law and applying
2 the facts to the law. And I think that's what
3 he's doing and that's the question that he was
4 asked.

5 THE COURT: Well, at this point in time, I'm just
6 going to have to respectfully overrule that.

7 MS. CRUM: All right. So -- and what I'll do ---

8 THE COURT: If I -- and what applies to them,
9 applies to y'all too, so.

10 MS. CRUM: Yes, sir. I understand. And what I will
11 do is just do a continuing objection, so that
12 I don't have to keep ---

13 THE COURT: Okay.

14 MS. CRUM: --- popping up and down.

15 MR. SUMMER: So, noted by my client.

16 THE COURT: So, you're going to have a continuing
17 objection?

18 MR. SUMMER: So, note that we -- we note her
19 continuing objection and would not ---

20 THE COURT: Oh, oh. That. I thought we were doing
21 a reciprocal continuing objection ---

22 (Laughter.)

23 THE COURT: All right. Okay.

24 **Q: I sure do wish I could remember what my last**
25 **question was, but I think -- I think it was how**

1 do -- how do you determine in the course and
2 scope of your duties which healthcare plan
3 applies to a CON application? I think that's
4 where I left off.

5 A: Basically, the -- the -- I use and advise my
6 client's to use the -- the State Health Plan
7 that is in effect at the time of filing -- at
8 the time of -- look -- if you don't see it,
9 looking at CONs, which is what this is all
10 about, the -- what's the applicable plan that's
11 in effect at the time you file with the agency.

12 Q: Okay. If -- you have regulation 61-15 in front
13 of you, do you not?

14 A: I do.

15 Q: Okay. And just take a quick look at that in
16 light of my question. When you're assisting a
17 South Carolina client with the development of
18 a CON application, what instructions do you
19 give that client about the application as it
20 relates to 61-15?

21 A: In 61-15 there's a couple of things. First
22 off, there's -- at Section 202, there's sort of
23 a definitional description of the -- the hard
24 pieces that required in the CON application.

25 Q: Yes, sir.

1 **A:** So -- so, of course, in terms of, you know, if
2 they're applicable, the assumption needs to be
3 is that all those pieces are -- are provided in
4 that -- you're in compliance with that
5 requirement. In addition, what is in -- in
6 addition what's in the regulation are a set of
7 -- of project review criteria that basically
8 structure sort of what the evaluatives that
9 will -- that need to be addressed in the
10 submission of the application.

11 **Q:** We sometimes shortcut that to PRCs, project
12 review criteria.

13 **A:** Sure.

14 **Q:** Okay. Just in case I accidentally do that
15 going forward. Are any other health plans, to
16 your knowledge, considered during the course of
17 or a challenge of a CON application?

18 **A:** The -- the -- I have seen Judge Anderson's
19 peers look at -- at an updated plan. I don't
20 know the wheres and wherewithals of -- of that.

21 **Q:** Okay. Is it your understanding that in order
22 for a CON application to be approved by the
23 Department of Health and Environmental Control
24 or DHEC, that it must be consistent with that
25 regulation 61-15?

1 **A:** Yes.

2 MS. CRUM: I've got a continuing objection.

3 **Q:** And if -- DHEC 4 has been put up. Do you
4 recognize that?

5 (DHEC Exhibit 4 was referenced at this time.)

6 **A:** Yes. This is the 2017, 2018 South Carolina
7 Health Plan, which shows an inactive date
8 about, you know, three quarters down, of June
9 9th, 2017. So, this would be the plan that was
10 in place at the time of the submission of the
11 MUHA Berkeley County Community Hospital
12 application.

13 **Q:** And the one upon which you relied in reaching
14 any opinions or conclusions?

15 **A:** Yes.

16 **Q:** Okay. Tell us if you will, Mr. Richardson,
17 where in that Plan we can locate information
18 about hospitals?

19 **A:** Chapter 3 of the plan focuses on -- on
20 hospitals.

21 **Q:** Okay. And what about the standards for general
22 hospitals?

23 **A:** The -- that's also presented in Chapter 3.

24 **Q:** Okay. Have you looked at the -- the record, if
25 you will; the DHEC record on the MUHA

1 application for its Berkeley -- its proposed
2 Berkeley County location?

3 A: I'm sorry. I was ---

4 Q: That's okay. No, no, no.

5 A: Have I looked at ---

6 Q: Have you looked at, if you will, the record --
7 the DHEC evaluation and opinion on the proposed
8 location of MUHA in Berkeley County?

9 A: Yes, I have.

10 Q: Okay. And are you familiar with what standards
11 the Department articulated that it found most
12 important from MUHA?

13 A: Yes. That would be the criteria that they
14 identified was applicable for this project.

15 Q: If you'll go to page 8 of this Exhibit. Can
16 you then tell us your -- or publish for the
17 Court the Standard 5 that you've testified to?

18 A: Standard 5 is shown, and just point of
19 reference, Standard 5 continues onto the next
20 page as well. But this basically, the -- the
21 -- sort of the ---

22 THE COURT: I don't need him to read Standard 5 to
23 me.

24 MS. SHOUN: Yes, sir, Your Honor. Thank you. Okay.

25 Q: Mr. Richardson, in your opinion as an expert in

1 the field of healthcare planning, does MUHA's
2 application, CON application for a proposed
3 location in Berkeley County comply with
4 Standard 5?

5 A: I think it does not.

6 Q: And can you articulate the reasons?

7 A: Sure. The -- the -- really I'm looking --
8 Standard 5, the guidance this gives me is
9 really presented in the last sentence of
10 Standard 5 there, where it states the applicant
11 must justify through patient origin and other
12 data the need for a new hospital at the chosen
13 site and the potential adverse impact a new
14 hospital at the chosen site would have on the
15 existing hospitals in the service area. So, I
16 think, you know, that's the -- for a project as
17 -- as being proposed here conceptually, that's
18 what Standard 5 requires.

19 Q: And to -- you said you don't feel like MUHA's
20 application for that proposed site in Berkeley
21 County meets that standard?

22 A: That is correct.

23 Q: Why not?

24 A: Let -- let me parse this. The -- the first is
25 the definition of patient origin, which

1 basically is defining the geography that this
2 -- this new hospital will serve. The -- MUHA
3 in its application basically, you know, not
4 only includes the -- the areas proximate to the
5 Berkeley Hospital, but includes the entirety of
6 the tri-county area, Berkeley, Dorchester and
7 Charleston County, as well as a secondary area,
8 which is a -- an array of counties that -- that
9 basically bounds the tri-county area. The --
10 my opinion is is that a definition of geography
11 that wide is inappropriate for a community
12 hospital as defi- -- proposed by this
13 applicant.

14 Q: Is there a distinct definition in any of the
15 applicable law of which you are aware that
16 defines community hospital?

17 A: No, there's not. The -- basically, the -- my
18 reading of MUHA's proposal is that they're
19 developing a community hospital in Berkeley
20 County in which they will treat the lower
21 intensity type patients and retain the high --
22 the high intensity, the -- you know, the
23 sickest of the sick, and the specialty of the
24 specialist patients in the downtown campus.
25 So, basically, the -- this is a non-tertiary,

1 non-specialty hospital. It's a community
2 hospital. And as a result, my opinion based on
3 my review of patient origin data and in my work
4 over the last -- last number of years, is that
5 I would expect that the primary draw for a
6 hospital of that type would be in close
7 proximity to the proposed hospital. And, you
8 know, in terms of -- you can ask me what is --
9 what is that. Well, in my planning, I
10 typically go eight miles, seven or eight miles
11 for primary service area, maybe going out to
12 ten miles for primary and secondary, but it's
13 a defined, relatively tight service area. Not
14 a geography that includes all the way down to
15 the peninsula to -- to Mount Pleasant to -- you
16 know, to Colleton County. That's not
17 appropriate for a -- a facility of this type,
18 especially as my opinion and expectation is is
19 that the emergency room is going to drive the
20 majority of business to this hospital and
21 emergency room business tends to be local,
22 proximate, you know, what's -- what's close and
23 accessible versus coming far away to this ED to
24 then -- to then gain admission to a facility.

25 Q: A couple of things in what you said I would

1 like to follow up on, if you'll indulge me.

2 You gave us your outlook on this proposed
3 hospital as is represented in MUHA's CON.

4 A: Yes.

5 Q: And please, please correct me if I'm saying
6 anything inconsistent with what you indicated,
7 but as I understand what you said, it would be
8 treatment of lower acuity, non-tertiary care.
9 And of course, then non-quaternary care. Is
10 that an accepted definition or understanding,
11 if you will, in the healthcare -- healthcare
12 planning industry of a community hospital?

13 A: I think it is, if you add in that it will not
14 have specialty care as well, such as behavioral
15 health, such as rehab, such as -- you know,
16 real speciality focused, you know, type work as
17 well.

18 Q: Okay. And you also talked about what you would
19 anticipate to be the -- the patient base, if
20 you will, that would result from ER visits.
21 Can you explain that a little more for the
22 Court?

23 A: The -- the -- in my experience, the -- the
24 smaller community hospitals, 100-bed set up
25 like this, is that I would expect that a good,

1 more than half, two-thirds of the admissions
2 for a hospital such as this, would be coming
3 through the emergency room. Basically, what
4 you have is that you have -- you don't have an
5 awful lot of scheduled high-end tertiary care
6 work being done. And the majority of -- of a
7 business tends to be lower intensity. And the
8 data show, you know, the data show -- now,
9 Berkeley County, 63 percent of all admissions
10 come through the emergency room. Berkeley
11 County residents per the RFA data, 63 percent
12 of the Berkeley County admissions for Berkeley
13 County residents come from the ED. And just
14 the -- the -- my knowledge and awareness that
15 ED draw tends to be very geographically tight,
16 drives the -- that ED volume is going to
17 further prove that a local service area versus
18 a, you know, six, eight county area covering a
19 good part of the state.

20 Q: For instance, not generally speaking in your
21 experience someone who would come from Mount
22 Pleasant to the proposed MUHA Berkeley site,
23 coming for an ER or ED visit.

24 A: Correct.

25 OBJECTION:

1 MS. CRUM: I'm going to object to the form of the
2 question. I think that was a leading question,
3 Your Honor.

4 THE COURT: I think it may have been.

5 Q: Mr. Richardson, what would you anticipate to be
6 the geographical distance on average, if you
7 will, from which patients would present to an
8 ER -- to the ER at the proposed MUHA site in
9 Berkeley County?

10 A: The -- I think with the distribution of
11 services that the options that are available,
12 I think it's going to be again, a similar --
13 it's going to be a seven, eight, nine, ten mile
14 geographic draw.

15 Q: Okay. And we're going to come back to that in
16 just a little bit. But we started talking
17 about Berkeley County. So, let's go down that
18 road just little bit. Are you familiar with
19 Berkeley County in general?

20 A: Yes.

21 Q: And are you familiar with the size of Berkeley
22 County, geographically?

23 A: Yes. It's a large geographic county.

24 Q: And what about its population?

25 A: Population is growing. It's not a huge county,

1 but population is growing. Population growth
2 appears to be concentrated primarily in the
3 southern portions of the county. Berkeley
4 County is large, but it's got some areas that
5 you can't -- you know, that really aren't --
6 aren't ever really going to develop in --
7 materially you've got forest, you've got the
8 lake.

9 Q: Yes, sir.

10 A: But basically is the -- you have a -- an
11 established population base in Moncks Corner,
12 which was the county seat, so the historical
13 core of -- of the county. And now you have the
14 growth of the county, which is more in the
15 southern area really. So, the Summerville,
16 North Charleston border area coming into
17 Berkeley County on the south.

18 Q: And in the course and scope of your assistance
19 to Roper Saint Francis in this particular
20 project and in the previous project, you --
21 have you had occasion to study the population
22 growth?

23 A: Yes.

24 Q: Okay. And is -- is it based on those studies
25 that you just offered the opinions that you

1 gave this court?

2 A: Yes, it is. The -- the, you know, there is
3 growth in terms of, you know, relative to other
4 portions of South Carolina where there is
5 decline. There is growth of, you know, one and
6 a half to two percent period of growth, which
7 is -- which is good solid, solid growth. You
8 know, it's not the best there is out there.
9 There are some places that are growing
10 dramatically quicker. And it's not unexpected.
11 I mean, you know, this is -- that growth is
12 what the Roper Berkeley facility was based on.
13 And to -- you know, there was an expectation of
14 growth and it is occurring. So, you know,
15 good.

16 Q: Good. Was -- was it that same growth that was
17 anticipated when the litigation occurred
18 relative to Roper St. Francis' CON application
19 for its -- its hospital in Berkeley County
20 that's not up and operating?

21 A: There was growth at the point of -- of filing
22 the CON back in 2008. There was growth during
23 the trial in 2010, 2012. There remains growth
24 ---

25 Q: Okay.

1 **A:** --- in terms of the -- the -- to me, that
2 supports the development of the Roper Berkeley
3 facility.

4 **Q:** Okay. And that -- do -- you know had surprises
5 in the changes in the growth, in the population
6 growth in Berkeley County since that time?

7 **A:** (Shakes head.)

8 **Q:** Okay. And we've put Demonstrative, I think, 7.

9 MS. SHOUN: I think it's our 7th Demonstrative, Your
10 Honor.

11 THE COURT: Well, the scene -- screen says Demo 1.

12 MS. SHOUN: Well, I think that's because it's
13 actually one of Trident's early ---

14 THE COURT: Oh, okay.

15 MR. SHOUN: --- exhibits, but -- and we can use that
16 number, I'm fine with that. There's no need to
17 change it.

18 (Demonstrative 7 was referenced at this time.)

19 **Q:** I would just ask, Mr. Richardson, if would look
20 at that and -- and just tell is -- does this
21 represent your understanding of the area in the
22 population density of Berkeley County?

23 **A:** Yes, it does. Basically, it's the -- along the
24 I-26 corridor. The majority of the growth is
25 in the southern portion of the county.

1 Q: And you see on there, Roper St. Francis, is the
2 location of it's facility?

3 A: I do. There's a blue dot there.

4 Q: Okay.

5 A: Entitled Roper Hospital Berkeley.

6 Q: And you see the red star?

7 A: Yes.

8 Q: What does that represent?

9 A: It represents MUSC Nexton Hospital, which would
10 be the MUHA hospital that we're talking about
11 here.

12 Q: That would be the proposed site for that?

13 A: Yes.

14 Q: Okay. And on this map do you also see any
15 other providers in close proximity to the
16 Berkeley County area or to Berkeley County?

17 A: Well, specifically, I see the Trident Medical
18 Center and the Summerville Medical Center
19 facilities, which are just to the south or
20 southwest of the Berkeley County line.

21 Q: And are you familiar with the bed count of
22 Trident?

23 A: Yes.

24 Q: Okay. What is that?

25 A: I believe Trident is just under 300, 290-

1 something.

2 Q: And what about Summerville?

3 A: Summerville's 1-2-4, 124.

4 Q: Okay. Now, I think you showed us on there
5 basically the location of the current Roper St.
6 Francis facility. In making your volume
7 forecasts for Roper St. Francis' Berkeley
8 County location, upon submission of its CON,
9 what kind of assumptions did you make?

10 A: That the -- pretty -- pretty straight forward
11 set of assumptions. The -- first, the
12 geography we used or that I used was Berkeley
13 County in total and this was a county-wide
14 perspective.

15 Q: And you used only Berkeley County?

16 A: I used only Berkeley -- I ended up at -- at the
17 end of the analysis adding in I expect 10
18 percent to come from beyond.

19 Q: Yes, sir.

20 A: Yeah. But just Berkeley County.

21 Q: Not tri-county.

22 A: Not tri-county, no.

23 Q: Why didn't you use the tri-county area? Isn't
24 it -- isn't the tri-county sort of the language
25 we hear in the applicable rates?

1 **A:** The reality is is that the -- a community
2 hospital, you know, where Roper's proposed
3 their -- I don't think we can be expected to
4 have any significant or large draw of patients
5 from either Charleston County -- there may be
6 a little bit from Dorchester County to the
7 adjacent area, but -- but we felt that Berkeley
8 County in total was -- was likely the best.

9 **Q:** And it's on those volume projections that you
10 supported Roper St. Francis' CON application?

11 **A:** That is correct. So, started with Berkeley
12 County as the geography, as the defined
13 geography. Next assumption was that the -- of
14 the Roper St. Francis non-tertiary, non-
15 specialty volume that was treated for Berkeley
16 County residents, the assumption was made that
17 half of those -- that half of that volume would
18 be served at the Berkeley County site. So, I'm
19 using -- just making up numbers. If there were
20 a hundred applicable patients, the -- from --
21 from -- served at Roper from Berkeley County,
22 the assumption was is that 50 percent of those
23 would stay and 50 percent would continue to go
24 on down to -- on down to the -- the existing
25 facilities. The ---

1 Q: The Roper facility downtown?

2 A: Yeah. The -- the -- a specific sort of tweak
3 to that, what we -- what I did was take the
4 historical volume of patients that were served
5 at Roper from Berkeley County, the applicable
6 patients and we drew that up to the point we --
7 and based on population growth. So, if -- if
8 they were a hundred historical, it's still
9 going to be 120 into the future and still half
10 of that 120 would be what would stay and then,
11 half would continue to go on. So, that's --
12 that's sort one layer or -- or this piece of
13 the onion skin for the forecast. The next was
14 the assumption that 10 percent of the remaining
15 patients from Berkeley County, the remaining
16 applicable, non-tertiary, non-specialty
17 patients from Berkeley County that are being
18 served at other hospitals, Trident,
19 Summerville, MUSC primarily ---

20 Q: Yes, sir.

21 A: --- that 10 percent of -- of their volume would
22 be redirected or cannibalized to this proposed
23 new facility. The third piece, once you added
24 those two Berkeley County sort of layers, the
25 assumption was made is that there'd be also 10

1 percent of total volume would originate from
2 beyond just -- just Berkeley County.

3 Q: At the time you supported or helped Roper St.
4 Francis support its CON application for its now
5 location in Berkeley County, we've talked about
6 Trident and we've talked about Summerville
7 being in close proximity. Are you aware of any
8 other healthcare facilities that were either
9 existing or planned at that time?

10 A: The -- the -- specifically, the Trident Moncks
11 Corner 50-bed hospital.

12 Q: Is that what resulted in the whole challenge in
13 the litigation?

14 A: Yes, it was.

15 Q: Okay.

16 A: Yes. The ---

17 Q: And what's your understanding of the status of
18 that particular facility now?

19 A: Still ongoing, still in development.

20 Q: Okay. And what's the size of that facility?

21 A: That is a -- another 50-bed facility proposed
22 to be located in the other population center in
23 Berkeley County, Moncks Corner.

24 Q: Okay. And based on your studies, your research
25 of population growth, the size of Berkeley

1 County and your volume projections, what was
2 your opinion as to the location of Roper St.
3 Francis in its current location and of the new
4 Trident 50-bed community hospital and its
5 proposed location?

6 A: The -- it was my opinion and it continues to be
7 my opinion that a 50-bed hospital where Roper
8 is, plus a 50-bed hospital where -- where
9 Trident's proposed in the Moncks Corner, both
10 can still work.

11 Q: Okay.

12 A: And I -- I think they both can be developed and
13 accepted from a reasonably planning
14 perspective.

15 Q: Affected by a 128-bed hospital if it goes in?

16 A: The -- a 120-bed hospital as proposed by MUHA
17 is a very different and unique animal. A
18 couple of reason; you know, two and a half
19 times the size of either the Roper-Berkeley
20 facility or the Moncks Corner facility --
21 Trident Moncks Corner facility. But also, what
22 you have is that you've got two and half times
23 the capacity going three to four miles from the
24 Roper -- Roper site. So, it's not the -- the
25 original concept was one hospital to basically

1 serve the new high growth area in the south and
2 one to serve sort of the -- you know, the --
3 the Moncks Corner hub. You now have both of
4 those, but layering on two and a half times the
5 capacity right next door to the Roper site.

6 Q: Okay. I think you said -- you -- you told us
7 -- you -- you're aware of the -- the general
8 distance between Roper Berkeley as it now exist
9 and the proposed MUHA site?

10 A: Yes.

11 Q: Okay. You've been to the site?

12 A: Yes, I have.

13 Q: Okay.

14 A: I've driven from -- excuse me. From the
15 Berkeley Hospital on over to where the -- the
16 site plan indicates that the M -- that the MUHA
17 facility will be on Nexton Parkway.

18 Q: How long did it take you to drive there?

19 A: It was about three plus, four miles. It was
20 seven or eight minutes.

21 Q: Okay.

22 A: It -- you know, it's right there. The Nexton
23 community really is just about adjacent to the
24 -- to the existing Roper facility.

25 Q: We heard some testimony yesterday from --

1 elicited from Mr. Johnson concerning whether
2 Roper St. Francis wanted to capitalize on being
3 -- and I'm quoting here, "first-to-market,"
4 close the quote there. Do you -- were you in
5 the court room yesterday?

6 A: Yes, I was, and I recall him saying that.

7 Q: Okay. From a healthcare planning perspective
8 based on your education, experience, is that a
9 bad thing?

10 A: I think it's a good thing in terms of -- of
11 being first-to-market, it basically allows
12 Roper to -- to hopefully, you know, gain their
13 volume in a -- in a -- in a time frame such
14 that they can get a -- get their expected
15 volume such that they can run a very feasible
16 operation. And I think being first-to-market
17 from a community perspective is a wonderful
18 thing. They -- they -- yes, Trident and
19 Summerville are located to the southern -- the
20 southern tier of the -- of the county, but
21 within Berkeley County, there's not been an
22 inpatient facility for 34 years. So, first-to-
23 market, you know, pretty quickly, you know,
24 that's a great thing. You know, there's
25 nothing bad about it.

1 Q: In your experience in healthcare planning, if
2 a facility such a Roper St. Francis or Roper
3 St. Francis opening in its current Berkeley
4 County location, is there generally a
5 significant financial investment in such a
6 location?

7 A: Yes, there is.

8 Q: And from a healthcare planning perspective,
9 would you agree it's prudent to try to, if you
10 would, protect that to the extent it can be
11 protected or at least -- yeah, I think protect
12 might be the word.

13 A: I think from a health planning perspective,
14 from a -- from a business standpoint, you know,
15 Roper's invested, you know, a lot money in that
16 -- in that area and that site to serve those
17 patients. You know, the fact that they're
18 first to open, I think is a great thing. It
19 allows them to, you know, to move into their --
20 their forecasting and hopefully, become
21 profitable.

22 Q: During the course of assisting Roper St.
23 Francis, first in the submission of its
24 application, its CON for the current location
25 of its Berkeley Hospital and again, in

1 assisting Roper St. Francis in the particular
2 matter about which we're here today, have you
3 had the opportunity to study historical data
4 concerning MUHA and its proposed location?

5 A: Yes.

6 Q: In that data, have you come across anything
7 that would support a reason that MUHA could not
8 have been the first to market in the Berkeley
9 County area?

10 A: The -- I saw nothing in the information
11 presented by MUHA or elsewhere that would
12 basically -- would have prohibited MUHA from,
13 you know, moving into the marketplace, you
14 know, proposing back in 2008 when -- when Roper
15 did. The -- for whatever reason MUHA has
16 appeared to historically decide that they're
17 putting their investments on the peninsula and
18 -- and they have been. You know, during all
19 this time when -- when Roper's trying to move
20 out, you know, we see by action that the -- the
21 inpatient side, MUHA basically has taken a
22 different direction. You know, they could have
23 gone to a -- to Berkeley, but they -- they
24 decided to stay there.

25 Q: Trident did to, correct?

1 OBJECTION:

2 MS. CRUM: Object to the form of the question.

3 THE COURT: Leading, again.

4 MS. SHOUN: Okay.

5 MS. CRUM: I'm sorry.

6 MS. SHOUN: I assume.

7 Q: Are you -- you've testified today about another
8 entity who has sought to open their hospital in
9 Berkeley County?

10 A: Yes.

11 Q: Okay.

12 A: The -- Trident filed a CON application back in
13 2008 as well.

14 Q: Okay.

15 A: Just as -- as MUHA could have.

16 Q: Okay. Mr. Richardson, did you submit any
17 materials to DHEC in opposition to MUHA's
18 community hospital project?

19 A: Yes. I -- I sent a letter into the agency. I
20 included information that I had prepared, as
21 well as information that Mr. Johnson had
22 prepared and included it in the letter.

23 Q: Why did you submit that letter?

24 A: For one, they -- procedurally, the -- the -- I
25 have -- we have the ability to -- to present

1 opposition statements on positions to the
2 agency as -- as part of their process. And it
3 was Roper's position and my position that the
4 development of the proposed MUHA Berkeley
5 County facility was not in the best interest of
6 the community or Roper Hospital.

7 Q: And we've put on the screen DHEC CON 741; is
8 that the letter to which you're referring?

9 (DHEC Exhibit 1 was referenced at this time.)

10 A: Yes.

11 Q: Okay. Have your opinions set forth in the
12 letter changed as you sit here today?

13 A: No. If they -- the -- basically, the -- the
14 general opinions are there, is that the
15 Berkeley County with the development of Roper
16 Berkeley now open, with the development of
17 Trident Moncks Corner, with the understanding
18 that Trident Medical Center in North Charleston
19 and Summerville Medical Center are providing
20 care to Berkeley County residents, you know,
21 the -- it was and still is my opinion that
22 there is access and reasonable access to care
23 for inpatient services and patients in Berkeley
24 County. Second is that -- my opinion was is
25 that the service area, as defined by MUHA, just

1 is not a reasonable forecast for what they're
2 proposing to do.

3 Q: Let's look briefly, if we can, at your
4 particular letter -- at your letter and some
5 particular points contained in there. I
6 believe you state in here Berkeley County is
7 not an underserved healthcare market?

8 A: Yes.

9 Q: Can you explain that statement?

10 A: Sure. I think as presented in that summary,
11 it's pretty straightforward.

12 Q: Yes, sir.

13 A: We -- basically, you have -- from a situation
14 where there were no acute care hospitals
15 located within the boundaries of Berkeley
16 County, you know, at this point in time, you
17 now had two approved projects, one to the
18 south, one to the north, that were going to
19 come in and -- and provide good care, good
20 access to care. I think it states here, in
21 terms of the development of another 128 has the
22 ability to -- to basically undermine some of
23 that rational development and distribution and
24 potentially run the risk of excessive
25 development at this point in time.

1 Q: In your second point, and you've touched on
2 this already, is that MUHA's proposed community
3 hospital service area is not realistic or
4 reasonable. Will you just revisit that for us
5 briefly?

6 A: Included in the application basically was a
7 definition of service area that included the
8 entire tri-county area ---

9 Q: Yes, sir.

10 A: --- as well as, you know, described as a band
11 of counties to the north of the tri-county
12 area.

13 COURT REPORTER: North of the what? I'm sorry, I
14 didn't hear you.

15 A: North of the tri-county area. You know,
16 basically it's a geography that -- that is not
17 reasonable or appropriate for a community
18 hospital.

19 Q: Okay. Thank you. You also state MUHA, in your
20 opinion, did not provide sufficient information
21 to support the patient volume forecasts where
22 it's proposed in a community hospital. And the
23 ultimate forecast volumes in the CON are
24 unrealistically overstated. Can you explain
25 that?

1 **A:** Sure. Really our parse that into two pieces.

2 **Q:** Sure.

3 **A:** And it probably should've been two points, but
4 the -- the -- in the materials provided to DHEC
5 that I reviewed, to prepare this app -- prepare
6 this letter, there really was, you know, the
7 building blocks that MUHA used in preparing its
8 forecast and its analyses were missing. The --
9 for example, the -- the -- in terms of the --
10 the detailed utilization schedule for the
11 proposed financials, yeah. Planning side, they
12 have the volume forecast, not the dollarization
13 ---

14 **Q:** Yes, sir.

15 **A:** --- that they -- they weren't there. The basic
16 building blocks in terms of -- you know, there
17 was a description in terms of -- from this
18 unreasonable service area, what portion of
19 patients in each zip code would be brought into
20 the -- into the new hospital. But there was
21 never any presentation of what's the baseline
22 of MUHA patients and they started with -- to
23 get the -- they basically just presented the
24 end result. So, the -- the -- the building
25 blocks to basically do a validation or a check

1 to make sure that what's presented is
2 reasonable was not there.

3 The second piece, the ultimate volume
4 forecasts are unreasonably overstated. Issue
5 there basically goes to by having a too large
6 service area, you basically forecast for too
7 patients that -- that can be expected to be --
8 be served in this hospital. And -- and let me
9 make you a major -- just -- just layer on this;
10 the proposed concept of MUHA in this
11 application is that 100 percent of patients to
12 be served at MUHA's 128-bed community hospital
13 in Berkeley County would be MUHA patients.
14 What they're saying is that there'll be no
15 adverse impact. There'll be no patients that
16 will be shifted from other hospitals in
17 whatever service area that would be served in
18 Berkeley. They basically said 100 percent of
19 the patients to be served would otherwise have
20 been served at -- at MUHA. So, no redirection,
21 not cannibalization from other providers.

22 Q: So, if I understand, are you saying that the
23 projection was then 100 percent of the patients
24 to be served at the proposed MUHA site in
25 Berkeley County, would be coming off the

1 peninsula or other areas?

2 A: The -- the assumption is that they would be
3 residents that are -- that are located within
4 that too large service area.

5 Q: I see.

6 A: And ---

7 Q: Okay.

8 A: And rather than going to the peninsula, they
9 would go to the new hospital. You know, and
10 for, you know, local patients, sure. You know,
11 that -- I think that can and will happen. But
12 to have -- make an assumption that, you know,
13 patients coming from Mount Pleasant, coming --
14 patients coming from adjacent to MUHA's
15 existing facility, they're going -- going to go
16 sort of counter traffic up 26 to the new site,
17 I don't think is reasonable.

18 Q: Okay.

19 A: So -- so, the -- so, with the assumption that
20 all they're going to do is treat their own, the
21 -- I think the ultimate volume forecast, they
22 are unreasonably overstated. The -- because
23 they're not going to be getting their patients
24 from these disparate areas. Second, discussed
25 in the -- in the -- in the letter is that the

1 lengths of stay that are included in their
2 forecast, basically are too high.

3 Q: Okay.

4 A: And ---

5 Q: We're going to go through that in a little bit.

6 A: Okay.

7 Q: Once we go through your slides. And just to
8 briefly go through this, if we can -- and I
9 don't mean to cut you off.

10 A: Huh-uh.

11 Q: Okay. Number 4 talks about drive time
12 comparisons. Did -- what drive time
13 comparisons are referenced there?

14 A: The -- MUHA in its application put pages of
15 information that basically showed what the
16 drive time to the new facility would be versus
17 drive time to the -- to the existing -- or
18 basically -- basically, they focused on drive
19 time to the new facility. The -- and based on
20 that, there was a -- sort of a hierarchy in
21 terms of what percentage of patients they would
22 expected to get redirected to the new facility.
23 Basic concept is that the -- narrow situations
24 where the drive times and new facility would be
25 well beyond what it would be to existing MUHA

1 facilities. Yet, there was an expectation that
2 there would be patient shifts or patients would
3 -- rather than going to the closer hospital,
4 they'd go to the further hospital. And -- and
5 -- and that -- that does not seem right.

6 Second is, in the letter, there was a
7 discussion and there was detail presented that
8 the drive time comparisons that were in the CON
9 versus some information that was provided
10 during the -- the CON completion process were
11 different. And so, just confidence in terms of
12 the information and data as well.

13 Q: Let's talk about different information. We'll
14 -- put on the screen what's been marked as MUHA
15 38C. Do you recognize that?

16 (MUHA Exhibit 38c was referenced at this time.)

17 A: I have seen this. This is -- this is part of
18 the discovery package.

19 Q: Okay. And is -- was that -- to your knowledge,
20 is that a recent production?

21 A: Yes. It ---

22 Q: Okay.

23 A: It would have been the -- during this
24 litigation prep.

25 Q: Okay. The prep for the litigation?

1 **A:** Yes.

2 **Q:** Okay. And describe for us, if you will, Mr.
3 Richardson, what that purports to represent.

4 **A:** Well, basically here in terms of, you know,
5 I'll give the example of the first zip code
6 that's presented, which is 29401, which is
7 descriptively -- descriptively shown as
8 peninsula Charleston. And basically what this
9 shows is that the driving miles is two minute
10 -- two miles. Driving time is nine to twelve
11 minutes.

12 **Q:** But that's to the downtown MUHA location?

13 **A:** To the downtown location.

14 **Q:** Okay.

15 **A:** Yet the data show that the -- the same drive to
16 MUHA Berkeley would be 27 miles, 28 miles, and
17 a 30, 40 minute drive time. The -- and the
18 next is basically is the variance between those
19 two. Basically shows is that the driving to
20 MUHA Berkeley would be 25, 26 miles further and
21 drive time would be 21 to 28 minutes longer,
22 yet MUHA expects that more than a third of
23 their existing -- of -- of those type patients
24 living in the peninsula of Charleston would go
25 to the new facility. And I think that just,

1 you know, does not support that contention.

2 **Q:** Let's take just randomly another one and that
3 would be the Sea Islands drive time
4 projections.

5 **A:** Okay.

6 **Q:** If you'll look at those and explain those for
7 us, please.

8 **A:** The -- the -- it's a similar presentation.

9 MS. CRUM: I'm sorry. I couldn't hear what ---

10 MS. SHOUN: The Sea Islands. Yes, ma'am. I'm
11 sorry.

12 MS. CRUM: I thought you said the zip code.

13 MS. SHOUN: I didn't, but ---

14 MS. CRUM: Okay.

15 MS. SHOUN: --- I can.

16 MS. CRUM: I'm sorry. I -- I just thought you did.
17 I'm sorry.

18 MS. SHOUN: No, no. It's okay.

19 **A:** The two Sea Island zip codes basically show a
20 similar fact presentation where travel time to
21 the MUHA Berkeley facility is, you know, 30
22 minutes or more. The -- for both of those
23 versus travel time to MUHA downtown. Yet
24 there's an expectation that 30 percent of that
25 business would rather than going to the -- the

1 closer facility, would go to the further
2 community Roper Berkeley facility. And again,
3 I think that that's -- that just does not make
4 sense.

5 Q: Okay. Now, you would agree with me that
6 there's one on there that shows a little bit
7 shorter drive time; is that right?

8 A: There are two.

9 Q: There are two. I'm sorry. Okay.

10 A: There's North Charleston, which basically is --
11 from a drive time is -- is two to nine to ten
12 minutes closer. And there's also Moncks
13 Corner, which is in the northern part of
14 Berkeley County, which is significantly closer.

15 Q: And interestingly on the North Charleston where
16 we don't have a comparison as to what the drive
17 time would be to Trident or Summerville?

18 A: Correct.

19 Q: And on the other one as well, we don't have a
20 drive time comparison to Trident or
21 Summerville?

22 A: That is correct.

23 Q: Okay. And if we could then, I'm sorry, go
24 back. I'm sorry I'm jumping around a little
25 bit. Go back to your letter submitted to DHEC

1 in opposition to MUHA's CON application.

2 A: Okay.

3 Q: And I think one more.

4 A: I think we're on point five now.

5 Q: Yeah. We just finished four, I believe. Thank
6 you.

7 A: Point five -- excuse me. States there was
8 inadequate information or documentation to the
9 support the financial projections and
10 forecasts. And the -- the -- my observation
11 there from a planning perspective, I think
12 there was inadequate information or
13 documentation of the volume forecasts. I think
14 I would defer to Mr. Johnson from yesterday in
15 terms of just -- just other information.

16 Q: Just as far as the financial ---

17 A: Correct.

18 Q: Okay, thank you. Then number 6, you believe it
19 will adversely impact existing and approved
20 providers; correct?

21 A: Yes. They ---

22 Q: And we're going to go over than a little bit
23 more when we get to your slides, Mr.
24 Richardson, but I don't want to cut you -- I
25 don't want to cut you off. I really don't.

1 But to any extent you don't anticipate covering
2 that in your slides that we're going to get to
3 in a moment, please feel free to -- to support
4 your position set forth in number 6 there.

5 A: I believe the slides I presented will -- will
6 do that.

7 Q: Okay. And then lastly, the proposed -- I think
8 that's last. Is there an eight? The proposed
9 new MUHA location is inconsistent with project
10 review criteria identified by DHEC and its CON
11 completeness -- completeness letter. Describe
12 that for the Court, if you will please.

13 A: Well, basically, the agency in their
14 completeness letter identified what they said
15 where the applicable or the -- the project
16 review criteria that should be considered for
17 this. And my opinion is that the -- the need
18 or specific to the need side under the
19 definition of a service area is that the --
20 that the applicant did not meet any of that
21 project review criteria. I'll make another
22 comment too is that the -- I think that the
23 project review criteria that were identified by
24 DHEC in its completeness letter was
25 significantly remiss by not including the

1 adverse impact project review criteria, which
2 is listed as the -- as part of the applicable
3 bucket for bringing criteria in the State
4 Health Plan. You know, there was no -- no
5 indication that adverse impact, you know,
6 should have, would be reviewed or assessed.

7 Q: And in your experience as a healthcare planner,
8 is that a critical element?

9 A: The -- every new healthcare project basically
10 needs to be assessed on a balancing -- you --
11 every project you've got -- you've got good
12 things and less good things happening in terms
13 of -- now, you could put a hospital or require
14 a service on every corner and that would just
15 do a great job in terms of having access and
16 get right to it. Now, the balancing of that is
17 that, you know, its not going to be able make
18 -- not be able to keep it open because it's
19 certainly going to lose a lot of money.
20 There's not going to be enough staff to take
21 care of all those. So, there's need to be a
22 balancing in every project and the adverse
23 impact that a new facility will have anywhere,
24 need -- in my opinion, needs and must be
25 balanced to the -- to the positive benefits

1 that may accrue with the -- with a proposed
2 project or development.

3 **Q:** Okay. One moment.

4 MS. SHOUN: I beg the Court's indulgence, Your
5 Honor. As Ms. Crum says in her depositions,
6 and we all get very excited, I think I can mark
7 off some questions.

8 THE COURT: That's a wonderful thing.

9 MS. SHOUN: Our eyes all get very bright when --
10 when Ms. Crum tell us that.

11 **Q:** Do you have an opinion, based on your
12 experience in healthcare planning, what the
13 letter of completeness intends, what it's for,
14 what does it do?

15 **A:** From a planning perspective, in terms of
16 working with CONs, it basically, you know, it
17 sets the indication and the expectations to
18 what the agency will do in terms of its value
19 to exempt and its assessment of a given project
20 or application.

21 **Q:** And does it signal that all the criteria have
22 been considered and met?

23 **A:** The ---

24 **Q:** Or it should.

25 **A:** The ---

1 OBJECTION:

2 MS. CRUM: Object to the form.

3 MS. SHOUN: I'll rephrase it.

4 Q: What's your understanding of what it
5 represents?

6 A: The definition of the criteria that is in the
7 completeness letter?

8 Q: Yes, sir.

9 A: That basically -- to me, that's telling the
10 applicant and the world what will be assessed
11 and reviewed and considered in the -- in the
12 evaluative coming to the decision.

13 Q: And you've told us you disagree with that
14 determination?

15 A: I specifically disagree with the exclusion of
16 adverse impact from that consideration.

17 Q: Okay. In its CON application for its proposed
18 Berkeley location, is it your understanding
19 that MUHA is redirecting, relocating or
20 eliminating a facility or service?

21 A: MUHA basically is proposing to move an
22 institutional bed need to Berkeley County.
23 It's not existing services or programs that are
24 gonna be transferred or repositioned. This is
25 the need based on their peninsula operation is

1 what they're proposing.

2 **Q:** And is it your understanding from a healthcare
3 planning perspective that it could technically
4 actually accomplish that?

5 **A:** I don't know what you're asking.

6 **Q:** That it could take its institutional bed
7 calculation and to move it to a location that's
8 not on the peninsula.

9 **A:** I believe that is an -- is an allowable action
10 as long as there is a need for the location
11 site, 128 beds -- in this situation, long as
12 there is a defined and true need for the 128
13 beds in southern Berkeley County.

14 **Q:** So it can technically do that but still has to
15 meet the criteria?

16 OBJECTION:

17 MS. CRUM: Object to the form; leading.

18 **Q:** In order to transfer the bed calculation what
19 does MUHA have to establish?

20 **A:** The -- my opinion is that -- I think the door's
21 open that they have the ability as an option to
22 move, but they need to basically go through the
23 evaluative threshold to document and to show
24 that there is a need for that 128-bed facility
25 at that south Berkeley site, so it's just,

1 yeah, they can, but should they and does it
2 meet the evaluative criteria. And I think it
3 does not.

4 Q: Okay. Mr. Richardson, did you submit anything
5 other than the letter shown to DHEC earlier in
6 opposition to MUHA's proposed project in
7 Berkeley County? I'm sorry since this
8 litigation has begun. Did ---

9 A: I'm sorry?

10 Q: Let me back-up for a minute. Has your
11 deposition been taken in the course of this
12 litigation?

13 A: Yes, it has.

14 Q: And was it taken by MUHA on behalf of MUHA?

15 A: Yes, Ms. Crum.

16 Q: Yes. And did you submit any information at
17 that point in the course of the litigation that
18 sets forth your position in opposition to
19 MUHA's proposed project?

20 A: Yes, through the discovery I provided work
21 files and documents.

22 Q: Okay.

23 A: As well as at my deposition I provided summary
24 slides that, you know, encapsulated my
25 opinions.

1 Q: Okay. Thank you. Thank you for helping me get
2 there. Can we put on the screen what has been
3 marked as Roper St. Francis 14 and if you will
4 look at that, Mr. Richardson, and tell me if
5 you identify those?

6 (RSF Exhibit 14 was referenced at this time.)

7 A: Sure. This is an exhibit that I prepared.
8 This is taken directly from my deposition.

9 Q: Okay. And if you will, I'm going to ask you if
10 you'll take us through each of these slides and
11 give us some explanation as you go -- as you go
12 through them and I will stop and ask some
13 questions in between just to make sure that we
14 are clearly articulating for the court the
15 meaning of what's on there in case it's not
16 clear.

17 A: Certainly. The first slide basically, the --
18 was created, you know, based on my question in
19 terms of what's MUHA actually doing up in
20 Berkeley County today. And they had accessed
21 information from the South Carolina Revenue and
22 Financial Affairs group. I have the ability to
23 access public data that show what county
24 residents are doing and how much volume they're
25 generating and where they're going. So what I

1 was able to do here by the State data set, and
2 this is for 2018, which is the most current
3 data available through this source, what this
4 showed is that the MUHA served a total of 4091
5 Berkeley County residents. Now, it's important
6 to note that that 4000 includes all type
7 patient's: it includes psychiatric; includes
8 OB; it includes tertiary; it includes
9 transplants. You know, it's everything they
10 do, and it includes all ages. And the reason
11 I'm making that distinction is the project
12 proposed by MUHA is for age 16+ only and for
13 community hospital non-speciality, non-tertiary
14 type care.

15 Q: Okay.

16 A: So in this data set, in order to get to sort of
17 an apples and apples comparison, what I did
18 first was identify the volume of mental illness
19 patients, Berkeley County resident mental
20 health -- mental illness patients that were
21 served at MUHA, and that's the 596.

22 Q: And you deducted that?

23 A: Yes, I did. Yes.

24 Q: Okay. All right.

25 A: The second is attempting to get an idea of

1 their OB service because they -- basically
2 MUHA's proposing a med/surg bucket of beds and
3 an OB bucket of beds.

4 THE COURT: Med/surg?

5 A: Medical/surgical.

6 MS. SHOUN: Medical/surgical.

7 THE COURT: Oh.

8 A: So basically the medical/surgical stuff, as
9 well as a separate obstetric care. So, the --
10 in order to try to get some compare, I also
11 attempted to get the volume that MUHA is
12 treating for Berkeley residents for obstetric
13 type work. And that's the complications of
14 pregnancy, childbirth and the puerperium. What
15 that basically is is that the RFA data
16 aggregates the information in terms of clinical
17 classification categories. And this is sort of
18 that top-level, this is a level I category, and
19 so the -- so I've tried to identify via that
20 approach what the MUHA OB volume from Berkeley
21 County would be.

22 Q: And this is data you would rely on in the
23 course and scope of your work for Roper St.
24 Francis or any other client?

25 A: It's what every, you know, planner or

1 consultant would use within the state.

2 Q: Okay. All right. Is there anything else on,
3 and I'll call slide one, of you will?

4 A: Bottom line, what it shows is that the 2018
5 MUHA treated 698 OB type Berkeley County
6 residents and treated 2,797 medical/surgical
7 type Berkeley County residents. Important to
8 note again that that ---

9 THE COURT: When you say MUHA treated, at their
10 peninsula hospital?

11 A: Correct. So, this is the historical what
12 happened. These patients came from Berkeley
13 County and were treated at MUHA facility.

14 Q: Okay.

15 A: Important to note for that medical/surgical
16 grouping, again, that is all ages which is --
17 means this is a bigger number than would be
18 treated at the Berkeley hospital. And this
19 includes tertiary and specialty patients, which
20 I wasn't able to carve out in this data set.

21 Q: Okay.

22 A: So, 2,797 is a -- you know, is an estimate.
23 It's too high, but it's an estimate.

24 Q: Okay. And is it your understanding, just to be
25 clear, that that tertiary and specialty

1 practice or those patients are anticipated by
2 MUHA to be carved out for any proposed
3 community hospital in Berkeley County?

4 A: Yes, as part of MUHA's forecast approach, they
5 basically carved out what they say are
6 specialty and tertiary patients, identifying
7 them by DRG.

8 Q: And tell us what that is.

9 A: DRG is a diagnostic related grouping.

10 Q: Okay.

11 A: Which basically is a -- is a grouping of
12 similar type patients. For example, there's an
13 open heart DRG; there's a normal delivery DRG.
14 So it's -- MUHA in their application basically
15 defined what DRGs they are not expecting to be
16 treating out there in Berkeley County and it's
17 a list of specialty and tertiary DRGs. Ms.
18 Crum asked at deposition in terms of is that a
19 reasonable presentation. There's not a black
20 and white defined list of this is what you must
21 have and not have. I tend to work with my
22 hospitals to get that. But I have no problem
23 with the presentation that MUHA had.

24 Q: Of carving out this ---

25 A: Of carving out, yes.

1 Q: Yes, sir. Okay.

2 THE COURT: So by using the DRGs to define the level
3 of acuity, is that ---

4 A: They're basically saying that they're not gonna
5 be treating the tert- -- high acuity type
6 patients.

7 THE COURT: Yeah.

8 A: And they're determining what book of business
9 to carve out, what they're getting up there,
10 based on how many patients were in each DRG.

11 THE COURT: I get it.

12 A: Which is the -- I've used that same approach.
13 That's an okay way to do it.

14 Q: Okay. Anything else on slide one, Mr.
15 Richardson?

16 A: No. No, thank you.

17 Q: Okay.

18 A: No, ma'am.

19 (Laughter.)

20 Q: Okay. If we can go to slide two.

21 A: The reason for creating this slide was
22 basically to try to get an estimate in terms of
23 how does MUHA's treatment of Berkeley County
24 residents compare to what they're forecasting
25 in their CON application. The -- and, again,

1 for the Roper Berkeley approach, I think is a
2 reasonable approach. The estimate was that
3 half of the Roper Berkeley volume treated at
4 existing facilities from Berkeley County
5 residents would stay in county and half would
6 go out. So what I tried to look at here was to
7 try to see what's the book of business that
8 MUHA's treating of Berkeley County residents
9 today. And from the prior slide and we saw
10 that there were 2700 med/surg discharges and
11 698 OB discharges, for a total of 3,495
12 discharges. What this shows, however, when you
13 compare that to the volume they have in their
14 project, you know, they're forecasting they're
15 going to do 5,700 discharges in total year
16 three from the CON.

17 Q: Yes, sir.

18 A: So, whereas I thought, you know, a reasonable
19 predictor was half of Roper St. Francis' volume
20 would stay. The reality is is that even if
21 MUHA got all of their volume from Berkeley
22 County and we look just at Berkeley County like
23 we did with Roper St. Francis, there's not
24 enough business to cover what they're
25 forecasting to do. You know, we thought half

1 of what we get in our existing facilities may
2 stay. You know, these guys they have to assume
3 that if it's Berkeley County, which I think is
4 a reasonable geography ---

5 Q: Yes, sir.

6 A: If they're looking at Berkeley County, they
7 need to get well more than they're doing today.
8 So just -- I'm basically saying here is that
9 the -- with Berkeley County as the appropriate
10 geography, their project does not work.

11 THE COURT: I want to back up and understand ---

12 MS. SHOUN: Yes, sir.

13 THE COURT: --- what you said just now that leads
14 off of what you said earlier. You did three
15 assumptions.

16 A: Right.

17 THE COURT: You did 50 percent would go to Roper St.
18 Francis, would go to other hospitals ---

19 A: 50 percent ---

20 THE COURT: Now, you said stay, but ...

21 A: Yeah, 50 percent of Roper residents treated at
22 Roper facilities would stay, so ---

23 THE COURT: Stay where?

24 A: Stay at Berkeley -- at the Berkeley County
25 hospital.

1 THE COURT: Okay.

2 A: So of the pool of Berkeley County residents
3 that are treated at Roper, half of those would
4 stay in Berkeley County and half would continue
5 to go to Roper.

6 THE COURT: Okay. And then you said ten percent
7 would be cannibalized ---

8 A: Basically ---

9 THE COURT: --- to MUSC?

10 A: MUSC, more from Trident, but MUSC and Trident.

11 THE COURT: Okay.

12 A: And then there'd be ten percent ---

13 THE COURT: From other areas?

14 A: From beyond.

15 THE COURT: Okay.

16 A: The -- now, MUHA says we're only treating our
17 own. You know, they consciously say this is
18 going to be 100 percent redirection. We're not
19 gonna take any patients from anybody else. And
20 what this shows is if they're only treating
21 their own and Berkeley County is a reasonable
22 way to look at this, they don't have enough of
23 their own if they get 100 percent of it to
24 cover their volume. And if they -- if they
25 only get -- if they're only able to keep half,

1 **it's even more of a gap.**

2 THE COURT: Well, let's say they didn't have an ER -

3 --

4 **A: Right.**

5 THE COURT: --- would that be a realistic

6 projection? Because you would not be pulling

7 in people through the ER ---

8 **A: Right.**

9 THE COURT: --- so, you know, I don't know if you
10 can actually do that; I'm just asking.

11 **A: They -- I don't think they're gonna get 100**
12 **percent redirection. You know, if it's a**
13 **facility that has 100 percent scheduled cases,**
14 **sort of, you know, linear acceleration therapy**
15 **where all your cases are scheduled and defined,**
16 **you know, then if you move your radiation**
17 **therapy center from one space to another,**
18 **you're probably gonna get everyone to follow**
19 **across. But in this case, I don't -- in this**
20 **case, and even without an ED, you know, unless**
21 **they were 100 percent business that, you know,**
22 **is prescheduled, prearranged, I don't think**
23 **it's likely they're gonna get 100 percent. A**
24 **lot closer without an ED and without having**
25 **outpatient access, which is local. But even on**

1 the extreme, it won't be 100 percent, but maybe
2 get closer. But even if they get the hundred
3 percent, they missed -- they missed their
4 forecast.

5 THE COURT: Thank you.

6 Q: To the Court's point, Mr. Richardson, is MUHA's
7 proposed location in Berkeley County for its
8 community hospital inclusive of anything?

9 A: Yes, it is.

10 Q: Okay.

11 A: Well, it's inclusive of an ED and it appears
12 that it's inclusive of an ED at the hospital
13 and a second freestanding ED on the other side
14 of I-26.

15 Q: All right. Tell us about that. What do you
16 know about that?

17 A: What I know about that is that the -- in the
18 CON proposal, the -- MUHA had proposed taking
19 a planned freestanding ED that was just off I-
20 26 on the west side of 26 and at the point of
21 opening a new hospital, the expectation
22 would've been to reposition or relocate that
23 freestanding ED to the hospital.

24 Q: Yes, sir.

25 A: It appears now that the freestanding ED that is

1 west of 26 will remain and a second, sort of a
2 subsequent ED will still be established at the
3 hospital. So, the concept in the CON was we've
4 got a freestander over here, once the hospital
5 gets up and moving, we're gonna move it across
6 and merge it in. But what appears now is that
7 now that's not the case. Is that right now is
8 that the freestsander the other side of I-26
9 will stay and a freestanding ED will be
10 established and placed at the new hospital. So
11 it's double ED access coming in rather than --
12 rather than no ED.

13 THE COURT: I guess the increase of another ED -- or
14 the addition of another ED increases the
15 potentiality of cannibalization from other
16 hospitals or what?

17 A: I think it does. I think the ---

18 THE COURT: What's your problem with that is what
19 I'm asking?

20 A: My problem with that is that the -- I thought
21 there was gonna be adverse impact assuming that
22 the freestanding ED was gonna be moving across,
23 so there'd just be one before and one after.
24 By having two EDs, I think that there's the
25 potential for even further grabbing patients

1 from other providers.

2 THE COURT: Go ahead.

3 MS. SHOUN: Thank you, Your Honor.

4 Q: Mr. Richardson, redirecting your attention to
5 slide two, have you offered us your opinions
6 represented by that slide? Have we finished
7 those?

8 A: Yeah, I think we beat those pretty well.

9 Q: You do? Okay.

10 A: Even if they get 100 percent, there's not
11 enough. Even if they get 100 percent Berkeley
12 County and Berkeley County is the applicable
13 geography, there's not enough to support this
14 project.

15 Q: Okay. Then if you'll go to slide three and
16 explain your data and your conclusions
17 represented there.

18 A: The reason for this slide was -- a couple
19 things. First off is that the -- I really do
20 think that the 50-bed sizing for the Roper
21 Berkeley facility is a reasonable sizing for
22 the volume that they have in Berkeley County
23 and for who they are. And what this shows is
24 that this is -- this would have been updated
25 data from what was in the original Roper

1 Berkeley CON application and what was presented
2 at trial. What this basically shows is that
3 the Roper system serves -- 2018, served 3,200.
4 The number under Roper system fourth line down
5 is 3,231 medical/surgical type discharges from
6 Roper [sic] County and they served 633 OB type
7 patients. So basically where you are, you're
8 at about 3900 applicable discharges that
9 Roper's treating from Berkeley County today.
10 The -- if you look at the MUHA numbers combined
11 -- to the side there, you know, they're just a
12 -- they're a little bit below what Roper's
13 doing in terms of those applicable pools. And
14 the so what there really is the -- I think the
15 50-bed sizing is reasonable and appropriate.
16 But MUHA's coming in with a two and a half as
17 many beds based on the same book of business of
18 Berkeley County and that just -- just doesn't
19 square. I think that is just an unreasonable
20 approach. Another thing I'll make -- a comment
21 I'll make here is that their -- in some of the
22 preliminary discovery, there were discussions
23 that MUHA has a higher volume, treats a higher
24 number of Berkeley County residents than Roper
25 does. Therefore, maybe they ought to be the

1 one being approved. Now, even if you look at
2 the top line all type patients, MUHA's got 70
3 -- 150, 160 additional patients above -- above
4 Roper. You know, even if you accept that, that
5 doesn't show -- 50 beds are needed for Roper's
6 volume. That doesn't show that two and a half
7 times that is needed for MUHA. But the
8 reality, the real applicable volume, Roper's
9 got more volume from Berkeley County than MUHA
10 does.

11 Q: And this shows that -- or tell me what this
12 shows as far as Trident's volume.

13 A: Well, this shows that Trident, which is similar
14 to where we were at trial years ago, Trident is
15 the market leader in Berkeley County in terms
16 of the market share, in terms of the -- you
17 know, a little less in terms of the OB side,
18 but overall, you know, they've got a good half
19 of the book of business. So half of Berkeley
20 County residents are utilizing -- are going
21 just beyond the southern border to the Trident
22 or the Summerville facilities. And Trident
23 here is the Trident Medical Center, as well as
24 The Summerville Medical Center. Roper is Roper
25 downtown, St. Francis, and Mount Pleasant, so

1 it's the three hospitals.

2 **Q:** And it looks -- if my maths' not quite right,
3 but it looks like Trident has more Berkeley
4 resident discharges, almost twice as many as
5 MUHA.

6 **OBJECTION:**

7 **MS. CRUM:** Object to the form of the question;
8 leading.

9 **Q:** What's that difference in numbers, if you will,
10 Mr. Richardson, between the discharges of
11 Berkeley County residents for the Trident
12 system and those for MUHA?

13 **A:** The Trident system -- I assume by market share
14 and by volume, is more than double than MUHA
15 has.

16 **Q:** Okay. And yet what is Trident's issue CON for
17 Berkeley County Community Hospital?

18 **A:** Their proposal is for a 50-bed facility in
19 Moncks Corner.

20 **Q:** Anything else on this slide we need to tell the
21 Court?

22 **A:** I don't think so.

23 **Q:** Okay. If you'll go to the next one, please.
24 Let me back up just a minute if I may, Mr.
25 Richardson, from this. When you looked at