

THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

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APPEAL FROM THE ADMINISTRATIVE LAW COURT  
John D. McLeod, Administrative Law Judge

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Case No. 09-ALJ-07-0332-CC

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Trident Medical Center, LLC, d/b/a  
Berkeley Medical Center, .....Appellant/Respondent,

v.

South Carolina Department of Health and  
Environmental Control and Roper St. Francis  
Hospital-Berkeley d/b/a Roper St. Francis Hospital,

Of Whom South Carolina Department of Health and  
Environmental Control is the .....Respondent, and

Roper St. Francis is the .....Respondent/Appellant.

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Case No. 09-ALJ-07-0333-CC

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Trident Medical Center, LLC, d/b/a  
Berkeley Regional Medical Center, .....Appellant/Respondent,

v.

South Carolina Department of Health and  
Environmental Control, and Roper St. Francis  
Hospital-Berkeley, Inc. d/b/a Roper St. Francis  
Hospital-Berkeley,

Of Whom South Carolina Department of Health and  
Environmental Control is the .....Respondent, and

Roper St. Francis is the .....Respondent/Appellant.

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Case No. 09-ALJ-07-0336-CC

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CareAlliance Health Services and Roper  
St. Francis Hospital-Berkeley, ..... Respondents/Appellants,

v.

South Carolina Department of Health and  
Environmental Control and Trident Medical  
Center, LLC ..... Respondents,  
Of whom Trident Medical Center, LLC is the ..... Appellant.

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1 just quit at that, explaining what the  
2 Committee is?

3 Q: I'll take you through it. First of all, when  
4 you go to promulgate a Plan, you and your staff  
5 create the first draft; is that correct?

6 A: Yes, that is correct.

7 Q: Okay. And then you will schedule a meeting of  
8 the Health Planning Committee and then you  
9 present that draft to the Health Planning  
10 Committee for its consideration; is that  
11 correct?

12 A: That's correct.

13 Q: Okay. The Health Planning Committee then  
14 reviews that draft and they have the ability to  
15 make changes, correct?

16 A: That's correct.

17 Q: And they direct you on making those changes or  
18 additions or deletions to the Plan?

19 A: That's correct. They vote on each section as  
20 we discuss it at the meeting.

21 Q: And based upon their direction of you, you come  
22 up with a draft Plan for publication; is that  
23 a fair statement?

24 A: It is. After the Planning Committee approves  
25 the draft Plan it is sent out for public

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1 comment, which means we publish a notice in the  
2 State Register, send copies to all the state  
3 repository libraries, everything we do is  
4 posted on the DHEC website so it's public  
5 knowledge. And then we schedule the four  
6 regional public hearings. So that starts when  
7 they -- when the notice is published in the  
8 State Register, that starts the public comment  
9 period on the draft Plan.

10 Q: And that public comment period is required by  
11 law, isn't it?

12 A: Yes.

13 Q: Okay. And that period usually, typically lasts  
14 for 30 days?

15 A: We do not hold the public hearings until at  
16 least 30 days after the notice is published in  
17 the State Register. So it typically goes,  
18 ballpark, 35 to 37 days.

19 Q: Okay. And you hold those public hearings  
20 usually in the Pee Dee in Florence, Lowcountry  
21 in Charleston, Columbia and Greenville, don't  
22 you?

23 A: North Charleston and Spartanburg. Greenville  
24 started charging us to use their courtroom so  
25 we moved to Spartanburg.

1 Q: The purpose of the public comment period and to  
2 have those public meetings is to allow any  
3 interested persons, but especially providers,  
4 an opportunity to comment on the Plan; is that  
5 correct?

6 A: Correct.

7 Q: It's fair to say that especially hospitals who  
8 have spent a great deal of capital investing in  
9 hospitals have a vested interest in the CON  
10 program and its administration; wouldn't you  
11 agree with that?

12 A: Yes.

13 Q: Okay. And this process that we go through, the  
14 statutory, regulatory process, is required by  
15 law to give them an opportunity to see what's  
16 in the new State Health Plan before it is  
17 actually finalized?

18 A: Correct.

19 Q: Do you receive comments in written form from  
20 interested persons?

21 A: Yes.

22 Q: And then do you reconvene, after the public  
23 comment period, do you reconvene the Health  
24 Planning Committee?

25 A: Yes, sir. Once we receive all of the comments

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1 after the public comment period ends, we make  
2 copies of all the comments and then we draft  
3 staff responses to all of the comments and we  
4 send the comments and the staff responses to  
5 the Committee members and also publish on the  
6 DHEC website so that everyone can see everyone  
7 else's comments and what the staff proposed  
8 responses are to those comments without having  
9 to go through Freedom of Information and  
10 request a paper copy. So it's accessible where  
11 everyone can see.

12 Q: When the Healthcare Planning Committee comes  
13 back to look at your revised draft or your  
14 proposals for change, what do they do in that  
15 meeting?

16 A: We take the Plan, section by section, and  
17 review the comments that were received on that  
18 section and any proposed changes or revisions  
19 to it, and then they vote on whether to accept  
20 any of those changes or to leave it as-is and,  
21 like I said, we go section by section until  
22 we've reviewed all comments, all the sections  
23 of the Plan.

24 Q: So as part of their charge of overseeing and  
25 directing staff and promulgation of the Plan,

1 they actually have to vote on those changes  
2 before they are, before you will incorporate  
3 them; you have to be directed to do that?

4 A: They are advisory to the Board, we answer to  
5 the Board, so yes, we go by what the Committee  
6 votes to put in the Plan.

7 Q: Okay. And once you have that Plan finalized at  
8 that stage and approved by the Health Planning  
9 Committee where does it go?

10 A: It is sent to the DHEC Board for final  
11 approval. Usually the chairman of the Planning  
12 Committee and Ms. Dukes, who's the health  
13 regulation deputy commissioner, will present it  
14 at the DHEC Board meeting and they will do just  
15 like the Planning Committee did; go through the  
16 Plan section by section and vote to either  
17 approve it, make changes, or if there are some  
18 issues that they believe require further study,  
19 they can defer action on a particular section  
20 and request that staff and the Planning  
21 Committee revisit it to address whatever issues  
22 they raise at the DHEC Board meeting.

23 Q: But more often than not the DHEC Board's going  
24 to approve what comes from the Health Planning  
25 Committee, right?



1 A: Yes.

2 Q: Okay. And what date does it then become  
3 effective? When does it become the new Plan?

4 A: The Board meets the second Thursday of every  
5 month so the Plan becomes the Plan of record at  
6 the opening of the next business day. So 8:00,  
7 8:30 Friday morning it is the new Plan of  
8 record. So any applications that come in the  
9 same day that the Board votes on the new Plan  
10 are still considered to be under the old Plan  
11 and then the next business day the Plan becomes  
12 effective.

13 Q: Let's take a look at the Act. First of all,  
14 let's look at -- for purposes of our discussion  
15 I'm going to use one Plan. I'm going to use  
16 the '08-'09 Plan for our discussion, even  
17 though there are several Plans. There are two  
18 that are issue in this case and then the  
19 current Plan. But let's look at the '08-'09  
20 Plan.

21 A: Okay.

22 Q: Go to Joint 4, please. If you look on the  
23 first page of the Plan, are the Planning  
24 Committee members' names on there?

25 A: Yes, they are listed on this page.

1 Q: And Mr. Doug Bowling; is he in the courtroom  
2 today?

3 A: Yes, he is.

4 Q: And who does he work for?

5 A: Roper.

6 Q: Was he on the Planning Committee when the '08-  
7 '09 was approved?

8 A: Yes, he was.

9 Q: And is he still on the Planning Committee?

10 A: Yes.

11 Q: Let's look at the table of contents and if you  
12 don't mind, just try and explain from the table  
13 of contents to the judge how you put this  
14 together; what are the sections and what are  
15 their relevances?

16 A: Okay. Starting with chapter one, that is more  
17 the programmatic information. It's the legal  
18 basis of why we do the Plan, how we go about  
19 doing it, constitution of the Planning  
20 Committee. It references the other standards  
21 that we work with, such as DHEC health  
22 licensing, health construction, other state  
23 agencies like Department of Mental Health, the  
24 DAO-DAS, just the working relationships that we  
25 have with them and how we consult with them.

1 You know, we don't develop this in a vacuum, we  
2 work with them. Then there are the statement,  
3 which I guess is a legal statement, about  
4 interpretation of the Plan, and then safety of  
5 patient care was an issue that was raised a few  
6 years ago so we incorporated some language  
7 about it. Chapter II is where we start getting  
8 into the actual inventory, excuse me, the  
9 projections of need for healthcare facilities  
10 and services. Depending on the services there  
11 will be an inventory, an explanation of what  
12 the need methodology is, how it was determined,  
13 the existing facilities, and what the  
14 projection of need would be for that particular  
15 bed or service. And you can see it starts with  
16 the general hospitals, long-term acute  
17 hospitals, critical access, which are  
18 components of general hospitals. Some  
19 services, OB, neo-natal, pediatric, and then we  
20 get into, at least in this Plan,  
21 cardiovascular, megavoltage, PET/CT, which is  
22 technology, then get into the outpatient  
23 facilities which is ambulatory surgical  
24 facilities, free-standing ERs, and then we're  
25 on the next page. Some speciality hospital

1 beds, psychiatric rehabilitation, different  
2 alcohol and drug abuse, and then the long-term  
3 services of nursing homes, home health  
4 agencies. And then Chapter III is the  
5 inventory for the inpatient facilities. We  
6 have an inventory, we have the statewide  
7 facilities which are basically facilities that  
8 don't impact the inventory or bed need  
9 projection for a service. For example, the  
10 state mental health facilities, we don't count  
11 them in the psychiatric bed need calculations  
12 because they serve a totally different  
13 population. There's a different method of  
14 getting into their service than psychiatric  
15 services of Palmetto Health or Three Rivers or  
16 whatever. So the statewide facilities are  
17 inventoried first and then we have the state  
18 divided into four regions for inventory  
19 purposes, which is essentially the Upstate is  
20 Region I, the Midlands is Region II, the Pee  
21 Dee is Region III, and then the Lowcountry is  
22 Region IV. So we have the inpatient  
23 facilities inventoried for each region. So we  
24 have all of the general hospitals by county,  
25 all the psychiatric hospitals, all the rehab,

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1 all of the residential treatment for children  
2 and adolescents, and all the nursing homes. So  
3 that -- you can go to Chapter III to find out  
4 what particular inpatient services are  
5 available in a given inventory region.

6 Q: Let's take a look, if you don't mind, at the  
7 Act itself. I'd like to walk you through that.  
8 You've described to us how the Board is  
9 appointed and how it serves, you've also  
10 described to us the process that you go through  
11 with that Health Planning Committee. Let's  
12 look at Section B. Basically that's your  
13 mandate to prepare a Plan, correct?

14 A: Correct.

15 Q: And the second sentence of B says the Plan, at  
16 a minimum, must include. Now, that's a  
17 statutory mandate to your department, correct?

18 A: I'm not a lawyer, but yes, I would assume yes.

19 Q: You work for the State of South Carolina,  
20 right?

21 A: Correct.

22 Q: The General Assembly and the Governor have  
23 promulgated this Act, right?

24 A: Yes.

25 Q: Okay. And so would you take this as a

1 directive from your employer to do something?

2 A: Yes. I'll agree with that.

3 Q: Okay. So the Plan at a minimum must include,  
4 number one, an inventory of existing healthcare  
5 facilities, beds, specified health services,  
6 and equipment. What's the purpose of having an  
7 inventory in the State Health Plan?

8 A: Well, before you can make any kind of  
9 projection or determination of whether  
10 additional beds or services are needed, you  
11 need a baseline number, you need to know what's  
12 already existing. And so, therefore, we need  
13 to know in a particular county or service area  
14 how many beds, how many linear accelerators are  
15 already existing before we can try and  
16 determine whether there's a need for any  
17 additional beds or equipment.

18 Q: It refers to healthcare facilities. Is a  
19 hospital a healthcare facility in South  
20 Carolina?

21 A: Yes.

22 Q: As defined by law?

23 A: It's, I believe, defined in the CON law what a  
24 healthcare facility is.

25 Q: And that includes a hospital?

1 A: Yes.

2 Q: A general, acute care hospital?

3 A: Yes.

4 Q: Such as what Trident does and what Roper does?

5 A: Correct.

6 Q: So you've got to have an inventory of the  
7 existing hospitals, that's part of your  
8 inventory, correct?

9 A: Correct.

10 Q: Is it a fair statement that you have to do the  
11 inventory because you need to know what the  
12 utilization is of existing resources before you  
13 can project future need?

14 A: Right. Because we would need to know the  
15 number of beds and the number of patient days  
16 or visits or whatever the numbers that would be  
17 needed for the calculations for projecting  
18 need.

19 Q: All right. Then number two is projections of  
20 need for additional healthcare facilities,  
21 beds, health services, and equipment. How do  
22 you project need? Conceptually.

23 A: Okay. Normally you would take the existing  
24 facilities in an area and we define service  
25 areas differently for different services, so

1 this is somewhat of a generic answer. We look  
 2 at the current utilization of the existing  
 3 providers. We develop a standard such as  
 4 minimum utilization rate, for example, like  
 5 linear accelerators, we look for the existing  
 6 providers to be at 80 percent of the capacity  
 7 before we would consider another provider in  
 8 that area. So we would look at the existing  
 9 providers, what they're doing right now,  
 10 compare that to the minimum that would be  
 11 required in order to approve another provider  
 12 in the area, and -- sorry, calculate -- sorry,  
 13 that explanation went in the weeds a little at  
 14 the end.

15 Q: Okay. So bottom line is you come up with some  
 16 type of a mathematical projection based on  
 17 existing utilization of what that need is going  
 18 to be in the future?

19 A: That's a much better explanation than mine, but  
 20 yes.

21 Q: Well, it's a left-side, right-side thing. I  
 22 know you're better at math than I am. Let's  
 23 talk a little bit about -- let's finish, we'll  
 24 finish going through this and then what I want  
 25 to do is I want to talk to you about some



1 specifics of different types of facilities.  
2 Again, the Plan, at a minimum, must include  
3 we've figured out it's an inventory and  
4 projection. So you've got to have inventory of  
5 hospitals, projections for hospitals. Number  
6 Three, standards for distribution of healthcare  
7 facilities. Now, we've agreed that a hospital  
8 is a healthcare facility as defined under state  
9 law, right?

10 A: Correct.

11 Q: Explain to me what's the purpose of focusing of  
12 distribution; what does distribution mean?

13 A: The purpose of focusing on distribution is that  
14 you want to ensure that there is accessibility  
15 for all residents of however you have defined  
16 the service area; whether it's multi-county,  
17 region, or a single county, that the purpose is  
18 to avoid having all of those services located  
19 in a single location or a smaller area of the  
20 region if there are other portions of that  
21 service area that don't have access to that  
22 service, that it would be, from our  
23 perspective, better to have the services  
24 available in multiple locations within the  
25 service area rather than concentrated in a

1 single location.

2 Q: Effectively guiding the distribution of  
3 facilities helps create access for patients; is  
4 that a fair statement?

5 A: Yes. How services are distributed does affect  
6 access.

7 Q: And one of your goals and one of the criteria  
8 in your regulations is to increase access for  
9 the citizens of the state of South Carolina to  
10 basic healthcare?

11 A: Correct.

12 Q: And that would also include increasing their  
13 access to hospital services?

14 A: That would be one of them, yes.

15 Q: Okay. Now, in developing standards for  
16 distribution this Number Three speaks to a  
17 number of things. Scope of services to be  
18 provided should factor into your standards,  
19 right?

20 A: Correct.

21 Q: Utilization should factor into your standards?

22 A: Yes.

23 Q: Occupancy rates should factor into your  
24 standards?

25 A: Yes.

1 Q: Travel time?

2 A: Yes.

3 Q: So the statute requires that you have a travel  
4 time standard in the State Health Plan,  
5 correct?

6 A: I think it says it needs to be factored into  
7 how the standards for distribution are  
8 developed.

9 Q: Well, let's look at the -- were you here when  
10 I had my discussion with Ms. Brandt about DHEC  
11 language and English language?

12 A: Yes, sir.

13 Q: DHEC language and plain language. And you  
14 heard that line of testimony, correct?

15 A: Yes.

16 Q: And that pertained to the bed transfer section  
17 of the 2008-2009 Plan, I think it's on J, II-9  
18 of Joint 4 which carries on through the eight  
19 components on II-10. So you remember that line  
20 of questioning?

21 A: Yes.

22 Q: Okay. I'm really just trying to narrow how  
23 much time we spend on things today. Would you  
24 concur in her conclusions regarding what is  
25 plain language and what is DHEC language in

1 that line of questioning?

2 A: No, I would not.

3 Q: Okay. We'll get to that later in the day.  
4 Let's talk about plain language and English  
5 language as it pertains to the statute.  
6 Standards for distribution of healthcare  
7 facilities beds, specified health services, and  
8 equipment. So I've got to develop those. The  
9 Plan, we've got to go back to the beginning of  
10 the sentence because there's a colon. The Plan  
11 at a minimum must include standards and those  
12 standards must include scope of services,  
13 utilization, occupancy rate, and travel time.  
14 That's a directive from the Legislature that  
15 you have to have a travel time for a standard,  
16 a standard for travel time; isn't that correct?

17 A: I would not interpret it that way.

18 Q: Okay. That's interesting. I want to read it  
19 one more time. The Plan at a minimum must  
20 include standards. You agree that the Plan  
21 must include standards?

22 A: Yes.

23 Q: You would also agree that those standards would  
24 be for distribution of healthcare facilities,  
25 right?

1 A: Correct.

2 Q: And we've determined that's hospital, correct?

3 A: Right.

4 Q: So now if we're talking about a hospital, the  
5 Plan at a minimum must include standards for  
6 distribution of hospitals, that is clearly  
7 implicit in the Act, right?

8 A: Yes, I would agree with that. Yes.

9 Q: And those standards must include, it says  
10 standards for the distribution of healthcare  
11 facilities including, that's not a suggestion,  
12 that's a directive, isn't it?

13 A: Our interpretation is that the Legislature  
14 mandated that the Department develop standards  
15 and criteria for healthcare services, and this  
16 includes some of the things that you mentioned;  
17 utilization, occupancy, etcetera. We take the  
18 travel time into consideration when we're  
19 developing the service areas. But no, there is  
20 not a specific time, travel time criteria  
21 listed in every section of the Plan.

22 Q: There should be, though, shouldn't there?

23 A: I would not agree to that.

24 Q: DHEC's interpretation is that they don't have  
25 to do that; is that a fair statement?

1 A: It is that we were mandated to develop a Plan  
2 and we are given the ability to incorporate the  
3 items that are -- like the utilization, the  
4 occupancy, regionalization. But no, we did not  
5 interpret that to mean that there had to be a  
6 travel time standard for every section of the  
7 Plan.

8 Q: Okay.

9 A: And that's been the way since before I was  
10 here.

11 Q: And that's the way you do it today?

12 A: It's been done that way since 1980, excuse me,  
13 since whenever this section was added to the  
14 law. I believe it was somewhere around 1992,  
15 '93 when the regs were changed and this was  
16 added. So since this was added to the Plan it  
17 has been interpreted that way.

18 Q: The reason this section of the Plan was  
19 included was basically to mandate that the  
20 Board follow a Plan; isn't that correct?

21 A: Prior to the law change, staff has always been  
22 bound by the Plan. The Department, excuse me,  
23 the Board used to have the ability to declare  
24 a public health emergency and approve an  
25 application that was not consistent with the

1 Plan. And that ability was removed when the  
2 law was amended somewhere around 1993. But I  
3 can't say that this section was specifically  
4 added to address the Board's abilities.

5 Q: All right. Well, let's say what we can agree  
6 to. Prior to this change in the Act in the  
7 early 1990s the Board could deviate from the  
8 Plan and approve applications that were not  
9 consistent with the State Health Plan, correct?

10 A: That is correct.

11 Q: After the change in the Act, the Board can no  
12 longer do that?

13 A: Correct.

14 Q: Then we'll let the Court conclude what the  
15 rationale for that was. All right. Let's look  
16 at Number Four. Again, the Plan at a minimum  
17 must include inventory, projection, standards,  
18 and Number Four is a general statement as to  
19 the project review criteria considered most  
20 important in evaluating Certificate of Need  
21 applications, correct?

22 A: Correct.

23 Q: You do not have projections for standards for  
24 the creation of a hospital articulated in the  
25 State Health Plan, do you?

1 A: There is not a specific articulation of  
2 standards that specifically say creation of a  
3 new hospital. The Department relies on the  
4 entire general hospital bed need section.

5 Q: Okay. In fact, you do not project a need for  
6 hospitals, you only project a need new beds;  
7 isn't that correct?

8 A: That is correct.

9 Q: Look in the State Health Plan over at II-75  
10 through II-78. What section of the Plan is  
11 this?

12 A: I'm sorry, it's not up yet.

13 Q: Okay. You've got a hard copy; did you know  
14 that you have a hard copy there?

15 A: I've got these Joint Exhibits but I don't know  
16 what is where.

17 **MR. SUMMER:** May I approach the witness, Your Honor.

18 **THE COURT:** Yes, sir.

19 Q: I just want to make sure that you can see and  
20 if you look in here go to Number Four, Mr.  
21 Shelton, Joint Exhibit Number 4. That will be  
22 your '08-'09 Plan. And that may be easier for  
23 you to read.

24 A: Yes, I am a Luddite as well, so yes, I'm more  
25 --



1 Q: I still prefer paper.

2 A: -- go with paper.

3 Q: That's the way I live. This is the ambulatory  
4 surgery section of the Plan, II-3 through II-  
5 78, correct?

6 A: Well --

7 Q: II-75. Did I misspeak? I apologize. II-75  
8 through II-78.

9 A: Well, actually the whole section goes through  
10 83 if you include the inventory and the  
11 footnotes.

12 Q: Correct. Explain to the Court what an  
13 ambulatory surgical facility is.

14 A: It's an outpatient facility. Patients cannot  
15 stay there overnight, except 23 hours, but it's  
16 designed to provide surgery, obviously on an  
17 outpatient basis. They are considered  
18 potentially cheaper because they don't have to  
19 offer the services that a hospital provides so  
20 they're -- they have some benefits of  
21 accessibility, they're easier for a patient to  
22 access going to a free-standing ASF versus  
23 going to the outpatient services within a  
24 hospital. So their benefits include  
25 accessibility. They tend to specialize in

1 certain types of care like Moore Clinic,  
2 they're all orthopaedic surgeons, they offer an  
3 ASF so they specialize in doing orthopaedic  
4 ambulatory surgery procedures, whereas the  
5 hospital outpatient department you might have  
6 an orthopaedic and then a gallbladder and then  
7 something else. And so, like I said, there are  
8 benefits to going there. From a hospital  
9 perspective they are sometimes viewed as  
10 cherry-picking, in other words, they take the  
11 patients that are insured or are easiest to  
12 care for and then leave the hospital with the  
13 uninsured or more complicated cases. And so  
14 there is not universal agreement on the  
15 benefits of an ASF depending on where you  
16 stand.

17 Q: It's fair to say that an ambulatory surgery  
18 facility is much smaller than a hospital?

19 A: Oh yes.

20 Q: Okay. And much less expensive to create,  
21 correct?

22 A: Yes, I agree with that.

23 Q: But they can only treat a certain number of  
24 types of surgeries, correct?

25 A: By regulation they are supposed to have an open

1 medical staff so if a gastroenterologist wanted  
2 to practice at Moore Clinic, then according to  
3 the law then Moore Clinic should allow him to  
4 practice there. But --

5 Q: That wasn't the focus of my question.

6 A: Oh, I'm sorry. I misunderstood you.

7 Q: Right. You couldn't do open heart surgery in  
8 an ambulatory surgery facility, could you?

9 A: Open-heart, no. I'm not aware of open heart  
10 being done on an ambulatory basis.

11 Q: Once again, let's get down to basics. You  
12 cannot keep a patient overnight, can you?

13 A: Correct.

14 Q: Are you familiar with the term acuity?

15 A: Yes.

16 Q: Okay. So higher acuity patients that have to  
17 be taken overnight can't go to an ambulatory  
18 surgery center for care?

19 A: Right. Those are the patients I was trying to  
20 explain to the Judge about those are the ones  
21 that the hospitals get because they're higher  
22 acuity, they're sicker, they can't be treated  
23 at an ASF.

24 Q: Let's just take a simple knee repair, where  
25 I've got a torn meniscus and I'm going to have

1 that repaired. That's typically a type of  
2 surgery that can be done in an ambulatory  
3 surgery facility, correct?

4 A: Yes.

5 Q: It also can be done in the outpatient surgery  
6 facility of a hospital, correct?

7 A: Correct.

8 Q: Okay. So what can be done for either surgical  
9 or medical patients -- what an ambulatory  
10 surgery center does is a small subset of  
11 surgery-only patients, correct?

12 A: There is a subset, yes. You can't do  
13 everything, right.

14 Q: Very limited population that can be serviced,  
15 we're talking about higher acuity patients that  
16 need surgery and/or hospital stays, there's  
17 only a small subset of what a hospital does  
18 that an ambulatory surgery center can see,  
19 correct?

20 A: Yes, I'll agree with that.

21 Q: There's been a great deal of concern about the  
22 adverse impact that an adverse impact that an  
23 ambulatory surgery centers can have especially  
24 on community hospitals; would you agree with  
25 that?

1 A: That concern has been expressed, yes.

2 Q: And the Department has been sensitive to that  
3 concern; has it not?

4 A: Yes.

5 Q: And it's not unusual for a hospital, especially  
6 a rural hospital, to oppose the construction of  
7 an ambulatory surgery center in a community,  
8 correct?

9 A: I would have to go back and look at the  
10 applications we've received because, quite  
11 frankly, in the last few years the number of  
12 ASF applications we've received have decreased,  
13 but, I would say prior to the last five years  
14 there was a lot more objection from hospitals  
15 when ASFs were approved in general. I can't  
16 give you specific percentages.

17 Q: And their concern was that the diversion of  
18 those patients and that revenue, especially  
19 from the paying patients, would adversely  
20 impact the hospital, correct?

21 A: Yes. In the 2004-2005 Plan there was a -- when  
22 we did the draft Plan, there was a proposal to  
23 put a moratorium on the approval of new ASFs.  
24 So back six or seven years ago, yes, there was  
25 more concern. That concern has not been

1 expressed, at least in part, because we've  
2 received very few ASF applications in the last  
3 few years.

4 Q: Well, you also have tightened up the criteria  
5 at least through, I don't want to talk about  
6 the current Plan, --

7 A: Okay.

8 Q: -- but at least through the '08-'09 Plan. Look  
9 at Number Ten on II-77.

10 A: Okay.

11 Q: In no case can more than one ASF in a county be  
12 approved at a single time; do you see that?

13 A: One new one, yes.

14 Q: Right. And then go up to Number Nine above it.  
15 Okay?

16 A: Okay.

17 Q: Before an application for a new ambulatory  
18 surgery facility can be accepted for filing all  
19 existing ambulatory surgery facilities in the  
20 county where the proposed facility is to be  
21 located must have been licensed and operational  
22 for an entire year; do you see that?

23 A: Yes. Uh-huh (affirmative response).

24 Q: And submitted data on the Department's annual  
25 questionnaire to allow for a determination of

1           their utilization, correct?

2   A:   Correct.

3   Q:   This is an effort to make certain that there's  
4       enough need before you do a new ambulatory  
5       surgery center, correct?

6   A:   Need plus looking at the impact on the existing  
7       providers.

8   Q:   Because you open up a new one and it's going to  
9       take volume away from the hospital or other  
10      ASFs in the community, correct?

11   A:   There is that potential, yes.

12   Q:   And we want those facilities to operate at an  
13      optimum level, in other words we want them to  
14      operate at a optimum utilization level to  
15      ensure that there's a return on investment and  
16      to ensure that there are prevalent resources,  
17      in terms of staffing and everything else, for  
18      those facilities, correct?

19   A:   Once the facility is licensed, yes, we would  
20      want them to succeed.

21   Q:   And when you look at this data a year later,  
22      they're going to have to be operational for a  
23      year. Let's take this logically. If only one  
24      can be approved at a time and it's got to be  
25      constructed, correct?

1 A: Correct.

2 Q: And generally that's going to take about a  
3 year?

4 A: I would accept that.

5 Q: So from the time it gets approved it's going to  
6 take at least a year to be opened and then  
7 you're going to need a year of data, correct?

8 A: Correct.

9 Q: And that data is then going to have to be put  
10 on a joint annual report and submitted to DHEC,  
11 correct?

12 A: Correct.

13 Q: All right. And joint annual reports go through  
14 September 30 of a given year, correct?

15 A: They are actually done on the facility's fiscal  
16 year. The American Hospital Association sets  
17 up their JARs -- I'm sorry, should I explain  
18 the JARs?

19 Q: Sure, I think that's a good idea.

20 A: We have what's called the JARs, the Joint  
21 Annual Report, so J-A-R is the acronym. It  
22 started for hospitals, it's done between  
23 ourselves at DHEC, ORS, which is part of the  
24 State Budget and Control Board, and South  
25 Carolina Hospital Association. So that's kind

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1 of how it became the Joint Annual Report.  
2 Because the American Hospital Association has  
3 an annual statistical report that they want  
4 from hospitals and we needed statistical data  
5 to use in the CON program, so there was an  
6 agreement between the three entities to create  
7 one standard report that would meet AHA's need  
8 and our need. So that's how the JAR started;  
9 it started with hospitals. But we now collect  
10 them for all of the types of facilities that we  
11 cover under the CON programs. We have nursing  
12 homes, we have utilization data from linear  
13 accelerators, it's a little over 500 reports  
14 that we get every year. So they're sent out  
15 January or February of a year to cover the  
16 previous year's data, so right now we are  
17 getting ready to send out 2011 JARs to all 500-  
18 odd healthcare facilities in the state. So we  
19 leave it up to the provider to give us 12  
20 months of data. Some of them maintain their  
21 data on a calendar year basis, some of them do  
22 it on the federal fiscal year basis. So it's  
23 just basically we want the last fiscal year's  
24 worth of data from the facility. So about half  
25 the hospitals in the state give us October 1st

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1 through September 30th and the other half do  
2 January 1st through December 31st. MUSC is on  
3 the state year so they go July 1st through June  
4 30th of every year. But essentially what we  
5 get is 12 month's worth of data from the JAR is  
6 what we use to input into the Excel  
7 spreadsheets where we make the calculations  
8 that we use for projecting need in the Plan.  
9 So yes, we have to get a year's worth of JARS  
10 data from a facility before we would, under  
11 this Plan, consider another applicant in that  
12 county.

13 Q: And you would agree with me that the JARS are  
14 essential for you in order for you to evaluate  
15 the utilization of existing resources and then  
16 to project into the future what the need is  
17 going to be for those resources, fair  
18 statement?

19 A: Yes. We use the utilization data to generate  
20 the future need calculations.

21 Q: Going back to Number Nine, it continues to  
22 discuss the data and it says the data will not  
23 be prorated or projected in the future but  
24 based upon or based on actual utilization. You  
25 want a full year of hard data on an ASC before

1 you'll look at creating another one in that  
2 service area, fair statement?

3 A: Under the previous Plans there was not that  
4 statement and we had applicants that were  
5 giving us two or three years, excuse me, two or  
6 three months worth of data and prorating it out  
7 a year and trying to say that this is what's  
8 the utilization. And so in this Plan we made  
9 it explicit that we needed a full year of JARS  
10 data and that we would not accept prorated or  
11 projected numbers, we wanted the actual full  
12 year's worth of data from the provider.

13 Q: And you previously testified the reason you  
14 want to know that is you want to see how is  
15 that new facility being utilized and what is  
16 the negative impact it may be having on  
17 existing providers, correct?

18 A: Look at the impact, yes, correct.

19 Q: Correct. Okay. So we're looking at what  
20 adverse impact occurs. The way this is  
21 structured, okay, from the time that one ASF is  
22 approved takes a year or more of construction  
23 and got to have a year of full reportable data.  
24 It's probably two and a half or three years  
25 before you could accept another application in

1 that service area under this criteria, under  
2 these standards; wouldn't you agree with that?

3 A: Under this particular Plan, which is why things  
4 were later modified. But since we're dealing  
5 with the '08-'09, yes. Under this Plan, yes.

6 Q: Okay. Well y'all do change things from time to  
7 time, don't you?

8 A: Right. There was the current Plan that we're  
9 under effect right now. This particular --  
10 there was a new section added that addressed  
11 counties with greater than 100,000 population  
12 so the one-year wait was waived for those  
13 counties because the concern that was expressed  
14 was that if you just -- take York County as an  
15 example, purely hypothetical, but if you're  
16 trying to decide between a group of eye  
17 surgeons proposing to locate in Fort Mill and  
18 some orthopods looking to locate in Rock Hill,  
19 those two organizations are not going to take  
20 the same patients, they're not going to  
21 interact at all. And so one of them would have  
22 to wait two to three years to build an ASF  
23 because a group of orthopaedic surgeons 20  
24 miles down the road were building an ASF. So  
25 that's why we modified the criteria for the

1 largest counties where you would be most likely  
2 to have that kind of situation, that the wait  
3 is no longer there. So yes, that is an example  
4 of how the Plan does get modified over time.

5 Q: You'd agree with me that because physicians  
6 typically own ASFs, that this has been an topic  
7 of substantial comment and debate in the State  
8 Health Plan process, correct?

9 A: At times. Some years it is, some years it  
10 isn't. And I would also qualify that some of  
11 them are physician-owned, some of them are  
12 corporate, some of them are joint ventures.  
13 But yeah, physicians, a good percentage of the  
14 ASFs do have physician ownership.

15 Q: You've now testified that we want to monitor  
16 the utilization and the adverse impact, which  
17 is why we're doing these things one at a time,  
18 not approving a bunch of them, because we're  
19 concerned about what impact it may have on  
20 hospitals, correct?

21 A: Yes.

22 Q: Okay. Is it not counterintuitive to you that  
23 you don't have a concomitant section in the  
24 State Health Plan for the creation of a new  
25 hospital because wouldn't a new hospital have

1 a much greater adverse impact on existing  
2 providers than a small ambulatory surgery  
3 center?

4 A: I'm sorry, Mr. Summer, could you say that  
5 again? I'm sorry.

6 Q: We previously agreed ambulatory surgery centers  
7 are small healthcare facilities that do very  
8 simple surgeries, agreed?

9 A: Agreed.

10 Q: Okay. We've also agreed that hospitals have  
11 higher acuity patients, see a much larger  
12 patient population than an ambulatory surgery  
13 center, correct?

14 A: Yes.

15 Q: They see people with pneumonia, correct?

16 A: Correct.

17 Q: They see people with heart disease, don't they?

18 A: Yes.

19 Q: They see trauma victims, don't they?

20 A: Some, yes. Uh-huh (affirmative response).

21 Q: Well, they see emergency patients?

22 A: Correct. Yes.

23 Q: All right. Who have injuries, correct?

24 A: Yes. Uh-huh (affirmative response).

25 Q: So I've got medical and surgical patients of

1 all types that are seen in a hospital?

2 A: Agreed.

3 Q: Okay. Isn't it logical that building a new  
4 hospital, a brand new hospital in a service  
5 area, and where it is located would have a far,  
6 potentially far greater impact than adding an  
7 ASF to that service area?

8 A: There is that potential; yeah. A lot of it is  
9 market-specific as to what type of impact it  
10 would have.

11 Q: But conceptually from a planning perspective?

12 A: Yes.

13 Q: A new hospital is going to hurt an existing  
14 hospital financially far greater than a new  
15 ambulatory surgery center?

16 A: The potential is greater for more types of  
17 patients being taken away by a new hospital  
18 than would be taken away by a new ASF.

19 Q: Okay. And that is not just in financial terms,  
20 it's also in staffing terms, isn't it?

21 A: I'm sorry. You're saying a new hospital would  
22 take more staff away than a new ASF?

23 Q: Yes.

24 A: There would be that concern that, yeah, there  
25 could be competition for staff, yes.

1 Q: Okay. But the Plan doesn't have a standards  
2 section for the creation of a new hospital,  
3 does it?

4 A: No, we do not specifically say this is the  
5 standard for a new hospital.

6 Q: Let's look at what you do do. You do beds; is  
7 that a fair statement?

8 A: Yes, sir. Uh-huh (affirmative response).

9 Q: And you only project bed need, correct?

10 A: Yes. Uh-huh (affirmative response).

11 Q: You do not project need for new facilities?

12 A: No.

13 Q: You would agree with me distribution, i.e., the  
14 location of a hospital is important from a  
15 health planning perspective, isn't it?

16 A: Yes, that would be one of the things we would  
17 consider, yes, sir.

18 Q: When we took your deposition, your testimony  
19 was we don't want all the hospitals clustered  
20 in an urban area. We'd like to get them to  
21 where there are medical underserved people, do  
22 you remember that testimony?

23 A: I don't remember that being hospitals. I  
24 thought we were talking about nursing homes and  
25 dialysis centers when we talked about trying to



1 locate them in areas that -

2 Q: So you're telling me it's more important to  
3 have a nursing home in a medically underserved  
4 area than a hospital?

5 A: No, sir. I was saying that when we had the  
6 discussion about allocating services rather  
7 than clustering them in one area, I believe  
8 that was the section of my deposition where we  
9 talked about nursing homes used to be  
10 consolidated. For example, in the Pee Dee, all  
11 of the nursing homes were clustered around  
12 Florence so people from the surrounding  
13 counties had to come to Florence and bed need  
14 projected the encouraged nursing homes closer  
15 to the communities they were built, where the  
16 patients lived. We also talked about dialysis  
17 centers because people used to have to come to  
18 the major metropolitan areas to receive  
19 dialysis and what we did in the Plan was  
20 encourage the development of the dialysis in  
21 the smaller, or rural counties so that the  
22 patients had access and did not have to come to  
23 the cities several days a week for dialysis.  
24 I'm just saying that's where I believe our  
25 discussion was about distribution, not about

1 hospitals.

2 Q: So, but you agree that the same logic applies  
3 to hospitals, wouldn't you?

4 A: I wouldn't dispute that.

5 Q: You would not dispute that. That's another way  
6 of saying you would agree?

7 A: Yes, I would agree. Just trying to give you a  
8 little variety.

9 Q: All right. Well, thank you. The Court of  
10 Appeals likes the same things.

11 A: Okay. I will keep that in mind.

12 Q: And my purpose in talking about this is simply  
13 that creating access, creating opportunities  
14 for like medically underserved populations, the  
15 poor, people who don't have access to  
16 transportation, those are things that we want  
17 to see encouraged in the development of our  
18 healthcare delivery system under the  
19 certificate of need program, correct?

20 A: Agreed.

21 Q: Okay. Let's look at the bed section in the  
22 Plan now. I believe it starts -- again, we're  
23 in Joint 4. We're on II-4. Is this where the  
24 federal section begins?

25 A: 2008-2009, yes, it starts on II-4.

1 Q: Okay. And you will recall, well first of all,  
2 let's do this. This is the bed need section of  
3 the Plan, is that a fair statement?

4 A: Yes, it's the general acute beds, yes.

5 Q: We have established we don't have a hospital  
6 need section, we have a bed need section,  
7 correct?

8 A: That's correct.

9 Q: Now, I think what would be good for the Court  
10 is for you to explain the bed need section, how  
11 you look at the inventory, how you evaluate  
12 utilization and how you project into the future  
13 about who's going to need beds and where  
14 they're needed.

15 A: Okay. The actual calculations meet the  
16 methodology explain how we calculate the need  
17 for possible need for beds starts on II-7. So,  
18 Section Eight, would explain that calculations  
19 are made for individual hospitals. That has  
20 changed over time. We used to calculate by  
21 county. Now, we calculate for the individual  
22 hospitals and then we take the bed need for all  
23 of the hospitals in a given county and sum them  
24 to get the overall bed need for the county.  
25 So, this may be easier if I tried explaining it

1 on the Excel calculations. That might make it  
2 a little easier to try and follow what I'm  
3 saying. So, if you don't mind, let me find the  
4 county that I pulled easily -- II-12. That's  
5 the first page of Excel calculations.

6 Q: Okay.

7 A: And let's see. Let me see if it would be  
8 easier to do here or here. Okay. At the top  
9 of the page you see Region I and you've got  
10 AnMed Healthcare, AnMed Medical Center and then  
11 AnMed Women's and Children's Hospital. Those  
12 are the two existing hospitals in Anderson  
13 County.

14 Q: Okay.

15 A: We have three separate age categories. You see  
16 under 18, 18-64 and 65 and above and then  
17 there's a total.

18 Q: We refer to those as age cohorts, don't we?

19 A: That is correct.

20 Q: Thank you. So, cohort is a subset?

21 A: Yes, a grouping of. So, under the 2006  
22 population, you can see it's 42,240 under 18  
23 patients in the Anderson County, etcetera, just  
24 adding those up, it winds up with being 173,710  
25 total patients and that is in 2006. So, that

1 is the baseline population that we used in the  
2 calculations.

3 Q: And that's a real number. That's an existing  
4 population base, correct?

5 A: That -- those are the projected populations  
6 according to the state demographer for that  
7 year.

8 Q: Well, hang on a minute. We're on the '08-'09  
9 Plan, right?

10 A: Correct.

11 Q: And the state demographer is part of the Office  
12 of Research and Statistics, correct?

13 A: Correct.

14 Q: Of the Budget and Control Board?

15 A: Correct.

16 Q: So, and I may have this wrong, but isn't the  
17 2006 number basically what we would say the  
18 official estimate of the existing population in  
19 2006?

20 A: Correct. It's based off of the 2000 census  
21 numbers. ORS, or excuse me, state demographer  
22 just projects every year from the 2000 census  
23 number. So, they projected that this was the  
24 number. They don't do an actual count every  
25 year, so this is the official state

1 demographer's numbers for 2006. They said the  
2 total, projected total of 173,710 people in  
3 2006.

4 Q: All right.

5 A: The next column is 2013 and it's also the  
6 demographer's projection. So, it adds up to  
7 185,160 so between 2006 and 2013, the state  
8 demographer thinks there's going to be almost  
9 12,000 additional people in Anderson County.

10 Q: Okay.

11 A: The next column is the 2006 patient days. And  
12 this is the data that's taken from the JARS  
13 that we referenced earlier. We get a JAR from  
14 AnMed Medical Center, we get a separate JAR  
15 from AnMed Women's and Children's. So, we take  
16 the utilization by each of those hospitals, so  
17 AnMed provided a total of 81,213 patient days.

18 Q: Let's talk a little about patient days. That's  
19 not average daily census, that's total number  
20 of patients that you had during the year and  
21 the number of days that those patients were in  
22 the hospital, correct?

23 A: That is correct.

24 Q: Thank you. So, that's the actual number of  
25 days that patients were there total?

1 A: Correct.

2 Q: Okay.

3 A: So, there are a little of 81,000 patient days  
4 at AnMed and I believe that's 9,230 patient  
5 days at Women's and Children's. And  
6 unfortunately because of space concerns there  
7 are a couple of columns that get hidden, so  
8 that's why people sometimes have a little  
9 trouble understanding the calculations. But,  
10 what is hidden is that we take the 2006 patient  
11 days for each of the age cohorts, so there are  
12 2,734 patient days in the under 18 population  
13 at AnMed Health Medical Center in 2006.

14 Q: And that's because people who are 18 and under  
15 are the lowest utilizers of impatient  
16 facilities, aren't they?

17 A: That's correct.

18 Q: They're healthy?

19 A: Correct.

20 Q: Okay.

21 A: We divide that 2,734 by the 2006 population of  
22 42,440 and that gives us a use rate and I don't  
23 know what it is because the column is hidden,  
24 but we do that for the other two age cohorts as  
25 well. So, there's a use rate for the under 18,

1. a use rate for the 18 to 64 and a use rate for  
 2. the 65 and over based on 2006 numbers; this was  
 3. the use rate for 2006. Then, what we do is we  
 4. take those use rates and apply them against the  
 5. 2013 population projections. Essentially, what  
 6. we're saying is if their use in 2006, if the  
 7. use rates stay the same, in 2013, this is how  
 8. many patient days they're going to have. And  
 9. that column's hidden, so you don't get to see  
 10. what the actual numbers are, but what we then  
 11. do is we divide that number by 365, also  
 12. hidden, and that gives you the next column  
 13. which says "Proj ADC". That's the projected  
 14. average daily census.

15. Q: And what it's going to be to service that  
 16. future population in 2013?

17. A: Yeah. What we're saying is if the 2006 use  
 18. rates stay constant, then in 2013, on an  
 19. average day, average daily census, there are  
 20. going to be eight patients that are under 18  
 21. years of age at AnMed Health. It would be  
 22. about 120 of 18 to 64 and I'm sorry, I can't  
 23. even decipher that number. I think it's 119  
 24. that are 65 and over so that's going to give  
 25. you an average daily census of 246. We project



1 in 2013 there are going to be 246 people in the  
2 hospital on a daily basis. And then we have to  
3 figure out how many beds the hospital actually  
4 needs to service that average daily census.  
5 That's the next column that says "Percent Occ".  
6 We have three different occupancy factors that  
7 we use and they're dependent on the size of the  
8 hospital and it's explained on II-6, the bottom  
9 section, number four narrative, the last three  
10 things down there. It says 0 to 174 is 65  
11 percent, 175 to 349 is 70 percent, and  
12 hospitals greater than 350 beds are 75 percent.  
13 So, we have different occupancy factors because  
14 smaller hospitals have less flexibility to  
15 handle spikes in utilization. Utilization goes  
16 up in winter because of flu. It's lesser in  
17 the summer. It's lesser on weekends. But they  
18 need a certain number of beds to be able to  
19 handle the maximum number of patients that  
20 they're likely to have. So, bigger hospitals  
21 have more flexibility. Five percent for  
22 Palmetto Richland is a lot different than five  
23 percent for Bamberg. They just have a lot more  
24 flexibility so therefore, we require the bigger  
25 hospitals to be at a higher occupancy rate

1 before we think they need to add more beds.  
2 So, smaller hospitals have to project to be at  
3 65 percent occupancy before the bed need  
4 methodology would show additional beds needed.  
5 The medium-sized ones would be 70, the big ones  
6 like Richland have to be at least 75 percent.  
7 So, that's what the occupancy factor does using  
8 AnMed as the example.

9 Q: Before we leave the occupancy factor, can I ask  
10 you a couple of policy questions?

11 A: Sure.

12 Q: Isn't what you're doing as an agency in order  
13 to promote cost containment, you're trying to  
14 make sure that before a hospital spends  
15 millions of dollars adding beds, that it really  
16 needs them, correct?

17 A: I would agree with that, yes.

18 Q: And because the more capital we add in the  
19 healthcare delivery system, the greater the  
20 ultimate costs are going to be to the patient,  
21 correct?

22 A: I'll accept that, yes.

23 Q: Okay. So, again, that's part of why your  
24 agency is trying to guide that effective  
25 establishment of healthcare facilities?

1 A: Yes.

2 Q: One reason.

3 A: Agreed.

4 Q: All right. Go ahead.

5 A: Okay. So, using AnMed as the example again,  
6 they're projected average daily census for 2013  
7 is 246 beds. You look over a couple columns,  
8 you can see "Exist beds". The number of  
9 existing licensed beds. So, we calculate bed  
10 need based on licenses bed, not set up and  
11 staffed beds. Some hospitals may have beds  
12 that are, you know, offline. They've converted  
13 them into offices or other things, but they  
14 still have the hook ups, etcetera, that allow  
15 them to be licensed. But we calculate it on  
16 the actual licenced capacity, not the ones  
17 they've set up and staffed. So, AnMed has 423  
18 existing licensed beds as of the date of the  
19 Plan. They're projected average daily census  
20 is 246 and divide that by 75 percent, that  
21 gives you a total projected bed need for 2013  
22 of 329 beds. They already have 423 existing  
23 beds, so we project that for 2013 AnMed has 94  
24 more beds than they need to serve their  
25 projected average daily census. Same thing

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1 with AnMed Women's and Children's. You go  
2 through all the calculations and you wind up  
3 with negative 28 beds needed. So then the last  
4 thing we do is we sum the numbers for the  
5 county, so you see an Anderson County total,  
6 there's a total bed need for the county of 373  
7 beds, there's a total existing of 495, so  
8 overall Anderson County has 122 more beds than  
9 we think they're going to need for 2013 and the  
10 calculations are pretty much the same for other  
11 parts of the state, that's just how the  
12 calculations are done.

13 Q: Anderson is going to have to increase their  
14 utilization before they're going to have a need  
15 for any more beds, aren't they?

16 A: Significantly.

17 Q: Right. So, I mean, it's fair to say we can  
18 look and say that in the foreseeable future,  
19 Anderson's got plenty of beds?

20 A: Agreed.

21 Q: Okay. I assume, we can just briefly touch on  
22 this, but changes in the healthcare delivery  
23 system oftentimes affect why we have some of  
24 these over-bedded situations, don't they?

25 A: Right. I mean surgery is a good example.

1 Twenty years ago, everyone got admitted the  
 2 night before. I mean I've had five knee  
 3 operations and was always admitted the night  
 4 before, stayed a couple of days after. Now  
 5 knee surgery is done on an outpatient basis for  
 6 anything that isn't a high acuity-kind of  
 7 thing. Like if the person has concerns about  
 8 anesthesia or something like that where it  
 9 would be better to do them in a hospital, but  
 10 a lot of that is also reimbursement-driven.  
 11 The insurers aren't going to pay for you to  
 12 stay in the hospital for three days after your  
 13 knee surgery, so obviously you're not going to  
 14 be there.

15 Q: Patient choice also figures into this too,  
 16 doesn't it?

17 A: Patients are guided -- yeah, patients do have  
 18 choice. They tend to be guided either by their  
 19 physicians or their insurers. Because some  
 20 insurers have agreements with certain hospitals  
 21 or other providers and if you go in the  
 22 network, you only pay a smaller percentage, but  
 23 if you decide to go out of network, it's your  
 24 choice. You can go to another provider, but  
 25 you're going to have to pay a bigger percentage

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1 of that cost yourself out of pocket. So yeah,  
2 you do have choice but sometimes there are  
3 constraints put upon your choice.

4 Q: Well, everybody in Anderson doesn't go to  
5 AnMed, correct?

6 A: Correct.

7 Q: There is significant out-migration to  
8 Greenville Hospital System as well?

9 A: I would presume so, yes.

10 Q: Okay. So, people or physicians are going to  
11 affect where they end up for that care?

12 A: Correct.

13 MR. SUMMER: I think this is probably a good time  
14 for a break, if that's all right.

15 THE COURT: Ten minutes. We will be in recess.

16 (Off the Record)

17 Q: All right. I think we have now gone through  
18 the bed need calculations. Again, the reason  
19 I'm asking you about what Ms. Brandt testified  
20 is I really would like to narrow the scope of  
21 testimony. One of the conclusions she agreed  
22 with me on is that the only way that Roper,  
23 from the Department's perspective, okay? From  
24 the Department's perspective, the only way that  
25 Roper can build a hospital in Carnes Crossroad

1 is to attempt to utilize the bed transfer  
2 section which begins on II-9 of the '08-'09  
3 Plan, would you agree with that?

4 A: I hate to do this to you, but can you say that  
5 one more time?

6 Q: Let's do it this way. Rather than trying to  
7 repeat the question. Turn with me quickly to  
8 II-18.

9 A: Okay.

10 Q: We'll just walk through it. We're in, again,  
11 Joint 4, II-18. The service area involved in  
12 this case is a three county service area,  
13 correct?

14 A: That is correct.

15 Q: Berkeley County is not the service area under  
16 the Plan, is it?

17 A: Correct.

18 Q: Okay. So the service area is Berkeley,  
19 Charleston, Dorchester as one single geographic  
20 unit, correct?

21 A: Right. Utilization for those three counties is  
22 summed to create a total for the service area.

23 Q: Trident has a bed need of how much under this  
24 Plan?

25 A: This Plan, 56 additional beds.

1 Q: Summerville has a bed need for how many?

2 A: Twenty-four.

3 Q: And based on your prior testimony, it's because  
4 the use rate at those facilities is high enough  
5 to generate a bed need, correct?

6 A: Correct. Their 2006 utilization was sufficient  
7 that if that rate stayed the same in 2013, they  
8 would need additional beds to serve their  
9 projected average daily census.

10 Q: Okay. How about -- and I see Charleston  
11 Memorial, they are off the Plan horizon because  
12 they are closed; is that correct?

13 A: Their beds were transferred to MUSC, yes.

14 Q: Okay. And MUSC has a negative bed need of 65  
15 under this Plan, correct?

16 A: Correct.

17 Q: Roper and Roper Mount Pleasant has a negative  
18 bed need of six?

19 A: That's correct.

20 Q: Bon Secours-St. Francis, also part of the Roper  
21 System, has a negative bed need of 17, correct?

22 A: Correct.

23 Q: Those facilities are jointly owned, aren't  
24 they?

25 A: That's my understanding, yes.



1 Q: There's an alliance that owns all of these  
2 hospitals, correct?  
3 A: Yes.  
4 Q: And East Cooper Medical Center has an excess of  
5 40 beds?  
6 A: Correct.  
7 Q: The planning region has an excess of 48 beds?  
8 A: Yeah. That's correct.  
9 Q: Okay. You would agree with me that under this  
10 Plan, Roper cannot add beds to any of its  
11 current facilities, can it?  
12 A: Add beds, no.  
13 Q: No. And that would be inconsistent -- any  
14 application that sought to add beds would be  
15 inconsistent with the State Health Plan,  
16 correct?  
17 A: We would not approve it.  
18 Q: Could not approve it. Okay. If they had -- so  
19 now, let's go back to Section J under II-9.  
20 I'm fully aware of the Department's  
21 interpretation of this language. And my  
22 question to you is, under the Department's  
23 interpretation of this language, the bed  
24 transfer section beginning in II-2 Section J,  
25 one through eight, this is the only mechanism

1           that the Department recognizes that Roper could  
2           apply to build a new hospital somewhere,  
3           correct?

4       A:    I cannot say that's the only way the Department  
5           -- the reason is I'm not familiar with any  
6           application that attempted it by any other  
7           method, so I would say that the Section J, that  
8           starts on II-9 and goes through II-10 is what  
9           I am familiar with applicants relying upon in  
10          order to transfer beds to create a new  
11          hospital.

12       Q:   Okay.   You are the person at the Department  
13           principally responsible for the promulgation of  
14           this Plan, are you not?

15       A:    That's correct.

16       Q:    Are you aware of any other section of this Plan  
17           that Roper could have utilized to create a new  
18           hospital?

19       A:    Not that I can think of.   We do use the bed  
20           need section as a whole in reviewing the  
21           application, but, yeah, the Section J would be  
22           the part of the bed need section that Roper  
23           would rely on.

24       Q:    There's no positive bed need for Roper, right?

25       A:    That's correct.

1 Q: So they can't use a positive bed need to create  
2 a new hospital, can they?

3 A: Correct.

4 Q: All right. And if there's no positive bed  
5 need, this Section J is the only other section  
6 that the Department currently recognizes as  
7 being a mechanism for the creation of the new  
8 hospital?

9 A: There is no other language in the need  
10 projections.

11 Q: That would allow them to create a new hospital?

12 A: Correct.

13 Q: All right. Now that we've established this is  
14 the only way, I want to ask you a few  
15 questions, okay?

16 A: Okay.

17 Q: Since you cannot concur in the English language  
18 exercise we had with Ms. Brandt, let's you and  
19 I take a stab at it, all right?

20 A: Yes, sir.

21 Q: Okay. Changes in the delivery system due to  
22 healthcare reform have resulted in the  
23 consolidation of facilities in the established  
24 medical provider networks. Would you agree  
25 that the Palmetto merger was a consolidation of

1 facilities?

2 A: Yeah, a consolidation or merger, yes.

3 Q: That's an example of consolidation, right?

4 A: Yes.

5 Q: You're also aware that provider networks can be  
6 established between hospitals, they can  
7 affiliate themselves, correct?

8 A: Correct.

9 Q: The word facilities, is that singular or  
10 plural?

11 A: It is plural.

12 Q: And is plural in the English language one or  
13 more than one?

14 A: It's more than one.

15 Q: So, that language contemplates the  
16 consolidation of more than one facility, two or  
17 more, correct?

18 A: You would have to have two to consolidate, yes.  
19 A consolidation would have to be done by more  
20 than one entity.

21 Q: All right. Now, if you would please, briefly  
22 look back to II-4 in Joint 4. This is all part  
23 of the hospital bed need section, correct?

24 A: Correct.

25 Q: Okay. A hospital. This is A(1)(a). A

1 hospital, in quotation marks, means a facility.

2 Do you see that language?

3 A: Yes, sir. I do.

4 Q: Okay. So, when we go over to II-9 in J, that  
5 refers to hospitals, right?

6 A: Hospitals amongst other healthcare entities,  
7 yes. I'm sorry, no, you're right. In this  
8 particular section is related to hospital bed  
9 need, so, yes.

10 Q: This is hospitals.

11 A: I'm sorry, I was thinking of the definition of  
12 healthcare facilities, I'm sorry. This is  
13 related to hospital beds.

14 Q: Thank you. If we look at the word networks, is  
15 that singular or plural?

16 A: Networks is plural in this sentence.

17 Q: Okay. These consolidations and agreements may  
18 lead to situations where affiliated hospitals,  
19 do you see that word hospitals?

20 A: Yes, I do.

21 Q: Is that singular or plural?

22 A: It's plural.

23 Q: Is plural one or more than one?

24 A: More than one.

25 Q: So, it's two or more hospitals is what's

1 contemplated in this section, correct?

2 A: Yes, there are two or more hospitals.

3 Q: Okay. They may wish to transfer beds between  
4 themselves. Do you see that?

5 A: Yes.

6 Q: Okay. In order to serve their patients in a  
7 more efficient manner. A proposal to transfer  
8 or exchange hospital beds requires a CON and  
9 must comply with the following criteria. Would  
10 you turn with me over to page II-10.

11 A: (Witness does as instructed.) Okay.

12 Q: All right. Number one, a transfer exchange of  
13 beds may be approved only if there's no overall  
14 increase in the number of beds, correct?

15 A: Correct.

16 Q: In other words, I can't say I want to transfer  
17 20 beds from Baptist to Richland, but then add  
18 30 beds at Richland, it would have to be 20 for  
19 20, agreed?

20 A: I'm sorry, can you say that example again,  
21 please?

22 Q: You have to use existing beds; is that a fair  
23 statement? You can't use this section to use  
24 additional beds that don't already exist; isn't  
25 that how you read that?

1 A: I'm sorry, you said that this section cannot be  
2 used to generate additional beds beyond  
3 existing; is that what you said?

4 Q: Yes.

5 A: I would agree that Number One would not let you  
6 add more beds than currently exist.

7 Q: Okay. Number Two, such transfers may cross  
8 county lines. However, the applicant must  
9 document with patient origin data the  
10 historical utilization of the receiving  
11 facility, correct?

12 A: Right, and that's what the Department has  
13 interpreted the new facility to be.

14 Q: All right. And receiving facility, we've  
15 established now for purposes of this bed  
16 transfer section, that we did on the previous  
17 page, II-9, that facility means a hospital,  
18 correct?

19 A: Correct.

20 Q: Okay. And the receiving facility by residents  
21 of the hospital giving up beds. A facility is  
22 a hospital. Is there a Carnes Crossroads  
23 hospital currently in existence today?

24 A: No.

25 Q: Okay. Number Three, should the response to

1 criterion two fail to show a historical  
2 president of residents that the county  
3 transferring the beds utilizing the receiving  
4 facility, the applicants must document why it  
5 is in the best interest of these residents to  
6 transfer the beds to a facility with no  
7 historical affinity for them. So, it refers  
8 back to the historical utilization of the  
9 receiving facility as expressed in Number Two,  
10 correct?

11 A: Yes, it's saying if there isn't a historical  
12 precedence, then --

13 Q: You've got to tell me why you're trying to do  
14 what you're trying to do?

15 A: Right. It's not that -- yeah, you have to  
16 justify why -- if there's not a historical data  
17 to show it, then you need to be able to  
18 justify why it would be in the best interest to  
19 have the bed transfer.

20 Q: If you look at that phrase receiving facility,  
21 that's a hospital. The receiving hospital is  
22 a hospital, correct?

23 A: It will, it -- yes, it would be a hospital,  
24 yes.

25 Q: And that hospital has to have historical



1 utilization, you're going to have to review the  
2 patient origin data. The historical  
3 utilization of how patients accessed that  
4 hospital, correct?

5 A: Yeah. Yeah, that's the part where the  
6 Department has utilized the patient origin and  
7 historical utilization from the existing  
8 facility that's proposing to create the  
9 satellite facility. The Department has used  
10 the historical utilization from that facility  
11 to show the utilization for what's proposed to  
12 be the receiving facility.

13 Q: You would agree with me that there's not  
14 currently a hospital facility at the Carnes  
15 Crossroad property, correct?

16 A: I would agree there's only a proposed hospital  
17 for that location.

18 Q: So, you would agree with me no hospital  
19 currently exists at that location, correct?

20 A: No, there isn't an existing hospital at that  
21 site.

22 Q: Therefore, there is no historical utilization  
23 of that site, is there?

24 A: You can't have utilization from a facility  
25 until it's operational.

1 Q: Right. There can be no historical utilization  
2 data until the facility is operational,  
3 correct?

4 A: I would agree with that, yes.

5 Q: Okay. Look at Number Three. If -- should the  
6 response to criterion two fail to show a  
7 historical precedent of the residents of the  
8 counties transferring the beds utilizing the  
9 receiving facility, the applicants must  
10 document why it is in the best interest of  
11 these residents to transfer the beds to a  
12 facility with no historical affinity for them,  
13 correct?

14 A: Correct. Yes. So, in this particular case, it  
15 would be the county transferring the beds would  
16 be Charleston County because the beds are being  
17 transferred from Charleston to Berkeley County.

18 Q: Right.

19 A: So, the applicant would have to justify or  
20 document why it's beneficial to the residents  
21 of Charleston to have the Berkeley County  
22 hospital created.

23 Q: Number Three refers to a receiving facility,  
24 correct?

25 A: Which is what we have consistently interpreted

1 as the satellite, which we agree on.

2 Q: Let's do this. I'm not disputing what the  
3 Department's interpretation is.

4 A: Okay. That's good.

5 Q: Don't understand it, don't agree with it, but  
6 I'm not disputing it. What I want to do is  
7 simply ask what the language says. So, let's  
8 look at the receiving facility.

9 MR. LONG: Objection, Your Honor, if we ask him what  
10 the language is, the witness can tell him what  
11 the language is and that's what he's doing.

12 THE COURT: Well, what's your objection?

13 MR. LONG: I don't think he can direct the witness  
14 how to answer the question by telling him that  
15 certain phrases or sentences are off limits.

16 THE COURT: Well, in a sense, you're right, but I  
17 find that the witness is, in my judgement,  
18 being evasive by making long answers out of  
19 what simply could be answered yes or no. I'm  
20 going to overrule your objection.

21 Q: Second line of number three refers to the  
22 receiving facility, correct?

23 A: Yes, that's the way that it's written, yes.

24 Q: We've established that a facility under this  
25 section of the Plan is a hospital, correct?

- 1 A: Agreed.
- 2 Q: And that this language contemplates that a
- 3 hospital will receive the beds, correct?
- 4 A: Correct.
- 5 Q: Go to Number Four. The applicants must explain
- 6 the impact the transfer of the beds on the
- 7 healthcare delivery system of the county from
- 8 those beds were taken and negative impacts must
- 9 be detailed along with perceived benefits of
- 10 such an agreement. Is the word applicants
- 11 singular or plural?
- 12 A: It's plural.
- 13 Q: Is plural one or more than one?
- 14 A: It's more than one.
- 15 Q: So, it contemplates at least two or more
- 16 applicants, correct?
- 17 A: Yes, it is -- the language was written to be as
- 18 broad and flexible as possible, so, yes,
- 19 applicants is the wording, yes.
- 20 Q: That contemplates two or more applicants,
- 21 correct?
- 22 A: Yes. Correct.
- 23 Q: Go next to Number Five. The facility receiving
- 24 the beds. We've established that the word
- 25 facility in this section means hospital,

1 correct?

2 A: Agreed.

3 Q: We've also established that there is no  
4 existing hospital at the Carnes Crossroads  
5 property, correct?

6 A: Correct.

7 Q: So, there is no facility to receive the beds at  
8 Carnes Crossroads as we stand here today, is  
9 there?

10 A: Not as we stand here today, no, sir.

11 Q: Okay. This is interesting, too, Number Five,  
12 the facility receiving the beds must  
13 demonstrate the need for additional bed  
14 capacity, would you agree with me that  
15 additional is more? Is something more than  
16 what currently exists?

17 A: Correct. Now, there is no bed capacity in  
18 Berkeley County.

19 Q: Berkeley County is not a planning region, is  
20 it?

21 A: No, sir. But that's where the applicant is  
22 proposing to transfer the beds to.

23 Q: Well, for decades your agency consider Trident  
24 as the provider of services for Dorchester and  
25 Berkeley County, didn't it?

- 1 A: That's my understanding, yes.
- 2 Q: Let's make this clear. This is -- let's go
- 3 over real quickly and look at Joint Exhibit
- 4 Number 6 please.
- 5 A: Six.
- 6 Q: Joint Exhibit Number 6.
- 7 A: Okay.
- 8 Q: This is the 2001 South Carolina Health Plan, is
- 9 it not?
- 10 A: Yes. Uh-huh (affirmative response).
- 11 Q: And let's turn over to the inventory section,
- 12 II-17.
- 13 A: Okay.
- 14 Q: Look at II-17, that's the bed inventory from
- 15 the 2001 State Health Plan, correct?
- 16 A: Uh-huh (affirmative response).
- 17 Q: And if we look, if we see where Beaufort County
- 18 stops?
- 19 A: Yes. Uh-huh (affirmative response).
- 20 Q: And then you see the totals for
- 21 Berkeley/Dorchester County?
- 22 A: Yes, six. Yes, they are.
- 23 Q: Separate from Charleston, isn't it?
- 24 A: Yes, it is.
- 25 Q: What are the only two hospitals that the

1 Department recognized as serving those two  
2 counties in 2001?

3 A: In the 2001 Plan, it was Trident and  
4 Summerville.

5 Q: So, the Department has consistently,  
6 historically recognized that Trident and  
7 Summerville served those counties, correct?

8 A: Yeah. I would agree with that, yes.

9 Q: Trident Medical Center is technically in  
10 Charleston County, isn't it?

11 A: I believe it is North Charleston, about two  
12 miles or so from the border.

13 Q: But you still listed it as being the hospital  
14 for Berkeley and Dorchester Counties, didn't  
15 you?

16 A: In that Plan, we did, yes, sir.

17 Q: And in all previous Plans you did, too, didn't  
18 you?

19 A: Yes, we had that discussion, yes.

20 Q: And you have no idea why the Department changed  
21 that policy in 2003, do you?

22 A: No, that was done before I was the person in  
23 charge of doing the data, so I took it over  
24 with the 2004-2005 Plan and that's the way it  
25 was in the spreadsheet from the previous Plan,

1 and so, as I explained in my deposition, I was  
2 operating under the assumptions that was the  
3 way had been in Plans prior to the 2003 Plan.

4 Q: Let's go back to the English exercise in the  
5 2008-2009 Plan. That's II-10, is where we  
6 were.

7 A: Okay.

8 Q: The facility receiving the beds must  
9 demonstrate the need for additional capacity.  
10 Additional capacity assumes that capacity  
11 currently exists, doesn't it?

12 A: Either there is no capacity or --

13 Q: This assumes, Number Five assumes that  
14 additional capacity will -- the facility  
15 receiving the beds has to demonstrate the need  
16 for additional capacity. So, this criteria  
17 assumes that there already is some capacity at  
18 the receiving facility, doesn't it?

19 A: Yes, I believe that's the way it's worded, yes.

20 Q: Okay. And then it speaks to both historical  
21 and projected utilization. So, in order to  
22 have historical, you have to exist to have  
23 historical utilization at a receiving facility,  
24 wouldn't you?

25 A: I believe that is what I said in my deposition,



1 yes.

2 Q: Okay. I only want to mention Number Six  
3 because I believe it is going to come into play  
4 later in this case. Roper would not be able to  
5 utilize the loss of these beds to add beds  
6 downtown, would they?

7 A: That's correct. Once the beds are transferred,  
8 it's a permanent transfer, which I think is  
9 part of Number Eight, that it's a permanent  
10 transfer.

11 Q: And they would have to live with whatever the  
12 consequences of that decision are, won't they?

13 A: Yeah, which I think would be 266 beds left at  
14 their downtown facility.

15 Q: And that's a tertiary-care medical facility?

16 A: Right.

17 Q: With an open heart program?

18 A: Yes, they do offer open heart.

19 Q: They have a very successful open heart  
20 department, don't they?

21 A: I would have to look at the numbers to see how  
22 they're doing, but yes.

23 Q: Number Seven. First of all, have you reviewed  
24 the CON application in this case?

25 A: No, sir. I did not.

1 Q: Okay. You did attend project review however,  
2 didn't you?

3 A: Yes, I was at the project review. Yes.

4 Q: I'm going to ask you questions about the  
5 project review now. Well, we'll finish this  
6 first. A written contract or agreement between  
7 the governing bodies. Is the word bodies  
8 singular or plural?

9 A: It's plural.

10 Q: Does it contemplate one -- is plural one or  
11 more than one?

12 A: It's more than one.

13 Q: Okay. So, governing bodies would be two or  
14 more entities, correct?

15 A: Yes, I think in this case, I think the  
16 Department interpreted Roper being the body,  
17 but that was beyond the scope of my  
18 involvement.

19 Q: Correct. And I understand the Department's  
20 interpretation and my question doesn't go to  
21 the Department's interpretation.

22 A: Okay.

23 Q: It goes to the word bodies. Is it singular or  
24 plural?

25 A: It's plural.

- 1 Q: And plural is more than one, correct?
- 2 A: That's correct.
- 3 Q: And it contemplates two or more bodies, doesn't
- 4 it?
- 5 A: As written, yes.
- 6 Q: Okay. Of the affected facilities, is that
- 7 singular or plural?
- 8 A: Plural.
- 9 Q: Contemplates tow or more, doesn't it?
- 10 A: Agreed.
- 11 Q: Okay. Two or more facilities. And facilities
- 12 are hospitals, correct?
- 13 A: In this section yes, facilities are hospitals.
- 14 Q: And then Number Eight. Each facility giving up
- 15 beds must acknowledge in writing that this
- 16 exchange is permanent. Any further transfers
- 17 would be subject to the same process. That's
- 18 just a logical follow from Number Six, isn't
- 19 it?
- 20 A: That's correct.
- 21 Q: Okay. While we're in the Section Two -- keep
- 22 that opened. I know you don't agree with me on
- 23 the language of the statute, but I still want
- 24 to ask you a question. Do you have the copy of
- 25 the statute that I gave you?

1 A: Yes, I still do.

2 Q: It's 44-7-180. I didn't say it earlier for the  
3 record. That was the statute that has a  
4 process for appointing the Health Planning  
5 Committee and it also has the mandates for your  
6 Department to create a Plan, correct?

7 A: Yes, that's correct.

8 Q: And that Plan has to have certain minimum items  
9 included in it, correct?

10 A: Correct.

11 Q: And if we look, it says the Plan at a minimum  
12 must include, Number Three, standards for  
13 distribution and one of those standards of  
14 distribution says travel time, correct?

15 A: That's correct.

16 Q: And when you think of standards for  
17 distributions and travel time, that is  
18 typically expressed in the time it would take  
19 a patient to travel to get to the service or  
20 the facility; is that a fair statement?

21 A: That would be a reasonable definition, yes.

22 Q: Okay. If you look at II-11, the standard for  
23 travel time for general acute care hospitals in  
24 South Carolina is expressed as follows.  
25 General hospital beds are located within

1 approximately 30 minutes of travel time for the  
2 majority of the residents of the state. Would  
3 you agree with me that is the time travel  
4 standard mandated by the State Health Plan for  
5 hospital beds?

6 A: No. That if it was a standard, it would be  
7 listed with the need calculations. Because we  
8 have the standards, which are the A through J,  
9 etcetera. What you have on II-11 is the  
10 listing of the relative importance criteria at  
11 the top of the page. That paragraph is a  
12 general statement that Mr. Whiteside and I  
13 added and it's there, I think you'll find, for  
14 all other sections of the Plan. That's just a  
15 general statement as to the current status of  
16 hospitals in the state. It wasn't intended to  
17 be a specific criteria that hospitals needed to  
18 be located within 30 miles or 30 miles from  
19 existing. It was only a statement of this is  
20 what the current situation is in the state.  
21 And generally hospital services are available  
22 for the majority of people within 30 minutes  
23 travel time and they --

24 Q: How did you make that computation? What was  
25 the majority of the population? What number?

1 Was it 2.2 million? What was the number and  
2 how did you determine that that 2.1 or 2.2,  
3 whatever was a simple majority, how did you  
4 determine with 77 hospitals in the state of  
5 South Carolina that that number of people was  
6 in, one-way, 30 minute one-way travel time?  
7 I'm just curious?

8 A: Well, it was done in 1994 or 1995, so I can't  
9 be perfectly precise as to how we did it, but  
10 it involved looking at the existing hospitals  
11 that we had in the state at the time and  
12 looking at the population of each county and  
13 trying to determine which parts of the state  
14 were more than 30 minutes away from an existing  
15 hospital and northern Berkeley is an example.  
16 It's part of the state that is more, or was  
17 more, than 30 minutes travel time. But as far  
18 as a specific percentage, I can't tell you that  
19 it was 78 or 80 percent or whatever. Like I  
20 say, we just looked at it and stated that for  
21 the majority of people in the state, they have  
22 a hospital within 30 minutes travel time.

23 Q: Let's go back to the statute, please. And I  
24 like to do the same thing with the statute that  
25 you did with the bed transfer section. Would

1 Was it 2.2 million? What was the number and  
2 how did you determine that that 2.1 or 2.2,  
3 whatever was a simple majority, how did you  
4 determine with 77 hospitals in the state of  
5 South Carolina that that number of people was  
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9 be perfectly precise as to how we did it, but  
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11 that we had in the state at the time and  
12 looking at the population of each county and  
13 trying to determine which parts of the state  
14 were more than 30 minutes away from an existing  
15 hospital and northern Berkeley is an example.  
16 It's part of the state that is more, or was  
17 more, than 30 minutes travel time. But as far  
18 as a specific percentage, I can't tell you that  
19 it was 78 or 80 percent or whatever. Like I  
20 say, we just looked at it and stated that for  
21 the majority of people in the state, they have  
22 a hospital within 30 minutes travel time.

23 Q: Let's go back to the statute, please. And I  
24 like to do the same thing with the statute that  
25 you did with the bed transfer section. Would

1           you agree with me that the statute says the  
2           Plan at the minimum must include?

3       A:     Yes, I agree with you on that, yes.

4       Q:     And must means you shall do it, correct?

5       A:     Correct.

6       Q:     Okay.     And there are four items expressed  
7           there, number three is that the Plan at a  
8           minimum must include standards for distribution  
9           of healthcare facilities.     Do you see that  
10          language?

11      A:     Correct.   Yes.   Uh-huh (affirmative response).

12      Q:     And we already established that healthcare  
13           facilities include hospitals, correct?

14      A:     Correct.

15      Q:     General acute care hospitals as expressed on  
16           Section II-11 of the 2008-2009 Plan, correct?

17      A:     I'm sorry, what page, David?   I'm sorry.   Mr.  
18           Summer.

19      Q:     Not hospitals.     We're talking about general  
20           acute care hospitals that are in that Section  
21           of the Plan beginning on II-4 through II-20.

22      A:     Yes.

23      Q:     Good.     Those standards must include travel  
24           time, correct?

25      A:     That's what's written there, yes.



1 Q: Okay. So, as for hospital beds and hospital  
2 travel times, is your testimony there is no  
3 standard in the Plan as required by the  
4 statute?

5 A: There is not a travel time standard in the  
6 Plan. The need for hospitals is done on an  
7 individual hospital basis and then summed by  
8 county.

9 Q: We've already established there are absolutely  
10 no standards or criteria for the creation of a  
11 hospital in the South Carolina State Health  
12 Plan, are there?

13 A: There are not a specific criteria for the  
14 creation of a new hospital.

15 Q: There are no projections of need for the  
16 creation of new hospital facilities, are  
17 there?

18 A: No, and quite honestly with the current  
19 methodology, I would see that as potentially  
20 being problematic and this, because this -- and  
21 this is me speaking as Les Shelton, Planner,  
22 this is not the Department, because I've never  
23 run this by anybody else, so this is me  
24 expressing my opinion based on the bed need  
25 methodology is that there is --

1 MR. LONG: Your Honor, I'm afraid -- I'm not sure he  
2 can do that, so I would object. I'm not sure  
3 he can just express his opinion because he's  
4 not an expert.

5 THE COURT: Sustained.

6 A: Well, I will withdraw -- well, I will see if I  
7 can --

8 Q: Let me ask you another question. You've also  
9 testified that there are no standards for  
10 distribution of hospitals in the Plan, are  
11 there?

12 A: No, it's maintained on a county basis. That's  
13 how we keep up with it.

14 Q: Bed basis, right?

15 A: And then inventoried by county.

16 Q: Right. But you inventory beds, not hospitals?

17 A: We do have an inventory of hospitals that's in  
18 Chapter III of the Plan.

19 Q: Once again --

20 THE COURT: Wait just a moment, because I don't want  
21 my understanding to be skewed. You said you do  
22 it by county, where actually you have a three  
23 county planning area, you do it in that  
24 instance on the basis of the three county area  
25 without taking the individual counties into

1 account; isn't that right?

2 A: Yes, sir. The majority of the hospitals in the  
3 state are done on a county basis.

4 **THE COURT:** You've answered my question.

5 A: Yes, sir. We also have Lexington and Richland  
6 County as the only other service area where  
7 there are more than one county involved in the  
8 service area. We have the Berkeley,  
9 Charleston, Dorchester, those three counties  
10 are considered a service area and then we have  
11 Lexington and Richland where the utilization  
12 and the population calculations are shared  
13 between the two counties.

14 **THE COURT:** So, your original statement was not  
15 absolutely correct?

16 A: It did not include Berkeley, Charleston and  
17 Dorchester because they are done on a service  
18 area, not on a county basis.

19 **THE COURT:** Thank you, sir.

20 A: Okay. I'm sorry that was not clear.

21 Q: Your answer is not entirely correct for II-19?  
22 Orangeburg and Calhoun are also combined as  
23 counties as well, aren't they?

24 A: I'm sorry. You're right, I did leave out  
25 Orangeburg and Calhoun.

1 Q: There's real, historical precedent for the way  
2 you do that, isn't there?

3 A: Yes, it's based on historical precedent.

4 Q: Okay. The historical precedent is those two  
5 counties went together and formed a health  
6 services district. That health services  
7 district built one hospital to serve both  
8 counties, therefore you look at that being  
9 their service area. Calhoun and Orangeburg who  
10 jointly own that hospital.

11 A: Right it is the Regional Medical Center of  
12 Orangeburg and Calhoun Counties.

13 Q: That's the same reason why the Department, for  
14 decades, considered Trident to be the hospital  
15 for Berkeley and Dorchester Counties, correct?

16 A: Since 1987, that's been my understanding. I  
17 presume since the hospital was built before  
18 then, but I can't speak to the Department  
19 before '87 but --

20 Q: But that's your understanding?

21 A: Yes.

22 Q: Going back to the line of questioning that we  
23 have -- you would agree that there are no  
24 projections of need for additional hospitals in  
25 the State Health Plan, correct?

- 1 A: That is correct.
- 2 Q: And you would agree that there are no standards  
3 for distribution of hospitals within the  
4 current State Health Plan?
- 5 A: I'm sorry, say that again?
- 6 Q: There are no standards for distribution of  
7 hospitals within the State Health Plan?
- 8 A: Let me see here for a second. I don't believe  
9 so. No.
- 10 Q: Thank you. The Lexington/Richland phenomenon,  
11 you know, if you look at it you can't tell that  
12 you -- I'm trying to think of a word -- cross-  
13 pollinate the population or whatever. Would  
14 you explain for the Court what you do there?
- 15 A: Okay. It would probably be easier to go to  
16 Chapter III because that's where the actual  
17 explanation is. I'm sorry, let me find the  
18 page number to refer you to. Okay. It is III-  
19 16.
- 20 Q: III-16.
- 21 A: III-16, yes.
- 22 Q: Okay. III-16. Excuse me. Okay.
- 23 A: Okay. Number Two, general hospitals. It talks  
24 about the federal facilities and then the  
25 second sentence. All facilities are

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1 conforming, that's archaic at this point. It  
2 talks about whether facilities conform with  
3 codes, so that doesn't really matter for this.  
4 And then the next, or the rest of the paragraph  
5 explains that basically there is significant  
6 utilization of Richland County facilities by  
7 Lexington County residents and some use of  
8 Lexington Medical Center by Richland County  
9 residents. So, if you took just strictly 100  
10 percent of Richland County's population and  
11 used it for calculating the need for Richland  
12 County hospitals, that would overestimate the  
13 need for Richland County hospitals because a  
14 significant percentage of their patients are  
15 Lexington County residents. At the same time,  
16 that would artificially decrease the projected  
17 bed need for Lexington. So, since 1981, the  
18 earliest Plan I could find, that was when the  
19 Department started modifying the population  
20 projections. They take the utilization data,  
21 the patient origin data that they get from ORS  
22 at the Budget and Control Board and it tells  
23 you the percentage of patients from a  
24 particular county, where they went to for  
25 service. They can tell you for all Richland

1 County residents for a particular year, this is  
2 where they went to receive hospital care and  
3 they can get into it by specialty, etcetera.  
4 But essentially in this particular Plan, the  
5 2008-2009 Plan, for Richland County, we used  
6 91.7 percent of the Richland County population  
7 and 42.5 percent of the Lexington County  
8 population. So, when you go back to the  
9 Chapter II where we had the 2006 population and  
10 the 2013 population, the Richland County  
11 projections are going to be 91.7 percent of the  
12 projected Richland pop and 42.5 percent of the  
13 projected Lexington population. And that gives  
14 you the population numbers that are to be used  
15 in the calculations. When you look at  
16 Lexington County, we do 57 and a half percent  
17 of Lexington and 8.3 percent of Richland  
18 County, so those are the population projections  
19 used for the Lexington Medical Center bed need  
20 calculations. But that's the only service area  
21 where that adjustment is made. We've looked at  
22 it and there are other areas in the state, like  
23 Greenville/Spartanburg, Georgetown/Horry, but  
24 there just wasn't the significant cross-  
25 utilization that we see between Lexington and

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1 Richland.

2 Q: And I assume you do that so neither county will  
3 overbuild, neither hospitals will overbuild in  
4 the communities.

5 A: Well, like I said, it would overstate the need  
6 for Richland and it would also potentially  
7 punish Lexington because they would be  
8 potentially having a greater need than the  
9 calculations would show because of the  
10 populations used in the numbers.

11 Q: All right. Let's go back to this time travel  
12 number on II-11. Thirty minutes travel time  
13 for the majority of the residents of the state  
14 for general hospital. Is it your testimony  
15 that that's not a standard that's required by  
16 law?

17 A: It was not put in the Plan as a standard to be  
18 used as part of a CON review, no.

19 Q: What gratuitous reason was it included?

20 A: It was put in there for information purposes,  
21 like I said, Mr. Whiteside and I put it -- if  
22 you go through this entire Plan, every section  
23 of the Plan has the listing of the relative  
24 importance of the project review criteria and  
25 then underneath it is a statement of what



1 services, you know, what the availability is  
2 now for that service. Because the last finding  
3 we have to make that is also required by that  
4 44-7-180 number four is the general statement  
5 as to including a finding as to whether the  
6 benefits have improved accessibility to each  
7 type of facility, service and equipment may  
8 outweigh the adverse effects caused by the  
9 duplication of any existing facility, service  
10 or equipment. What we're saying is, this is  
11 the current situation. Right now, hospitals  
12 are generally available within 30 minutes of  
13 the majority of the population and if we have  
14 new applications under this section of the  
15 Plan, the benefit in this case, it says on II-  
16 11, the benefits then improved accessibility  
17 will be equally weighed with the adverse  
18 effects of duplication in evaluating  
19 certificate of need applications for these  
20 beds. It was put in there as an explanation of  
21 where we are right now to lead into if we get  
22 a new application, whether we're going to give  
23 more deference to increased accessibility or  
24 adverse effects of duplication. And as worded  
25 in this Plan, it says they will be equally

1 weighted.

2 Q: I am confused. Why would you arbitrarily pick  
3 the number 30 minutes? And why would you put  
4 it there if it's not a standard?

5 A: I don't believe it was arbitrarily picked. I  
6 believe it was based on when we looked at the  
7 utilization back in 1994-95, because -- during  
8 the old federal health planning days, we used  
9 to have what were called the National  
10 Guidelines for Health Planning. These were  
11 guidelines that the Feds sent to the CON  
12 programs saying here are some national  
13 guidelines and if you go back to some of the  
14 old Plans, that predate the ending of the  
15 federal program, in other words, if you go back  
16 to a Plan that exists before 1985, the  
17 standards are different back then and they  
18 reference the National Guidelines for Health  
19 Planning standards and it's quite possible that  
20 that 30 minute travel time was a standard for  
21 hospitals under the old federal health planning  
22 guidelines and that's where we could have  
23 potentially taken that 30 minute travel time,  
24 because that used to be a federal guideline and  
25 it may have been chosen. I cannot specifically

1 tell you right now why we chose 30 versus 45  
2 versus 60. I'm just saying that one potential  
3 source of that 30 minute travel time may have  
4 been that that was an old federal guideline  
5 that they used and so --

6 Q: Well, it's a shame we don't have a federal  
7 guideline. Would you agree with me that having  
8 folks located within 30 minutes one-way travel  
9 time is optimum? Desirable? Pick a word. Why  
10 is the language there?

11 A: Like I said, it was there specifically added to  
12 give an explanation of what things are like in  
13 South Carolina. We did not have to have that  
14 statement there. We could have left it off  
15 altogether. It could have gone strictly from  
16 the last project review criteria listed to a  
17 simple statement that the benefits would be  
18 equally weighted or not. That we are not  
19 required to add that. That was a decision that  
20 we're not required to add it to this section.

21 Q: The statute requires a time travel standard for  
22 hospitals. Is your testimony that there is no  
23 time travel standard for hospitals in the  
24 current State Health Plan? Is that your  
25 testimony?

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1 A: We did not have a specific time travel standard  
2 in the 2008-2009 Plan.

3 Q: And 30 minutes is purely gratuitous?

4 A: It was given as an explanation of where the  
5 majority of the state, how far they had to go  
6 where the services were available to them  
7 within a certain amount of time. Like I said,  
8 we have the exact same information listed in  
9 other sections of the Plan. If you look at  
10 them, you will find the same kind of statement.

11 Q: So, is it your testimony that it has no  
12 relevance, the time travel, for the service,  
13 for inpatient hospitalization?

14 A: It was not used as a standard for calculating  
15 hospitals.

16 Q: Is it a goal? Would you like to have everybody  
17 in South Carolina within 30 minutes one-way  
18 travel time of a hospital?

19 A: It was not stated as a goal. That might be a  
20 reasonable goal. I don't know what the  
21 national numbers are right now.

22 Q: You're not even sure that the National  
23 Guidelines were the genesis for this statement,  
24 are you?

25 A: Like I said that was 1995. No, I don't

1 remember what I did 17 years ago specifically  
2 for that particular statement. No, I do not  
3 remember.

4 Q: Is it fair to say that you've been working with  
5 the Department since 1987, that if you don't  
6 know what the relevance of this language is, no  
7 one at the Department knows what the relevance  
8 of this language is?

9 A: I'm the oldest person in the Department, yes.

10 Q: Is there anybody else would have a clue about  
11 why you put it in there?

12 A: There is no one that goes back that far, no.

13 Q: I want to talk to you a little bit about  
14 creating new hospitals based on bed need.

15 A: Okay.

16 Q: In my prior discussions with you about bed  
17 need, you indicated because Roper had a  
18 negative bed need, they couldn't use positive  
19 bed need to go out and create a new hospital.  
20 Do you recall that?

21 A: I believe I said they couldn't add additional  
22 beds and used that to build a hospital, new  
23 hospital. I don't remember my specific  
24 response to that question.

25 Q: I think we have established the only way they

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1 can get a hospital under the current Plan is  
2 through the Department's tortured  
3 interpretation of the bed transfer section,  
4 correct?

5 A: I would agree that the bed transfer section is  
6 the only way they can do it, yes.

7 Q: That's the only way they can do it. All right.  
8 Let's look at a place of somebody who's got a  
9 positive bed need. Beaufort Memorial Hospital,  
10 on II-18, they have a positive bed need of 41,  
11 correct?

12 A: Give me just a second please. I'm sorry.  
13 Beaufort. II-18. Okay. Yes, I'm there.

14 Q: They have a positive bed need of 41, right?

15 A: That's correct.

16 Q: They could build a satellite hospital and build  
17 50 new beds?

18 A: That is correct.

19 Q: That's the maximum they could build?

20 A: Right. They can build the greater of the  
21 actual bed need or up to 50 beds. Just like  
22 Trident could have done 56 beds. They had a  
23 projected need for 56, so they could have built  
24 a 56 bed facility under this Plan.

25 Q: Beaufort with that positive bed need could

1 build a 50 bed facility, but there's no limit  
2 on what you would allow a hospital with a  
3 negative bed need to transfer? Under your  
4 current policy as you interpret it now, you  
5 could create a 100 bed hospital if you wanted  
6 to transfer that many beds, couldn't you?

7 A: You're correct. There is no limitation on the  
8 number of beds that could be transferred.

9 Q: Do you not find that logically inconsistent?

10 A: I'm -- part of the concern is that we don't  
11 want to put a constraint on a new hospital --  
12 I mean, excuse me. Let me say it again. There  
13 may be good reasons why a hospital would want  
14 to build more than 50 beds. For example, the  
15 Roper facility that went over in Mount Pleasant  
16 I believe is an 85 bed facility. So, I'm not  
17 certain that we're in a position to be putting  
18 a maximum on the number of beds that a hospital  
19 could use to create a new facility. They may  
20 have some very good reasons to go to a specific  
21 number, and so we don't want the Plan to  
22 artificially constrain an applicant. If we  
23 said that you can build up to a 50 bed  
24 hospital, then 50 beds may not be financially  
25 feasible for a particular entity, but 60 might

1 be. So that could be a situation where if we  
 2 put a specific limitation in the Plan, that  
 3 could artificially constrain the ability of an  
 4 applicant to propose to build a new facility.  
 5 Just making up an example, Lexington is very  
 6 successful. They've done a lot of  
 7 construction. They've added a lot of new beds.  
 8 They are frequently generating a need for more  
 9 beds, but not always. They could make a  
 10 decision that transferring 100 beds to create  
 11 a new hospital in the Town of Lexington would  
 12 make sense financially, etcetera, for them and  
 13 if we say that you're only allowed to transfer  
 14 up to 50 beds or X number of beds, then that  
 15 could preclude them for applying for a hospital  
 16 that would potentially be, you know, of great  
 17 value to them and to the residents of Lexington  
 18 County. Just purely as a hypothetical example.

19 Q: Are you familiar with the Ethics Committee  
 20 opinions about what health -- people on the  
 21 Health Planning Committee can and can't vote  
 22 on?

23 A: Yes, I remember that discussion, yes.

24 Q: Basically they can't vote on or participate in  
 25 discussion of matters that come before the



1 Health Planning Committee that only apply to  
2 their hospital.

3 A: Yes.

4 Q: Mr. Bowling presented at project review on  
5 behalf of Roper in this case, didn't he?

6 A: I, I believe he was there. I don't remember if  
7 he or Ms. Cantwell, or who was the primary  
8 presenter, but yes, he was present at the  
9 meeting and I believe, yes, he did take place  
10 in the presentation, but I'm not sure he was  
11 the primary presenter. I can't remember  
12 specifically, but yes, he was involved at  
13 project review.

14 Q: Okay. And he was there to promote a project  
15 for his hospital, was he not?

16 A: Yes. Uh-huh (affirmative response).

17 Q: Okay. And you didn't have a problem with that?  
18 As a member of the Health Planning Committee?

19 A: No, because he is appearing on behalf of his  
20 hospital. And he is not appearing on behalf of  
21 the State Health Planning Committee. Just like  
22 when we have a CON application from McLeod  
23 Hospital in Florence, then Dick Tinsley, who is  
24 a vice president of McLeod, he typically makes  
25 presentations on behalf of McLeod. He is also

1 a member of the Planning Committee. So, I  
2 don't see someone from the Planning Committee  
3 who is involved in the development of the Plan,  
4 appearing on behalf of the facility they work  
5 for -- in a project review meeting for a CON  
6 that is under a Plan that has already been  
7 approved by the DHEC Board. I don't see how  
8 you can say -- and I'm not a lawyer, but I  
9 wonder how the Ethics Commission could say that  
10 Mr. Bowling works for Roper, he's one of the  
11 top people at Roper, but because he's involved  
12 in this section of the Plan, then he is not  
13 allowed to participate in any part of a  
14 certificate of need review. I'm not a lawyer,  
15 but I don't think that that State Ethics  
16 Commission ruling on Plan development precludes  
17 all involvement in a CON application. That  
18 would have to be something that a lawyer or the  
19 Ethics Commission would decide, but I just  
20 personally can't see how his participation on  
21 a voluntary committee that's advisory to the  
22 DHEC Board, they don't even make the final  
23 decision. He is one of 14 people that makes  
24 recommendations to the DHEC Board and I don't  
25 see how a Plan that was approved by the Board

1 and then Mr. Bowling participating in a CON  
2 application that came under that Plan, I can't  
3 see how he would be prohibited.

4 Q: Are you aware of whether or not that agency has  
5 ever inquired with the Ethics Commission for an  
6 advisory opinion on this subject?

7 A: No. Not asked that particular question, no.

8 MR. SUMMER: Beg the Court's indulgence?

9 THE COURT: Yes, sir.

10 Q: If you would be so kind as to answer questions  
11 from opposing counsel. Thank you so much for  
12 your time and attention.

13 MS. BIGGERS: Your Honor, it's 12:24, do you have a  
14 preference as to whether I proceed with  
15 questioning or whether we take a lunch break  
16 now?

17 THE COURT: What's the consensus of the group?

18 MR. LONG: I'm fine with whatever counsel wants to  
19 do.

20 THE COURT: Let's break now then and come back at  
21 2:00. Recess until 2:00.

22 (Off the Record)

23 THE COURT: Ms. Biggers.

24 MS. BIGGERS: Thank you, Your Honor.

25 MR. SHELTON - CROSS EXAMINATION BY MS. BIGGERS:

1 Q: Mr. Shelton?

2 A: Yes. Uh-huh (affirmative response).

3 Q: Just going back to your experience briefly, can  
4 you tell the Court how many years experience do  
5 you have working with DHEC, specifically with  
6 the State Health Plan?

7 A: Since November of 1987, so for a little over 24  
8 years.

9 Q: How many years?

10 A: Twenty-four. I'm sorry.

11 Q: And over those years have you seen any changes  
12 in health planning?

13 A: Yes. There have been changes in planning, just  
14 like there have been changes in the healthcare  
15 delivery system over the last 20-odd years.  
16 Like I say, once upon a time there was a  
17 federal program with regional agencies and now  
18 there's just a state program. We've added new  
19 services that weren't around years ago. The  
20 delivery systems have changed. We talked some  
21 about ambulatory surgery centers this morning.  
22 How hospital utilization has changed because  
23 the payment mechanisms have changed, like we  
24 discussed, orthopaedic surgery, you know,  
25 hospitals used to admit patients for surgeries

1 like that. Now you have ambulatory surgery  
2 centers. Hospitals are treating those patients  
3 on an outpatient basis, so all of those affect  
4 the healthcare delivery system and as a result,  
5 we have to make changes to our methodologies,  
6 our inventories, etcetera, to reflect those  
7 changes.

8 Q: Having seen those various changes in healthcare  
9 planning over your years at DHEC, has that  
10 influenced at all the manner in which you go  
11 about putting together drafts of the Health  
12 Plan?

13 A: I'm sorry, can you restate that?

14 Q: Sure. You just described the changes that you  
15 had seen in health planning since you've been  
16 at DHEC. Does that have any influence over  
17 what you have in mind when you were working on  
18 putting together language for the Health Plan?

19 A: Well, we do a Plan every two years and as part  
20 of that process, before we put a draft together  
21 to send to the State Health Plan Planning  
22 Committee, we have to look at what changes  
23 there have been in the healthcare delivery  
24 system, any new equipment, anything that would  
25 change -- proposed methodologies that would be

1 added to the Plan or in some cases, we have had  
2 services that have been removed from the Plan.  
3 We used to review CT scanners for CON. That no  
4 longer happens. We used to review dialysis.  
5 That no longer happens. So, every time that we  
6 do a new Plan, we make an assessment of what  
7 the current healthcare system is and if there  
8 are any changes, any things that need to be  
9 added or amended in the methodology to account  
10 or adjust for these changes.

11 Q: Now, what is your exact role with putting  
12 together a draft of the South Carolina Health  
13 Plan?

14 A: I am the primary person responsible for the  
15 development of the Plan. I have one person  
16 that I supervise, Misty Hallman. She is the  
17 primary data person. Now, I talked this  
18 morning about the Joint Annual Reports, the  
19 JARS. She is the primary person that sends the  
20 JARS out to the facilities and collects  
21 utilization data from them. Misty and I work  
22 together to do all of the calculations, the  
23 inventories and the standards and criteria for  
24 each section of the Plan and both Misty and I  
25 are staff to the State Health Planning

1 Committee. And we have other functions as well  
2 as far as the Plan goes that's --

3 Q: How long has it been just you and Misty and  
4 what is Misty's last name?

5 A: Hallman. H-A-L-L-M-A-N.

6 Q: How long has it been just you and Ms. Hallman  
7 working on the State Health Plan?

8 A: Ms. Hallman started October of 2008. We had a  
9 year, approximately, from about November of  
10 2007 to hiring Ms. Hallman in 2008 where I was  
11 the sole person doing the Plan.

12 Q: And during that period of time, were you the  
13 senior planner?

14 A: That was when I took over the position,  
15 approximately October of 2007. That's when the  
16 job title of senior planner was created.

17 Q: And prior to October of 2007, what was your  
18 title?

19 A: I think it was Program Management Specialist,  
20 I think is the state vernacular for my job.

21 Q: Who did you work with prior to that with  
22 regards to the Plan?

23 A: The person with the primary responsibility for  
24 the Plan was Albert Whiteside and at the time  
25 he was a bureau chief and then I was the last

1 person -- he used to have several people under  
2 him, through retirements, I was the last person  
3 that worked together with Albert on developing  
4 the Plan.

5 Q: And I believe you said you started working on  
6 the Plan at DHEC in '87; is that correct?

7 A: I was hired November of '87, so the '88 Plan  
8 would have been the first one I worked on.

9 Q: Who did you work under when you first started?

10 A: I always worked directly under Mr. Whiteside.  
11 The people above him changed over the years,  
12 but Mr. Whiteside was my direct supervisor  
13 until his retirement.

14 Q: Now, who's State Health Plan is the South  
15 Carolina State Health Plan?

16 A: It's ultimately the DHEC Board's. I mean the  
17 staff develops it. The Planning Committee  
18 recommends it, but the final approval goes --  
19 is done by the State Board of Health and  
20 Environmental Control.

21 Q: Is that by statute?

22 A: Yes. Uh-huh (affirmative response).

23 Q: And you just mentioned the Health Planning  
24 Committee. Can you tell us more about that  
25 Committee and who comprises it?



1 A: Like I said this morning, it's a 14-member  
2 committee. Twelve are appointed by the  
3 Governor equally between healthcare providers  
4 and payers of healthcare services, insurers,  
5 and then consumers. So, 12 are gubernatorial  
6 appointees, the DHEC Board represents --  
7 chooses one of their members to be the Board's  
8 representative on the Committee and then the  
9 State Director of Consumer Affairs is an ex-  
10 officio member of the Committee.

11 Q: Is there any written instruction anywhere as to  
12 the types of members that comprise the Planning  
13 Committee?

14 A: Nothing beyond what's in the statute that I'm  
15 aware of.

16 Q: Okay. Well, the groups that you just mentioned  
17 that comprise that, are those groups  
18 specifically mentioned in the statute?

19 A: I believe the statute says equally weighted  
20 amongst -- I'm sorry, let me find 44-7-180.  
21 Let's see here. Okay. This is Section A.  
22 There is created a Health Planning Committee  
23 comprised of 14 members. The Governor shall  
24 about 12 members which must include at least  
25 one member from each congressional district.

1 In addition, each of the following groups must  
2 be represented among the Governor's appointees.  
3 Healthcare consumers, healthcare financiers,  
4 including business and insurance and healthcare  
5 providers. Then the law is amended to include  
6 an administrator of a licensed for-profit  
7 nursing home.

8 Q: So, I think for instance Mr. Summer asked you  
9 about Mr. Bowling being on the Committee. Who  
10 would have appointed Mr. Bowling to the  
11 committee?

12 A: That would have been Governor Sanford.

13 Q: And what group would he have represented?

14 A: The healthcare providers.

15 Q: So that's not specifically Roper Hospital, is  
16 it?

17 A: It's a healthcare provider position on the  
18 Committee.

19 Q: Now, what has been your personal experience  
20 with drafting the hospital section,  
21 specifically within the Plan? What has been  
22 your role over your years at DHEC with regard  
23 to the hospital section specifically?

24 A: Okay. Initially, Mr. Whiteside was the primary  
25 person in charge of the hospital section of the

1 Plan and Vernon Schroder, until he retired in  
2 2004 was the primary data person for that  
3 section. So, I had more of an adjunct role  
4 until Mr. Schroder retired in which case I took  
5 over the data responsibilities for the  
6 calculations and inventories and when Mr.  
7 Whiteside retired, I took over full  
8 responsibility for that section.

9 Q: And when you mentioned the adjunct role, what  
10 do you mean by that?

11 A: I would -- there were sections of the Plan that  
12 I was the primary person responsible for and  
13 there were sections of the Plan that Mr.  
14 Whiteside took responsibility for. But, we  
15 shared information with each other. When  
16 something was proposed, we would vet it through  
17 each other. Mr. Whiteside would write it and  
18 then he would give it to me to analyze,  
19 critique. We would discuss, but he maintained  
20 the primary responsibility for that section.

21 Q: And did you have any personal participation in  
22 drafting the actual language that went in to  
23 the hospital section over those years?

24 A: Yes, I participated in the development of the  
25 wording over the years.

1 Q: Does the -- let's just look at the 2008-2009  
2 Plan because that is what Mr. Summer was  
3 looking at with you this morning.

4 A: Is that 4?

5 Q: Its Joint Exhibit 4. Does the 2008-2009 South  
6 Carolina Health Plan contain standards and  
7 criteria in regard to hospitals?

8 A: Yes, it does.

9 Q: Please tell us where we can find that.

10 A: That would be in -- pages bear with me just a  
11 second. The general hospital section starts on  
12 II-4 and goes through the footnotes on II-20.

13 Q: Okay. Can you just explain to the Court why is  
14 the hospital section set up the way that it is  
15 in the South Carolina Health Plan?

16 A: I'm sorry, can you repeat?

17 Q: How do you set it up? Can you just explain to  
18 us how is that section set up?

19 A: How is it formatted or how was it created?

20 Q: How is it created? Can you explain to us what  
21 the substance of it is and why you have put it  
22 together in that manner?

23 A: Okay. I think the general format has stayed  
24 the same over the years. We start with  
25 defining what a general hospital is. Then we

1 define how we measure the capacity for a  
2 facility. There's some health licensing  
3 guidelines that are referenced in it as far as  
4 which types of rooms are counted or not counted  
5 as licensed beds. And then we have the  
6 inventory, we explain how the inventory is  
7 maintained. Then we have the actual narrative  
8 that starts explaining the need calculations.  
9 It starts with the explanation of the occupancy  
10 factors that we discussed this morning, that  
11 vary by the size of the facility. Then we get  
12 into the actual methodology for calculating the  
13 bed need and that has changed at times over the  
14 years. At different points of time we had a  
15 shorter period. We used to project out six  
16 years rather than seven years. We've used  
17 different occupancy factors over the years.  
18 And at times, we used to calculate hospital bed  
19 need strictly by county. That changed around  
20 2003, because we had what most people refer to  
21 as the Florence hospital situation. There are  
22 four hospitals in Florence County, McLeod is  
23 the big regional hospital. They had incredibly  
24 high utilization, about 88 to 82 percent, which  
25 I think the people from Trident would agree is

1 an exceedingly high, very hard to manage  
2 census, when you're running that high on a  
3 daily basis, but because we projected the need  
4 on a county basis, there were hospitals like  
5 Lower Florence that was at 20 percent  
6 occupancy, so there was no overall need in the  
7 county, so what we were saying was that McLeod  
8 couldn't have more beds because Lower Florence  
9 wasn't using theirs. Which was unfair to  
10 McLeod, so that's when we changed the  
11 methodology to calculate the need on an  
12 individual hospital basis. So that way McLeod,  
13 based on their own utilization, could add beds,  
14 even if Florence County service area as a whole  
15 didn't show a need for additional beds. So,  
16 that was one of the things that's evolved over  
17 time and from some other experiences in the  
18 2008-2009 plan, we added the, what's been  
19 referenced previously as Sections D and Section  
20 E that explain the situations of when  
21 applicants can apply to build a hospital in a  
22 county based on whether there's an overall  
23 excess of beds in the county or an overall need  
24 for additional beds in the county. So, we have  
25 standards D and E that were added in this

1 particular Plan to address how the Department  
 2 would handle those types of applications and  
 3 then Section F was also added, which is the  
 4 description that's on II-8, was added in this  
 5 Plan that explains regardless of how you create  
 6 a new hospital, any new hospital that is  
 7 approved must perform these minimum services.  
 8 They have to have a 24-hour ER. They have to  
 9 offer inpatient medical services, both surgical  
 10 and non-surgical and there's a list of 25  
 11 different diagnostic and service categories  
 12 that CMS, the Center for Medicare and Medicaid  
 13 Services, breaks their diagnostic categories  
 14 into and we require that hospitals, any new  
 15 hospital provide at least six of these services  
 16 and they're listed on eight and nine, on a  
 17 daily basis. The concern for that was that an  
 18 applicant would come in to build a specialty  
 19 hospital. For example, Med-Cath is a company  
 20 that specializes in cardiac only hospitals.  
 21 That's all they do is cardiac. And concern  
 22 expressed was that if a single specialty  
 23 hospital was built, then they would focus on  
 24 just those patients, would cherry-pick, you  
 25 know, the best of those patients. The other

1 general hospitals in that area would then be  
 2 left with the less desirable patients and also  
 3 since this hospital wouldn't have an emergency  
 4 room, then they could successfully avoid having  
 5 to deal with ER patients. So, the existing  
 6 hospitals would continue to have to fully cover  
 7 ER services. So, that's why we put this in  
 8 that if you build a new hospital, it has to  
 9 have an ER, it has to not be a single specialty  
 10 hospital and it has to offer inpatient  
 11 services, both surgical and non-surgical.

12 Q: Okay. Since you described section F on II-8 as  
 13 applying to new hospitals, is that something  
 14 that, for instance, Roper's application would  
 15 have to comply with?

16 A: Yes. The wording says no additional hospitals  
 17 will be approved unless. So, regardless of how  
 18 a hospital is created, it cannot be approved  
 19 unless it meets section F.

20 Q: Now, I think in hearing your testimony and also  
 21 I know in my own discussions about the Plan and  
 22 what's contained in the Plan, can you tell us,  
 23 is there a distinction between what you've  
 24 referred to as the bed need section for  
 25 hospitals and the inventory of hospitals?



1 A: Yes, those are two different things.

2 Q: Where is the inventory for hospitals located in  
3 the 2008-2009 Health Plan?

4 A: Okay. As I explained this morning, Chapter III  
5 in the Plan is the inventory section, where I  
6 talked about the four different inventory  
7 regions and then the statewide inventory  
8 region. So you would refer back to Chapter III  
9 of the Plan.

10 Q: And could you tell us what page you're looking  
11 at when you get to it?

12 A: Okay. The statewide description starts on III-  
13 2, that goes through page eight. And then III-  
14 9 is the beginning of inventory Region I, which  
15 is the upstate, the Greenville, Spartanburg,  
16 Anderson area.

17 Q: What area would Roper and Trident fall under?

18 A: They are in inventory Region IV, the Low  
19 Country. So, that's the last inventory region  
20 in the Plan.

21 Q: What page number does that begin on in the '08-  
22 '09 Plan?

23 A: The narrative starts on page III-31.

24 Q: And can you point to us the page that  
25 specifically discusses, well, Charleston since

1 Roper and Trident are in Charleston?

2 A: Okay. The first part of the inventory is the  
3 general hospital inventory. That starts on  
4 III-32. And it's alphabetical by county. So,  
5 it starts with Aiken and Allendale, Bamberg,  
6 Barnwell, Beaufort and then Charleston  
7 counties. All the Charleston facilities then  
8 Colleton and then the Summerville facility and  
9 so forth.

10 MS. BIGGERS: Can we pull up specifically on the  
11 Charleston County inventory for hospitals?

12 Q: And what page again did you say?

13 A: That's III-32.

14 Q: And, also are Roper and Trident listed in the  
15 Charleston County inventory?

16 A: Yes, the inventory lists the actual physical  
17 location of each facility. You see it has the  
18 name of the facility, and then there's a  
19 footnote, the name of the county that it's in,  
20 which is Charleston County, and then the actual  
21 city within the county. So, like Roper-Mount  
22 Pleasant is listed in Mount Pleasant. Trident  
23 is listed in Charleston, that probably should  
24 be North Charleston.

25 Q: What does the inventory say about Berkeley

1 County with regard to hospitals?

2 A: There are no existing -- in this Plan there are  
3 no existing hospital beds in Berkeley County,  
4 so there --

5 Q: Is that specifically stated in the inventory  
6 you're looking at on page III-32?

7 A: We do not say that there is, there are no  
8 hospitals in Berkeley County.

9 Q: But how about Roper and Trident? Are they --  
10 is Berkeley County mentioned with respect to  
11 either of those with regard to inventory?

12 A: Not in the '08-'09 Plan, because at the time  
13 the Plan was drafted, obviously the decision  
14 hadn't been made. The current Plan, the one  
15 we're under right now, once Ms. Brandt issues  
16 a decision, she says the CON staff's decision  
17 is to approve the application, in this case  
18 both applications for Berkeley County, I take  
19 that letter. In this inventory section, I add  
20 those facilities. Kind of place-holding them  
21 so that we know that we've approved 100 beds  
22 for Berkeley County. Obviously they're under  
23 appeal, so they're not under construction. But  
24 that's why you have licensed beds and then  
25 survey beds as a category. Survey beds means

1 that they have been approved. They have a CON  
2 approval or they're under appeal, but they're  
3 not yet licensed. So, it would show between  
4 Beaufort County and Charleston County, there  
5 would be a listing that would show the Roper  
6 facility with 50 survey beds and then the  
7 Trident facility with 50 survey beds. We would  
8 list one as Moncks Corner and one as Goose  
9 Creek and it would show 100 existing survey  
10 beds and no licensed beds and the Roper  
11 inventory would be adjusted downward, the 316  
12 survey beds would be reduced to 266, because  
13 there's no overall change in Roper's bed  
14 compliment, it's just 50 of them would be moved  
15 to Berkeley County. So, in the inventory we  
16 would move them to Berkeley County and then in  
17 the Charleston we would take them away. So,  
18 the licensed beds won't change because the  
19 place isn't built yet, but survey is how we  
20 keep up with which CONs have been issued and  
21 where the beds are going to be allocated. We  
22 do have a couple of facilities that are  
23 notorious for not being able to keep up with  
24 the various projects that they've set up over  
25 the years and have tried in the past to take

1 beds from one application and use them in  
2 another, and we've had to tell them, no, you  
3 can't do that because those beds are already  
4 committed to another project. So, the  
5 inventory is very important for keeping up with  
6 what is under construction, what is proposed,  
7 what the final outcome is going to be once all  
8 of the projects are completed. So, there's a  
9 column that says FN, and that stands for  
10 footnote, so, you notice every hospital in  
11 Charleston County has a footnote, so there's  
12 obviously a lot going on in the Charleston  
13 County area because we've got footnotes for  
14 every facility there.

15 Q: Those footnotes that you just mentioned, are  
16 those also referenced in the bed plan  
17 methodology section for general hospitals?

18 A: They are taken into consideration. We have to  
19 use the survey beds, what the outcome will be  
20 in the calculations. So, for example, Trident,  
21 in this Plan, shows a need for 56 beds. I  
22 think we've discussed that. Showed the bed  
23 need for Trident was 56 beds. When the CON was  
24 approved, in the need calculations, we would  
25 add those 50 beds to the existing because we've

1 approved them for Trident. So, the number of  
2 existing beds would go up by 50 at Trident and  
3 it would still show a need for six beds for  
4 Trident because they could have applied for up  
5 to 56. They chose to apply for 50, we approved  
6 them for 50. We adjust the bed need  
7 calculation by those 50 beds and then we adjust  
8 the Berkeley/Charleston/Dorchester service area  
9 totals by 50 beds. Roper didn't change the  
10 total number of beds, they just moved them.  
11 But Trident actually added 50 beds to the  
12 service area so we'd have to adjust the service  
13 area totals to reflect that there are another  
14 50 beds approved for the  
15 Berkeley/Charleston/Dorchester service area.

16 Q: Now, this morning Mr. Summer questioned you  
17 about the inventory and I believe you got into  
18 a discussion about the AnMed. Do you remember  
19 discussing the AnMed?

20 A: Yes.

21 Q: Well, let's actually look at the 2004-2005  
22 South Carolina Health Plan, which is Joint  
23 Exhibit 3. And if you'll turn to II-10.

24 A: (Witness does as instructed.)

25 Q: Is AnMed included on page II-10 of the '04-'05

1 Plan?

2 A: Yes, it is listed. At that point in time, we  
3 had approved the creation of the Anderson area  
4 Women's and Children's Hospital which was 72  
5 beds that were transferred from the existing  
6 Anderson Area Medical Center. And that's  
7 footnote number one.

8 Q: Where is 'footnote number one?

9 A: I'm sorry, if you look at Anderson Area Medical  
10 Center and Women's and Children's Hospital and  
11 then there is a number one following, yes,  
12 right where that's being pointed at, yes. The  
13 footnotes are actually on II-18.

14 Q: What does number one say on II-18?

15 A: It says CON issued to transfer 72 beds for new  
16 hospital.

17 Q: And what provision of the '04-'05 State Health  
18 Plan was utilized or if it wasn't, what  
19 provision of the State Health Plan under which  
20 that application was approved, was the  
21 applicable provision for that AnMed Women's and  
22 Children's Hospital?

23 A: It was done under what we call the bed transfer  
24 provision. I'd have to look because we  
25 revamped the numbering because of adding

1 standard D and standard E and standard F in the  
2 2008-2009 Plan, so the 2004-2005 Plan, it was  
3 standard H. It says the exact same thing that  
4 J says in the 2008-2009 Plan. But under this  
5 Plan, it would have been section H, but it's  
6 the bed transfer provision that allowed  
7 Anderson to transfer 72 existing beds to create  
8 the new Women's and Children's Hospital.

9 Q: Okay. Can you tell me more about the bed  
10 transfer provision. Let's just begin with when  
11 was it added to the Plan initially?

12 A: 1995.

13 Q: Were you a participant -

14 **THE COURT:** Excuse me. What year?

15 A: I'm sorry, 1995.

16 Q: Did you participate in the drafting of that or  
17 the inserting that into the initial Plan?

18 A: Yes, like I said Mr. Whiteside was the person  
19 primarily responsible for the hospital bed need  
20 section, but yes, I did work with him. I  
21 believe Mr. Whiteside, Mr. Grice, Mr. Frishman  
22 and possibly DHEC legal staff, but I can't say  
23 what attorney that might have been, were  
24 probably involved in the drafting of these new  
25 standards.



1 Q: From the perspective of the drafters of the  
2 Plan, such as yourself, what was the purpose  
3 for adding that provision?

4 A: Around that time period, you had had the --  
5 President Clinton's attempt at healthcare  
6 reform, which was about 1200 pages which  
7 ultimately didn't pass, but at the time as a  
8 result of that there was a lot of interest in  
9 creating new models, having, you know, new  
10 ventures, basically new ways of delivering care  
11 and there was concern expressed that parties  
12 might be interested in making some kind of  
13 exchange on beds and or services that the Plan,  
14 as written, would not permit them to do and  
15 because the Plan takes one to two years to  
16 update, to fully follow its cycle to create a  
17 new Plan, there was concern expressed that some  
18 projects that would otherwise be workable,  
19 might be good projects, but because of the way  
20 the Plan was written, it would not allow them  
21 to do so and, as we discussed this morning, the  
22 Board no longer had the authority to go beyond  
23 the Plan and approve something that wasn't  
24 consistent. So therefore, it was requested  
25 that we come up with some provisions that would

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1 allow facilities to exchange services and or  
2 exchange beds, including across county lines,  
3 across service area, even if it wasn't  
4 consistent with the projected need in the Plan,  
5 if they could meet the standards that were  
6 listed along with that section, the A through  
7 J, or whatever we discussed for beds. So,  
8 there is in each Plan since 1995 a provision  
9 that allows the transfer of services between  
10 facilities and a section that allows the  
11 transfer of beds between facilities, providers,  
12 if they can conform to the criteria that are  
13 required for it, that otherwise the Plan would  
14 say no, that's not consistent with the Plan, so  
15 therefore you can't do it.

16 Q: Do you recall what the first or an early  
17 example was of a CON that was actually approved  
18 for a bed transfer after that specific bed  
19 transfer language was added to the Plan?

20 A: The first bed transfer that I'm aware of was  
21 the creation of Providence Northeast Hospital  
22 in Richland County, that 50 beds were  
23 transferred from the downtown Providence  
24 Hospital to create a new hospital on the  
25 Northeast side of town.

1 Q: What was the transferring facility in that CON?

2 A: It was the existing Providence Hospital  
3 downtown.

4 Q: And what was the receiving facility in that  
5 CON?

6 A: It was, at that time Providence Northeast. It  
7 later became Columbia Providence Northeast and  
8 then Providence Northeast again.

9 Q: Was there an existing facility at the site of  
10 what eventually became Providence Northeast  
11 after the CON was approved?

12 A: There may have been a doctor's office building  
13 or something like that. But there's no  
14 licensed healthcare facility that I'm aware of  
15 that was at that site.

16 Q: Was there an existing hospital?

17 A: No, there was not.

18 Q: Have there been other instances since Parkridge  
19 Northeast where a CON was approved for a  
20 creation of a satellite hospital using the bed  
21 transfer provision?

22 A: I think you mean Providence Northeast. I think  
23 you said Parkridge Northeast.

24 Q: I'm sorry.

25 A: All though Parkridge is an example we're

1 familiar with.

2 Q: All right. Are there any other examples that  
3 you're familiar with?

4 A: We just looked at Anderson a few minutes ago.  
5 We talked about the Anderson Area Medical  
6 Center which was spun off to the Women's and  
7 Children's Hospital. The Village Healthcare in  
8 Spartanburg County, that was a new hospital  
9 that was created from Spartanburg Regional  
10 Medical Center. Obviously Parkridge here.  
11 There's Waccamaw Neck Hospital, which is now  
12 Waccamaw Hospital, it's in Georgetown County.  
13 We have the Roper facility that spun off into  
14 Mount Pleasant. Let's see. I'm sure there are  
15 others.

16 Q: Of those examples that you just mentioned, were  
17 there any existing bricks and mortar hospitals  
18 at the site of the receiving facility?

19 A: Not to my knowledge, there were no hospitals  
20 existing at any of those new proposed sites.

21 Q: And in your opinion as a drafter of the State  
22 Health Plan, were all of those CON applications  
23 consistent with the State Health Plan?

24 MR. SUMMER: I'm going to object, Your Honor.  
25 Unless he participated in project review and

1 worked on those applications, there's no basis  
2 for him to say that.

3 **MS. BIGGERS:** Your Honor, as a health planner, I  
4 think Mr. Shelton, his understanding of whether  
5 or not the transfer of beds from an existing  
6 facility to a location where there is no  
7 existing bricks and mortar facility, whether  
8 that is consistent with the Health Plan, just  
9 that part, I'm not talking about the rest, just  
10 that part, I think that is certainly within his  
11 realm of knowledge and pertinent to this case.

12 **THE COURT:** Ask your question again and let me hear  
13 it.

14 **Q:** Okay. Mr. Shelton, as the drafter of the State  
15 Health Plan, is the -- in all those examples  
16 that you listed for us, is the transfer of the  
17 beds from the transferring facility to the  
18 receiving facility consistent with the bed  
19 transfer provision even though there was not a  
20 bricks and mortar facility at the receiving  
21 site?

22 **MR. SUMMER:** And I'll express the same objection.  
23 His role is to create the Plan, and for  
24 instance in this case he had testified he had  
25 not reviewed either of the certificate of need

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1 applications. In order for you to make a  
2 conclusion about whether or not an application  
3 in a project is consistent with the Plan, at a  
4 bare minimum you've got to read the  
5 application, so if Ms. Biggers can lay that  
6 foundation and say that he's reviewed the  
7 applications, he's familiar with them and  
8 believes that that transfer was consistent,  
9 then there at least would be a foundation for  
10 it. But as it stands right now, making that  
11 decision is not part of his job description, it  
12 belongs to the Department.

13 **MS. BIGGERS:** Your Honor, I think I could actually  
14 approach this in a different way where I can  
15 lay a foundation.

16 **THE COURT:** Why don't you do that.

17 **MS. BIGGERS:** I will. Thank you.

18 **Q:** Mr. Shelton, were you hear for Ms. Brandt's  
19 testimony?

20 **A:** Yes.

21 **Q:** Do you recall Ms. Brant testifying about the  
22 application, the process for DHEC receiving and  
23 reviewing CON application?

24 **A:** Yes.

25 **Q:** Do you recall her mentioning your name with

1 regard to the initial process when an  
2 application first comes in the door?

3 A: Right. Mr. Whiteside used to handle this  
4 function until he retired, since he was the  
5 primary person in charge of the Plan. Since  
6 his retirement, the procedure that the CON  
7 reviewers have followed is when they receive a  
8 CON application, then they either ask me in  
9 person or send me an email to let them know  
10 whether I think the project is consistent with  
11 the Plan or not, because we cannot accept an  
12 application for a project that is inconsistent  
13 with the Plan. So, I believe she testified in  
14 this case, and I think I said in my deposition,  
15 that Lisa Saunders was the primary reviewer and  
16 that when she received these two applications,  
17 she asked me or electronically requested an  
18 answer from me as to whether I thought the  
19 applications were consistent with the  
20 applicable Plans or not.

21 Q: With regard to the examples you gave me a few  
22 moments ago, out of, were those any among those  
23 examples that you recall personally discussing  
24 with a reviewer whether or not they initially  
25 appeared to be consistent with the Plan?

1 A: I'm sorry, can you say that again?

2 Q: Okay. Do you recall the examples you listed  
3 for me a few moments ago about bed transfer  
4 CONs to a site where there was no bricks and  
5 mortar facility?

6 A: Okay. Yes.

7 Q: Okay. Do you recall any if any of those  
8 specific examples were ones where you had been  
9 requested to determine upon initial, your  
10 initial review, they were consistent with, or  
11 appeared consistent in your opinion with the  
12 State Health Plan bed transfer provision?

13 MR. SUMMER: I'm going to object, Your Honor. He  
14 just testified that that was performed by Mr.  
15 Whiteside until his departure. Mr. Whiteside  
16 was terminated by the Commission at the end of  
17 2007. So, he wouldn't have been able to  
18 perform that function, by his own testimony,  
19 until beginning in 2008. So, he has testified  
20 that he performed that function as to these two  
21 applications. I have no objection for him  
22 answering the question as to those. But his  
23 own testimony says he did not perform that  
24 oversight function prior to Mr. Whiteside's  
25 termination which was the end of 2007. Now,



1 all of those examples are prior to that  
2 termination, so I would object. He's already  
3 said he did not do that.

4 **MS. BIGGERS:** Your Honor, first of all, Mr. Summer  
5 has for, I believe the third or fourth time  
6 attempted to insert testimony into this record  
7 which has not come in through any source,  
8 through any witness regarding an alleged  
9 termination of Mr. Whiteside and other CON  
10 employees. This question has been asked and  
11 asked again. Repeatedly it has been answered  
12 by witnesses, they have no knowledge whether a  
13 termination has occurred or has not occurred.  
14 I object to his characterization and his  
15 attempt to bring that testimony into Court.

16 **THE COURT:** Well, I'm not even considering that.

17 **MS. BIGGERS:** Okay.

18 **THE COURT:** What I'm interested in is this witness'  
19 testimony.

20 **MS. BIGGERS:** My second -- I'm sorry, Your Honor.

21 **THE COURT:** Let's deal with one thing at a time.

22 **MS. BIGGERS:** Okay.

23 **THE COURT:** My response is that he hasn't answered  
24 the question yet, we don't know what his answer  
25 is going to be. Let's see what -- your

1 objection should not be so much as a question  
2 as to the answer. If it tramples some rule of  
3 evidence.

4 **MS. BIGGERS:** Thank you, Your Honor.

5 Q: And would you like me to repeat --

6 A: Yes, please.

7 Q: Okay. My question was, of the examples that  
8 you have listed, do you recall whether you  
9 have, you personally were involved in reviewing  
10 whether or not any of those applications  
11 appeared to meet the State Health Plan bed  
12 provision?

13 A: I believe they all predate when I took over  
14 that function. The only one I can think of  
15 that might be in question is Village  
16 Healthcare, but I believe even that was still  
17 when Mr. Whiteside was performing that  
18 function.

19 Q: Okay. Then let's talk about the ones you just  
20 mentioned before this objection that you did  
21 review which I believe are, I believe you said  
22 the two under review today, are they a part of  
23 this litigation?

24 A: Yes. The Roper and Trident applications. Ms.  
25 Saunders asked for my opinion as to whether

1 they were consistent with the Plan or not.

2 Q: And what was your opinion?

3 MR. SUMMER: I am going to object. Mr. Long  
4 wouldn't let me get opinions from this witness  
5 and I think it would be manifestly unfair for  
6 the Department to be able to solicit opinion  
7 information from this witness when I wasn't  
8 allowed to do so.

9 MS. BIGGERS: Your Honor, this is a factual  
10 question. It is through the past DHEC fact  
11 witness. It was discussed as his part of the  
12 review process. Mr. Shelton has testified as a  
13 fact witness that he was asked this question.  
14 I'm attempting to elicit the factual answer as  
15 to what the opinion was that he provided.

16 MR. SUMMER: Same objection; I note it for the  
17 record.

18 THE COURT: All right. I overrule the objection.  
19 On the basis that he's simply telling what he  
20 did.

21 MS. BIGGERS: Thank you.

22 Q: Mr. Shelton, again, what information did you  
23 provide to Ms. Saunders when Ms. Saunders asked  
24 you those questions?

25 A: The Trident application was filed under the

1 2004-2005 Plan. They asked for 50 beds. The  
2 Plan showed a need for 56 beds and so therefore  
3 the project was consistent with the Plan. The  
4 Roper application came in under the 2008-2009  
5 Plan and based on the bed transfer provision  
6 that the Department has consistently allowed  
7 the creation of a new hospital from an  
8 existing, I made the determination that it was  
9 consistent with the Plan.

10 Q: Now, let's move on. You've already discussed  
11 for me some examples of transferring CONs or  
12 approved transferring beds. Is there a  
13 distinction between transferring beds and  
14 transferring bed need?

15 A: Yes. Transferring beds means physically taking  
16 beds that are physically licensed at one  
17 location and moving them to a new location.  
18 And that's what Roper is proposing to do. They  
19 have licensed beds downtown that they are  
20 proposing to physically relocate to a Berkeley  
21 County site. What Trident is proposing to do  
22 is taking the projected bed need, there is a  
23 need for 56 beds in the 2004-2005 Plan, that  
24 are projected as needed for Roper -- excuse me,  
25 for Trident Medical Center, and they are going

1 to locate those beds that are projected as  
2 needed at a Moncks Corner site in Berkeley  
3 County. So, those are the two different ways of  
4 creating a new facility. You either move the  
5 existing beds, you move the bed need, or you do  
6 like Trident did with Summerville, when  
7 Summerville Hospital was created, it was a  
8 combination of the two. There was a bed need  
9 projected for 69 beds and then they transferred  
10 31 existing beds from Trident to get a CON to  
11 create a 100 bed new hospital. So, Summerville  
12 was kind of actually created from both. They  
13 took bed need and they took existing beds from  
14 Trident in order to create Summerville Medical  
15 Center. Seacoast Medical Center in Horry  
16 County was created from the bed need transfer,  
17 like Trident is proposing to do in this case.  
18 Loris Hospital had a bed need and they took  
19 that bed need and instead of adding additional  
20 beds at Loris, they created a 50 bed new  
21 hospital in the Little River area of Horry  
22 County. So, that is a previous example of what  
23 Trident is proposing to do with their Berkeley  
24 County application here.

25 Q: Okay. And about the Summerville allocation you

1 mentioned, is Summerville Medical Center owned  
2 by Trident Health System?

3 A: It's my understanding they're all part of one  
4 system, the two hospitals and then the free-  
5 standing facility. They're all components of  
6 Trident Health System.

7 Q: And with regard to the CON that was approved  
8 for Summerville Medical Center that you just  
9 testified about, they transferred bed need as  
10 well as actual beds. Was there an existing  
11 bricks and mortar hospital in Summerville that  
12 those beds were transferred to?

13 A: Not that I'm aware of.

14 Q: Okay. Thank you. Those are all my questions.

15 **MR. SHELTON - CROSS EXAMINATION BY MR. LONG:**

16 Q: So, Trident actually used the same provision  
17 that they're criticizing Roper for to build the  
18 hospital at Summerville; is that correct?

19 A: I believe the Summerville facility was created  
20 before the bed transfer provision, as we call  
21 it, was added to the Plan. And I think  
22 Summerville was under the 1989 Plan. I think  
23 the CON was issued in 1990. The bed transfer  
24 provision was first in the 1995 Plan.

25 Q: So, there was nothing in the State Health Plan

1 that allowed you to transfer beds when they did  
2 that, right? Wasn't prohibited, wasn't  
3 addressed?

4 A: Right. There was no language that addressed it  
5 either way.

6 Q: Okay. And so they took the position, I guess,  
7 since the Plan didn't prohibit it, then they  
8 could do it, right?

9 A: I would have to presume. I did not review the  
10 application.

11 Q: You didn't testify -- and I think you -- I want  
12 to remind you of something. I know you know  
13 this and I know you're also sitting on the  
14 stand. Let's turn to the State Health Plan,  
15 Joint Exhibit 4 on page III-35.

16 A: (Witness does as instructed.)

17 Q: This is part of the inventory. If we could  
18 blow up footnote number seven. You might want  
19 to look on the other page, but footnote number  
20 seven applies to Trident Medical Center, right?

21 A: That's correct. Yes.

22 Q: And what does footnote number seven say about  
23 Trident?

24 A: Okay. It is explaining, basically how 25  
25 additional beds, hospital beds were added at

1 Trident, so it is saying that a CON was issued  
2 on November 27, 2007, to convert the 25 nursing  
3 home beds in the skilled nursing center to  
4 general acute beds for a total capacity of 296  
5 general acute beds. The CON was SC-0761. The  
6 license for 296 acute beds and the Trident  
7 Medical Skilled Nursing Center closed on May  
8 1st of 2008.

9 Q: So Trident didn't actually have 56 beds under  
10 the '04-'05 Plan, they used 25 of them for this  
11 CON, right?

12 A: No. There is a different provision in the Plan  
13 that allows -- if a facility has space that was  
14 once, that was used for nursing home beds,  
15 psychiatric, rehab, substance abuse and that if  
16 the facility closed, then those beds could be  
17 converted to hospital beds, on the premise that  
18 we would rather have them in use then having an  
19 empty unit just sitting there unused. So,  
20 there's a provision that -- I would have to  
21 find the exact language.

22 Q: Well, let me -- let's back up. I think we  
23 might be getting off a little bit. Let's go  
24 back to the year '04-'05 Plan, because I want  
25 to talk to you a little bit about Trident's



1 application of the '04-'05 Plan, so that's  
2 Joint Exhibit 3. We've been saying 56 beds was  
3 their bed need, so let's confirm that. Let's  
4 get the right number if we can so you can  
5 explain to me some confusion I may had with it.  
6 Turn to page II-17 and let's look at Trident  
7 Medical Center's bed need under the '04-'05  
8 Plan. Have you got it?

9 A: Okay. Yes.

10 Q: The actual bed need is 42, right?

11 A: In the '04-'05 Plan, it's 42.

12 Q: And, so it wasn't -- when they applied, it was  
13 42, the Plan showed 42 beds, right?

14 A: Correct.

15 Q: And there's a provision that allows a facility  
16 to build up to 50 beds for economic unit.

17 Q: Okay. If -- all right. Let's turn over to  
18 section D of the Plan.

19 MR. SUMMER: Excuse me, can you tell me what Plan  
20 we're in today?

21 MR. LONG: Yeah, this is '04-'05.

22 MR. SUMMER: Great, thanks.

23 MR. LONG: It's Joint Exhibit 3.

24 Q: All right. Let's look at page II-7.

25 A: II-7 of the '03 Plan?

- 1 Q: No, '04-'05.
- 2 A: Oh, I'm sorry. '04-'05 Plan, II-7. Okay. All
- 3 right.
- 4 Q: Let's look at section D. And we did look at
- 5 this yesterday, so I don't want to spend too
- 6 much time on it, but this is the section or
- 7 paragraph that Trident used to try to transfer
- 8 bed need to Moncks Corner, they proposed to
- 9 transfer this bed need to Moncks Corner to
- 10 build a hospital there, right?
- 11 A: I would presume so, yes.
- 12 Q: Okay. Has the Department, in its past, allowed
- 13 hospitals to transfer bed need to construct a
- 14 new hospital at a new location under this
- 15 section right here? Section D?
- 16 A: Yes, the Sea Oaks Medical Center would be an
- 17 example of that from Loris projecting a need.
- 18 Q: Are there other examples in the past?
- 19 A: That's the only one I'm aware of that was
- 20 strictly bed need transferred.
- 21 Q: Okay. And -- but Summerville was both, right?
- 22 A: Yes. Summerville and Patewood Hospital in
- 23 Greenville are both examples where a
- 24 combination of projected bed need and existing
- 25 licensed beds were transferred to create a new

1 licensed hospital.

2 Q: And you would agree with me that there's  
3 nothing in this language of section D that says  
4 anything about constructing a new hospital?

5 A: It does not specifically reference construction  
6 of a new hospital.

7 Q: And references to hospital in the section are  
8 hospital, singular, correct?

9 A: Correct.

10 Q: And it talks about in addition, as in one  
11 addition to the hospital, right?

12 A: Uh-huh (affirmative response). Correct.

13 Q: Okay. But it does require the applicant to  
14 show need for the additional beds, right?

15 A: Correct.

16 Q: And it actually allows you to construct more  
17 beds than up to 50, right?

18 A: Yes, we do have that provision. It has been  
19 there. It allows hospitals to build the  
20 greater of the actual need or up to 50 beds to  
21 allow for an economical unit.

22 Q: Why is that in there? What is the purpose of  
23 up to 50 provision?

24 A: We had situations where hospitals would be  
25 projected to have a need for say 10 or 15

1 additional beds and the hospital could have  
2 used the additional beds, but it would not be  
3 cost efficient to try and build to just house  
4 that many new beds. There's so much  
5 construction costs and such involved in trying  
6 to add on to a hospital that it was not cost  
7 effective for them to try and create a small  
8 addition, and so therefore, we added this  
9 provision that a hospital could add up to 50  
10 beds to create a more cost-effective addition,  
11 and like everything else, this went through the  
12 Plan development process, there was a lot of  
13 discussion, a lot of comments during it, but  
14 the hospitals were favorable. It was  
15 advantageous for them because they needed the  
16 additional beds, but it just wasn't cost  
17 effective for them to try and add five, ten  
18 beds at a time.

19 Q: And one reason in addition to that of  
20 construction is that most hospitals are kind of  
21 laid out in a wing or a floor, right? So, it's  
22 more cost effective for them to have a large  
23 number of rooms kind of together, right? In  
24 either a wing or a floor? That's part of it  
25 too, right?

1 A: Yeah, that was part of the efficiency of it.

2 Q: And so this is kind of one of those situations  
3 where you might have to spend a little more  
4 money on construction, but you've accomplished  
5 the goal by being more efficient to provide  
6 better service to patients, right?

7 A: Right. And also may head off the need for  
8 future expansion later on. If you get the 50  
9 beds now, that may take care of your needs for  
10 a number of years rather than doing  
11 incremental, getting ten beds and then a couple  
12 years later needing another ten. So, it was  
13 determined that 50 beds was a reasonable number  
14 to use, that you could add, make a cost  
15 effective addition, but at the same time you  
16 weren't unfairly getting too many beds that you  
17 could use against your competitors. Like if we  
18 said you could add 100 beds, I think that would  
19 be a little too much. That's going beyond cost  
20 effectiveness, that's kind of, you know, going  
21 way beyond what you're projected as needed.

22 Q: And -- well, part of that is because you're  
23 weighing that balance, that tension between the  
24 amount of -- whether the beds are actually  
25 needed or not, right?

1 A: Like I say, the bed need is projected for seven  
2 years in the future, so we're saying if their  
3 utilization is the same, then they are going to  
4 need this number of beds. So utilization  
5 fluctuates year by year so the hospital may go  
6 up, it may go down. But we think that that's  
7 going to be a sufficient number of bed to take  
8 care of their needs, so the 2008-2009 Plan, we  
9 were projecting out for 2013, I believe. So.

10 Q: You'd agree with me that in the healthcare  
11 delivery system, the way that healthcare is  
12 delivered and used by patients changes over  
13 time, right?

14 A: Yes, it does evolve, yes.

15 Q: And the reason for that is that one population  
16 grows or subtracts, right?

17 A: It can impact, yes, particularly if you have  
18 like high growth of the elderly, like along the  
19 beach and coast. Because the elderly typically  
20 need more health services, be a little sicker,  
21 stay a little longer. So, if you have a big  
22 influx of the elderly, or your population ages,  
23 then that could impact the potential future  
24 need for inpatient services.

25 Q: It's not just the elderly then, I mean, it's

1 the population as a whole, right? Because  
2 families use hospitals to deliver babies, and  
3 people have surgeries, correct?

4 A: Yeah, I agree that, yeah, population growth  
5 will potentially increase the need for hospital  
6 services. I was just mentioning the elderly as  
7 a particular segment, that if you get the elder  
8 that's really going to impact the potential  
9 future use.

10 Q: Correct. And also the population moves, right?  
11 There are areas of the state where a lot of  
12 people used to live and now we have areas of  
13 the state, well, let me ask it this way, we  
14 have areas of the state where people had much  
15 smaller population years ago, now have  
16 significantly larger populations, right?

17 A: There are populations that grow every census  
18 and there are counties that actually have fewer  
19 people in 2010 than they had in 2000.

20 Q: Right, and as that movement occurs in the state  
21 there's a need to change the healthcare  
22 delivery system to accommodate that, isn't  
23 there?

24 A: I think as you get more people there would be  
25 more demand.

1 Q: Look at an extreme example. Roper Downtown has  
2 been a hospital for 150 years, right?

3 A: I will accept that.

4 Q: So, the state's a little different today than  
5 it was in 1850 in regards to medical care,  
6 isn't it?

7 A: I would hope so.

8 Q: I would hope so, too. So, this bed transfer  
9 provision is designed, is it designed to be  
10 flexible?

11 A: Our intent was it, was to make it as broad as  
12 possible because, at the time, there was this  
13 whole discussion of new service delivery  
14 systems, new models, mergers, acquisitions, and  
15 so we wrote it as broadly as we could, and  
16 hopefully as flexible as you could, with that  
17 our goal was to prevent the Plan from  
18 prohibiting what otherwise might be a good  
19 idea. In other words, if someone has a good  
20 proposal that actually, you know, appears  
21 logical, appears feasible, but the only reason  
22 they can't do it, is because the Plan says as  
23 written, that's not allowed, then that's the  
24 reason for having fairly flexible, fairly broad  
25 exception is that if you can justify why there

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1 should be an exception to the Plan then the  
2 Plan won't be the thing that prohibits it from  
3 happening.

4 Q: Let's take a look at the, let's go back in the  
5 '08-'09 Health Plan, let's look at page II-9.  
6 The reason for that, what you just explained  
7 there, and the way the Department deals with  
8 that is they require you to have a certificate  
9 of need to transfer beds, right? And that  
10 specifically set forth in subsection J, you  
11 have to apply, it requires a CON, right?

12 A: Yes, a CON is required to transfer beds.

13 Q: And that is so that the applicant can show the  
14 Department the need for what they want to do,  
15 why they want to do it, and what the benefits  
16 of that would be, and the Department can make  
17 a discussion as to whether it's appropriate or  
18 not, right?

19 A: That would be true.

20 Q: Now sometimes the Department gets an  
21 application for a service or when -- that's not  
22 mentioned in the State Health Plan at all.  
23 Isn't that right?

24 A: That does happen.

25 Q: One of the more recent examples is the

1 development of CyberKnife, right?

2 A: It was an issue, yes, because it was not --  
3 CyberKnife is a specialized type of linear  
4 accelerator, but its capacity and utilization  
5 is different than a typical linear accelerator.  
6 So, when Roper did apply for a CyberKnife, and  
7 I believe that was an issue of how to review it  
8 since its capabilities, etcetera, were  
9 different than the linear accelerator standards  
10 we in the Plan at the time.

11 Q: Right, and even before Roper, St. Francis in  
12 Greenville, applied for a CyberKnife, but then  
13 actually ultimately abandoned it; do you recall  
14 that?

15 A: I don't remember that.

16 Q: But the Department -- the CyberKnife was new  
17 technology, but it still required a CON, and  
18 one of the reasons it required a CON is because  
19 the costs of the project were above the  
20 threshold.

21 A: I'll accept that, yes. Uh-huh (affirmative  
22 response).

23 Q: Because there are thresholds set forth in the  
24 CON Act that if your equipment is above a  
25 certain amount, or if your cost is above a

1 certain amount, you have to get a CON, and it  
2 has to be review by the Department, right?

3 A: Correct.

4 Q: Okay. Now in this particular section here,  
5 section J, which is runs on page II-9 and II-10  
6 of the '08-'09 Plan, there is no prohibition  
7 against transferring beds and construct a  
8 hospital, correct?

9 A: It does not state that.

10 Q: Okay. And when you're going to file a CON, you  
11 have to pay a fee to file a CON, don't you?

12 A: The application fee is \$500; that's the minimum  
13 it's going to cost you.

14 Q: And when you're finished you have to write  
15 another check after that, right?

16 A: There are either two or three different places  
17 where you would pay fees depending on the total  
18 of the project cost.

19 Q: And so, a transfer of beds is going to be one  
20 application, two facilities, right?

21 A: Correct.

22 Q: Okay. Nowhere on this subset on page II-10 is  
23 there, say, that the receiving facility has to  
24 be existing, right?

25 A: It does not say that.

1 Q: It never says that?

2 A: It does not state that.

3 Q: Now, when this issue came up before in the  
4 Parkridge case, you actually testified before  
5 the DHEC Board on a remand from the  
6 Administrative Law Court as to this provision,  
7 right?

8 A: That is correct.

9 Q: You were one of the people who testified in  
10 that hearing, correct?

11 A: Correct.

12 Q: And the DHEC Board stated that its State Health  
13 Plan, even though it was actually dealing with  
14 the '04-'05 Plan, but it's the same language,  
15 right?

16 A: That section of language is the same, yes.

17 Q: In '04-'05 it's the same as it is in '08-'09,  
18 right?

19 A: Correct.

20 Q: And the DHEC Board held, in Joint Exhibit 16,  
21 which we looked at yesterday, that that  
22 provision allows the transfer of beds to create  
23 a hospital, construct a new hospital, right?

24 A: That was their determination.

25 Q: Okay. And so from your position today, that

1 situation is over, right? DHEC Board has  
2 spoken, the Plan allows it.

3 A: DHEC staff reports to the DHEC Board, the DHEC  
4 Board made that determination, so therefore we  
5 are bound and beholden to the Board's  
6 determination.

7 Q: Earlier this morning Mr. Summer asked you about  
8 -- and just one question, there have been times  
9 where the DHEC Board has overridden or changed  
10 the proposed Plan, right? It has happened,  
11 right?

12 A: They have changed sections, they have also  
13 remanded stuff back for further review, and,  
14 so, yes, it has happened, where the Board  
15 hasn't necessarily taken what the staff and the  
16 State Health Planning Committee have  
17 recommended to them.

18 Q: Now, let's look over at the bed need section,  
19 II-12, real quickly. You'd agree with me,  
20 wouldn't you, that the bed need formula in the  
21 State Health Plan is a mechanism to determine  
22 the need for additional beds, right?

23 A: That is correct. We are projecting, in this  
24 Plan, in 2013, how many beds each particular  
25 this facility is projected to need at that

1 time.

2 Q: Now if you're a hospital that's in a certain  
3 situation where you have an excess -- like we  
4 looked at AnMed earlier this morning, right?

5 A: Correct.

6 Q: And they're showing under this Plan an excess  
7 of 94 beds, right?

8 A: Correct.

9 Q: Okay. Does the Department take the beds back  
10 from them? Take them away from them?

11 A: There is no mechanism to do that.

12 Q: Right, because they had the beds, they get to  
13 keep the beds, this is just a tool to measure  
14 what the need would be in the future, right?  
15 This formula?

16 A: It is our projection of how many beds we think  
17 they will need.

18 Q: Okay. And the formula or the tool to determine  
19 whether additional beds should be added in the  
20 future is irrelevant to whether beds should be  
21 transferred between two facilities, isn't it?

22 A: This is the bed need projection, it's projected  
23 how many beds are need by a facility.

24 Q: And it has nothing to do with the bed transfer  
25 provision, does it?

1 A: No, this is strictly calculation of need.

2 Q: Okay. Let's talk about a hospital bed, okay?  
3 Well, first, do you have a copy of that  
4 statute? And, I don't -- Your Honor, we don't  
5 have that on screen, but I think you had it  
6 earlier.

7 A: The 44-7-180, or?

8 Q: One eighty, correct. Your Honor, do you still  
9 have that copy, do you have it handy? I'm just  
10 going to ask him a couple of questions about  
11 it.

12 THE COURT: 44-7-180?

13 MR. LONG: Yes, sir.

14 Q: Mr. Summer asked you a lot of questions this  
15 morning about this statute; I just wanted to  
16 direct your attention to one 44-7-180(B), and  
17 particularly subsection 3, because this is the  
18 one about standards, right?

19 A: Correct.

20 Q: Okay. It says, standards for the distribution  
21 of healthcare facilities, beds, specified  
22 health services, and equipment, okay? Those  
23 are four different things, aren't they? I mean  
24 there's four things listed there, right?

25 A: Correct, yes.

1 Q: Now, is equipment the same thing as facility?

2 A: No.

3 Q: Okay. And specified health services would  
4 include those specific services in the Health  
5 Plan, like open heart surgery, or  
6 catheterizations, or linear -- give me another  
7 service if you can think of one quickly.

8 A: PET/CT.

9 Q: PET/CT. Great, good example. All right. Those  
10 are specified services listed in the Plan that  
11 the Plan addresses, right?

12 A: Correct.

13 Q: Okay. And then it says specifically beds,  
14 right?

15 A: Correct.

16 Q: Okay. Now, every hospital has to have beds,  
17 right?

18 A: Yes.

19 Q: And really, no other -- and the reason they  
20 have to have beds is because the hospital keeps  
21 people overnight, that's what makes it a  
22 hospital, right?

23 A: Agreed.

24 Q: And if you're going to be inpatient in a  
25 hospital in a bed, you would agree with me that



1 that facility has to have the ability to  
2 operate on you, right? They have to have the  
3 ability to do operations, right? Surgery?

4 A: Yes.

5 Q: They also have to ability to do imaging, right?

6 A: That would be standard for a hospital, yes.

7 Q: They also need the ability to be able to  
8 dispense medications to you, right?

9 A: Correct.

10 Q: They also need to have the ability feed you.

11 A: Correct.

12 Q: They also need to have the ability to basically  
13 -- to operate a lab, to review the tests and  
14 all that they're going to run on you, that you  
15 may need as a patient.

16 A: Yes.

17 Q: Okay. So, all those things that go along with  
18 that, are included when you talk about a bed,  
19 right?

20 A: I'm sorry, say that again.

21 Q: All of the things that go along with staying in  
22 a hospital are included when you start talking  
23 about a bed in the State Health Plan, right?

24 A: Yeah. I mean, a bed is in a hospital, and  
25 hospital is basically all of the things you

1 described, those are components of being a  
2 hospital.

3 Q: Now, we talked this morning a little bit about  
4 financial feasibility, and you said typically  
5 that the Department often looks at the  
6 regulations and would like to see positive cash  
7 flow in the third year, right?

8 A: I think I said based on my memory of the regs,  
9 I think that it was I said, is that we looked  
10 for a facility to be financially viable by the  
11 third full year of operation.

12 Q: But you'd agree with me that in a hospital, not  
13 every service or everything that is done by a  
14 hospital is profitable to the hospital, is it?

15 A: There are certain services they need to make  
16 money on to cover their losses from things like  
17 the emergency room. Emergency rooms are money  
18 losers, so they have to make money from other  
19 services to cover the loss from that service.

20 Q: And sometimes hospitals build facilities or  
21 offer services that they'll never make money  
22 on, on just the service, right? On the  
23 facility?

24 A: I would presume that, yes, there are some  
25 services that they just have to fund from other

1 sources, that aren't profitable by themselves.

2 Q: So part of that, another factor to consider in  
3 that determination is whether they can afford  
4 do it, right? So they have the means to fund  
5 the service or the facility?

6 A: I think that would tie in with the whole  
7 financial feasibility issue, yes.

8 Q: And in the discussion this morning about  
9 ambulatory surgery facilities, one of the  
10 concerns that hospitals have about ambulatory  
11 surgery facilities is that it's kind of cherry-  
12 picking at service that is more financially  
13 viable or lucrative to the hospital than other  
14 services, right?

15 A: That is what they allege, yes.

16 Q: And that's really the tension between  
17 ambulatory facilities and hospitals, right? Is  
18 because the ambulatory surgery facilities is  
19 not going to take -- what they're taking is  
20 financially lucrative, right?

21 A: That, again, is what's alleged, yes. They are  
22 cherry-picking and taking the profitable, easy-  
23 to-care-for cases and the hospitals are being  
24 left with the more difficult, less-profitable  
25 ones.

1 Q: And that can actually cause more damage to the  
2 hospital than actually having a hospital near  
3 it, because a hospital near it would also have  
4 do the stuff that's not as financially  
5 profitable, right?

6 A: I'm not that conversant with hospital finances  
7 to be able to say.

8 Q: But it's possible, isn't it?

9 A: I guess it would be potentially, yes.

10 Q: Depends on the circumstances, right?

11 A: Yes, I guess it would be dependant on what  
12 types of services each hospital specialized in,  
13 so if the new hospital was offering the same  
14 service -- okay, just for example, if Hospital  
15 A is a big open heart provider then Hospital B  
16 gets into open heart then, yeah, it could  
17 obviously have a big impact because cardiac is  
18 a profitable area. But if they start offering  
19 ER services Hospital A won't complain because  
20 ER is a money loser so they'll be glad to take  
21 all the ER send to Hospital B.

22 Q: Right, right. You also testified about cost  
23 containment. That's a complicated area of  
24 healthcare, isn't it?

25 A: That's an area -- I don't deal with the

1 financial information, I'm a data person  
2 primarily, so I tend to not get into the  
3 financial side.

4 Q: Because reimbursement for healthcare facilities  
5 is not like normal business, is it?

6 A: They have people that specialize in medical  
7 billing and there are a number of courses that  
8 are offered by the AHA and others on how to  
9 properly code and most efficiently code in  
10 order to get reimbursed properly, so, yes, it  
11 is a very convoluted field.

12 Q: And sometimes hospitals -- Mr. Gallati, you  
13 were here when Mr. Gallati testified, didn't  
14 you?

15 A: Yes, sir.

16 Q: And you heard him testify about the da Vinci  
17 Robot, right? Do you remember that?

18 A: Yes.

19 Q: And that was a situation where he testified  
20 that his hospital spent money and the  
21 reimbursement that they were going to get was  
22 actually going to be less if they would have  
23 without the machine, right?

24 A: That would be a trade-off that they made, it  
25 cost them some money, but I think the trade-off

1 was in the quality that there was some safety  
2 and additional quality of surgery through using  
3 the robotics rather than, you know, the human  
4 hand. And so even though it cost them money to  
5 do the robotics, that the quality of the  
6 surgery they provided was better. So even  
7 though they lost the money, it was a better  
8 outcomes for the patient so it was a trade-off  
9 they were willing to make.

10 Q: Right, the patient benefitted so they were  
11 willing to spend the money, right?

12 A: Correct.

13 MR. LONG: One moment, Your Honor.

14 Q: That's all I have Mr. Shelton, thank you.

15 A: Thank you.

16 THE COURT: Mr. Summer?

17 MR. SHELTON - REDIRECT EXAMINATION BY MR. SUMMER:

18 Q: Thank you, Your Honor. The benefit of sitting  
19 here for days on end is that you continually  
20 find new things. Remember the line of  
21 questioning that Ms. Biggers had about the  
22 inventory. That was something I hadn't asked  
23 you about, was III and the inventory. And I  
24 believe she took you to the inventory in the  
25 2008-2009 Plan. Do you remember that line of

1 questioning?

2 A: Generally, yes.

3 Q: I think you turned her attention to Region IV.

4 A: Correct.

5 Q: And that beings on -- and we're in Joint 4 --  
6 we're in Joint 4, III-31 and that's the Region,  
7 Region IV that you said that Berkeley County  
8 was in, correct?

9 A: Yes.

10 Q: And she made you look in the inventory and  
11 said, find me Berkeley county, where is  
12 Berkeley county. Do you remember that line of  
13 questioning?

14 A: Yes.

15 Q: And you said it doesn't exist.

16 A: I said it did not exist in the list of general  
17 hospitals.

18 Q: I'm not suggesting that Berkeley County doesn't  
19 exist, I'm just suggesting that it's not here,  
20 and you said you couldn't find it here and it's  
21 not listed here, is it?

22 A: Not listed in the general hospital section, no,  
23 it would be, obviously, in the nursing home  
24 section and possibly some other services, but  
25 no, there is not a listing of Berkeley County

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1 hospitals in that inventory because none were  
2 approved at the time that we approved the 2008-  
3 2009 Plan.

4 Q: Let's go back, though. You used to have it in  
5 your Plans, and I'm going to go back to Region  
6 IV, in the 2001 Plan.

7 A: Okay.

8 Q: And I don't know why, but we don't have a lot  
9 of copies of these, but that's III-53, do you  
10 see that?

11 A: Yes, I do.

12 Q: And is that 2001 Plan?

13 A: Yes.

14 Q: Okay. And where does it list as the Berkeley  
15 County hospital?

16 A: It shows one existing hospital for  
17 Berkeley/Dorchester, which is -- it shows 345  
18 existing beds.

19 Q: Okay. Let's go backwards a few pages. It's  
20 referring to the Trident System, is it not?  
21 Look at the beds.

22 A: I believe so, yes. Let's see. I'm not sure  
23 why it shows one existing because it's --

24 Q: And it's one licensee, isn't it?

25 A: That would possibly explain it, yeah, because



1           there are two distinct hospitals, but my  
2           understanding is they're under a single  
3           license.

4       Q:   This is the same Plan we looked at earlier that  
5           listed Trident in the beds needs section as  
6           Berkeley County, the Berkeley/Dorchester  
7           Planning Region, correct?

8       A:   You said 2001 or 2003? I'm sorry, I don't  
9           remember.

10      Q:   That's all right. Let's go look at it real  
11          quick, I'll put it right back in front of you.

12      A:   Oh, no. You're right, it was 2001.

13      Q:   2001.

14      A:   2003 was when it was changed. Yes, 2001 did  
15          show it as one.

16      Q:   So, you used to inventory Berkeley and  
17          Dorchester County as having a hospital, and  
18          for some reason, the Department just quit doing  
19          it after 2001, didn't it?

20      A:   That is the way it appears. I was not the  
21          person that did that and was not aware that it  
22          had been changed until you brought it up in the  
23          deposition, so, there is, unfortunately, no one  
24          here that can explain that.

25      Q:   Mr. Long has referred to the statute again, and

1 I'm going to try to handle these jointly. Ms.  
2 Biggers also referred to criteria for new  
3 hospitals. But again, your testimony is that  
4 the standards and the projections that appear  
5 in the Plan are for beds, not hospitals,  
6 correct?

7 A: That is correct. We do not project a specific  
8 need for hospitals, for new hospitals.

9 Q: So the testimony that you and I went through  
10 earlier today, regarding the mandates and the  
11 statute, those mandates refer to hospitals,  
12 correct?

13 A: I'm sorry, Mr. Summer, can you repeat that  
14 please?

15 Q: Go ahead and pick up your statute.

16 A: Got it.

17 Q: And you would agree with me that 44-7-180 says  
18 that the Plan, at a minimum, must include --  
19 and we referred to that early in the day as  
20 being a statutory mandate, remember that?

21 A: Yes, I do.

22 Q: And you have an inventory for hospitals,  
23 correct?

24 A: That is correct.

25 Q: But you have no projections of need for

1 hospitals, do you?

2 A: Correct, we only project the need for beds,  
3 because, it is better to project a need for  
4 hospital beds and then allow the applicant to  
5 locate those beds, in whole or in part, at the  
6 existing site or at a new site, I think, versus  
7 the Department making the determination that  
8 DHEC says County X needs a new hospital.  
9 Because the way the bed need is calculated it's  
10 based on the utilization of the individual  
11 facilities. The existing facilities are  
12 driving the bed need. So, the potential  
13 problem that I can see with the Department  
14 determining that there is a need for a new  
15 hospital versus the need for additional beds in  
16 a county is that you are potentially limiting  
17 the ability of the existing provider to expand.  
18 And they're the ones that are driving the bed  
19 need. I will make a, just -- Aiken County, is  
20 an example, there's a hospital there, Aiken  
21 Hospital. And if they're successful, they have  
22 high utilization, they have a bed need, they  
23 have a positive bed need, and if we make a  
24 determination that there is a need for an  
25 additional hospital in Aiken County rather than

1 there is a need for additional beds in Aiken  
2 County then that appears to be precluding the  
3 ability of the existing Aiken hospital to  
4 expand at their existing site, because DHEC is  
5 saying we need a new hospital in County X, in  
6 Aiken County DHEC's lifted utilization and we  
7 think we need a new hospital, not we think  
8 Aiken needs to expand. We've made the  
9 determination that we need a new hospital in  
10 that county and so therefore Aiken Hospital  
11 might have room to expand, might have plans to  
12 expand, but instead the Department is saying,  
13 Aiken, you've been so successful, we think we  
14 need to put a new hospital in the county. So  
15 that is the potential concern I can see with  
16 the Department taking the bed need projections  
17 and actually saying there is a need for a new  
18 hospital versus projecting that there is number  
19 of beds needed, and according to the Plan the  
20 applicant can locate them, in whole or in part,  
21 at they're existing site, or at a new location  
22 to best meet their needs.

23 Q: That's interesting. Where is that expressed in  
24 the Plan?

25 A: I'm saying that is a concern of -- if you

1 wanted the Department to project the need for  
2 a hospital using the current bed need  
3 methodology, which is based on the utilization  
4 of the existing hospitals, the only way to  
5 generate the need for a new hospital would be  
6 from the utilization of the existing hospitals.

7 Q: I don't think you understood my question. This  
8 was, that's an interesting articulation of  
9 policy. I've been doing this thing for three  
10 decades, I've never heard anybody espouse that.  
11 Is it in the Plan somewhere that you're  
12 deferring or delegating this to the existing  
13 hospitals?

14 A: No, we say that a hospital's need is calculated  
15 on individual facility basis, and no, there is  
16 not a projection of need for a new hospital.  
17 There is not a standard that says DHEC says  
18 County X needs a new hospital.

19 Q: The Plan is silent on this whole thing that you  
20 just said. The Plan is silent on that, isn't  
21 it?

22 A: Correct. That's why, like I said, we rely on  
23 beds. We approve beds and the applicants are  
24 the best people to determine whether to locate  
25 the hospital in a new location or expand their

1 existing. That's their decision. They have  
2 professional staff that make those kind of  
3 determinations.

4 Q: You're delegating it to the applicant to decide  
5 when and where to build any hospitals; is that  
6 what you're basically saying?

7 A: We are not telling hospitals when and where to  
8 build, we are projecting -- we are taking  
9 their utilization and we are saying that  
10 Trident, you are successful, we think you are  
11 going to need additional beds in order to treat  
12 all the patients that we envision you seeing a  
13 few years from now. So here, we project that  
14 you need additional beds and we're going to  
15 approve the CON and it's going to be up to  
16 Trident to decide do we expand Trident Medical  
17 Center or do we take some or all of those beds  
18 and locate them in another site.

19 Q: All right.

20 A: We leave that to the applicant to justify to  
21 the Department why that is the best thing for  
22 their patients and I think that's better than  
23 the Department trying to tell Trident what they  
24 need to do. We're telling Trident you've got  
25 a bed need, if y'all want to fill the bed need,

- 1           you tell us how you're going to do it.
- 2       Q:     Interesting logic.   Let's go to II-19 in the
- 3           2008-2009 State Health Plan.
- 4       A:     That's Joint 4?
- 5       Q:     Just let me know when you get there.   We're
- 6           going to look at 18 and 19.
- 7       A:     Eighteen and 19.   Right.   Okay.
- 8       Q:     All right.   Your logic is Trident, you've got
- 9           a bed need of 56.   We're using this Plan.
- 10       Trident, you've got a bed need of 56, you're
- 11       successful, you tell us where you want to put
- 12       those beds and what you want to do with them.
- 13       Isn't the logical corollary of that if you go
- 14       to page II-19, Roper-St. Francis?   Okay?   They
- 15       have a negative bed need, whether you look at
- 16       Roper or Bon Secours, joint ownership between
- 17       the two of them, they have a negative bed need
- 18       of 23.   Roper, you're being unsuccessful, tell
- 19       us where you want to put a new hospital.   Isn't
- 20       that logically inconsistent?
- 21       A:     Well,   there are potential reasons why a
- 22       facility has less than, less utilization than
- 23       projecting additional need.
- 24       Q:     Why would we let an unsuccessful hospital build
- 25       a 100 million dollar facility out of its

1 natural market? Your premise was you develop  
2 bed need, you're successful, patients like you,  
3 they come to you, doctors like you, they use  
4 you. You have a positive bed need, we're  
5 delegating you and you tell us where you want  
6 to build those beds. The logical corollary to  
7 that is if you have a negative bed need, you  
8 shouldn't be allowed to build a new hospital  
9 until you can demonstrate that you can do it  
10 well. Isn't that the logical corollary to this  
11 premise that you just espoused?

12 A: It could be. Like you had never heard my  
13 logic, I had never heard your logic. So I  
14 guess we're equal on that. But --

15 Q: Let me take you to another line of questioning  
16 that Mr. Long walked you through with this  
17 notion that somehow the word beds included the  
18 kitchen and dietary and the emergency room and  
19 all the imaging and all of the surgery suites  
20 and everything that goes into creating a  
21 hospital; do you remember that line of  
22 questioning?

23 A: Yes.

24 Q: Okay. You would agree with me that when you  
25 add all those things up you get a hospital,



- 1 correct?
- 2 A: Yes. In this case, yes.
- 3 Q: ER services is not beds, correct?
- 4 A: Agreed.
- 5 Q: Okay. OB services are not generally acute care
- 6 beds, okay?
- 7 A: Yes, they are. OB is a --
- 8 Q: Let's use other things. Imaging. Imaging is
- 9 not, correct?
- 10 A: Agreed, yes.
- 11 Q: Okay. An ambulatory surgery center is not a
- 12 hospital bed?
- 13 A: Agreed.
- 14 Q: Okay. Operating rooms are not a hospital bed.
- 15 All those things together create a hospital.
- 16 A hospital is a healthcare facility under South
- 17 Carolina law, correct?
- 18 A: Agreed.
- 19 Q: And when we look at that statute, the Plan at a
- 20 minimum must include projection of needs for a
- 21 hospital, correct?
- 22 A: For a healthcare facility, yes.
- 23 Q: And we don't have those, do we?
- 24 A: No, we do not project a need for hospitals
- 25 specifically, we project the need for beds.

1 Q: If we did, we probably wouldn't be sitting here  
2 having this debate, would we?

3 A: We would have a totally different bed need  
4 methodology in order to accomplish that so I'm  
5 not sure what the end result would be because  
6 we would have to put that in the Plan and that  
7 would obviously generate a whole bunch of  
8 discussions and comments. So it could be done,  
9 I'm just not sure the end result would be.

10 Q: You'd actually have to work to do it, wouldn't  
11 you?

12 A: It would create -- it would require a whole lot  
13 of input from the Hospital Association and  
14 individual hospitals because it would be a  
15 significant change in, a potentially  
16 significant change in how bed need is  
17 calculated and there could be potentially  
18 winners and losers under. Depending on how  
19 the methodology works out, how the language is  
20 created, there could be hospitals that would be  
21 in favor of this, hospitals opposed to it, the  
22 Hospital Association may not be able to take a  
23 position one way or the other because they  
24 like to have general consensus before they take  
25 a position. So it would require a whole lot of

1 input from a whole lot of parties and I can't  
2 say right now what the finished product would  
3 look like. If we tried to create such a  
4 methodology, it would certainly make for some  
5 interesting public hearings and committee  
6 meetings and possibly DHEC Board meeting.

7 Q: Look at your statute again. Your Legislature  
8 gives you two years, two years to put a Plan  
9 together, doesn't it?

10 A: Minimum two, yes, sir.

11 Q: And your Legislature said give me an inventory,  
12 you've given me an inventory. Your Legislature  
13 said give us projections of need for additional  
14 hospitals. You haven't done it, have you?

15 A: That is not in the Plan.

16 Q: Your Legislature also said give us standards  
17 for distribution of hospital facilities; you  
18 haven't done that either, have you?

19 A: No, we projected by individual facility and  
20 some by county. We tell you what need there is  
21 in a county and if there's need, then you can  
22 locate it in some or part within that service  
23 area. We do not specifically say there needs  
24 to be a hospital in Bethune rather than Camden  
25 in Kershaw County.

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1 Q: There are no standards --

2 THE COURT: Excuse me. You indicated the desire to  
3 recess at 3:45 and Mr. Baehr just left.

4 A: Mr. Baehr just left.

5 MR. SUMMER: He's got to catch a plane. Is that all  
6 right, Your Honor?

7 THE COURT: Well, I thought you wanted him here for  
8 everything and that was the reason you wanted  
9 to recess.

10 MR. SUMMER: I would like to finish this witness.

11 THE COURT: Absolutely. My time is yours.

12 MR. SUMMER: Okay. And so he --

13 MR. LONG: We'd like to finish, Your Honor. We  
14 thought he might be able to stay and that was  
15 part of our reason for that. But we didn't  
16 make it.

17 THE COURT: Go ahead.

18 Q: Going back again, the Plan at a minimum must  
19 include standards for distributions of  
20 hospitals and it does not contain those, does  
21 it?

22 A: Right. Yes.

23 Q: You've got two years to put this together. If  
24 it's going to take some effort and some work,  
25 the Legislature gives you two years to get that

1 accomplished, don't they?

2 A: Right. The law requires a Plan every two  
3 years.

4 Q: Thirty-three states in the Union have  
5 certificate of need, don't they?

6 A: Some variation of it, yes.

7 Q: Okay. And 33 states have figured out ways to  
8 administer that program. You have ways to go  
9 and look what other states do in terms of their  
10 projection of need for hospitals, don't you?

11 A: Yes, it is possible to do so. Yes.

12 Q: Understand what my concern here is. We are in  
13 agreement there's a statutory mandate and this  
14 is something the Department has failed to do.  
15 As the director of the Plan don't you think you  
16 have a responsibility to make this happen?

17 A: Okay. The Plan -- that standard has been there  
18 since 1995 until this hearing. No one has ever  
19 expressed that concern. So I was not aware  
20 that anyone was concerned because we go through  
21 the Plan development process, every two years  
22 the Plan is put out there. If the concern had  
23 been expressed that there was not the things  
24 you have mentioned, then yes, we would have  
25 addressed them at some point in time during the

1 last 17 years. But no, the issue has never  
2 been raised until now and we believe that the  
3 standards have been adequate. There has not  
4 been concern expressed until this case about  
5 the need methodology and the standards. So no,  
6 we -- it is possible for us to do so but, no,  
7 until this point, no, there are not time travel  
8 standards in the distribution that you asked  
9 about. No, they're not in the Plan.

10 Q: I'm confused. Didn't you testify on this very  
11 issue before the DHEC Board?

12 A: I'm sorry?

13 Q: Didn't you testify on this very issue before  
14 the DHEC Board?

15 A: I'm sorry, which specific issue?

16 Q: How about in the Parkridge case, did you not  
17 testify about this very issue, the bed transfer  
18 section, before the DHEC Board?

19 A: Yes, the bed transfer, yes, we did discuss the  
20 bed transfer position.

21 Q: And didn't part and parcel of that bed transfer  
22 dispute, the fact that there aren't any other  
23 criteria anywhere in the Plan on how to build  
24 a new hospital?

25 A: Yes, that was that -- that was part of the

1 Parkridge case. I was talking specifically  
2 about the things you asked about, are there no  
3 travel time standards in the Plan and I was  
4 agreeing, there are no travel time standards in  
5 the Plan.

6 Q: Well, it's a lot more than travel time  
7 standards; it's utilization, occupancy rates,  
8 regionalization, time travel, all of those have  
9 to be done as standards for the distribution of  
10 a hospital, not beds, but as a hospital,  
11 correct?

12 A: I hate to do this, Mr. Summer, but could you  
13 please restate that?

14 Q: I'll withdraw the question because we've beaten  
15 this dog all day long. Now, what I want to do  
16 is try to ask you a few questions and wrap this  
17 up.

18 A: Yes, sir.

19 Q: Ms. Biggers walked you through a number of  
20 different scenarios: Anderson County creating a  
21 hospital, Providence Northeast creating a  
22 hospital, Roper Mount Pleasant creating a  
23 hospital, Georgetown and Waccamaw creating a  
24 hospital, Loris creating a hospital. Do you  
25 remember all that line of questioning?

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1 A: Yes, sir.

2 Q: Okay. Is it fair to say that most of those  
3 hospital creations were not opposed by other  
4 competitors in the market place?

5 A: I'm not aware of Anderson. I'm not certain  
6 about Providence Northeast, I don't think  
7 anybody, that one may have been appealed.  
8 Let's see, Loris was appealed by Grand Strand.

9 Q: Correct. Parkridge was appealed by --

10 A: Yeah, Parkridge obviously.

11 Q: Newberry and Lexington.

12 A: Yeah, both those hospitals appealed that one.  
13 I don't believe Village Healthcare in  
14 Spartanburg was appealed. I think St. Francis  
15 may have appealed the Patewood Hospital in  
16 Spartanburg County, but I don't think that went  
17 to the Administrative Law Court. I think that  
18 appeal got dropped. Waccamaw I'm not sure.  
19 Grand Strand may have, I think Grand Strand  
20 appealed the Waccamaw decision because they  
21 were building a hospital very close to the  
22 Horry County line. I think Grand Strand took  
23 the position that that was close to their  
24 county, so I think Grand Strand appealed the  
25 Waccamaw decision. And I don't know about the



1 Roper Mount Pleasant. I don't know whether  
2 that one was appealed or not. I think since  
3 East Cooper and Roper were both applying, I  
4 don't know whether they appealed each other or  
5 how that worked out. I know both applications  
6 were approved, but I think there was some  
7 requirement that Roper couldn't start building  
8 until after the East Cooper facility had  
9 reached a certain point during the process. So  
10 some of them were likely appealed, some were  
11 not. Some were not opposed.

12 Q: To the best of your knowledge has the DHEC  
13 Board expressed an opinion on the bed transfer  
14 section other than the opinion that they issued  
15 in the Parkridge case?

16 A: Parkridge was the only case.

17 Q: To the best of your knowledge are the two  
18 orders in the Parkridge case regarding the bed  
19 section, Judge Kittrell's original order and  
20 Judge Durden's order, those were the only two  
21 orders that deal with the bed transfer case for  
22 the ALJ, aren't they?

23 A: That's all I'm familiar with.

24 Q: Okay. Do you remember Mr. Long's line of  
25 questioning where he referred you to Section J,

1 the bed need section, and said the word  
2 existing does not appear there anywhere; do you  
3 remember that?

4 A: Yes, sir.

5 Q: Okay. But you would agree based upon your  
6 prior testimony that a receiving facility would  
7 have to exist in order to receive the beds,  
8 correct?

9 A: I believe that was what I said earlier.

10 Q: I understand the Department has a different  
11 language, but in terms of the Plan meaning of  
12 the words a receiving facility must be in  
13 existence in order to receive the beds, mustn't  
14 it?

15 A: I think that's what I agreed to earlier today.

16 Q: And the only way you can be a hospital facility  
17 in the state of South Carolina is to have a  
18 license, correct?

19 A: Correct.

20 Q: You also talked a little bit about the Loris  
21 case. Loris was moving a bed need to an  
22 existing standalone ER and surgery center,  
23 weren't they?

24 A: Yes. Uh-huh (affirmative response).

25 Q: And Moncks Corner, Trident has a Moncks Corner

1 facility that is a standalone ER that operates  
2 under its license, doesn't it?

3 A: I believe that's correct. If you don't mind me  
4 just double checking if it's in the Plan.

5 Q: Please do.

6 A: And I'm pretty sure that we have it in there.  
7 I'm sorry, I was looking in the wrong Plan.  
8 Yes, they do.

9 Q: But there is a licensed healthcare facility  
10 there, isn't there?

11 A: Yeah. It's under the auspices of the Trident  
12 Emergency System. Because freestanding ERs  
13 have to be affiliated with an existing  
14 hospital's ER, so they're with Trident.

15 Q: When is the last time you went to Roper  
16 Hospital?

17 A: Probably two years ago, maybe two or three  
18 years ago.

19 Q: I realize that we've had a number of references  
20 to it being there for 150 years, but would you  
21 agree with me that it is a state-of-the-art  
22 modern facility on the Charleston peninsula?

23 A: I think parts of it are newer than others.

24 Q: Would you consider it to be dilapidated?

25 A: Not from what I remember.

1 Q: Okay. And, in fact, they've done quite a bit  
2 of renovations and replacements recently,  
3 haven't they?

4 A: Yeah, that whole area because you have the  
5 Medical University right next -- I'm mostly  
6 familiar with it because my wife was doing her  
7 Master's at MUSC and so she was spending a week  
8 in residence in Charleston every semester. So  
9 seeing Roper was peripheral to making frequent  
10 trips to the MUSC graduate school which is  
11 right there near Roper.

12 Q: You would agree with me that it is a modern,  
13 well-constructed facility?

14 A: Yes.

15 Q: Okay.

16 MR. SUMMER: Thank you, Your Honor. Thank you, Mr.  
17 Shelton, I appreciate your time.

18 A: Thank you.

19 THE COURT: Anything we need to take up before we go  
20 into recess?

21 MR. SUMMER: Your Honor, I would like to raise an  
22 issue for the Court's consideration.

23 MOTION - BY MR. SUMMER:

24 MR. SUMMER: I would like to renew our motion for  
25 summary judgment based upon the testimony of

1 these two. When Your Honor denied our motion  
2 for summary judgment on whether or not the bed  
3 transfer sectioned provided a mechanism to  
4 create the Roper Hospital in Carnes Crossroad,  
5 your ruling was you wanted to take testimony,  
6 you wanted to hear about it. We've now heard  
7 from two Department witnesses and I'm not being  
8 flippant, but there clearly is a very, in my  
9 mind, arbitrary, ad hoc environment in this  
10 agency that they utilize to approve these  
11 applications without due consideration, without  
12 due deliberation, without a framework to  
13 evaluate these applications. Both witnesses  
14 testified under oath only one way for Roper to  
15 have a hospital, had to be the bed transfer  
16 section. And despite their evasiveness and  
17 what I believe to be incredibly illogical  
18 assertions about what the language is, they  
19 each had to admit what the plain English  
20 language is. Our motion laid out the rules of  
21 statutory construction and the number one rule,  
22 as expressed by *Marlboro Park* in the Court of  
23 Appeals, Judge Kittredge, is that you give them  
24 in a plain and ordinary meaning. Under their  
25 plain and ordinary meaning there's not a way to

1 do this. Granting us summary judgment on this  
2 issue, one, avoids the cost of two more weeks  
3 of trial, which with attorneys and experts,  
4 some of whom are more expensive than me, adds  
5 a great deal of cost to all of our clients. If  
6 this is a legal issue at some point in time  
7 that you believe you have enough information on  
8 to make a legal determination, we would ask for  
9 you to please do that in order to avoid that  
10 cost. And I know only Your Honor will know  
11 when you feel like there's a sufficient amount  
12 of information has been provided. But if we're  
13 looking at statutory construction, we're  
14 looking at the plain language of the Plan, this  
15 doesn't provide Roper a means to get there and  
16 these witnesses said there's no other means to  
17 get there. What's the legal effect of having  
18 done that? They have not opposed our  
19 application. What they have said, and I would  
20 encourage the Court to look at the pre-hearing  
21 statement and the original petition is that  
22 they think we should have ours and that they  
23 should have theirs. Their only appeal is that  
24 if you were to deem these competing, that  
25 they're better. And the most recent ruling on

1 that for the Court is that is if you get to the  
2 issue of whether or not they're competing,  
3 you're going to remand it. But I would suggest  
4 to the Court that you don't have to go there.  
5 That if you determine that they have no legal  
6 means, it's got to be consistent with the Plan,  
7 and if their application is inconsistent with  
8 the Plan threshold issue, then they're not  
9 entitled to do this and they -- therefore, that  
10 would end the case. Now, I'm certain there  
11 would be appeals and I'm certain we would have  
12 to go forward with that, but our position is --  
13 and these witnesses testified as to the plain  
14 meaning of those words. And I would suggest to  
15 the Court that the belabored and tortured  
16 testimony was because we had to juxtapose the  
17 clear and plain meaning of those words with  
18 this interpretation that says we can kind of do  
19 what we want to do. So, Your Honor, I would  
20 just again renew that motion for summary  
21 judgment and ask the Court when it believes it  
22 has enough information to consider it. But  
23 based upon the Court's prior ruling I think  
24 that what you were saying was you needed  
25 information. We've now heard from the two

1 senior members of that organization and I think  
2 there are plenty of admissions against interest  
3 in this record what the language is, and the  
4 Court can read that language to make that  
5 determination.

6 **RULING - BY THE COURT:**

7 **THE COURT:** Thank you. Without argument from Mr.  
8 Long, I'm going to deny your motion at this  
9 time. You may renew it later in the  
10 proceeding.

11 **MR. SUMMER:** Thank you, Your Honor.

12 **THE COURT:** We'll be in recess until 1:00, Monday.  
13 Have a good weekend.

14 **MR. SUMMER:** Thank you, Your Honor.

15 (There being nothing further, the hearing recessed at  
16 4:11 p.m.)

17 **DAY 6 - MONDAY, FEBRUARY 6, 2012**

18 **THE COURT:** Thank you, ladies and gentleman. Be  
19 seated please. Mr. Goldman will not be with us  
20 today. Ms. Patrick, good to have you back.  
21 Anything we need to take up preliminary?

22 **MR. LONG:** I don't think so, Your Honor.

23 **THE COURT:** No post-game analysis?

24 **MR. LONG:** We could do that.

25 **MR. SUMMER:** We've all extended our sympathies and



1           condolences to Mr. Richards. He's from up  
2           around Boston.

3   **THE COURT:** Mr. Thomas?

4   **MR. THOMAS:** Trident would call Mr. Richard Baehr to  
5           the stand.

6   **THE COURT:** Mr. Baehr, come up here to be sworn in.

7   **RICHARD ALLEN BAEHR,** being duly sworn, testifies as  
8           follows:

9   **MR. BAEHR - DIRECT EXAMINATION BY MR. THOMAS:**

10   Q: Good afternoon, Mr. Baehr. Would you please  
11       state your full name for the record?

12   A: Richard Allen, A-L-L-E-N, Baehr, B-A-E-H-R.

13   Q: I know you started this morning in Chicago at  
14       about 3:30. What time did you leave your  
15       house?

16   A: 4:15.

17   Q: Okay. And I know you're under the weather, so  
18       please, at any time you need to take a break,  
19       just let me know and we'll ask for the Court's  
20       indulgence on that.

21   A: Thank you.

22   Q: Mr. Baehr, would you -- where do you live right  
23       now?

24   A: I live at 1813 North Lincoln Park West in  
25       Chicago.

1 Q: Where did you grow up?

2 A: I grew up in New York, actually about a quarter  
3 mile from Yankee Stadium.

4 Q: Are you a Giants fan?

5 A: I was.

6 Q: Please take the -- first of all, let's go ahead  
7 and introduce the Petitioner's Exhibit 1 and  
8 what I'm going to do is hand you kind of a big  
9 notebook here that's got the Exhibits we're  
10 going to be going through today.

11 A: Okay.

12 Q: Collated. What is Exhibit Number 1?

13 A: Exhibit Number 1 is my resume and a list of  
14 cases in which I've offered expert witness  
15 testimony. Either depositions or depositions  
16 and trial testimony.

17 Q: Okay. Why don't you take the Court through  
18 your education, you know, starting from  
19 college.

20 A: Okay. I went to Kenyon College in Ohio. I got  
21 a Bachelor of Arts in Political Science, minor  
22 in Economics. I then taught public school for  
23 four years in New York City, and while I was  
24 doing that, I got a Master of Arts in Education  
25 at the City College of New York, and then I

1 went to get a Master of Science in Management  
2 from Sloan School at MIT. They call it a  
3 Master of Science in Management. It is an MBA,  
4 basically the same degree. And I received that  
5 degree in 1975.

6 Q: Okay. Any honors or awards from -- while,  
7 throughout your education?

8 A: Yeah, I was an Honors graduate at Kenyon and in  
9 the Honor Society of the education program and  
10 I was first in my class at MIT.

11 Q: Why don't you walk the Court through your  
12 employment history after graduating MIT.

13 A: Sure. I was hired by a professor's consulting  
14 firm in Amherst, Massachusetts. A firm that  
15 was started by professors from the finance  
16 department at the University of Massachusetts  
17 in Amherst. They started a healthcare  
18 consulting firm. I was the second person they  
19 hired out of business school to add to the  
20 professors who were either working full time or  
21 part time with the firm. And I basically have  
22 stayed in that field since. That firm went  
23 public --

24 **THE COURT:** Since what year was that?

25 A: I started in 1975. That firm went public in

1 1983, it was acquired by another firm, bought  
2 itself back and while all this was going on, I  
3 still did the same thing I was doing through  
4 out the period. Eventually, the firm was sold  
5 to what was then Ernst & Young, it was actually  
6 Ernst & Winnie and then it became Ernst &  
7 Young, which was the big national accounting  
8 firm and I was the partner in charge of the  
9 finance and planning practice for the Midwest,  
10 in the Chicago office. And then in 1992, I  
11 retired as a partner in Ernst & Young and went  
12 off on my own. Formed Richard A. Baehr &  
13 Associates, which is what I've done since.

14 Q: Okay. In terms of publication and teaching,  
15 could you just briefly touch on that for the  
16 Court?

17 A: Yeah. Especially during the first 20 years of  
18 my career, I gave a lot of seminars for various  
19 hospital associations, whether national or  
20 state. And wrote some articles, co-authored a  
21 book on turning around troubled hospitals to  
22 the American Hospital Association.

23 Q: Okay. Have you ever done any kind of bond  
24 work?

25 A: Yes.

1 Q: Can you explain that to the Court?

2 A: Yeah, the firm I started with --

3 Q: And what does that entail? I'm sorry.

4 A: What do you need?

5 Q: What that would entail.

6 A: Yeah, sure. The firm I started with, Amherst  
7 Associates, was one of the very few firms in  
8 the country that was accepted as a firm that  
9 could publish feasibility studies within the  
10 prospectus or offering statement for tax-exempt  
11 bond issues that were sold by underwriters to  
12 basically provide financing for, generally  
13 hospitals around the country. Amherst was --  
14 there were a couple of accounting firms. There  
15 was a firm named Booze-Allen and Amherst were  
16 really the only firms that were doing this for  
17 about 10 years and I was basically the  
18 individual in charge of about ten to 12 of  
19 those published studies during the time I was  
20 at Amherst.

21 Q: Why don't you take the Court through your CON  
22 experience, if you would.

23 A: Sure. I've had experience in a lot of  
24 different ways in certificate of need. In some  
25 cases, assisting hospitals in the preparation

1 as well in the litigation area. In some cases,  
2 assisting hospitals in preparing the CON and  
3 later went to litigation. In other cases, I  
4 was brought in by various organizations,  
5 generally that were challenging another  
6 hospital in a certificate of need case and  
7 again, that list of cases, which would cover  
8 about 30 years, is in this three page summary  
9 of expert witness testimony.

10 Q: Okay. And you mentioned you've been in cases  
11 where you've actually opposed hospitals before?

12 A: Yes.

13 Q: Okay.

14 A: And in some cases, similar to this where there  
15 was more than one hospital that was seeking to  
16 get certificate of need approval, so in some  
17 sense they were competitive cases.

18 Q: Okay. How about in HCA affiliated hospitals?  
19 Have you ever opposed an HCA affiliated  
20 hospital in a CON case?

21 A: Yes.

22 Q: Okay. Now, have you ever told an applicant who  
23 was your client there was not a need for a  
24 hospital they wanted to build, that they had a  
25 weak case?

1 A: Yes.

2 Q: Have you ever told that to HCA?

3 A: Yes.

4 Q: Have you ever developed hospital financial pro  
5 formas for CON applications?

6 A: Sure. Basically any time you have to submit a  
7 certificate of need application, there is a  
8 financial pro forma that's included in the  
9 application. Regardless of which state you're  
10 involved in. And there's times that pro formas  
11 have been prepared before as part of, for  
12 instance, a strategic planning effort before a  
13 hospital made a decision whether to go ahead or  
14 not on a particular project.

15 Q: And have you ever testified about hospital pro  
16 formas that you did not develop on your own?

17 A: Yes. Quite a few times.

18 Q: All right. Is that unusual in your line of  
19 work?

20 A: No. Again, if I'm being brought in on a case  
21 where the organization that hires me is not  
22 applying themselves but they're challenging an  
23 application, then my job is to review that  
24 application which means including reviewing the  
25 financial information. I've also been brought

1 in sometimes on behalf of a client that is  
2 proposing an addition or new hospital, an open  
3 heart surgery program, whatever the case may be  
4 and I did not participate in the original  
5 certificate of need process, but was brought in  
6 for the litigation, which meant I had to review  
7 the financial projections that had been  
8 prepared by someone else.

9 Q: Okay. Are you familiar, Mr. Baehr, with the  
10 applicable South Carolina Health Plans for  
11 these two projects?

12 A: Yes.

13 Q: Okay. Are you familiar with the project review  
14 criteria that are set forth in regulation 61-  
15 15?

16 A: Yes.

17 Q: Have you ever been qualified as an expert in  
18 healthcare planning and finance in CON cases in  
19 the past?

20 A: Yes. In eight or nine states including South  
21 Carolina.

22 Q: Okay. Your Honor, at this time I'd like to  
23 offer Mr. Baehr as an expert in healthcare  
24 planning and healthcare finance.

25 MR. LONG: No objection, Your Honor.



1 MS. BIGGERS: No objection.

2 THE COURT: Without objection he's so admitted.

3 MR. THOMAS: Okay. Thank you.

4 Q: Mr. Baehr, could you explain to the Court how  
5 you became involved in this case?

6 A: Sure. I got a call from Mr. Summer, the middle  
7 or third week of May in 2008 indicating that  
8 the Trident Health System was looking for  
9 support in preparing an application for a 50  
10 bed hospital to be located in Moncks Corner in  
11 Berkeley County.

12 Q: Okay. What were you asked to do by Trident?

13 A: We were asked to prepare the Section B-11,  
14 basically the need section of the application  
15 as well as, you know, review some of the other  
16 parts of the application that were related and  
17 help out as necessary in answering questions  
18 from the State once the application had been  
19 submitted and if litigation occurred in the  
20 future, as it has in this case, to be willing  
21 to offer expert testimony.

22 Q: Okay. Did they ask you to do, did Trident ask  
23 you to do anything for project review?

24 A: Yes, I made a presentation at project review.

25 Q: Okay.

1 A: I also submitted a couple of letters right  
2 after project review before the decision was  
3 made by the Department.

4 Q: And were you asked by HCA to offer opinions on  
5 the financial pro forma's in the prospective  
6 application?

7 A: Yes, they have asked me to do that here. And  
8 also, I commented as well during the project  
9 review in some of the letters that were follow-  
10 ups.

11 Q: Okay. The Court has heard some of this  
12 information before, but just generally, can you  
13 explain your understanding of how Trident  
14 Medical Center was originally formed?

15 A: Yes. My understanding is there was a 60 bed  
16 hospital in Berkeley County and a 78 bed  
17 hospital in Dorchester County. Both of them,  
18 I believe, were county-owned facilities and in  
19 1972, as a result of some discussion,  
20 negotiations, planning efforts, the decision  
21 was made that HCA would come in, build a 200  
22 bed hospital in the North Charleston area. The  
23 two existing hospitals would close and this  
24 hospital would then become essentially a  
25 hospital that was better capitalized, able to

1 make the kind of investments to keep the  
2 hospital competitive and to better serve those  
3 communities which did not have that same  
4 financial wherewithal and basically be serving  
5 the North Charleston community as well as the  
6 two counties where the hospitals had closed.

7 Q: Okay. Can you describe the general process of  
8 how you went about developing the need analysis  
9 which appears in Joint Exhibit 1?

10 A: Sure. The first is I kind of try to become as  
11 familiar as I can with the applicant and the  
12 service area. But the approach we took in this  
13 case, this was a growth market, Berkeley County  
14 has been a growth market, so we wanted to  
15 become familiar with the history of Trident and  
16 what they had done. And this in a sense was  
17 consistent with what they had done in  
18 Dorchester County, had originally started with  
19 an outpatient facility, and then built an  
20 inpatient facility. This was similar. So, the  
21 question was how do you forecast utilization  
22 for this new facility. The first thing was  
23 that the hospital had bed need under the 2004-  
24 2005 Plan under which it applied, the bed need  
25 was listed as 42 beds. But the hospital had

1 subsequently taken 25, used 25 beds of that 42  
2 bed need as a result of a conversion of long-  
3 term care beds, so the remaining need under the  
4 2004-2005 Plan was 17 beds. And they were  
5 applying for 50 beds as allowed under this  
6 Plan. Now, the 2008-2009 Plan, a draft version  
7 of that was available at the time we were  
8 helping out putting this application together.  
9 And that indicated in that Plan, Trident  
10 Medical Center would show a need for 56 beds as  
11 well as Summerville Medical Center for 24. So  
12 clearly, as of the last data point that was  
13 available, which was as of 2008 would have been  
14 this draft 2008-2009 Plan. There appeared to  
15 be substantial growth projected and a high  
16 enough occupancy at Trident Medical Center to  
17 create that kind of bed need and the way the  
18 State does it, they take the last year they had  
19 data, 2006, they project seven years in the  
20 future. They do it by age group creating  
21 essentially a use rate for each age group in  
22 terms of basically patient days per 1,000  
23 population. So, we knew there was growth. We  
24 knew that essentially applying for these beds  
25 was consistent with the State Health Plans.

1 So, the question then became how do you go  
2 about forecasting the actual bed need. And  
3 what we did was --

4 Q: I'm just going to stop you right there.

5 A: Sure.

6 Q: I think we're going to launch into that in a  
7 second though. Did you work with anybody in  
8 creating this analysis?

9 A: Sure. I worked with Tom Davidson, who is  
10 another expert. Who has testified in other  
11 cases in other states who I worked with at  
12 three different firms. First at Amherst  
13 Associates, my old firm. Then at Ernst & Young  
14 and I've worked with him since in several  
15 cases. He's an independent consultant.

16 Q: And why do you work with Tom?

17 A: I'm comfortable with him. It's more efficient.  
18 There's certain things he does better than me  
19 in terms of putting tables together and he's  
20 better at Excel than I am. I'd waste a lot of  
21 my client's hours if I had to build those  
22 tables, so it's a good team. We've done it a  
23 bunch of times before and I'm comfortable with  
24 him. I've used other people in other  
25 situations, Dan Sullivan. So --

1 Q: Is there any work that Mr. Davidson did that  
2 you did not check, review or confirm?

3 A: No.

4 Q: Okay. I want to go back and just make sure,  
5 did you review fully the records for Trident  
6 Medical Center and the Berkeley Medical Center  
7 project and the Roper St. Francis Berkeley  
8 project in this case?

9 A: Yes. Especially, for instance, at the time of  
10 project review, both applications had been  
11 declared complete, so we had a record.

12 Q: Okay. Can you quickly -- take your time,  
13 actually, go through the other documents that  
14 you reviewed on which some of the opinions  
15 you're going to be giving here today were  
16 based?

17 A: Sure. I reviewed some of the documents  
18 surrounding the application by the Roper System  
19 for their 85 bed hospital at Mount Pleasant.  
20 I reviewed some of the documents for  
21 Summerville Medical Center's application for a  
22 30 bed addition. I reviewed the JARs for  
23 several of the hospitals for several of the  
24 years. I reviewed, obviously, the DHEC records  
25 for both of the applicants. Hundreds and

1 hundred and thousands of pages of discovery in  
2 this case, which is what's filling this court  
3 room on all sides.

4 Q: What's your, just generally, what's your  
5 understanding of where the actual Berkeley  
6 Medical Center is slated to be located?

7 A: It will be in Moncks Corner adjacent to the  
8 site where the hospital now has an emergency  
9 room and some outpatient facilities.

10 Q: Okay. Let's do this. I want to actually go  
11 into Joint Exhibit 1, so you take this  
12 notebook.

13 A: (Witness does as instructed.)

14 MR. THOMAS: Your Honor, we're going to be going  
15 into the DHEC record, and I think what we're  
16 going to try to do for you is try to put it up  
17 here on the screen as we go through it.

18 Q: Mr. Baehr, will you turn to page 36 in the DHEC  
19 record, the Trident DHEC record which is Joint  
20 1?

21 A: Yeah, I'm there.

22 Q: Okay. And did you, did you develop the  
23 information that went into this chart?

24 A: Yes.

25 Q: Okay. And this is the forecast Berkeley

1 Medical Center utilization chart?

2 A: Yes, for the years 2012 through 2016.

3 Q: Okay. Now, before we launch into this chart,  
4 what's your understanding of where Roper St.  
5 Francis Berkeley's proposed hospital is going  
6 to be located in terms of the zip code?

7 A: Yeah. My understanding is the zip code is the  
8 same one as the Berkeley Medical Center,  
9 they're both in the zip code 29461.

10 Q: Okay. And what -- how close is Roper St.  
11 Francis Berkeley to the 29483 zip code?

12 A: I was going to say 12 miles, but I think the  
13 traffic engineer said 11.8 so, good enough.

14 Q: I'm talking about the Roper St. Francis  
15 Berkeley proposed location.

16 A: Yeah, I'm saying Moncks Corner to Roper St.  
17 Francis Berkeley?

18 Q: No, how close is Roper St. Francis Berkeley to  
19 the 29483 zip code, which is the --

20 A: Oh, it's on the border.

21 Q: Okay. And is there anything significant about  
22 those two zip codes, 29461, which is the Moncks  
23 Corner and the 29483 on the Berkeley County  
24 side?

25 A: Yes, those are the two zip codes that in our



1 projection, which we did by zip code, produces  
2 by far the largest number of patients for the  
3 proposed new hospital. In fact, those two zip  
4 codes combined account for about 60 percent of  
5 the patients volume that we expect to see at  
6 the new hospital. Even though the projected  
7 market share is higher in some of the zip codes  
8 around the lake, the populations are smaller.  
9 So in terms of the number of patients that are  
10 produced for the system, it turns out to be  
11 smaller than, for instance, 29483 which is a  
12 fairly populous zip code. Over 60,000  
13 population, in which we assume that 20 percent  
14 of the market share of the Trident volume for  
15 the Berkeley Medical Center.

16 Q: Okay. Let's go back to the DHEC record here.

17 A: Sure.

18 Q: We're on the DHEC record, page 36. Would you  
19 take the report, you know, summarize for the  
20 Court what the utilization projection is over  
21 the projected years for the BMC operation?

22 A: Yeah. You always expect a build-up when you  
23 have a new facility. You don't expect to get  
24 to your -- likely third or fourth year volume  
25 in the first year. And that's what's projected

1 here. Basically, 2014 through 16 you're at a  
2 fairly steady state, 67, 69 percent.  
3 Essentially, out of the 50 beds, the hospital  
4 is projected to fill close to 35.

5 Q: Okay. What I'd like you to do now is just  
6 basically go back for us and I think the needs  
7 analysis starts on page 23 to 24, in there. In  
8 the Trident DHEC record.

9 A: Sure.

10 Q: And if you could, explain to the Court kind of  
11 how you went through the analysis of the chart  
12 we just looked at. Where it would be possibly  
13 about 69 percent full in 2016.

14 A: Correct. It -- first of all, when we decided  
15 to do this on a zip code basis, and there are  
16 some zip codes that straddle county lines. For  
17 instance, zip code 29483, which is an important  
18 zip code, I think in this case, is in both  
19 Dorchester and Berkeley County. The land area  
20 is a little more than half in Berkeley County,  
21 but it looks like about two-thirds of the  
22 population, if not slightly more than that is  
23 on the Dorchester side. So, that's a zip code  
24 where we had to make some allocations. But  
25 basically, we picked all those zip codes which

1 are the zip codes within the county or almost  
2 exclusively within the county, plus 29483 and  
3 to a much lesser extent, 29485 which is another  
4 Dorchester zip code with a small piece, very  
5 small piece in Berkeley. And we made a  
6 forecast, essentially taking -- starting with  
7 all of Trident's volume. And you can see this  
8 starts on page 27, 28, we went through every  
9 zip code in the three counties, Berkeley,  
10 Dorchester and Charleston, and we looked at  
11 first, population. We wanted to see how much  
12 the population has grown because if you look at  
13 the way the State forecasts bed need, the State  
14 looks at essentially your historical  
15 utilization based on age group. They apply  
16 population growth by those age groups and then  
17 you have a projected future volume which is  
18 going to be higher if the population is  
19 growing. They then assign a target occupancy  
20 rate based on your size. If you're a  
21 relatively small hospital, 100 beds, 65  
22 percent. If you're 175 to 350, 70 percent and  
23 over that, they expect you can achieve 75  
24 percent. So, what we wanted to do is be  
25 familiar with how the State forecasts and then

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1 use essentially a close approximation of that.  
2 The state population data is done on a county  
3 basis. All right. Because we were looking at  
4 zip codes, we used a different population  
5 source, which is Claritas, which is population  
6 forecasts by individual zip code. So, that's  
7 really where we started. We started with a  
8 population to see how the population was  
9 changing in these three counties by zip code.  
10 You know, if you look back on page 25, you can  
11 see that Berkeley and Dorchester County both  
12 are projected to grow fairly substantially over  
13 a 15-year period and Charleston County to a  
14 lesser extent. Dorchester is the fastest  
15 growing county on a percentage basis, then  
16 Berkeley and then Charleston. Yes, sir?

17 **THE COURT:** I have a question. You mentioned that  
18 one of the zip codes straddles the Berkeley  
19 Dorchester line and that you had to make an  
20 allocation because most of the population lay  
21 in Dorchester County. How would you determine  
22 the population?

23 **A:** That's a good question. We actually looked at  
24 census track data. And did as well as we could  
25 because it doesn't totally 100 percent align.

1 So some of it you have to do by eye, but we try  
2 to fit in those census tracks that essentially  
3 were in one part of the, you know, that were in  
4 one county versus those that were in the other  
5 county and we came up with about a 70/30 split.

6 THE COURT: Thanks.

7 A: You're welcome. So, anyway, the county  
8 populations are, and again, this is projected  
9 fairly rapid growth and it turns out that the  
10 census data came in with numbers that were  
11 higher than the State's projection for 2010.  
12 And also than the Claritas projection for 2010.  
13 What I might note though, is Claritas lists zip  
14 codes by the county in which they're  
15 predominantly in. So they assign all the  
16 population for 29483, which is this allocated  
17 zip code, to Dorchester. If you took out the  
18 portion of that zip code that's actually in  
19 Berkeley, then Claritas' projection for  
20 Berkeley County population is actually slightly  
21 higher than the State number. They were more  
22 accurate than the State, essentially, going  
23 forward after you make that allocation.

24 Q: Real quickly, could you explain to the Judge  
25 just what Claritas is?

1 A: Yeah. They're a firm that does demographic  
2 forecasting. They analyze census information.  
3 They analyze whatever economic data they can  
4 find on communities. And they project  
5 generally at the level you're looking for.  
6 Whether it be census track which is available  
7 from the census and they then make  
8 determinations going forward between the ten  
9 census years so people can use that data  
10 because the census only comes every ten and  
11 states, some states they update every single  
12 year. Other states, they may not do it but  
13 every five years, so these kind of firms are in  
14 business essentially to provide the data in  
15 between the census years. And also to help you  
16 at a more discrete level such as the zip code  
17 which is not available in some -- for instance,  
18 some of the state population data.

19 Q: Now, is Claritas something you typically rely  
20 on in your practice?

21 A: Yes, I've relied on them in many, many cases  
22 over the years.

23 Q: I just wanted to get that clear.

24 A: Sure, no problem. So, anyway, we got a five-  
25 year forecast for the growth of the Berkeley

1 County zip codes, the Charleston County zip  
2 codes and the Dorchester zip codes. Excuse me.  
3 That's on pages 24 and 25. And then we picked  
4 certain zip codes we thought were going to be  
5 the most critical here. In part based on  
6 geography and that was probably the most  
7 important indicator, especially for those zip  
8 codes in the northern part of the county. We  
9 just thought it was logical if you have a  
10 facility in Moncks Corner, this would improve  
11 access. It would certainly serve those  
12 communities in central and northern Berkeley  
13 County. But some of those zip codes that are  
14 in other parts of the county would also be  
15 contributors and again the 29483 is of  
16 particular significance because a significant  
17 piece of it is in Berkeley County. The -- on  
18 page 27, we started again looking at historic  
19 occupancy levels of the hospitals in the market  
20 and you can see for instance that, this is  
21 actually page 30 when you looking at the DHEC  
22 application it's 27, but the Bates stamp number  
23 is 30. And you see Trident Medical Center is  
24 70 percent occupancy and Summerville Medical  
25 Center is 71 percent occupancy. Those are the

1 two hospitals that had the highest occupancy  
2 rating that year and they also have the highest  
3 occupancy rate on the next page for the 2006  
4 data. This is important because why do some  
5 hospitals show bed need and other hospitals  
6 don't. The hospitals that have higher existing  
7 occupancy rates than the target occupancy for  
8 their bed size essentially need beds. Those  
9 are the ones that will show a need for beds  
10 when you project volume going forward. Those  
11 hospitals that have current occupancy rates  
12 that are well below the target occupancy rates,  
13 say in the 50s or low 60s, they may wind up  
14 showing some bed need in seven years, but only  
15 because there's an anticipation of significant  
16 population growth and in the case of -- really  
17 all the other hospitals, if you look at the  
18 2008-2009 Plan, even with that growth, only the  
19 two Trident hospitals showed any positive bed  
20 need and this three county service area. And  
21 that bed need was 56 again in 2008-2009 for  
22 Trident, 24 for Summerville. Combined need is  
23 80, which is exactly what Trident's applied  
24 for. Fifty in one location, Berkeley County,  
25 30 additional beds in Dorchester.



1 Q: All right.

2 A: The next thing we did is come up with really  
3 our methodology for how we would forecast the  
4 volume for the new Berkeley Medical Center and  
5 in a sense we created what I'll call a  
6 threshold test. And that test was, how much is  
7 the Trident system itself growing? Is there  
8 enough volume growth in the entire Trident  
9 system to support essentially a new 50 bed  
10 hospital in Berkeley County. And remember the  
11 2008-2009 Plan showed Trident Medical Center  
12 with a 56 bed need and this is in 2008. That's  
13 the year we're talking about. So, that bed  
14 need essentially means you could build 56 beds  
15 on the current campus or you could move beds  
16 somewhere else and create a new hospital. They  
17 made a decision to create a new hospital in  
18 Berkeley County to serve a population they had  
19 been serving since 1975. And it's consistent  
20 again with the State need methodologies. So,  
21 what we wanted to see was is there enough  
22 growth in the Berkeley system, the Trident  
23 system and we expected it would be. You know,  
24 given that there was a need for 56 beds and it  
25 turns out that it is. That there's more than

1 enough growth in the Trident system so that  
2 even with a new 50 bed hospital in Berkeley  
3 Medical Center, Trident could support, with  
4 it's growth system-wide, all of the patient  
5 days in 2000, whatever year you're looking at  
6 as the last year, for this new hospital. That  
7 doesn't mean that there won't be any patient  
8 that would be admitted to this system that  
9 might be picked up from another system. This  
10 was, again, a threshold test and I described it  
11 that way in the deposition. It's really a look  
12 to compare the two numbers. You've got a 56  
13 bed need. You build a 50 bed hospital. The  
14 two of them match. You've got a forecast of  
15 the entire system that's going to grow 42 in  
16 average daily census that will support a new  
17 hospital that's going to have an average daily  
18 census of roughly 35 by 2016. Again, it works.

19 Q: Okay.

20 A: So, given that, the approach we took was to  
21 forecast by zip code the future volume of the  
22 Trident system. And again, we started first by  
23 looking at all volume. Tertiary and non-  
24 tertiary. Which means we included all the  
25 volume we expected the Trident system to get

1 including some things like open heart surgery  
2 and neurosurgery, things that might not be  
3 done, actually won't be done at this new  
4 hospital.

5 Q: Okay. For the record, so is that, is that  
6 chart on page 34, does it -- I just --

7 A: Let me quickly check.

8 Q: On 34, the Trident Health System DHEC record?

9 A: Yes.

10 Q: Okay.

11 A: That's the growth of 15,000, if you look at  
12 page 34, if you look at the increase in patient  
13 days over 2007, it's 15,431 projected over the  
14 2007 volume by 2016. That's a growth in  
15 average daily census, if you look at that  
16 bottom number in that column of 42.3.

17 Q: That's for the whole system?

18 A: Whole system. Now, if you look on the right  
19 side, and you look at the forecast Trident  
20 Health System growth just for non-tertiary --

21 Q: Okay. You said the right side, you mean  
22 Trident 35?

23 A: Thirty-five, right.

24 Q: Okay.

25 A: Okay. I got it all on pages, and saying left

1 right, I do apologize if someone doesn't.

2 Q: No problem.

3 A: But just looking at non-tertiary, non-  
4 specialty, the projected growth through 2016 is  
5 36.6. So obviously, there's an average daily  
6 census growth of about six for tertiary, 36 for  
7 non-tertiary and here we're going to have a new  
8 hospital which is going to have a non-tertiary  
9 volume of about 34 to 35 by the last year. So,  
10 the numbers work. Okay. It means by 2016  
11 there's no deficit. There's enough growth in  
12 the system so that even with a new hospital,  
13 there will be still more patient days in the  
14 system than there were at the start.

15 Q: Okay. So based on your analysis that you just  
16 went through with the Court, in your opinion,  
17 is there a need for a 50 bed hospital in Moncks  
18 Corner as described in this application?

19 A: Yeah, I think there's a need for a 50 bed  
20 hospital. That Trident has a need for 50 beds  
21 and Moncks Corner, actually Berkeley County is  
22 the better was to say this. We've done need  
23 projections for the county. And our assessment  
24 is that there's a need for a single, 50 bed  
25 hospital in the county. So, what Trident is

1 proposing to do meets the 50 bed need for the  
2 county based on the county's projected growth  
3 overall, again, during the same period.

4 Q: Okay. Let me ask you this, when you did this  
5 analysis, you didn't -- well, did you do it  
6 with the knowledge that a second hospital would  
7 be applied for in Berkeley County?

8 A: No.

9 Q: Okay. How would your analysis have changed if  
10 you knew there was going to be a second  
11 hospital in Berkeley County?

12 A: Yeah, I have my doubts that the hospital would  
13 have been able to get to a viable census with  
14 a second hospital in Berkeley County being  
15 built particularly in its location and again,  
16 the major issue is that hospital is being  
17 located on the border of two zip codes which  
18 account for 60 to 65 percent of the expected  
19 census of the new hospital. If you have a new  
20 hospital plunked down right in the midst of the  
21 two zip codes which form the core volume for  
22 the new hospital, and that new, and that new  
23 Roper Hospital is going to be much closer to  
24 those patients, then would be at Berkeley  
25 Medical Center, why would patients by-pass the

1 Roper facility to go further north to Moncks  
2 Corner? Our assumption was that a hospital in  
3 Moncks Corner, if it were the only hospital  
4 being built, would get a reasonable percentage  
5 of that 29483 zip code. If Roper puts a  
6 hospital down where it's proposing its  
7 hospital, I think the volume in that zip code,  
8 for instance, would be a small fraction of what  
9 we projected.

10 Q: Okay. We just kind of went through the  
11 inpatient analysis. Would you turn to page 38  
12 of Joint 1 of the DHEC record?

13 A: Sure. Yeah.

14 Q: Okay. Did you do some projections for  
15 outpatient as well?

16 A: We did outpatient as well. I should note one  
17 thing. This is kind of important. I explained  
18 how we got to a forecast of the Trident system.  
19 We went by the historical patient days and we  
20 projected population growth to see how that  
21 number would grow over time. Well, how do you  
22 convert that to the Berkeley Medical Center?  
23 Well, what we did was zip code by zip code we  
24 made an assumption about what percentage of  
25 Trident volume would move essentially to the

1 new hospital. So, in the zip codes that are  
2 close to the Moncks Corner location, we assumed  
3 that about half, roughly 50 percent of Trident  
4 volume would shift. In zip codes that were  
5 much further south, in North Charleston or  
6 Goose Creek, we assumed only one to two percent  
7 of Trident's existing volume would wind up at  
8 a Moncks Corner facility. So basically, it's  
9 the zip codes in the north, the Moncks Corner  
10 zip code and that 29483 that are where this  
11 hospital will rely on for its volume. And we  
12 made that allocation. Zip code by zip code we  
13 projected what that percentage would be and we  
14 did the same thing for outpatient with one  
15 difference. For outpatient, for emergency  
16 room, for ambulatory surgery and for other  
17 outpatient facilities, we assumed those zip  
18 codes in the north that the transfer from  
19 Trident to the new hospital wouldn't be 50  
20 percent, but 80 percent. Okay. We thought  
21 that on an outpatient basis that there would be  
22 a higher transfer of existing business to the  
23 new facility.

24 Q: And so is that the outpatient analysis that's  
25 found on 38 through 40?

1 A: Yes.

2 Q: Okay.

3 A: And there is backup, then, that begins on page  
4 44 that goes for a lot of pages.

5 Q: Okay. We'll get to that. I want to ask you  
6 another question.

7 A: Sure.

8 Q: Is it your understanding that Roper St.  
9 Francis- Berkeley is going to abandon any of  
10 its operations in Moncks Corner?

11 A: No.

12 Q: Okay. What do you understand that Roper St.  
13 Francis Berkeley has, or excuse me, that Roper  
14 St. Francis has in Moncks Corner today?

15 A: They have an emergency room, they have some  
16 outpatient areas and they also have ambulatory  
17 surgery.

18 Q: Okay. And why is that significant?

19 A: Well, it means that they're still a competitor.  
20 Even if the hospital is built in Moncks Corner,  
21 it's -- Roper's not conceding, essentially, the  
22 outpatient volume in the northern part of the  
23 county.

24 Q: Okay. Or in Moncks Corner?

25 A: Or in Moncks Corner itself. Sure.



1 Q: Go to page 40 of the DHEC record for me.

2 A: Sure.

3 Q: Now is it your understanding that -- first of  
4 all, let's do this. Just a second, Your Honor.

5 A: You're allowed three timeouts, plus a 20.

6 Q: I'm going to hand you CON regulation 61-15.  
7 I'd like you to look at Standard 23 for me.

8 A: Sure.

9 Q: Is it your understanding this is the adverse  
10 impact standard for reviewing CON applications?

11 A: Yes.

12 Q: Okay. Would you just read 23-A and B into the  
13 record?

14 A: Sure. The impact on the current and projected  
15 occupancy rates or use rates in existing  
16 facilities and services should be weighed  
17 against the increased accessibility offered by  
18 the proposed services. That's A. And then B  
19 is, the staffing of the proposed service should  
20 be provided without unnecessarily depleting the  
21 staff of existing facilities or services or  
22 causing an excessive rise in staffing costs due  
23 to increased competition.

24 Q: In terms of Trident's project, is it going to  
25 have any, in your opinion, adverse impact on

1 the existing providers?

2 A: Again, our forecast was that Trident volume,  
3 that the Berkeley volume can be, can come from  
4 the Trident volume. There's enough Trident  
5 volume. Do I expect that there could be some  
6 adverse impact in terms of impact to others?  
7 Sure. I think that's possible. But I think  
8 when you weigh and balance the access  
9 improvement versus whatever I think is going to  
10 be fairly modest impact on other facilities,  
11 here I think the access improvement clearly  
12 wins. As we'll show later, there's a  
13 significant population that's not now within 30  
14 minutes drive time of an acute care facility,  
15 which would be if the Moncks Corner facility  
16 were built. And this really would be the first  
17 time you'd have a hospital since really 1972  
18 that enables that to be done and I think,  
19 basically, the balance of the two is heavily in  
20 terms of the access improvements.

21 Q: Okay. Now, you referenced earlier, I believe,  
22 page 40, 44 of Joint 1, Joint Exhibit 1?

23 A: Forty-four?

24 Q: Yeah. Go to that for me. That's appendix one.

25 A: Sure.

1 Q: And I guess through pages 100 and -- that's  
2 through page 128. Now, this is the appendix  
3 for -- or the raw data for some of the work you  
4 did?

5 A: Yeah. It basically shows how the model was  
6 built up. How the summary tables for inpatient  
7 utilization and outpatient utilization were  
8 developed. So, it shows, for instance, how the  
9 existing volume, for instance, at, in all the  
10 zip codes of Trident facilities. It shows  
11 projected population growth at -- and by zip  
12 code.

13 Q: And where did this information come from?

14 A: The historical data comes from the, there's a  
15 couple different sources depending on the year.  
16 And we used different ones different times in  
17 the application. But the data provided by the  
18 State has zip code data, which also provides  
19 market share data. The population data, again  
20 is from Claritas. And so again, this shows you  
21 the progression. How you get from the  
22 historical Trident volume by zip code to  
23 projected Trident volume by zip code for all  
24 patients.

25 Q: Turn to, it looks like the Trident DHEC record

1 page 74 for me.

2 A: Sure. Uh-huh (affirmative response).

3 Q: I think you referenced this page earlier.

4 A: Yeah.

5 Q: Could you -- and I want to give the Judge a  
6 little time to get there.

7 A: Yeah, and this is a very important slide and  
8 regrettably a lot of words and numbers and  
9 columns on the page. But basically, these are  
10 the zip codes in the three counties in the tri-  
11 county service area. And we divided the  
12 counties into one of five categories. What we  
13 call very low, low, medium, high or very high.  
14 And for instance, what does a very high column  
15 mean? It means that's a column, that's a zip  
16 code that we think is, because of its location,  
17 and if you look at the zip codes that are in  
18 the 50 percent category, these are Bonneau,  
19 Cordesville, Cross, Moncks Corner, Pineville,  
20 Pinopolis, St. Stephen. These are the zip  
21 codes that are around the lake or Moncks  
22 Corner. Where we think the maximum impact of  
23 this facility will be felt. So, we thought  
24 that the highest percentage of Trident volume  
25 would be shifted to the new hospital in that,

1 in these zip codes. Those are eight. There  
 2 are two others that are located to the east  
 3 where Trident's market share right now is not  
 4 as significant. And some of the volume from  
 5 those zip codes is now going south, including  
 6 to Charleston County. And there we assumed  
 7 that 25 percent of Trident volume. And then  
 8 that middle column only has on entry. That's  
 9 that 29483. That's that cross-county zip code  
 10 which has a large population. We assumed that  
 11 was a 20 percent zip code. So even though  
 12 Berkeley County residents are about 30 percent  
 13 of the population, we assumed that 20 percent  
 14 of Trident's volume would come from that, that  
 15 Berkeley's volume would come from Trident's  
 16 volume in that zip code. In other words, they  
 17 get -- one out of ever five Trident patients in  
 18 that zip code would instead be being seen at  
 19 Berkeley Regional Medical Center rather than  
 20 Summerville or Trident Medical Center. And  
 21 then the two columns to the left, very low and  
 22 low, these are the zip codes throughout  
 23 Charleston County and other areas of Dorchester  
 24 County where, just again by location, these are  
 25 to the south. They're already well-served by

- 1 existing facilities. Whether they be Trident  
2 Medical Center in North Charleston or  
3 Summerville Medical Center in Dorchester or the  
4 other facilities in Charleston County that are  
5 served by other providers, Medical University  
6 and Roper. We didn't see any reason why a  
7 facility in Moncks Corner would take a big  
8 piece of the Trident volume from those zip  
9 codes that are to the south.
- 10 Q: Okay. And if you turn to page 78 for me, in  
11 the Trident DHEC record.
- 12 A: Sure.
- 13 Q: There was a -- you recall and Mr. Rardin and  
14 Mr. Long put up a slide or maybe it was in his  
15 opening, but it kind of showed the various  
16 capture rates around the lake of 50 percent of  
17 the market share, that type of thing?
- 18 A: Uh-huh (affirmative response).
- 19 Q: So, with -- look at Cordesville. That  
20 particular location, which is zip code 29434.
- 21 A: Correct.
- 22 Q: Okay. That is a zip code in which Trident --
- 23 A: It's a 50 percent zip code.
- 24 Q: Yeah, 50 percent zip code, but how many  
25 patients does that result in for Trident on

1 average?

2 A: That's, the projection year is up by 2016, even  
3 with a 50 percent transfer of Trident volume to  
4 Berkeley Medical Center, that zip code would  
5 produce 54 patient days in a year. Which is  
6 about one admission a month.

7 Q: Okay. So simply because you're getting 50  
8 percent of market share in one area or capture  
9 doesn't necessarily mean a whole lot of  
10 patients for the facility?

11 A: Yeah, it depends on the population size and the  
12 volume that Trident historically has. Some of  
13 the zip codes in the north are bigger. St.  
14 Stephen is more substantial. Moncks Corner is  
15 clearly more substantial.

16 Q: Okay. Now, did Roper St. Francis do a zip code  
17 level analysis on the CON application?

18 A: They did not. I actually think that's a fairly  
19 significant deficiency in their application.

20 Q: Why?

21 A: If you don't know where they're going to draw  
22 their patients from, if you simply make an  
23 estimate for a county, it's very difficult to  
24 judge the reasonableness of a forecast. Where  
25 are they going to take patients from? The

1 Roper application projects they're going to  
2 have some market share pickup and some volume  
3 that's transferred from the existing Roper  
4 system. Well, if you know where they're  
5 projecting their patient volume, you'll have  
6 some idea of where they may be picking up  
7 volume from other providers. You can better  
8 judge, for instance, adverse impact. But the  
9 most significant thing is, I don't think the  
10 State can judge access improvement for the  
11 Roper application if they don't know what  
12 patient population they're serving. If 80 to  
13 90 percent of their patient population, which  
14 was, I think 80 percent was the estimate they  
15 used in one of the early drafts of the  
16 application, is going to come from a seven mile  
17 circle around the Carnes Crossroads site,  
18 basically those are people who are all within  
19 a 30 minute drive time of existing facilities  
20 now. There's no access improvement.  
21 Meaningful access improvement. In fact, most  
22 of the residents within that seven mile circle  
23 are south of the Carnes Crossroad location.  
24 So, unless you make a case for where you're  
25 going to improve access, I don't think the



1 State can simply say you've done your job.  
2 You've got a complete application.

3 Q: Let me ask you this. Do you know, do you  
4 recall what you've read in the DHEC records or  
5 from the State, and when I say the State, DHEC,  
6 did DHEC ever comment on this no zip code  
7 analysis by Roper?

8 A: No. The interesting thing is they asked for  
9 detailed information from Trident on what the  
10 impact would be specifically on Summerville  
11 Medical Center and on Trident Medical Center.  
12 But in the case of Roper, where they don't even  
13 have a forecast by zip code, they asked them  
14 for nothing. And you know, my general  
15 impression is when you read the Roper  
16 application and then you read the decision  
17 letter, the concept is if you move beds in from  
18 one location to another and you don't increase  
19 the overall bed count, the need argument  
20 doesn't really have to be made. Because I  
21 don't see how essentially that could be judged  
22 without knowing essentially where there patient  
23 population is coming from.

24 Q: Go back to DHEC record 74, or Trident's record  
25 page 74. The chart where you assumed various

1 percentages. Had you known Roper St. Francis  
2 Berkeley was going to be in the location where  
3 it's, you know, going, and I think that's clear  
4 in the record now. How would that have  
5 affected the analysis on this page?

6 A: Yeah. And the two zip codes in particular  
7 would have, I think, would have been cut a  
8 lot. The most drastic cut would have been in  
9 29483, which is now in the 20 percent category.  
10 And I think the number there might have been  
11 below five percent. If I knew that there were  
12 going to be two hospitals built. In the case  
13 of 29461, which is the Moncks Corner zip code,  
14 if you have another hospital that's in that zip  
15 code, is on the same road, 11, 12 miles down  
16 the road and the Moncks Corner outpatient  
17 facilities are remaining open for Roper, that's  
18 a competitive zip code. So the 50 percent  
19 transfer assumption, I think that one would  
20 have been cut substantially as well.

21 Q: Okay. Turn to page 129 in Trident's DHEC  
22 record for me if you would. That's B-12, the  
23 main application itself. Let me know when  
24 you're there.

25 A: I'm there.

1 Q: Okay. Now, there are basically three  
2 alternatives here which are to do nothing,  
3 build the additional beds at Trident and build  
4 in Moncks Corner. In your opinion, did Trident  
5 choose the best alternative?

6 A: Yeah, I do. It may not be the most lucrative.  
7 They might have had a higher margin by building  
8 50 beds at the Trident Medical Center, but in  
9 terms of access improvement for residents of  
10 Berkeley County, which is one of their goals,  
11 and was one of the goals when they established  
12 this system, you've got the most bang for the  
13 buck in terms of access improvement by locating  
14 those 50 beds in Moncks Corner.

15 Q: Okay. And turn to the next page if you would,  
16 Mr. Baehr. It's DHEC record 131.

17 A: Sure.

18 Q: And do you have an opinion, I know you've  
19 talked a little bit about this, but as to how  
20 this project improves access in the region, in  
21 this particular region in the tri-county  
22 service area?

23 A: Yeah, I think it significantly improves the  
24 distribution of beds. You're putting a modest-  
25 sized facility, 50 beds, into a region where

1 the population is spread out, rural, and right  
2 now a significant portion of that populations  
3 does not have access to a hospital within a 30  
4 minute drive time. This hospital, by being  
5 located there, addresses that. In fact, the  
6 estimates we've made is that 30,000 people who  
7 are not now within 30 minutes of an acute care  
8 facility would be if a facility were built in  
9 Moncks Corner. That's significant access in  
10 improvement. The whole county is projected to  
11 have a, is projected to have 170,000 population  
12 in 2010. About two thirds of the population is  
13 in the southern half of the county. So  
14 basically, if you look at the northern half of  
15 the county, roughly half or slightly over half  
16 will have significantly improved access as a  
17 result of this Moncks Corner facility. And I  
18 think that's meaningful.

19 Q: How about in terms of cost containment? That's  
20 not only a project review and CON application  
21 section, but it's also a purpose of the State  
22 Health Plan. How does this project improve it?

23 A: Yeah, I think first of all, you look at the  
24 project and here you have two in the same  
25 cycle, they're both basically the same dollar

1 estimate, it certainly looks like it's an  
2 appropriate estimate of capital costs done at  
3 the time in 2008. The second is the applicant  
4 here is part of a large multi-hospital system  
5 which has fairly significant programs in place  
6 that use centralized staff in a number of areas  
7 to improve efficiency and not require  
8 individual hospitals to try to find people to  
9 do some of those specialized functions. You  
10 have group purchasing that's enabled by a large  
11 system of this size. I think cost containment  
12 comes in part by being part of a multi-hospital  
13 system. You know, decades of experience in  
14 doing this and building new hospitals.

15 Q: Turn to page 140 in Trident's DHEC record for  
16 me, if you would.

17 A: Sure.

18 Q: I'm sorry, go to 142.

19 A: I was wondering. Okay.

20 Q: And do you have an opinion as to Trident's  
21 ability to staff the facility of Moncks Corner?

22 A: Yes. And I think -- again, there's growth in  
23 the market. So Trident's going to serve in one  
24 location or another, presumably, and staff will  
25 have to be added over time as the volume at the

1 Trident system grows in accordance with  
2 population. If Trident is moving a facility,  
3 essentially moving these 50 beds out into  
4 Moncks Corner, there are staff at the Trident  
5 facility or at Summerville or new staff they  
6 would have hired to handle that growth at one  
7 to two existing facilities who presumably can  
8 work at the new facility. Some of them might  
9 prefer to based on where they live now and  
10 location. So, I don't have any problem given,  
11 again, HCA's long record, Trident's record of  
12 staffing in the past that they would be able to  
13 find the people especially given the couple  
14 years that are required to build a new hospital  
15 of this size. I think 30 months was the  
16 estimated construction period. You know you're  
17 going to add staff. Fewer staff the first year  
18 and more needed the second year. I think this  
19 hospital, you know, the system of HCA and  
20 Trident both have experience in doing this.

21 Q: How about for two hospitals though?

22 A: Two hospitals makes it a little more  
23 problematic. Because -- and we didn't do any  
24 specific statistical test of this, but if you  
25 had, for instance, a number of Trident

1 employees currently, who live in the area near  
2 Carnes Crossroads, there's certainly a  
3 possibility --

4 **MR. LONG:** Your Honor, I object. I know he gets a  
5 lot of leeway being an expert, but he just said  
6 he didn't do any tests on it and then he  
7 started speculating on what might happen. So,  
8 I object to the speculation. By his own  
9 testimony.

10 **MR. THOMAS:** I think he can -- Mr. Long can  
11 certainly cross examine him on this, but, you  
12 know, what he's generally talking about is the  
13 market itself and what the effect of another  
14 hospital in that market could do to staffing  
15 generally. Especially that close together,  
16 Your Honor.

17 **THE COURT:** Overruled.

18 **A:** Yeah, I think it can have some impact. Again,  
19 there are, these are growing population areas.  
20 The southern part of Berkeley County is a  
21 growing population area. Some of the people  
22 who are moving in there are people who are  
23 working at healthcare facilities. Some of them  
24 may work at existing facilities downtown in  
25 Charleston. Others may work in Mount Pleasant

1 or East Cooper. Others might be working at  
2 Trident or Summerville. There's certainly more  
3 possibility of competition for staff if you  
4 have two facilities so close together being  
5 added at the same time.

6 Q: Okay. More competition, what effect can that  
7 have?

8 A: It can raise the price, essentially, of the  
9 labor inputs. It can raise average wage rates.  
10 Especially in the specialized services.

11 Q: Okay. I'd like you to turn in the DHEC record,  
12 Trident's DHEC record, Joint Exhibit 1, to page  
13 642 for me.

14 A: Same book? Okay.

15 Q: Let me make sure the Judge gets there as well.

16 A: Is this the same book you gave me?

17 Q: Yes. And, Judge, let me know. Okay. All  
18 right. Do you recognize these documents that  
19 appear on pages 642 through 646?

20 A: Yes.

21 Q: Okay. Have you had the opportunity to review  
22 -- well first of all, what are they?

23 A: These are projections of financial performance  
24 and also manpower, additional manpower required  
25 for the new Berkeley Regional Center, but the



1 projections include a projection for the entire  
2 Trident system including Berkeley, a standalone  
3 model for Berkeley and then the difference  
4 between the two which is essentially Trident  
5 other than Berkeley. Now, I might note that  
6 that's not, that's not quite as it sounds  
7 because the way this model is put together in  
8 terms of financials --

9 Q: I tell you what, before we launch into that,  
10 let me ask you a couple of foundation  
11 questions.

12 A: Sure.

13 Q: If I could. Did you create these financials?

14 A: I did not.

15 Q: Okay. All right. Who do you understand did  
16 create the financials?

17 A: My understanding is Steve Woodford prepared  
18 them. He was acting in a consulting capacity  
19 to the hospital and previously worked for  
20 Trident and he prepared these in conjunction  
21 with Ronnie Midgett, Karl Gorrell.

22 Q: Who do you understand those gentleman to be?

23 A: These two financial people who were working at  
24 Trident at the time. And there were multiple  
25 drafts. Lots of emails I read back and forth.

1 And this was the version that was submitted.  
2 There had been earlier ones that had been  
3 exchanged.

4 Q: And how do you typically go about determining  
5 whether or not pro formas that you did not  
6 create is a reasonable estimate of financial  
7 performance?

8 A: Yeah, the most important is to understand what  
9 they did. And that required conversations with  
10 the, all the individuals we just mentioned. I  
11 actually met with Mr. Midgett. I've had  
12 several conversations with Mr. Woodford and Mr.  
13 Midgett and Mr. Gorrell on the phone. And as  
14 careful review as I could to the assumptions  
15 and understanding how this fit together.

16 Q: Did you review any underlying documents to the  
17 pro formas?

18 A: Yeah, I reviewed some of the other documents on  
19 which some of the assumptions were based.

20 Q: Okay. Sara, would you put the Petitioner's 20  
21 on the screen for me? And do you recognize  
22 this document, Mr. Baehr?

23 A: Yes.

24 Q: Okay. What is it?

25 A: This is some documents that Mr. Midgett put

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1 together to try to isolate financial data for  
2 the Summerville Medical Center because the, the  
3 feeling was by Mr. Woodford, in some of the  
4 areas for assumptions, a hospital the size of  
5 Summerville would be a good surrogate to use  
6 for making some of the assumptions he was going  
7 to make for the Berkeley Regional Medical  
8 Center. It was a 94 bed hospital. It was more  
9 comparable than a 296 bed tertiary medical  
10 center. Now again, since Trident has a lot of  
11 their stuff combined in a lot of ways --

12 Q: When you say consolidated financial --

13 A: Consolidated financial statements. It took  
14 some effort to make some allocations to try to  
15 come up with what belongs to Summerville, what  
16 belongs to Trident. One can always quibble  
17 with those particular assumptions, but I think  
18 he was diligent, spent a lot of time on this.  
19 And I think it's a reasonable attempt that he  
20 did.

21 Q: Sara, can you just kind of scroll through the  
22 pages here of Exhibit 20 for the Judge, because  
23 there are several different pages, aren't there  
24 Mr. Baehr?

25 A: Yes.

1 Q: And is it your understanding that this Exhibit  
2 is -- keep going here to some of the back  
3 pages. Now, these pages here. On  
4 Petitioner's, it looks like 20. It may be the  
5 fifth page back. What do you understand these  
6 pages are?

7 A: Yeah, this was an attempt to do some of those  
8 allocations for some of the expense categories  
9 between the two hospitals.

10 Q: Okay. And did you have a discussion with Mr.  
11 Midgett about his allocation method?

12 A: Yes.

13 Q: Did you find it to be reasonable?

14 A: Yes, I think he was very careful.

15 Q: Okay. Put up Petitioner's 175 for me. Okay.  
16 And go to the next page. What do you  
17 understand the Petitioner's 175, it looks like  
18 it's Trident's Bates 269.

19 A: Yeah.

20 Q: What do you understand this document to be? I  
21 think it's several pages. And if you hang on  
22 here, you can also look here, you can flip to  
23 the tab 175.

24 THE COURT: You said 269?

25 MR. THOMAS: Yes, sir. I'm sorry. No, we're in

1           Petitioner's 175 which I've got on the screen  
2           there.

3   **THE COURT:**   Okay.   I don't have it.

4   **MR. THOMAS:**   Okay.   I can get it.

5   **THE COURT:**   My screen is not letting me.

6   A:   All right.

7   Q:   Let's let the Judge join us if we could.

8   A:   Sure.

9   **THE COURT:**   Petitioner's 175?

10   **MR. THOMAS:**   Yes, sir.

11   **THE COURT:**   All right.

12   Q:   Mr. Baehr, can you explain what Petitioner's  
13        175 is and how it, may be what is the basis of  
14        your opinion?

15   A:   Yes, these are detailed statements with  
16        assumptions that are the backup for the pages  
17        that were sent in with the application.

18   Q:   Okay.   And the first page here, well, excuse  
19        me.   I guess it's Bates label Trident 269.   The  
20        data at the top of the page, the inputs and  
21        that type of thing, where did that come from?

22   A:   The volume inputs came from myself.

23   Q:   Okay.   And so, just kind of going through this  
24        generally, this Petitioner's 175, could you  
25        tell the Court what your understanding of what

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1 Mr. Midgett and Mr. Woodford did?

2 A: Yeah. What they tried to do is come up with  
3 essentially a basis for forecasting each of the  
4 individual line items. Starting with gross  
5 revenues and getting into net revenues and  
6 contractual allowances. Because again, what  
7 hospitals bill is not what they collect. They  
8 get different payments from different third-  
9 party payers. The significant assumptions in  
10 here have to do with the fact that, to  
11 determine the appropriate payer mix, the mix of  
12 patients that are to be served at Berkeley  
13 Regional Medical Center, what was assumed was  
14 that the patients that are now seen at the  
15 Trident system will come from the eight zip  
16 codes in the central portion of the county  
17 starting with the Moncks Corner zip code and  
18 the other zip codes around the lake, plus  
19 29483, which is that cross-county zip code.  
20 Only the patients from those zip codes arriving  
21 at the facilities, at either Trident or  
22 Summerville, non-tertiary patients, they looked  
23 at what the payer mix would be. Because of  
24 those being the zip codes rather than, say  
25 Goose Creek, Ladson, other zip codes to the

1 south, you get a different mix. The patient  
 2 population in the north is not as favorable.  
 3 It has a lower percentage of patients that are  
 4 HMO, PPO, commercially insured; higher  
 5 percentage of Medicare, Medicaid. So that, I  
 6 thought, was the right way to do it. Using  
 7 essentially all of the data for all of the  
 8 patients for Berkeley County being seen at the  
 9 two hospitals would have made the Moncks Corner  
 10 facility in a sense, an average facility. And  
 11 in fact, because of its location, its serving  
 12 a disproportionate share of a lower income  
 13 population, with poorer insurance sources and  
 14 that it should be expected that that be  
 15 reflected in the financial performance of the  
 16 facility. So, that's what they used to come up  
 17 with the payer mix. And then in terms of  
 18 determining how much you're going to get paid  
 19 from those payer mixes over time, they started  
 20 with essentially the historical data for what  
 21 I call net to gross percentages, as  
 22 Summerville, and then going forward it was  
 23 based on charge increases versus the increases  
 24 that were expected to be paid for each of those  
 25 individual payers. So, I think that's a

1 reasonable way to do it. The one thing I will  
2 say on page 269, that first page, is I  
3 mentioned before that it's not exactly a  
4 standalone Berkeley financial. The reason is  
5 that right now there are services that Trident  
6 is providing at the Moncks Corner site. All  
7 right. It has the emergency room. It has some  
8 outpatient services. So, the way this model  
9 was built was the outpatient volume was not all  
10 outpatient volume as was expected at the Moncks  
11 Corner facility, but only that which is  
12 incremental. In other words, new volume on top  
13 of the base volume that's already being seen at  
14 that site. Because if you already have a  
15 Moncks Corner facility, it already has an  
16 emergency department, it already has outpatient  
17 volume. Let's assume that it's 10,000  
18 outpatient visits. And the first year in the  
19 new facility you project 20,000 outpatient  
20 visits. Well, 10,000 of that was already  
21 there. So 10,000 of it is new. So, the way  
22 Mr. Woodford did these financials is he would  
23 have reflected 10,000 visits to come up with  
24 the financial data, not the full volume of  
25 20,000. Now, on the inpatient side, it's



1 pretty much all the volume except for one year,  
2 and that's year three. And in year three, the  
3 total growth in the Trident system is a little  
4 bit less than the volume expected at the  
5 Berkeley Regional Medical Center. And what  
6 that means is, that, in a sense, that's  
7 cannibalization of the base of Trident's  
8 system.

9 Q: Let me just stop you, what do you mean by  
10 cannibalization for the Court?

11 A: Yeah, it means let's assume that Trident  
12 Medical Center had 10,000 patient days and it  
13 was expected in the future to have 12,000 days.  
14 And the new Berkeley Regional Medical Center  
15 was expected to have 2,000 days. Well, the  
16 Trident system is growing by 2,000 the Berkeley  
17 System is going to have 2,000, so it's a wash.  
18 The 2,000 growth for the Trident system in a  
19 sense is being transferred to the Berkeley  
20 Regional Medical Center. But in this one year,  
21 the forecast for the Trident system is a few  
22 hundred patients fewer, a few hundred patient  
23 days less than the volume that was projected,  
24 that we projected for the new Berkeley Regional  
25 Medical Center. So, in that one year, in a

1 sense, the Trident system would be below the  
2 10,000. It might be 9,800, 9,700 as an  
3 example. So, I call that cannibalization. It  
4 just means they have to, you know, in a sense  
5 subsidize the new hospital those few patients  
6 in that one year. But by year four and five,  
7 that disappears.

8 Q: Okay. In terms of the underlying documents and  
9 your meeting with the folks that created them,  
10 do you have an opinion as to the reasonableness  
11 of the assumptions that underlie the  
12 performance in this CON?

13 A: Yeah, I think they're reasonable. I think a  
14 lot of effort went into putting this together.  
15 I think there's a lot of careful attention. If  
16 I started from scratch, I'd come up with  
17 different numbers. If Mr. Knapp and I were on  
18 the same side and we were doing projections, we  
19 would probably come up with different numbers.  
20 That's the nature of forecasting. But  
21 reviewing the forecast by these individuals, my  
22 judgement is what they did is reasonable.

23 Q: Okay. And pro formas are estimates, correct?

24 A: Right. They're forecasts. Based on  
25 assumptions.

1 Q: Go back to Trident 644, the DHEC record for me  
2 on page 644 if you would.

3 A: Okay. Let me see.

4 Q: A lot of notebook juggling today.

5 A: All right. I've got it.

6 Q: All right. Let me give the Court an  
7 opportunity to get there. Okay.

8 THE COURT: Hold on.

9 MR. THOMAS: Yes, sir.

10 THE COURT: All right.

11 Q: Okay. Now, is this the semi-incremental pro  
12 forma that you just referenced?

13 A: Yes.

14 Q: Okay. And what does it show in terms of a new  
15 net income that is realized as a result of this  
16 project?

17 A: In 2014, which was estimated to be year three,  
18 about \$69,000 and increases to a little over  
19 two million by year five in 2016.

20 Q: Okay. And in terms of this project, do you  
21 have an opinion as to financial feasibility of  
22 the project with respect to, you know, that  
23 standard in the CON regulations? That project  
24 review criteria?

25 A: Yeah, I think there are two real tests you have

1 to meet with a pro forma. One is, is there  
2 going to be enough money to complete the  
3 project. In other words, does the application,  
4 does the applicant have resources to complete  
5 the construction of the project and I think  
6 that's the case here. The second is, is the  
7 net income improving over time. Does it get to  
8 a positive net income during the projection  
9 period, here by year three and the answer is  
10 yes.

11 Q: Okay. And just in general, for clarification  
12 of the record, does that opinion change if, if  
13 the assumption is there's another hospital in  
14 the market?

15 A: Yes, I do not believe this would be a  
16 profitable hospital in any of those five years  
17 if there were a second hospital built in the  
18 location where it's projected to be.

19 Q: Just standalone, Mr. Baehr, if this facility is  
20 allowed to go forward and be constructed,  
21 without another facility in the market, would  
22 you expect this facility to be more profitable  
23 than what is shown here in the pro forma?

24 A: No. I mean I think this is a reasonable  
25 estimate. Again, it was done in 2008. If you

1 were doing a new model now in 2012, you'd have  
2 different inputs in terms of inflation rates.  
3 You might have different data points, but at  
4 the time this was created in 2008, I think it  
5 was a reasonable estimate.

6 Q: Okay. Now, I'd like to discuss a few financial  
7 issues that have come up in this case.  
8 A: Sure.

9 Q: And we can maybe use as a basis some of the pro  
10 formas here in the application itself. Now, if  
11 you look on say, for instance, 644, where we  
12 just were.

13 A: Yes.

14 Q: There's depreciation expense.

15 A: Correct.

16 Q: On this page, correct?

17 A: Correct.

18 Q: Can you explain just for the record what that  
19 is and why it's an important expense to  
20 include?

21 A: Yeah, let's assume you build a new hospital  
22 that costs \$100 million. There's a portion of  
3 that that's land, a portion of it is for  
4 building. A portion of it is for fixed  
5 equipment. Some of it's for major moveable

1 equipment. And each of those different assets  
 2 have different useful lives. So, for instance,  
 3 let's assume you -- \$50 million was for  
 4 building. And the useful life was 25 years.  
 5 And I'm just throwing out estimates. The  
 6 depreciation means that one twenty-fifth, if  
 7 the useful life is 25 years, one twenty-fifth  
 8 of that 50 million would be a depreciation  
 9 charge in every year worth two million for the  
 10 building. And in essence, that depreciation  
 11 number matters even though it's not an expense,  
 12 it's not a cash expense, it's a real number  
 13 because over time, if hospitals are unable to  
 14 replace facilities that wear out, in other  
 15 words, when you get 20 years into the future  
 16 and you haven't reinvested essentially, there's  
 17 actually not a lot of depreciation left and you  
 18 have a facility that's basically crumbling. So  
 19 the depreciation number is an indication of  
 20 essentially future asset, future investment  
 21 that's going to be required to keep the  
 22 facility up to date.

23 Q: Okay. Mr. Baehr, we've heard a lot about  
 24 EBITDA. Can you just briefly say what is  
 25 EBITDA?

1 A: It's a measure of earnings or income before  
2 interest, taxes, depreciation and amortization.

3 Q: And can tax -- interest, taxes and amortization  
4 and well as depreciation impact profits?

5 A: Yes.

6 Q: Okay. Sara, would you put up Respondent 160 on  
7 the screen for me? Now, do you recall this  
8 slide that was presented by Roper, Trident  
9 Health System's financials that included a net  
10 revenue number and a EBITDA number?

11 A: Yes.

12 Q: Okay. And so what does it purport to show?

13 A: It purports to show that there is a measure of  
14 income, which is EBITDA of 311 million over  
15 four years or about 77, \$78 million a year.

16 Q: Okay. Now, in your opinion, is EBITDA a  
17 reasonable measure of the actual profitability  
18 of a health system?

19 A: No. Especially not the way HCA records its  
20 income because its management fee is below the  
21 line. It comes out after EBITDA has been  
22 calculated.

23 Q: Explain what below the line means.

24 A: All right. In other words, let's assume a  
25 hospital has EBITDA of \$60 million. If it has

1 depreciation of 10 million, if it has interest  
2 of five million, if it has management fee of  
3 five million, that \$20 million would come off  
4 of the EBITDA before you got to net income.  
5 So, in other words, if those were what a  
6 hospital's costs were in those three areas, the  
7 EBITDA is 60 million, but the net income before  
8 tax would be 40 million. If it paid tax at a  
9 35 percent rate, it would be paying 14 million  
10 in tax. So here you would have a \$60 million  
11 EBITDA, which would be reduced to 26 million  
12 net income after tax. So, I think it's  
13 misleading to look at an EBITDA number as if  
14 the numbers that are below the line don't  
15 matter.

16 Q: Well, and that's not money in the bank at the  
17 end of the year, is it?

18 A: No.

19 Q: And is your understanding that Trident is a  
20 for-profit company? It has to pay taxes?

21 A: Yes.

22 Q: Okay. And is that a substantial expense?

23 A: Yes. They have to pay if the corporation makes  
24 money.

25 Q: Now, the management fee that you mentioned, is



1 that a real expense?

2 A: Yes. The management fee, in essence, is a  
3 substitute for items that other facilities that  
4 don't have management contracts like this have  
5 above the line. In other words, they would  
6 have more salary expense to pay for positions  
7 and pay for services or more contractual  
8 services that are absorbed into this management  
9 fee. In other words, if you didn't have a  
10 management fee, you'd probably have tens of  
11 millions of dollars above the line in other  
12 costs that would show up on those other lines  
13 of the expense report.

14 Q: Okay. Would you put up Petitioner's 162 for me  
15 real quickly? And let's see here. Go to the  
16 next page please. Next page. Next one. This  
17 is page 162.

18 A: Which book is this?

19 Q: Next page. It's going to be in this book here.  
20 And go to tab 162.

21 A: Sure. All right. I've got it.

22 Q: And if you would turn to Roper-Berkeley 429-1  
23 for me.

24 A: Sure.

25 Q: This is a consolidated statement of operations

1 for the years ended December 31st of 2010 and  
2 2009. Do you see that?

3 A: Correct.

4 Q: Okay. Now, are you familiar with audited  
5 statements like this?

6 A: Yes.

7 Q: Okay. Have you reviewed them in the past?

8 A: Yes, the firm that acquired my old firm, Ernst  
9 & Young, is one of the four biggest accounting  
10 firms in the world.

11 Q: Okay. What was Roper's net income in 2009?

12 A: \$70,275,000.

13 Q: Okay. Now, the operating income for 2009 was  
14 how much?

15 A: \$29,129,000.

16 Q: What does Roper St. Francis include above the  
17 line in terms of expenses to its system that  
18 Trident includes below the line?

19 A: Depreciation and amortization and interest  
20 expense.

21 Q: Okay. So, if we added those expenses together  
22 and put them below the line, like Trident does,  
23 what would Roper's operating income look like  
24 in 2009?

25 A: Well, its EBITDA for 2009 would be \$76 million.

1 It would be the 47 million in depreciation and  
2 amortization plus interest added to the 29  
3 million to get \$76 million.

4 Q: Okay. And so that would be more of an apples  
5 to apples comparison, wouldn't it?

6 A: Yes, with one exception. It's still a little  
7 bit unfair because the management fee is below  
8 the line in the case of Trident and comparable  
9 expenses are already being deducted above the  
10 line in the case of Roper.

11 Q: Okay. And then the \$70.2 million that Roper  
12 earned in 2009, that money is not subject to  
13 state or federal income taxes?

14 A: No, it's not.

15 Q: Okay. All right. Go to Petitioner's 181 for  
16 me, Sara.

17 A: 181. I've got it.

18 Q: Okay. And if you would just see in the top  
19 right hand corner, some page numbers. If you  
20 would go to page nine in that Exhibit for me.

21 A: Sure.

22 Q: It's actually for the record Trident 810.

23 A: Okay. I've got it.

24 Q: Okay. I'm showing you Trident's net income  
25 statement for 2009, Mr. Baehr.

1 A: Correct.

2 Q: Does Roper's income statement that we just  
3 looked at, does it look similar to this one?

4 A: No.

5 Q: Okay. And how is it different?

6 A: Well, again, you have an EBITDA line and then  
7 below the line you would have depreciation,  
8 which is an above the line item for Roper.  
9 Below the line you have interest expense, which  
10 is an above the line item for Roper, below the  
11 line you have management fees, some equivalent  
12 portion of which would be above the line for  
13 Roper.

14 Q: Okay. Let me ask you this. So, the EBITDA  
15 here on Trident for 2009 was \$78 million and  
16 some change, correct?

17 A: Uh-huh (affirmative response).

18 Q: All right. So that doesn't, that doesn't  
19 subtract out the depreciation, interest and  
20 amortization, does it?

21 A: No.

22 Q: Okay. If you compared Trident's and Roper's  
23 2009 income statements with each other but  
24 equaled it all up, you know, the same expenses  
25 above the line or below the line, what's your

1 understanding of what these two would look  
2 like?

3 A: I think they're fairly comparable. The one  
4 thing that's impossible to know is how much of  
5 the management fee component, in the case of  
6 Trident is accounted for with similar items  
7 above the line in the case of Roper. It's some  
8 portion of it. I don't know the exact number,  
9 but the numbers are pretty comparable. And my  
10 general conclusion is that these are two  
11 systems that both have done well over the last  
12 few years and both are expecting to do well in  
13 the future.

14 Q: Okay. And so we saw that the net income for  
15 Roper in 2009 was about 70 million, right?

16 A: Correct.

17 Q: Okay. And the net income for Trident here on  
18 Trident 810, and Petitioner's 181 is 56.2  
19 million, correct?

20 A: Correct.

21 Q: But then, is this pre-tax or post-tax?

22 A: That's pre-tax.

23 Q: Okay. So then there would be another  
24 percentage that would be taken off the bottom  
25 line there too, correct?

1 A: Correct.

2 Q: Now, I think Mr. Long brought up in  
3 Petitioner's 181, if you would flip over to  
4 page 18 of that document --

5 A: 181?

6 Q: Yes. It's the same Exhibit.

7 **THE COURT:** Page what?

8 **MR. THOMAS:** Your Honor?

9 **THE COURT:** Page 181? I'm on 810 right now.

10 A: Okay. I see it.

11 Q: Okay. And this was the -- I believe Mr. Long  
12 questioned some of our Trident witnesses  
13 earlier about Trident's 2010 income statement  
14 because it had a \$92 million EBITDA. Do you  
15 recall that?

16 A: Correct.

17 Q: Okay. What was the actual net income for that  
18 year?

19 A: Seventy-one and a half million.

20 Q: Okay. And if you assume the 30 percent tax  
21 rate, what does that bring it down to?

22 A: Well, it would be more than 30. It's probably  
23 35 plus some state component. Forty might be  
24 a better estimate. It would be about 28  
25 million.

1 Q: Okay. So, simply because you have a high  
2 EBITDA number, that's not going to tell you  
3 what the bottom line is for the actual  
4 institution, is it?

5 A: No.

6 Q: Okay. In your opinion, would it be proper to  
7 simply ignore management fees and depreciation  
8 and taxes that Trident must pay when you're  
9 determining the profitability of Trident?

10 A: No, I think that would be misleading.

11 Q: Okay. Why might an organization be interested  
12 in EBITDA? What do they use that line item  
13 for?

14 A: Yeah. I mean there's certain things that  
15 people on-site can manage. Depreciation  
16 relates to some extent, for investments already  
17 made and capital decisions that have already  
18 been made. So, you can't penalize people on-  
19 site if the depreciation is X in a given year  
20 because you knew it was going to be X based on  
21 the projects they undertook. Similar for  
22 interest expense. Interest expense is  
23 associated with financings that have occurred.  
24 Decisions on financing, especially for instance  
25 in a system like HCA made a corporate level,

1 not on an individual hospital level. So, you  
2 can't judge the individual people on-site for  
3 that kind of category of expenses. But EBITDA  
4 is a reasonable basis for comparing the  
5 individual hospitals and managers for what they  
6 can manage. All right. Those expenses that  
7 are controlled. The ones that they are  
8 responsible for. Revenues and expenses on-site  
9 that are not assigned to them as a result of  
10 other issues or as a result of prior capital  
11 decisions.

12 Q: Okay.

13 THE COURT: Let me ask this.

14 MR. THOMAS: Yes, sir.

15 THE COURT: Is this EBITDA, is that singular to the  
16 hospital industry or is it used in industry in  
17 general?

18 A: Yeah, it's used -- generally it's used more for  
19 multi-hospital systems as a basis of  
20 comparability. Individual hospitals, I haven't  
21 seen it used as much. Generally there's more  
22 emphasis on --

23 THE COURT: What about in the automobile industry?  
24 Would it be used there?

25 A: Yeah, you'll hear, if you watch CNBC they're



1 talking about EBITDA numbers all the time.  
2 Q: Do you still have the project review criteria  
3 I handed you earlier?  
4 A: Yes, I do.  
5 Q: Okay. I'd like you to turn in the CON 61-15  
6 802 to project review criteria nine.  
7 A: Okay.  
8 Q: And --  
9 A: Do you happen to know what page that is?  
10 Q: Oh, I'm sorry. My pages probably look a little  
11 different than yours.  
12 A: It's 802, right?  
13 Q: Yeah. Probably towards the end.  
14 A: I've got it.  
15 Q: All right. Okay. And project review criteria  
16 nine is the, what's the title of it?  
17 A: Net income.  
18 Q: Net income. And could you read this into the  
19 record, this project review criteria standard  
20 into the record for the court?  
21 A: Sure. The project should show an improvement  
22 in its net revenue position over time.  
23 Especially the first three years until a  
24 steady, positive net income trend is attained.  
25 Any projected deviations from this pattern

1 should be explained.

2 Q: Okay. Is there any mention in this project  
3 review criteria about evaluating the project  
4 based on its EBITDA?

5 A: No.

6 Q: Okay. And have you ever known the Department  
7 of Health and Environmental Control in this  
8 state to evaluate an individual project by  
9 EBITDA?

10 A: I've not seen it in this state nor any other.

11 Q: Okay. Turn -- and I want you to look at the  
12 very next project review criteria.

13 A: Uh-huh (affirmative response).

14 Q: It's number ten. It's called debt service.

15 A: Uh-huh (affirmative response).

16 Q: And I'd like you to read 10(b) into the record  
17 for me.

18 A: Okay. Characteristics of the debt interest  
19 repayment arrangements, etcetera, should be  
20 consistent with those arrangements used by  
21 other health service entities in the state and  
22 consistent with accepted good business  
23 practices in the terms of assumption and  
24 retirement of debt.

25 Q: So, is it your understanding that DHEC requires

1 that in terms of assuming debt that it's got to  
2 be consistent with good business practices?

3 A: Yes.

4 Q: Okay. In your opinion, would you recommend  
5 that Trident assume debt or otherwise commit  
6 the funds for Berkeley Medical Center if the  
7 project would not return a positive net income?

8 A: That would depend on whether the positive --  
9 what time on the horizon you're looking at. If  
10 it wouldn't return a positive net income for  
11 five years or ten years, that's different than  
12 if it might not do it for 50 years. Also you  
13 need to look at the amount by which you would  
14 be under water. How large the deficit would  
15 be. I mean those are all considerations. But  
16 in general, if you're allocating \$100 million  
17 for a capital investment, that's money that,  
18 for instance, a system like HCA could allocate  
19 to other hospitals in other locations. A  
20 return is important. Consistency with the  
21 strategic objectives within a system are  
22 important. A case has to be made. The local  
23 people on-site simply don't say this is my  
24 budget and as a result it gets approved.  
25 You've got to make the case. You've got to

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1 argue for it. You have to -- in a sense,  
2 you're competing for capital with other  
3 facilities that are in the system that also  
4 have projects. That also have issues. That  
5 also have objectives and needs. So, if a  
6 project looks deficient on net income, if it  
7 looks like it's actually going to lose a fairly  
8 significant amount of money for a fairly  
9 significant period of time, I think that one  
10 would be a low priority.

11 Q: Okay. I want to talk a little bit about  
12 operations. In terms of your experience as a  
13 healthcare planner, what's your understanding  
14 of how most inpatients that are admitted to a  
15 hospital come to that situation?

16 A: Most inpatients are referred by physicians or  
17 come through the emergency room.

18 Q: Okay. Would you turn --

19 MR. THOMAS: We're going to go back to the DHEC  
20 record now, Your Honor.

21 A: Joint Exhibit 1?

22 Q: Joint Exhibit 1. Okay. Trident record page  
23 666.

24 A: What page was that?

25 Q: Page 666.

1 A: Okay.

2 Q: All right. And this is a table that summarizes  
3 admission source at least for Trident Health  
4 System facilities, what they would be for  
5 Berkeley County in 2007, do you see that?

6 A: Yes.

7 Q: Okay. And so, could you just kind of run  
8 through this report in terms of where Trident  
9 gets its --

10 A: Sure. In total, there were 8,437 admissions to  
11 the Trident system that came from residents of  
12 Berkeley County. And if we look at two lines,  
13 ER and non-healthcare facility, the combination  
14 of those two is slightly over 8,000. So  
15 basically, 95 percent of the admissions are  
16 coming from the emergency room or a non-  
17 healthcare facility typically means a  
18 physician.

19 Q: Okay. In terms of patients who have  
20 emergencies based on your experience in  
21 healthcare planning, where do patients  
22 generally tend to go?

23 A: In an emergency -- if they're admitted from an  
24 emergency room?

25 Q: Or if they have an emergency at home.

1 A: Oh, typically they will go to a close-by  
2 facility.

3 Q: Now, if Roper builds its hospital in Goose  
4 Creek, which will have an ED as it's required  
5 to have, do you have an opinion about what may  
6 happen to Trident's ED volume?

7 A: Yes, I think there will be some diversion that  
8 now is either going to Summerville or Trident  
9 Medical Center who would instead go to a closer  
10 facility which would be the Roper hospital in  
11 Carnes Crossroads.

12 Q: Okay. Have you been made aware of the Roper  
13 St. Francis physician employment practices?

14 A: Yes, generally familiar. Haven't seen any  
15 specific contract.

16 Q: Okay. You haven't seen any employment  
17 contract?

18 A: No.

19 Q: Okay. Sara, put up Petitioner's 93 for me.  
20 Did you happen to review this document that was  
21 produced in discovery?

22 A: Yes.

23 Q: Okay. If you would go to page 11 for me.

24 **MR. THOMAS:** Your Honor, and it would be Roper 1329  
25 for the record. I don't know, you might be

1 able to see this one on the screen, Your Honor.

2 **THE COURT:** I can see this one, thanks.

3 Q: What's your understanding of what this slide  
4 shows?

5 A: It basically says that Roper St. Francis  
6 Hospital is employing about half, 48 percent of  
7 the primary care --

8 **MR. LONG:** Your Honor, I'm going to object to that.  
9 He's either going to have to lay a greater  
10 foundation or the witness is not going to be  
11 able to testify to it. Because this is Roper  
12 St. Francis PowerPoint and he's asking him, you  
13 know, like he drafted it or something. I mean  
14 he didn't draft it. We need some foundation,  
15 something.

16 **MR. THOMAS:** I can do that.

17 **MR. LONG:** And ask the questions to the fact that  
18 the witness didn't draft the document.

19 **MR. THOMAS:** That's fine. I can do that, Your  
20 Honor.

21 Q: Okay. What's your understanding that the  
22 PowerPoint from Moody's update, what is that?

23 A: Yeah, well first of all, Moody's is one of the  
24 major rating agency services; Standard and  
25 Poor's is another one. That rates hospital

1 bond issues and if you have a significant  
2 amount of long-term and tax-exempt debt  
3 outstanding, they require you, on a periodic  
4 basis to make a presentation to them and update  
5 your financials and they can maintain the  
6 rating you've had to start with or they can  
7 change it. Some ratings can go up, some  
8 ratings can go down. Hospitals routinely send  
9 financial projections to the rating agencies.  
10 Sometimes they have meetings and have more  
11 elaborate presentations to discuss their  
12 strategy and objectives.

13 Q: Okay. And you didn't draft this document?

14 A: I did not draft this.

15 Q: This was produced to us by Roper St. Francis in  
16 the discovery process?

17 A: That's my -- yeah, it was produced in the  
18 discovery process and I'm assuming that Roper  
19 St. Francis prepared this for Moody's.

20 Q: Okay. And so again, first of all, you know, it  
21 says Mount Pleasant Hospital medical staff.  
22 Where is Mount Pleasant? Is it in the tri-  
23 county service area?

24 A: Yes.

25 Q: Okay. Do you know where the tri-county service



1 area it is?

2 A: Yeah, it's in Mount Pleasant. It's about seven  
3 miles up the road from the East Cooper  
4 facility.

5 Q: Okay. Are you talking about Roper St. Francis,  
6 their new hospital?

7 A: Yes.

8 Q: And so, what's you're understanding of Roper  
9 St. Francis' employment of primary care  
10 physicians in the Mount Pleasant market based  
11 on this slide?

12 A: Yeah, this slide indicates that about a little  
13 less than half of the primary care physicians  
14 in the Mount Pleasant area are now employed by  
15 Roper St. Francis.

16 Q: Okay. What's a primary care physician for the  
17 record?

18 A: These are the doctors who see patients and at  
19 times recommend them on to specialist, but they  
20 include general practitioners, internal  
21 medicine specialist or internists as they're  
22 called, obstetricans.

23 Q: Okay. Family practice?

24 A: Family practitioners. Pediatricians.

25 Q: Okay. And of course, did you draft this slide?

1 A: I did not.

2 Q: Okay. And this is Roper Berkeley 1330 within  
3 Petitioner's 93, correct?

4 A: Yes.

5 Q: What do you understand this slide, which was  
6 presented to Moody's, indicates in terms of  
7 Roper's medical staff development?

8 A: Well, that they are recruiting physicians and  
9 they anticipate growth in physicians which is  
10 to be expected. I think when you have a new  
11 hospital on-site that they're actively  
12 recruiting for new physicians.

13 Q: Okay. Does that include the specialists as  
14 well?

15 A: Yes.

16 Q: Okay. In terms of -- again, this is another  
17 slide within Petitioner's 93, Roper Berkeley  
18 1350 is the Bates. Do you understand Roper is  
19 actually going outside of the Tri-County market  
20 to employee physicians?

21 A: It appears to be, yes.

22 Q: Why would you do that?

23 A: To expand your overall service area. I think  
24 it's a tertiary system, it's probably looking  
25 for referrals to inpatient tertiary services in

1 downtown Charleston.

2 Q: Okay. Do you have an opinion as to what effect  
3 Roper St. Francis employment practices would  
4 have on Berkeley Medical Center if similar  
5 practices are in place in Mount Pleasant were  
6 applied in Berkeley County?

7 A: Yeah, I think it would result in significant,  
8 could result in a significant shift in the  
9 market.

10 Q: In terms of -- we'll get to Roper St. Francis'  
11 CON application, but do you recall any  
12 reference to these employment practices within  
13 Roper St. Francis' CON application?

14 A: I don't recall them right now.

15 Q: Okay. Turn to Petitioner's 157.

16 A: 167?

17 Q: 157.

18 A: And this is -- okay. That's a different book?

19 Q: Yes.

20 A: (Witness does as instructed.) 157 you said?

21 Q: Yeah. And Mr. Baehr, this may not be the  
22 correct Exhibit. Let me ask this question this  
23 way. Have you reviewed documents that would  
24 indicate where patients who present to the  
25 Roper St. Francis Moncks Corner ED are

1 transferred?

2 A: Yes.

3 Q: Okay. And where are most of those patients  
4 sent that come to Roper Moncks Corner Emergency  
5 Department in Berkeley County?

6 A: About three quarters, 75 percent are sent to  
7 either Roper Downtown or St. Francis.

8 MR. LONG: Your Honor, just for the record, based on  
9 this questioning, 157 had not been admitted.  
10 He's referenced --

11 MR. THOMAS: That's why I'm not --

12 MR. LONG: I just want it clear on the record, 157  
13 is not in.

14 MR. THOMAS: That's perfectly okay.

15 Q: Yeah, actually go to Petitioner's Exhibit 163  
16 for me.

17 A: Okay. I've got it.

18 Q: Okay. This was a chart that was entitled  
19 Transfers to Inpatient Hospitals from Roper St.  
20 Francis Berkeley ED 2009, Year to Date August  
21 2011, produced to us from Roper St. Francis  
22 Berkeley. You did not create this chart, did  
23 you Mr. Baehr?

24 A: I did not.

25 Q: Okay. And based on what you just said, let's

1 look at year to date August 2011. Out of the  
2 689 transfers from the Roper Moncks Corner ED,  
3 how many went to Trident Medical Center?

4 A: Thirty-eight.

5 Q: Okay. How many went to Summerville Medical  
6 Center?

7 A: Two.

8 Q: Okay. So 40 out of 689?

9 A: Seven percent.

10 Q: Okay. What are the two closest facilities,  
11 hospital facilities to the Roper Moncks Corner  
12 Emergency Department?

13 A: Trident and Summerville.

14 Q: Okay. Now, Mr. Baehr is that the patient  
15 bypassing Trident or Roper St. Francis  
16 transporting the patient to one of its  
17 facilities 30 miles away?

18 A: Well, clearly patients being transferred from  
19 the emergency department to an inpatient  
20 hospital, so there are orders that are being  
21 drawn up by a physician. And so this is being  
22 done essentially by medical staff at these  
23 facilities.

24 Q: Okay. Based on your experience in healthcare  
25 planning, do patients generally rely on the

1 referral suggestions of their physicians?

2 A: Yes. Not exclusively. There are some people  
3 who don't and some who have become much more  
4 sophisticated in evaluating alternative  
5 options. Are being a little choosier  
6 themselves, but the overwhelming majority still  
7 go with what their physicians recommend.

8 Q: Okay. Now, the question I've got for you, you  
9 know, if physicians decide to send patients to  
10 hospitals that may not be the closest hospital  
11 to the patient's residence, in your opinion is  
12 that indicative of a serious problem with  
13 patient access?

14 A: No. They -- access is an issue of whether  
15 there are quality facilities that are located  
16 within a reasonable driving time. That's the  
17 geographic access test. There's also financial  
18 access issues of whether patients of low income  
19 can have access to facilities also within a  
20 reasonable distance and whether there's a  
21 totally non-discriminatory policies as far as  
22 their admission and treatment. But, the idea  
23 that patient preference for a facility X over  
24 Y or hospital referral or emergency department  
25 referral of X over Y that bypasses close by

1 facilities doesn't indicate that there's an  
2 access issue.

3 Q: Do you still have regulation 61-15 up there  
4 close by?

5 A: Yes, I do.

6 Q: And if you would do me a favor and turn to  
7 Section 802-4(a).

8 A: Okay.

9 Q: And would you read that into the record, 4(a).  
10 Well, first of all 4 is acceptability. So if  
11 you will read 4(a).

12 A: The proposal of the applicant should have the  
13 support of affected persons including local  
14 providers in the target population. The lack  
15 of opposition should not be considered support  
16 for the purposes of this criteria.

17 Q: Okay. In terms of the kind of the local  
18 providers that are hospitals, are you aware if  
19 Trident received any local support from other  
20 hospitals?

21 A: Yes, I believe they got support from both East  
22 Cooper and from the Medical University of South  
23 Carolina.

24 Q: Okay. And is that significant to you?

25 A: Yeah. I mean any time you've got a new

1 facility that's being developed and everybody  
2 has some market share in every area, that's a  
3 potential loss of patients for another  
4 provider. The fact that those other providers  
5 endorse the Trident project in Moncks Corner is  
6 indicative that they think that whatever  
7 adverse impact they may experience is  
8 outweighed by the advantages of the services  
9 for, you know, the healthcare system.

10 **MR. LONG:** Objection. He can't speculate on the  
11 reason they gave support letters. He can only  
12 comment on what they wrote. I would move to  
13 strike the last answer.

14 **MR. THOMAS:** What portion do you want to strike?

15 **MR. LONG:** The end there where he starts commenting  
16 and speculating on the reason they may have  
17 given the support. Because he doesn't know.  
18 He hasn't spoken to them. You've laid no  
19 foundation for it and the letters just say we  
20 support the project. They speak for  
21 themselves.

22 **Q:** Another question.

23 **THE COURT:** Excuse me, what did you say?

24 **MR. THOMAS:** I can maybe lay some foundation for  
25 that for Your Honor.



1 THE COURT: Okay.

2 Q: Mr. Baehr, have you seen other instances in  
3 your 30 year plus career in health planning  
4 where competitors have supported applications?

5 A: At times and sometimes they don't.

6 Q: Okay. What's your understanding, based on that  
7 experience of why competitors may support an  
8 applicant?

9 A: They may think there's a need for it. They may  
10 think it's not going to hurt harm them too  
11 much.

12 Q: Okay.

13 MR. LONG: Okay. That's fine. Thank you.

14 Q: I believe you testified earlier you did review  
15 the Roper St. Francis DHEC record?

16 A: Yes.

17 Q: Okay. First of all, let me ask the Court, I  
18 know we've been going awhile here. Do you  
19 think we could take a quick break, Your Honor?

20 THE COURT: You say you need a break or you just  
21 think this is a convenient time?

22 MR. THOMAS: I need a break.

23 THE COURT: We'll take a ten minute break. Be back  
24 in five minutes.

25 MR. THOMAS: Thank you, Your Honor.

1 THE COURT: Let me say one thing before we leave.  
2 Due to Mr. Goldman's absence, I've not been  
3 able to get anybody to sit in my office. As a  
4 consequence, I've had to leave my cell phone  
5 on. I am expecting, possibly, a call on  
6 relevant case pending. Other than that, I  
7 won't disturb you with it, but it's necessary  
8 that I leave it on for that reason.

9 MR. THOMAS: No problem, Your Honor.

10 (Off the Record)

11 THE COURT: Back on the record.

12 Q: Mr. Baehr, I think you've got in front of you  
13 there what's been marked as Joint Exhibit 2?

14 A: Yes.

15 Q: Okay. And it's a Roper DHEC record?

16 A: Uh-huh (affirmative response). Yes.

17 Q: And do you have opinions related to this CON  
18 application that you're prepared to offer  
19 today?

20 A: Yes.

21 Q: Okay. Now, what do you understand Roper's  
22 project to be?

23 A: They are proposing to take 50 beds from the  
24 downtown Roper campus and move them into  
25 Berkeley County at a location where they own

1 land. In Carnes Crossroad to build a 50 bed  
2 hospital. So they'll take 50 beds that are  
3 currently on the license at the Roper Downtown  
4 facility to create a new hospital in Berkeley  
5 County.

6 Q: And you were here all last week, weren't you?

7 A: Yes.

8 Q: And you've heard Mr. Long question Trident  
9 witnesses about that, you know, how is a 50 bed  
10 hospital going to affect 390 beds at a  
11 tertiary-care center. Let me ask you this, how  
12 many med-surg beds do you understand Roper St.  
13 Francis will have?

14 A: I believe it's 36.

15 Q: Okay. And if those 36 med-surg beds would  
16 become full, and a patient presents to Roper  
17 St. Francis Berkeley emergency department, and  
18 would need immediate admission to a med-surg  
19 bed, in your opinion, based on what you've  
20 read, the testimony you've seen do you think  
21 Trident or Summerville would get the benefit of  
22 those patient transfers?

23 A: I don't. They've been transferring patients  
24 from the Moncks Corner ED to their downtown  
25 hospitals, which is a longer transfer, than it

1 would be from the Carnes Crossroad ED to those  
2 same facilities. And it appears that the  
3 percentage of transfers from the Moncks Corner  
4 ED to the downtown hospitals would be  
5 increasing as a percentage of the total. It's  
6 almost 80 percent in 2011, so my expectation  
7 would be if they don't have available beds at  
8 the hospital, that they would use available  
9 beds in the remainder of the Roper system.

10 Q: Okay. What's your understanding and based on  
11 the data that you've seen, and I think the most  
12 recent data we have for Roper St. Francis in  
13 Mount Pleasant was through August of 2011,  
14 what's your understanding of, say, how many  
15 available beds there are at the Mount Pleasant  
16 facility based on the data you've seen?

17 A: Virtually all of them. From what I've been  
18 able to tell through the first ten months that  
19 facility was open, which includes the first  
20 eight months of 2011, the facility was running  
21 about 11 percent average, 11 percent of  
22 capacity. Which means on an 85 bed hospital,  
23 they were filling a little over nine beds every  
24 day. So, there were 76 beds available on  
25 average. It doesn't mean every day, obviously,

1 during that period.

2 Q: Okay. In terms of tertiary-care patients, in  
3 your opinion, a patient who presents to the  
4 Roper St. Francis Berkeley emergency department  
5 but needs transfer to tertiary-care facility,  
6 will that patient necessarily be transferred to  
7 Trident Medical Center?

8 A: No. Again, they would be most likely, I think,  
9 again, given the history, from Moncks Corner  
10 transferred to Roper St. Francis downtown. Or  
11 to Medical University of South Carolina. There  
12 are some transfers out of the Roper Moncks  
13 Corner ED that are going to Medical University.

14 Q: Okay. Turn if you would in Joint Exhibit 2 to  
15 page 15 of Roper DHEC record.

16 A: Okay.

17 Q: And do you understand this to be the beginning  
18 of the need section?

19 A: Yes. Section B-11.

20 Q: And did you review this particular section?

21 A: Yes.

22 Q: Okay. And if you would turn over to page 17 pf  
23 that DHEC record for me.

24 A: Uh-huh (affirmative response).

25 Q: At the bottom of the page there, there's a

1 strategic justification for the project.

2 A: Uh-huh (affirmative response).

3 Q: Did you review those bullet points?

4 A: Yes.

5 Q: Okay. In terms of the first bullet point,  
6 providing the first local access to inpatient  
7 care within the Berkeley County area, do you  
8 have any opinions or comments on that?

9 A: Yeah, I think that's a statement I would  
10 describe as nonsense. It's a strong word, but  
11 I've seen a bunch of material in this case  
12 suggesting that because there's not a hospital  
13 physically located within Berkeley County that  
14 that county does not have hospital service.  
15 The Trident Medical Center was established with  
16 the approval of county people in Berkeley  
17 County and Dorchester County that closed their  
18 facilities because they preferred to have a  
19 hospital where Trident was located, which is  
20 about a mile best I can tell, or maybe a trot  
21 more than a mile, from the Berkeley County  
22 line. If the Trident facility was a mile  
23 further north and was just inside the Berkeley  
24 County line rather than being just outside it,  
25 would that noticeably change or improve access

1 to care for Berkeley County residents? I don't  
2 think so. I think they're serving the Berkeley  
3 County residents from the location they are and  
4 because there's not a physical hospital located  
5 within the boundaries of Berkeley County does  
6 not mean there is no local provider providing  
7 access. It's just not true.

8 Q: Do you have any comments on -- is it the  
9 prediction here in bullet one that it would be,  
10 it would provide the first local access?  
11 Didn't Trident apply first for a hospital?

12 A: Yeah, that's the second component. And is  
13 somewhat suggestive that these are competing  
14 applications and that they win. Because if  
15 Berkeley already submitted an application by  
16 the time Roper had applied, they certainly know  
17 that there's another application that's in the  
18 system. So, if this is the first local access  
19 they're in a sense dissing or arguing that the  
20 Berkeley, or Trident application that Berkeley  
21 is inferior.

22 Q: Okay. Look at the -- in bullet two, ensuring  
23 access to a community based not for profit  
24 inpatient provider within the Berkeley County  
25 area, again, in terms of Trident and Roper, in

1 terms of their financial success, do you have  
2 any opinions as to this?

3 A: Yeah, this statement is one that I have seen in  
4 other communities where you have competition  
5 for a new facility from a for-profit and not-  
6 for-profit. And the argument essentially is  
7 that the not-for-profits care about people,  
8 for-profits care about profits and they send  
9 their money out of the community. If you look  
10 at where the applicants are proposing to build  
11 their hospital here, the for-profit system is  
12 proposing to build in Moncks Corner. A lower  
13 income area, rural area, a high minority  
14 percentage of the population. And the not-for-  
15 profit system, just as the did in Mount  
16 Pleasant, has located a much more affluent  
17 area, a few miles from existing providers that  
18 are already serving that community. Clearly,  
19 in my judgement, in an attempt not to improve  
20 access, but to pick up market share of an  
21 affluent population.

22 Q: Okay. Now, the third bullet here in this  
23 strategic justification, enhancing access to  
24 care for the Roper St. Francis-aligned patients  
25 living within Berkeley County who currently



1 travel out of the local area for care, are you  
2 aware, Mr. Baehr, of any project review  
3 criteria in the CON regulations that supports  
4 the concept of enhancing access to care to  
5 patients who could have used closer facilities?

6 A: No. I also have an issue with the whole  
7 concept of Roper St. Francis-aligned patients.  
8 What does that mean? Does that mean a patient  
9 who visited Roper St. Francis this year? Last  
10 year? Is it someone who has a frequent  
11 hospital card and after five stays they get the  
12 sixth stay free? I don't understand what that  
13 means. Is it a permanent population of  
14 residents at Berkeley County who you could  
15 identify, you could walk through communities  
16 and say all of you who are Roper aligned,  
17 please stand up? I don't understand what that  
18 means. It's a meaningless concept in terms of  
19 healthcare planning. Healthcare planning in  
20 terms of access improvement relates to  
21 geographic access, financial access, not to  
22 convenience the patients who might have chosen,  
23 or have chosen for them by an emergency  
24 department or a physician, hospital X over  
25 hospital Y which might have been much closer.

1 Q: Okay. And on that same page there, you've got  
2 proposed service area definitions. And last  
3 week you heard Ms. Brandt testify that she felt  
4 the two hospital markets were -- or the two  
5 service areas for the hospitals were separate.  
6 Do you recall that?

7 A: I do.

8 Q: Okay. Can you explain to the Court from your  
9 reading of the CON applications what specific  
10 service areas Roper St. Francis Berkeley is  
11 serving and the Berkeley Medical Center service  
12 area to the extent there's any overlap?

13 A: Sure. First of all, I think there's  
14 substantial overlap. They are, after all, in  
15 the same county. Berkeley Medical Center is  
16 pretty much in the dead center geographically  
17 of the county. And its two most significant  
18 zip codes that it's relying on for patients  
19 are, as I mentioned earlier, the zip codes  
20 essentially bordering the Roper St. Francis  
21 proposed site in Carnes Crossroads. So, you  
22 have two hospitals in the same county, in the  
23 same zip code, on the same road about 12 miles  
24 apart and are both relying, if you look at  
25 Roper St. Francis' historical patient

1 population coming out of Berkeley County, they  
2 have a significant reliance on 29483, which is  
3 that zip code that's split between Dorchester  
4 and Berkeley County. They have a significant  
5 reliance on 29461, which is the Moncks Corner  
6 zip code and the zip code in which both  
7 hospitals will be located. One difference is  
8 that the Moncks Corner facility is not assuming  
9 it will get very many patients out of the Goose  
10 Creek zip code. And historically, that's been  
11 a very important zip code for the Trident  
12 Medical Center as well as for Roper. But, you  
13 don't have to have 100 percent overlap for  
14 facilities to be competing. They're providing  
15 the same services. They're both 50 bed  
16 hospitals with the same virtual mix and  
17 distribution of services and technologies  
18 they're putting into the county. Location-wise  
19 they're the same. And the third test for  
20 competition is whether the two hospitals  
21 applying leads to a situation where an excess  
22 of beds would be created if both were approved.  
23 And then I think the evidence is pretty strong  
24 in this case. Both prepared by Mr. Richardson  
25 and prepared by myself, that the growth in the

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1 market by Berkeley County, whether you look at  
2 seven years or eight years is basically in the  
3 order or magnitude of three or four addition to  
4 average daily census per day. If they use the  
5 latest population numbers and growth numbers  
6 which are a little higher, you may get up to  
7 five. Over seven years, that gives you 35 new  
8 patients in Berkeley County. That's not enough  
9 for 100 beds. It's enough for 50 beds. In the  
10 application, Roper's forecast was much lower.  
11 They were relying on about three additional  
12 patients per day for the entire county which  
13 gets you to mid-twenties. And you know, if you  
14 use eight or nine years.

15 Q: Let me back up because I know we're going to  
16 get in more detailed analysis with the  
17 competing application issue, but in your  
18 opinion, was Ms. Brandt's conclusion that the  
19 two service areas served by the two separate  
20 hospitals was indeed different or separate?

21 A: I think she's wrong.

22 Q: Now, if you turn to page -- I think it's Roper  
23 30, for me in the DHEC record.

24 A: Okay.

25 Q: Now, first of all, can you explain to Judge

1 McLeod what your understanding of the Roper  
2 need model or their demand model for its  
3 hospital?

4 A: Sure. Roper projects their volume at the new  
5 facility from three sources. One is within  
6 Berkeley County, a redirection of a certain  
7 percentage of Roper patients who would have  
8 otherwise gone to Roper facilities at some  
9 point in the future. So they, just like  
10 Trident did, the project future volume for  
11 Roper patients and if they reach a volume of  
12 say 3,000 discharges for Roper or 3,500  
13 discharges for Roper in the future, they assume  
14 50 percent of those would be seen at the new  
15 hospital. So, in other words, a transfer of 50  
16 percent of patients from the Roper volume that  
17 would otherwise be seen in the county. They  
18 also assume a market share pick up. And their  
19 forecast is that 90 percent of their patient  
20 volume will come from Berkeley County. Ten  
21 percent would come from other counties,  
22 presumably Dorchester and Charleston County.  
23 Of the 90 percent within Berkeley County, their  
24 numbers, the numbers Mr. Richardson developed,  
25 suggest that 54 of the 90 would come from the

1 redirection of patients --

2 Q: Fifty-four percent of the 90?

3 THE COURT: We're on Bates 30?

4 MR. THOMAS: Yes, sir.

5 A: Yeah, of the 90 percent that's from within the  
6 county, 54 percent comes from Roper  
7 redirection, 36 percent are new patients picked  
8 up from market share gains at the expense of  
9 other hospitals. The other ten percent are  
10 going to come from outside of the county; Roper  
11 doesn't tell you whether they would be  
12 redirection or whether they would be market  
13 share pick up. So, if you're trying to look at  
14 what's the maximum percentage based on the  
15 model they developed, of new patients,  
16 incremental patients they pick up the market  
17 share means, it's somewhere between 36 and 46  
18 percent.

19 Q: Okay. Now, page 30 of Roper's DHEC record,  
20 what's the actual number that Roper concluded  
21 would be redirected in terms of, I guess, their  
22 total discharges in 2015, which it looks like  
23 that number is 3,292.

24 A: Yes. Yeah, this is point three. And it's  
25 1,775.

1 Q: Okay. And these are patients that Roper  
2 assumes that would, rather than drive to Bon  
3 Secours, St. Francis in West Ashley or downtown  
4 or to Mount Pleasant would stay in the  
5 community; is that right?

6 A: That's correct.

7 Q: Okay. Now, in your opinion, is that 50 percent  
8 patient redirection assumption reasonable?

9 A: It's possible. The point I'd make is of that  
10 50 percent, fewer than half are accounted for  
11 by Roper's own growth in the market.

12 Q: Okay. Explain what that means.

13 A: Yeah, in other words, Roper had, if you look on  
14 page 30, DHEC page 30, look under point one.  
15 And it says 13,732 non-specialty, non-tertiary,  
16 non-specialty discharges served by all  
17 providers in 2006 in Berkeley County. The  
18 Roper share of that was 3,152. So, roughly  
19 about 23 percent. Okay. Now, look at number  
20 two. In 2015, the total market has grown from  
21 13,732 to 15,435. But the Roper volume has  
22 grown from 3,152 to 3,550. So in other words,  
23 the projection is that all of the growth in the  
24 Roper system in the county, by 2015 will only  
25 add 398 new admissions. But the redirection

1 that they're assuming from Roper St. Francis  
2 hospitals is 1,775. It's about four and a half  
3 times as large. So, in other words, growth,  
4 the growth -- and I think it's perfectly  
5 reasonable to assume when you're projecting  
6 utilization for a new hospital and you have a  
7 sponsoring system to assume that the growth in  
8 that system in the location you're building a  
9 new hospital is there for the new hospital.  
10 That's a -- you know, it doesn't mean every  
11 single new incremental patient, because each  
12 year you have a different group of incremental  
13 of outpatients who stay in a hospital. But  
14 that's a fair number. If they can only get  
15 growth of 398 of the 1,775, that means that  
16 almost 80 percent of the redirection is coming  
17 from the base, not from essentially the growth  
18 in the market. In the Trident model for  
19 instance, using the most current numbers, the  
20 update that was provided in this example, in  
21 this case, about 60 percent of the volume  
22 that's expected to come out of Berkeley County,  
23 actually a little over 60 percent of the volume  
24 that Trident, that Berkeley Regional Medical  
25 Center anticipates getting from Berkeley County

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1 is accounted for the Trident system growth in  
2 that county. So, 62 percent or whatever the  
3 number is, I think it's about 62 percent, comes  
4 from Trident growth in the market. In this  
5 application, the Roper number, it looks like  
6 about 22 percent of their growth, 22 percent of  
7 their projected volume and that's transfers  
8 from the Roper patients, is accounted for by  
9 growth. That's not a big number. And that  
10 makes the transfer assumption more speculative.  
11 That's the point. If you can account for 62  
12 percent of your patient volume by growth in  
13 your system in that county, then it's only 38  
14 percent that has to come from essentially  
15 transfers.

16 Q: Okay.

17 A: But if you only account for 22 percent of the  
18 growth, then 78 percent has to come from  
19 transfers and that's a much bigger number and  
20 I think it makes it more likely that it may not  
21 happen.

22 Q: Okay. Well, if it doesn't happen and you want  
23 to reach your forecast, the utilization  
24 forecast, how would you have to go about doing  
25 that?

1 A: You'd have to get more market share from other  
2 providers.

3 Q: Okay.

4 A: Which is more adverse impact.

5 Q: And let me go back to the concept, this concept  
6 of accessibility. Even assuming, you know,  
7 that the 50 percent redirection factor is  
8 correct. In your opinion, would these patients  
9 have serious problems accessing healthcare  
10 services in the event Roper St. Francis  
11 Berkeley is not built?

12 A: Again, this is where it would have been useful  
13 for Roper to have provided a forecast of where  
14 they expect their patients to come from. If  
15 they expected that 35 percent, 40 percent would  
16 be from northern zip codes in the county, then  
17 you could make an argument that there is some  
18 improvement. I mean it's not as much of an  
19 improvement in access as Moncks Corner, but  
20 it's a shorter drive than going to Trident or  
21 Summerville.

22 Q: Okay.

23 A: But, if 80 percent are going to come from a  
24 seven mile radius around Carnes Crossroad,  
25 which is what the number was in the original

1 draft of the application that I saw, those are  
2 patients that all have very good access right  
3 now to two existing hospitals. So, that's not  
4 an access improvement. That's a convenience  
5 issue for patients who actually have  
6 alternatives but for one reason or another,  
7 either physician direction or choice, have not  
8 gone to those hospitals.

9 Q: Okay. Let's talk a little bit about the market  
10 capture and just the actual numbers on page  
11 DHEC 30. Am I correct that it looks like of  
12 the 3,292 total discharges at Roper St. Francis  
13 Berkeley projected in 2015 that 1,188 of those  
14 would be from a ten percent market capture or  
15 they would come from other providers?

16 A: Yeah. What they would come from is ten percent  
17 market capture of non-Roper patients in the  
18 county.

19 Q: Okay. Do you have an opinion regarding the  
20 reasonableness of this assumption, the 10  
21 percent market share assumption regarding the  
22 utilization numbers?

23 A: I think it could well be larger. Given the  
24 location of the hospital, they are on top of  
25 us. Essentially seven miles from Trident

1 Medical Center, ten or 11 miles from  
2 Summerville Medical Center, and those areas  
3 between Carnes Crossroads and those two  
4 hospitals and even in the area just north of  
5 Carnes Crossroad that's within that seven mile  
6 circle, Trident Medical System has a higher  
7 market share in those zip codes than it does  
8 county wide.

9 Q: Okay.

10 A: Which means that Roper's market share is lower  
11 there than it is county wide. And Medical  
12 University's market share is lower there than  
13 it is county-wide. So, in a sense, you're not  
14 -- if you get most of your patients from that  
15 area, there's a high likelihood you'd be taking  
16 from the market leader rather than simply  
17 redirecting a smaller set, which are your own  
18 patients.

19 Q: And explain to the Court, it's my understanding  
20 that in -- once you get the 1,188 patients  
21 that's the market capture, the 1,775, which is  
22 the three year of Roper patients, that's 2,963  
23 non-tertiary patients?

24 A: Correct.

25 Q: And then, but the total amount is 3,292. So

- 1           that leaves I guess, 329 patients. Where do  
2           you understand those patients are coming from?
- 3       A:    From other counties. Presumably it's based on  
4           the location of the facility; it is very close  
5           to Dorchester County and it's very close to  
6           Charleston County. So there might be a small  
7           number, because of seasonal visitors and such,  
8           that might come from outside the region, but  
9           the great majority of that ten percent I would  
10          expect to come from Dorchester and Charleston.  
11          Conceivably more from Dorchester because again  
12          of the location of the facility.
- 13       Q:   And what health system has the highest market  
14          share for Dorchester County?
- 15       A:    Trident. It's slightly in excess of 60  
16          percent.
- 17       Q:    Is it higher or lower than the market share  
18          Trident has in Berkeley County?
- 19       A:    It's higher overall.
- 20       Q:    Okay. If the patients, if the majority of the  
21          patients that would be, I guess, captured from  
22          an in-migration basis, coming from Dorchester  
23          County, what opinion, if any do you have based  
24          on, based on your review of these applications?  
25          What if any opinion you have with respect to

1 the serious access problems of people in  
2 Dorchester County?

3 A: I don't think they have serious access issues  
4 that would be resolved by going to the Carnes  
5 Crossroads facility. I don't think they have  
6 serious access issues.

7 Q: In terms of -- look at page 31 for me in  
8 Roper's DHEC record.

9 A: Uh-huh (affirmative response).

10 Q: At the bottom of the page, there's a reference  
11 here to adverse impact.

12 A: Uh-huh (affirmative response).

13 Q: Do you have an opinion on Roper St. Francis'  
14 adverse impact on other providers or existing  
15 providers?

16 A: Yeah, and this is one of the places where the  
17 fact that there was already an application in  
18 the cycle is very important. Because the  
19 Trident application makes very clear that the  
20 first thing that's projected is Trident system  
21 growth and then a portion of that Trident  
22 system growth as well as historic Trident  
23 volume is going to be transferred to this new  
24 facility. But there's a reliance on growth as  
25 well. The Trident growth in Berkeley County is

1 important for the new Trident facility in  
2 Moncks Corner. If Trident is relying on its own  
3 growth to construct its own hospital, how can  
4 Roper take most of that growth away, which it's  
5 projecting it's doing, it's taking 1,188  
6 discharges out of total growth in the market,  
7 not counting Roper, of a little bit over 1,300.  
8 So it's coming up with about 90 percent of the  
9 growth in the market, Roper is taking. All  
10 right. Plus all of its own, plus some of its  
11 own redirection. If 90 percent of the growth  
12 in the market is gone, how is it possible for  
13 Trident to be successful in its application in  
14 Moncks Corner and meet its projections? The  
15 clear assumption you have to make after reading  
16 this is that the people that put this together  
17 fall in to one of two categories. They're  
18 unaware there was another application that was  
19 submitted, which I think is highly unlikely, or  
20 they were aware and either ignored it or  
21 believed that eventually or at one point only  
22 one would be approved, so only one is approved  
23 and you don't really need to worry about growth  
24 for the other system.

25 Q: The definition of adverse effects on other

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1 facilities that you read earlier from the  
2 regulation 61-15, it talked about just the  
3 impact on current occupancy?

4 A: Current and projected.

5 Q: Okay. Explain to the Court what you think that  
6 means.

7 A: Well, remember that -- how does the State come  
8 up with the calculation of bed need for  
9 individual facilities? They take their current  
10 utilization, according to age groups, in other  
11 words, how many are, how many patients did they  
12 see, how many patient days of service to those  
13 over 65 and how many under age 14, I think is  
14 one of the categories. Maybe it's 17, I don't  
15 recall off-hand. And they project forward  
16 based on the growth rate expected for that  
17 population segment over a seven year period.  
18 When the State determines that a hospital has  
19 bed need, it's because it's filling its beds  
20 adequately right now, it has a high enough  
21 utilization percentage now and it's anticipated  
22 to share in its historic market share of the  
23 growth of the market. So, in a sense, what the  
24 State does in its bed need formulation is it  
25 assumes constant market shares with each



1 hospital essentially growing based on its  
2 historic volume and the population growth in  
3 the market. If the State uses growth to  
4 determine bed need, growth matters.

5 Q: Thank you. Now, is it your understanding that  
6 the Summerville Medical Center, the 24 bed CON  
7 application, or excuse me, the 30 bed CON  
8 application is being opposed?

9 A: Yes.

10 Q: By whom?

11 A: By Roper.

12 Q: What's your understanding of the reasoning  
13 behind the opposition?

14 A: I read the transcript of the project review  
15 meeting and at least in one part of that  
16 transcript, which was Mr. Bowling's testimony,  
17 it appears that an argument was made that the  
18 Summerville project should be deferred until  
19 the State can see what the impact of the new  
20 hospital in Carnes Crossroads would be on  
21 utilization of Summerville. In other words,  
22 there might be some impact. Their utilization  
23 might drop. Their growth forecast might be  
24 lower. So, in essence they're arguing we might  
25 cause them some impact, so they should wait

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1 while we go ahead.

2 Q: Okay. Let me ask you something. Would you  
3 read the bottom of page DHEC record 31. For  
4 Roper. There's a second sentence there  
5 starting with, in fact.

6 A: In fact, no material adverse impact is expected  
7 on other local providers, as population growth  
8 alone and the resulting increase in market size  
9 is anticipated to offset any possible patient  
10 volume reductions.

11 Q: Okay. Based on what you just testified to, as  
12 to the opposition of Summerville; is this true?

13 A: No.

14 Q: Go to the Roper St. Francis DHEC record page 39  
15 for me.

16 A: Okay. I'm there.

17 Q: Okay. Do you have any opinions based on the  
18 alternatives that Roper St. Francis has listed  
19 in the CON application?

20 A: Yeah, I think they left out two significant  
21 ones.

22 Q: Which are?

23 A: One is they only recently acquired this  
24 property in Carnes Crossroads. There was  
25 certainly an opportunity to develop outpatient

1 facilities in this location, much as they have  
2 in the Moncks Corner location and try to  
3 essentially build up a presence in that market  
4 in anticipation at some point of potentially  
5 having a hospital. There's evidence that 2008  
6 was by no stretch of the imagination the year  
7 in which Roper was anticipating applying for a  
8 hospital in the Carnes Crossroad location. So,  
9 they clearly could have done this in stages and  
10 started with outpatients similar to what  
11 Trident did in Dorchester County. They first  
12 built outpatient facilities, then a hospital in  
13 Summerville. They started -- Trident started  
14 with outpatient facilities in Moncks Corner.  
15 Now has proposed to add a hospital there.  
16 Roper, in a sense, is just moving right into  
17 the hospital stage without any intermediation  
18 of developing outpatient facilities and also  
19 doing it with this transfer technique, which I  
20 think, you know, I think everyone heard last  
21 week, it seems to allow a hospital to pick any  
22 sized facility it wants so long as it's not  
23 adding beds in the Tri-County Area and just  
24 plunk them down from one hospital to another.

25 Q: Okay. And we'll talk about that in a minute.

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1 Look on page DHEC record 40 for me if you  
2 would.

3 A: Sure.

4 Q: Just the next page. And the question I have,  
5 in terms of what, if any, opinion do you have  
6 that there will be serious problems in terms of  
7 the cost availability or accessibility to  
8 obtain the type of care proposed by Roper St.  
9 Francis Berkeley in the event its project is  
10 not built?

11 A: I don't think you can make this case. This is  
12 something the State has to sign off on before  
13 they approve the certificate of need  
14 application. I don't understand what the  
15 serious problems would be in terms of cost  
16 availability or accessibility if this project  
17 were not approved. I see minimal to non-  
18 existent in access improvement as we will get  
19 into later when we show some Exhibits. If  
20 anything, it's a duplication of services.  
21 Spending an extra 100 million to \$150 million  
22 to put a second hospital when only one is  
23 needed. Patients have readily available  
24 facilities in the area surrounding the location  
25 where they've proposed to locate this facility.

1 And that, you know, raised another issue.  
2 There was an alternative that they could have  
3 done, which I think would have maybe made that  
4 answer a little bit different. They could have  
5 applied in Moncks Corner themselves.

6 Q: Okay.

7 A: They could have made it directly competitive.  
8 That's the location that improves access the  
9 most. Trident is proposing it. Roper propose  
10 it.

11 Q: They didn't do that?

12 A: They didn't do that.

13 Q: Okay. Flip over for me to Roper's DHEC  
14 application page 462.

15 A: 462?

16 Q: Yes.

17 A: Okay. I've got it.

18 Q: Okay. Now, did you review the pro formas in  
19 this case?

20 A: I did.

21 Q: Okay. And do you have any opinions -- well,  
22 first of all, let me ask you this. Which  
23 hospital do you think would be most profitable  
24 if only one were built?

25 A: If you're looking at a full model of all

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1 revenues and expenses, not just incremental, if  
2 you're looking at the site revenues and  
3 expenses, I think the payer mix in Goose Creek  
4 would be better and that income would be  
5 higher.

6 Q: Okay. Do you have any opinions just about the  
7 pro formas themselves? This is an incremental  
8 pro forma, isn't it?

9 A: Yes. In other words -- and I apologize again,  
10 Your Honor, for -- this model assumes that 50  
11 percent of the patients at the new hospital  
12 will be new patients to the Roper system. And  
13 the other 50 percent will be transfers.

14 Q: Right.

15 A: But that's not what their demand forecast  
16 suggests. Their need assessment doesn't have  
17 50 percent incremental.

18 Q: Right.

19 A: It has 36 percent incremental from Berkeley  
20 County and then some share of the 10 percent  
21 from out of the county. So, the correct number  
22 would be between 36 and 46 percent. Since they  
23 assume 50 percent here, these numbers are too  
24 positive. In other words, the revenue numbers  
25 would be lower. The expense numbers would drop

1 off a little bit too, but not as rapidly.

2 Q: Okay. Can you explain why to the Court?

3 A: Yeah. What you have is, there are certain  
4 expenses that are fixed. Whether a hospital  
5 has 20 incremental patients, ten incremental  
6 patients, 30 incremental patients, its  
7 depreciation number will be the same, its  
8 interest costs will be the same. Okay. Those  
9 are facility costs. They're not related to  
10 volume.

11 Q: So, if volume goes down or goes up, those  
12 depreciation and interest costs, they're  
13 staying the same?

14 A: That's correct. So essentially as you build  
15 volume, you presumably have a margin between  
16 your revenues and the net revenues, the ones  
17 you actually receive, and the expenses that are  
18 associated with treating the amount of business  
19 that comes into the hospital, what we call  
20 variable expense.

21 Q: Okay.

22 A: If you have fewer patients, the decline in  
23 revenue will be larger than the drop off in net  
24 income. And the drop off in expenses, which  
25 means your net income would drop.

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RECORD 001778

1 Q: Okay.

2 A: And it turns out that the Roper St. Francis  
3 model has a very, very steep slope which means  
4 --

5 Q: Yeah, explain that.

6 A: Which means the next incremental patient in the  
7 door is worth a lot to this hospital. By  
8 calculations I've done, which simply take these  
9 numbers and project them out for a full  
10 hospital, assuming all the patients were  
11 incremental, every patient Roper got was not a  
12 redirection, was something they picked up from  
13 market share, if you assume that, this hospital  
14 would make \$24 million. Okay. That's an  
15 astounding number for a 50 bed hospital. One,  
16 with which after 37 years in this business, I'm  
17 unfamiliar with.

18 Q: Okay.

19 A: For a hospital in its third year.

20 Q: Go to, if you would, sir, Petitioner's 69.

21 A: Petitioner's 69. All right. That's the white  
22 one?

23 Q: Yeah. Go to the --

24 A: Okay.

25 Q: Go to the third page in there if you would.



1 A: Okay.

2 **THE COURT:** Do you have another copy of that set?

3 A: Map 459?

4 Q: Yes, I believe that's right.

5 **MR. THOMAS:** I'll get you a copy of that.

6 A: Okay.

7 **THE COURT:** You don't have it with you?

8 **MR. THOMAS:** Yes, I do.

9 Q: All right. What do you understand 69,  
10 Petitioner's 69 to be?

11 A: These are unaudited financial numbers, revenue  
12 expense numbers for Roper Hospital at Bon  
13 Secours for the year ending December 31, 2010.

14 Q: Okay. Is it your understanding these were sent  
15 to, sent to Mr. Knapp from the attorneys in  
16 this case?

17 A: I didn't understand your question.

18 Q: Is it your understanding -- go back to the  
19 first page, to these statements of operation  
20 are actually sent to Mr. Knapp from the --

21 A: Yes.

22 Q: Mr. Knapp, he developed the pro formas for  
23 Roper?

24 A: Yes.

25 Q: Okay. All right. So, real quickly, Bon

1           Secours, what is Bon Secours' operating income  
2           there in --

3       A:     \$35,709,000.

4       Q:     Okay. Is that the, okay, I guess that's the  
5           net income, isn't it? How about just on the  
6           operating income basis?

7       A:     Okay. 34,900,000.

8       Q:     Okay. And the interest and depreciation and  
9           amortization and all that, that's included in  
10          that?

11      A:     They've all be counted.

12      Q:     Okay. And on Mr. Knapp's pro forma then, Roper  
13           St. Francis DHEC record 4062, the depreciation  
14           expense interest, that's above the line too as  
15           well, isn't it?

16      A:     Correct.

17      Q:     Okay. All right. So Bon Secours, has \$34.9  
18           million in operating income?

19      A:     Correct.

20      Q:     All right. Now, I'm going to hand you, Judge,  
21           what's been marked as Petitioner Exhibit 70.  
22           I don't know if you've got this one in that  
23           notebook. There it is. Right here.

24      A:     Okay.

25      Q:     And this is -- I've handed you an email from a

1 Mr. Rand from Roper St. Francis to Mr. Long,  
2 which Mr. Knapp was also cc'd and stuff. It's  
3 2010 Roper Hospital adjusted discharge data?

4 A: Correct.

5 Q: Adjusted patient days, correct?

6 A: Right.

7 Q: Also for St. Francis?

8 A: Yes.

9 Q: Okay. What were St. Francis' hospitals  
10 adjusted patient days in 2010?

11 A: 73,319.

12 Q: Okay. And do you recall what the, what the  
13 operating income was again?

14 A: Just shy of 35 million.

15 Q: Okay. So, based on looking at these two  
16 documents, for a hospital with 171, excuse me,  
17 73,000 patient days --

18 A: Adjusted patient days.

19 Q: Adjusted patient days, and an operating income  
20 of \$34.9 million, what does that tell you about  
21 the pro forma in Roper's DHEC record on page  
22 462?

23 A: Well, again, if you want to do an apples versus  
24 apples, which means you have to look at all the  
25 patient volume being treated as incremental, so

1 you can get a standalone hospital, in that  
 2 case, you would have a net income in excess of  
 3 24 million for the Roper St. Francis -Berkeley  
 4 site on total net revenues that would be about  
 5 double the number here. Roughly about 69  
 6 million. So, they would make 24 million on 69  
 7 million, which is awfully high. That's like  
 8 pushing 35 percent profit margin. Whereas --  
 9 and that's for a hospital that will have about  
 10 25,000 adjusted patient days. If you double  
 11 the number of inpatient days. So, if you look  
 12 then at Roper St. Francis, they have three  
 13 times as many days, and their net income is one  
 14 and a half times the size. And if you look at  
 15 Roper Downtown, their facility is about seven  
 16 times the size and their net income is a little  
 17 more than double. So again, that shows how  
 18 profitable on a standalone basis this hospital  
 19 is projected to be. And again, if it turns out  
 20 the assumption about redirection is inaccurate  
 21 and they get a lot more of their patients from  
 22 market share gains, you're going to see the net  
 23 income number moving towards that 24 million  
 24 number I saw. The odd thing is, based on what  
 25 they submitted to DHEC, the numbers are too

1 high. Because they're assuming too much  
2 incremental based on the material that Mr.  
3 Richardson put together. Mr. Knapp did not  
4 follow Mr. Richardson's model in putting  
5 together his financials. So, in fact, Roper  
6 St. Francis Berkeley would not have a positive  
7 net income on an incremental basis based on the  
8 assumptions Mr. Richardson put together and  
9 again, this is something presumably the  
10 Department might have been able to catch if  
11 they were reading the need section carefully,  
12 but they didn't. I mean they didn't ask them  
13 any questions about this kind of stuff.

14 **THE COURT:** Excuse me, Mr. Thomas.

15 **MR. THOMAS:** Yes, sir.

16 **THE COURT:** I'm familiar with the definition of  
17 incremental, but I think it would be helpful to  
18 me and pertinent to the record to have it  
19 defined as used in this context.

20 **MR. THOMAS:** Certainly.

21 A: I'd be happy to try. The -- because it's not  
22 done exactly the same by the two hospitals.  
23 That's the first thing to note. The way Roper  
24 does it is this, they assume patient volume,  
25 let's assume is X. Half of X, half of that

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1 patient volume they assume is coming from other  
2 Roper facilities. So, if there's a patient day  
3 in that pile, it's taking from A and giving it  
4 to B, but it's all within the Roper system.  
5 It's just an exchange of patients. There's no  
6 new income. It's just moving patients from one  
7 site to another site. Okay. Incremental in  
8 the Roper model is any patient not currently  
9 seen by Roper or not projected to be seen by  
10 Roper through the growth of the Roper system  
11 over time, that is taken from other facilities.  
12 In other words, the market share gains at the  
13 expense of other providers. If Roper's market  
14 share goes up, other market shares of other  
15 providers goes down. That's what they're  
16 dealing with with incremental. Okay. So their  
17 incremental is basically market share pick up.  
18 Okay. And I think when you're building a \$115  
19 million hospital, and put it in an affluent  
20 area, there's a competitor with a high market  
21 share, the expectation is your market share is  
22 going to go up and it's going to be profit for  
23 your business. Trident's incremental is a  
24 little different. What they did was they  
25 looked at the fact that the Moncks Corner site

1 already had some outpatient services. So, they  
2 looked at incremental as whatever was new to  
3 that site, okay, so, if there was existing  
4 10,000 emergency department visits, and the  
5 projection is that in the first year of the new  
6 facility there would be 15,000, the incremental  
7 part is only 5,000. Because they had already  
8 seen 10,000 in their own facility. Okay. But  
9 on the inpatient side since they had no  
10 inpatient facility, basically all of it is  
11 incremental other than that one small point for  
12 the third year which I described earlier. So  
13 basically, the Trident model treats all the  
14 inpatient as incremental and outpatient is  
15 incremental to the extent that it's higher than  
16 what were the base levels that the facility was  
17 running when it was just an outpatient  
18 facility. In the case of Roper, incremental is  
19 market share pick up.

20 **THE COURT:** All right, sir. We might have to  
21 revisit that later.

22 **A:** I understand. I mean the extent that if the  
23 State required every applicant to show full  
24 numbers for a site, it would make life a lot  
25 easier, but they don't seem, they don't do

1 that. That would make it easier -- because I  
2 think it's valuable to look at the full numbers  
3 for a hospital. You're building a new  
4 hospital, this is the P&L of that hospital, not  
5 a piece of it.

6 **THE COURT:** You're also saying that in this instance  
7 incremental means different things to different  
8 people?

9 A: Yeah. The way these were put together,  
10 correct.

11 **THE COURT:** Thank you.

12 Q: Turn to Roper's DHEC record page 468 and 469  
13 for me, Mr. Baehr.

14 A: Sure. (Witness does as instructed.)

15 Q: And this is Roper's combined statement of  
16 operations and obviously you didn't have any  
17 thing to do with --

18 A: Yeah, give me one second to switch books.

19 Q: Sorry.

20 A: All right. I've got it.

21 Q: Okay. Is this Roper's combined statement of  
22 operations based on a 2007 actual statement of  
23 operations?

24 A: 468?

25 Q: Yeah, starting on 468.



1 A: Yes.

2 Q: Okay. And this is projected on page 469 to the  
3 year 2017, correct?

4 A: Correct.

5 Q: In terms of going from -- let's do this. In  
6 2012, all right, which is obviously this year  
7 and through 2017 --

8 A: Uh-huh (affirmative response).

9 Q: What is, what's Roper's projected net revenues  
10 over that time period? And it doesn't have to  
11 be exact, but if you can estimate it.

12 A: Give me a second. I'm getting about five  
13 billion, 860 million.

14 Q: Okay. So, so around 5.8 billion. Does that  
15 sound about right?

16 A: Uh-huh (affirmative response).

17 Q: Okay. And in terms of its operating income, if  
18 you excluded depreciation and amortization,  
19 interest, have done that calculation or is that  
20 something you could do?

21 A: I could do it, sure.

22 Q: For that same time period?

23 A: Sure.

24 Q: If you would round of to, you know, the tens of  
25 millions that might speed things along.

1 A: Sure. It's about \$287 million of operating  
2 income and then you'd have to add back to that  
3 interest expense of about 74 million, that  
4 would take you to 361. I said 287?

5 Q: Yeah.

6 A: Okay. And you also have to add depreciation  
7 and amortization. It's about another 291. So,  
8 what was the subtotal before?

9 Q: Two eighty-seven plus about --

10 A: Sixty-eight?

11 Q: Yup.

12 A: It's about -- the total is in excess of 600  
13 million.

14 Q: Okay. Based on these projections, if -- I  
15 think we said 5.9 billion in net revenue and  
16 600 million or so of EBITDA, what, if any,  
17 opinion do you have regarding Roper St. Francis  
18 system's financial viability if Roper St.  
19 Francis Berkeley is not built?

20 A: Well, I'm assuming these numbers are, these  
21 numbers are with Roper St. Francis Berkeley or  
22 without?

23 Q: It's my understanding that they are without.

24 A: Well, it's a very profitable system and the  
25 projection suggest growth in income on a fairly

1 steady basis. Not dramatic increases, but, you  
2 know, increases basically year by year with one  
3 small dip they predicted in 2015.

4 Q: Okay. I'm going to switch gears real quickly,  
5 and, Mr. Baehr, did you have an opportunity to  
6 drive around Berkeley County recently?

7 A: I was driven around.

8 Q: Was that by Mr. Rardin?

9 A: Yes, I was in the car with him.

10 Q: Okay. Did you drive by Carnes Crossroads?

11 A: Yes.

12 Q: Development? And what did you see there?

13 A: I didn't see any houses. I mean it looked like  
14 some roads had been, did some road work, but no  
15 evidence of any development per say.

16 Q: Okay. How about Parks of Berkeley, they're on  
17 I guess the west side of 176 East. Did you  
18 notice any development of that subdivision?

19 A: No.

20 Q: Okay. Now, you were in the courtroom when Mr.  
21 Shelton was on the stand and he read the  
22 statute that Mr. Summer gave him that requires  
23 the State Health Plan to have a travel time  
24 standard, were you not?

25 A: Yes.

1 Q: Okay. Do we have Joint Exhibit 3?

2 MR. LONG: I'm going to object to the question.  
3 That's not what the statute requires.

4 MR. THOMAS: We're going to go back to the statute.

5 THE COURT: Restate your objection please?

6 MR. LONG: I'm sorry, Your Honor. I would object to  
7 the question. That's not what the statute  
8 says. I also object to -- I'll probably have  
9 objections to him going through -- Mr. Baehr is  
10 not qualified to interpret the CON Act. That's  
11 for Your Honor.

12 MR. THOMAS: Your Honor, I'm just going to have him  
13 read this and ask him what he understands it to  
14 mean. And not only -- Mr. Long is actually  
15 wrong because this sets the stage for the CON  
16 regulations, which have the project review  
17 criteria. In the project review criteria are  
18 what the whole budget is based on.

19 MR. LONG: I'll object to the question as he has  
20 phrased it because I don't think he can ask him  
21 questions about the statute.

22 MR. THOMAS: But I can --

23 MR. LONG: This is the enabling statute for the CON  
24 act. The Department is charged with  
25 interpreting -- applying, not interpreting,

1 applying the project review criteria to the  
2 applications. That's part of healthcare  
3 planning. He can ask him about the project  
4 review criteria. He's now moving into a  
5 completely different area, an area I might add  
6 was never raised with the Department below at  
7 any time, which has to do with this idea about  
8 the standards and whether the standards satisfy  
9 the statute or not.

10 **MR. THOMAS:** Actually, Your Honor, I'm asking him  
11 about the statute on a policy basis and what  
12 relevance does the travel time standard that,  
13 at least as I read the statute, indicates it's  
14 a requirement to be in the State Health Plan.

15 **THE COURT:** The travel time standard is part of the  
16 review criteria, right?

17 **MR. THOMAS:** Yes, sir. So that's all I'm asking.

18 **MR. LONG:** Your Honor, I would disagree with that.  
19 There's no -- the project review criteria don't  
20 say anything about you have to have a travel  
21 time standard. He's talking about the statute.  
22 The actual enabling statute from the CON Act  
23 that basically sets out the process and he's  
24 told you two or three -- I want to ask him  
25 this, I want to ask him that and what he wants

1 to ask him is what does this statute mean.  
2 What's the purpose behind it. He can't do  
3 that. That's for the Court. That's a legal  
4 interpretation.

5 **MR. THOMAS:** Well, Les Shelton is not a lawyer or a  
6 judge either and he went through this and he  
7 was allowed to go through this as a health  
8 planner for the Department. This is Trident's  
9 health planner and the only thing we're going  
10 to point him to is the travel time section in  
11 here and the required -- well, as we see it,  
12 it's a requirement. And then we'll take him  
13 through the State Health Plan, Your Honor, and  
14 the CON regulations which also reference  
15 accessibility and then the State Health Plan  
16 which references a travel time standard.  
17 They're saying it's not a standard, but if it's  
18 not a standard, you know, what Trident says is  
19 where is it? It's got to be a standard.

20 **THE COURT:** All right. I'm going to overrule the  
21 objection provided that he cannot give a legal  
22 opinion.

23 **MR. THOMAS:** Yes, sir. One second.

24 **THE COURT:** I'll say it another way. It's got to be  
25 within his field of expertise.

1 MR. THOMAS: Surely, Your Honor.

2 Q: Okay. Mr. Baehr, I'm going to hand you a copy  
3 of a statute here. Your Honor, this is  
4 probably the easiest way to give it to you.  
5 Now, Mr. Baehr, you see the Section B in the  
6 statute. It's entitled health planning. It's  
7 44-7-180, it's the Health Planning Committee  
8 appointment, composition, terms and allowances  
9 of the State Health Plan. Now, the State  
10 Health Plan, does that figure into what you do  
11 as a healthcare planner in the State of South  
12 Carolina?

13 A: Yes.

14 Q: Okay. And is that a guiding document in terms  
15 of review of CON applications for clients?

16 A: Yes, sir.

17 Q: Okay. Now, you'll see in Section B, at the end  
18 of that section, the Plan, at a minimum, must  
19 include, correct?

20 A: Uh-huh (affirmative response). Yes.

21 Q: All right. And then number three, standards  
22 for distribution of healthcare facilities,  
23 beds, specified health services and equipment  
24 including scope of services to be provided,  
25 utilization and occupancy rates, travel time,

1 regionalization and other factors. Do you see  
2 that?

3 A: Yes, I do.

4 Q: Okay. Where do you understand the travel time  
5 standard to be as it relates to this case?

6 A: Yeah, there is language --

7 **MR. LONG:** Objection, Your Honor, he's calling for a  
8 legal conclusion there because it's tied into  
9 the statute.

10 **THE COURT:** That's what he understood it to be.  
11 Overruled.

12 Q: Where do you understand the travel time  
13 standard to be?

14 A: Yeah, there is a section, in the acute care  
15 section, that I think addresses it.

16 Q: Okay. Would you go to -- well, we can go to  
17 the 2008-2009 State Health Plan, Joint 4.

18 A: I don't think I -- oh yeah, I do.

19 Q: Okay.

20 A: Number 4, 2008, or Number 3?

21 Q: Section 2 -- oh, number 4. I'm sorry. Joint  
22 Exhibit 4.

23 A: The 2008-2009 Plan?

24 Q: Yeah.

25 A: Okay.



1 Q: If you go to II-11 for me?

2 A: Sure.

3 Q: Bed detail.

4 A: Uh-huh (affirmative response).

5 Q: Okay. Is this what you were just referring to  
6 in your testimony in terms of --

7 A: Yes.

8 Q: And could you read the whole paragraph into the  
9 record for us?

10 A: Below G?

11 Q: Yes, below G.

12 A: General hospital beds are located within  
13 approximately 30 minutes travel time for the  
14 majority of the residents of the state and  
15 current utilization and population growth are  
16 both factored into the methodology for  
17 determining general hospital beds. The  
18 benefits of improved accessibility will be  
19 equally weighed with the adverse effects of  
20 duplication in evaluating certificate of need  
21 applications for these beds.

22 Q: Other than this reference to a travel time  
23 standard in Section II, are you aware of any  
24 other references to travel time?

25 A: Not in this acute care section, no.

1 Q: Okay. Now, this section states that the  
2 benefits of improved accessibility will be  
3 equally weighed with the adverse effects of  
4 duplication. And you just read that, correct?

5 A: Correct.

6 Q: Now, given the second sentence there, benefits  
7 of improved accessibility, what, if any,  
8 opinion do you have regarding of how that must  
9 be read with the line above?

10 A: Yeah, I don't know how the State could make  
11 that calculation of improved access versus  
12 adverse effects of duplication unless they have  
13 some standard by which to measure what's  
14 improved access. So, I read the two together.  
15 I read the 30 minutes as if you can demonstrate  
16 that you're improving access to those who are  
17 not within 30 minutes, and I think Mr. Shelton  
18 acknowledged that there's sections, certainly  
19 sections within Berkeley County where that 30  
20 minute travel time standard is not being met,  
21 or that 30 minute travel time is not being met.  
22 I think they have to be read together. Because  
23 if you don't have some objective measure by  
24 which to evaluate access improvement, you can't  
25 weigh and balance how much access improvement

1           there is versus how much adverse impact is  
2           caused by duplication and by taking patients  
3           away from existing providers.

4       Q:   Without that standard, would you agree that any  
5           decision regarding accessibility would be  
6           arbitrary?

7       A:   I think so.

8       Q:   Based on the definition in the CON application,  
9           or excuse me, the CON regulations, and the  
10          travel time standard that you just read for the  
11          Court, do you have an opinion regarding the  
12          accessibility of the hospital services for the  
13          residents of Goose Creek, Ladson, Summerville  
14          and the Carnes Crossroads area?

15      A:   I think it's very good.   You have multiple  
16          facilities which are in easy drive time.

17      Q:   Do you have an opinion regarding accessibility  
18          to hospital services at Roper St. Francis  
19          Berkeley would provide the residents of Moncks  
20          Corner, around the lake, central and eastern  
21          Berkeley County?

22      A:   Yeah, I think in the town of Moncks Corner, it  
23          certainly would be within a 15 mile drive time  
24          of their site in Carnes Crossroads, so I think  
25          that community would be served and most of the

1 communities to the north and to the east would  
2 not be. They would not fall within the 30  
3 minute drive time or 15 miles, which I think is  
4 a decent surrogate to 30 minutes drive time.

5 Q: Please pull out Petitioner's 4 for me real  
6 quick. Are you familiar with this Exhibit, Mr.  
7 Baehr?

8 A: Yes.

9 Q: Have you seen this before?

10 A: Yes.

11 Q: And the facility locations here, does the  
12 center here of the circle indicate the Carnes  
13 Crossroad area?

14 A: Yes.

15 Q: Okay. And does the H within the seven mile  
16 radius indicate where, to your knowledge, where  
17 Trident Medical Center is?

18 A: Yes.

19 Q: How about the H just outside, the hospital,  
20 Summerville Medical Center?

21 A: Summerville Medical Center.

22 Q: Okay. All right. And we'll go through this  
23 quickly, because I know we've been through this  
24 before. But from an expert basis, are you  
25 aware of where the population within this seven

1 mile radius is concentrated?

2 A: Yeah, I think most of it is below the, below  
3 where the point is. The blue point.

4 Q: Okay. So south?

5 A: South. And up. And there's a fair, and  
6 there's a fair amount of that which is not in  
7 Berkeley County.

8 Q: What's your understanding of what county the  
9 seven mile radius goes in to?

10 A: Some is in Dorchester and some is in Charleston  
11 County.

12 Q: Okay. In terms of the population within the  
13 seven mile radius, do you have any knowledge as  
14 to how much of it in terms of numbers?

15 A: Yeah, I've seen various estimates and various  
16 graphs. Again, this was in 2008 of roughly  
17 100,000 people.

18 Q: Okay. And in your opinion, do any of these  
19 residents have a serious problem with accessing  
20 inpatient healthcare services?

21 A: No, I mean seven miles is by no stretch of the  
22 imagination ever thought of as an access  
23 standard for acute care facilities. I mean,  
24 maybe it's convenience standard. People would  
25 like to be six minutes from a hospital instead

1 of ten minutes from a hospital, but seven  
2 miles, it's not much.

3 Q: Okay. Thank you.

4 A: Fifteen minutes.

5 Q: Now, we've gone through Trident's application  
6 to some degree to Roper's application. Did you  
7 attend project review for these two  
8 applications?

9 A: I did.

10 Q: Project review meeting?

11 A: I did.

12 Q: Okay. Were you asked to prepare anything for  
13 it?

14 A: Yes.

15 Q: Okay. What did you do to prepare for the  
16 project review meeting?

17 A: Well, I mean I reviewed both applications.

18 Q: Why did you review both applications?

19 A: Because I was convinced then and convinced now  
20 there's a need for only one 50 bed hospital in  
21 the county. So, I thought this was likely to  
22 be a decision that would be made comparatively  
23 between the two applications.

24 Q: Now, both the project review meeting -- who  
25 presented at that meeting? What applicants?

- 1 A: Both applicants.
- 2 Q: Okay. Now turn to if you would, I want to go
- 3 back to the Trident's DHEC record.
- 4 A: Okay. That's Joint 1?
- 5 Q: Yes, Joint 1 and if you go to page 770 for me.
- 6 A: Okay.
- 7 Q: Okay. Now, what do you understand this
- 8 document to be here?
- 9 A: It's a cover page with my name and my firm on
- 10 it.
- 11 Q: Okay.
- 12 A: But it's the beginning of my presentation.
- 13 Q: And did you prepare this document?
- 14 A: Yes.
- 15 Q: Okay. Now, what I would like us to do if we
- 16 could is run through this for the Court. What
- 17 was presented to DHEC back in, it looks like
- 18 May 21, 2009.
- 19 A: Okay.
- 20 Q: All right. And if you refer to the Bates pages
- 21 that you're going through.
- 22 A: Sure. Okay. Page 771 provides the market
- 23 shares currently for Berkeley County inpatient
- 24 market share. Trident roughly 53 percent.
- 25 Roper 23 percent.

1 Q: Okay.

2 A: Seven seventy-two is an important one. It's  
3 what I call a dependence comparison. Forty-two  
4 percent of Trident's system admissions came  
5 from Berkeley County residents in 2006, 15  
6 percent of Roper admissions did. Think about  
7 that for a second. The Trident system is two  
8 hospitals and one of the tables that we may get  
9 in to later, about 85 percent of the Trident  
10 admissions from Berkeley County come to Trident  
11 Medical Center and about 15 percent, roughly,  
12 go to Summerville. The reason for that is you  
13 can look at where the two hospitals are.  
14 Summerville is basically serving Dorchester  
15 County with some patients from Berkeley.  
16 Trident serves Dorchester County and North  
17 Charleston, but it also serves Berkeley County.  
18 In fact, you know, that's one of the reason why  
19 I used the word nonsense before, the concept  
20 that there's no hospital in Berkeley County  
21 because it's one of five counties that don't  
22 have hospitals and the other four have 20,000  
23 people and Berkeley has all of these people,  
24 but none of the other counties have a 296 bed,  
25 tertiary-care facility located one mile away,



1 which gets 42 percent of its patients from that  
2 county.

3 Q: And DHEC -- let's switch to the 2001 State  
4 Health Plan, how did DHEC allocate beds?

5 A: DHEC used to view the Trident location in North  
6 Charleston as well as the Dorchester Hospital,  
7 Summerville Medical Center, as serving the two  
8 counties of Berkeley and Dorchester. So even  
9 though it's located one mile south of Berkeley  
10 in Charleston, it was included within the  
11 inventory of Berkeley and Dorchester.

12 Q: Okay. Trident's beds were?

13 A: Yes.

14 Q: All right. Let's go to the next page here.

15 A: Sure. And this is the forecast which is  
16 similar to the table we've seen before.

17 Q: Okay.

18 A: The income statement which we've also seen  
19 before on 774, 773 was the utilization  
20 forecast. Seven seventy-five are the  
21 utilization projections for Berkeley, Roper St.  
22 Francis Berkeley and it's worth having just one  
23 second to look at a comparison of these two,  
24 774 and 775. On 775, the Roper facility is  
25 projected to lose 12 million. In 2015 it's

1 supposed to make a small profit of 285. That  
2 change from that first year to the third year  
3 is like going from nine patients to 17 or 18  
4 patients. All right. That's a remarkable  
5 change in net income from an increase or  
6 improvement in your census of only ten  
7 patients. That's again why I said I was  
8 skeptical, there's something wrong with these  
9 numbers and we actually found it and will  
10 present it later, the net revenue number is  
11 just out of balance. It's way too high  
12 compared to other Roper facilities. It's like  
13 substantially higher, which is one of the  
14 reasons you see this dramatic improvement in  
15 income as patients as there are a higher number  
16 of patients. Seven seventy-six was a  
17 comparison of bed need in the 2004, 2005 Plan  
18 and the 2008-2009 Plan. Now, again, Trident  
19 applied in 2004-2005, but not all 42 of those  
20 beds were available at the time. Twenty five  
21 had already been used. But at that same time  
22 they applied, draft 2008-2009 Plan was already  
23 out. It's mentioned in the Berkeley  
24 application. The Trident application  
25 references the bed need from the 2008-2009 Plan

1 as additional justification, essentially, for  
2 the need for a new 50 bed hospital. And you  
3 can see in the 2008-2009, one system's got a  
4 need for 80 beds. It turns out they've had two  
5 applications that exactly fill those 80 beds,  
6 that 80 bed need. Now, the Roper system has an  
7 excess of 23 beds.

8 Q: Okay. And explain DHEC record 777 of Trident.

9 A: Yeah. This was an attempt to show that the  
10 Roper St. Francis Berkeley facility --

11 Q: What I want to do real quickly, Judge, I know  
12 you don't have the best copy. I'd like to get  
13 this on the screen in color as it was  
14 presented.

15 **THE COURT:** Actually, my copy is pretty good.

16 Q: Oh, you do have it. Okay. Let me see here.

17 A: But the areas in black account for 60 percent  
18 of Trident Berkeley's --

19 Q: Go back.

20 A: I'm sorry.

21 Q: There we go. That's better.

22 A: That's much better. It's really better than a  
23 black and grey page. The areas in dark blue  
24 are two zip codes, 29461 and 29483. Now, those  
25 are the two facilities, the two zip codes which

1 account for 60 percent, slightly over 60  
2 percent of all the projected admissions to the  
3 Trident-Berkeley, the Berkeley Medical Center  
4 in Moncks Corner. And the Roper facility is  
5 going to be located, if you look at it, it's  
6 again, in the 29461, adjoining the 29483. Now,  
7 those two zip codes would clearly be very  
8 competitive between the two facilities. Not to  
9 mention that the Roper facility is also in the  
10 service area that provides a substantial  
11 number, a great majority of the patient  
12 population that comes to Trident Medical  
13 Center. Okay. Which are those zip codes just  
14 north of Trident Medical Center, which are  
15 within that seven mile circle that Roper chose  
16 to draw. No one requires that you draw a seven  
17 mile radius map in an application. If you do,  
18 it must have some significance. Similar to the  
19 way my view of the 30 minute drive time that's  
20 at issue in the State Health Plan. If it means  
21 nothing, it wouldn't be there. Where it's  
22 written in conjunction with the other language  
23 behind it, it means even more. Same here, you  
24 draw a seven mile radius, that's -- you're  
25 telling the world, that's essentially the area

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1           you expect to serve. That area is critically  
2           important to Trident Medical Center as well to  
3           the proposed to the potential success of the  
4           Berkeley Medical Center project.

5   Q:    So this slide, DHEC record 778, service area  
6           overlap, that was presented to the Department  
7           on May 21, 2009; is that right?

8   A:    Yes. Correct. And you know, as best I can  
9           tell, by reading and I guess we'd have to get  
10          the Department's opinion later.

11   Q:    Okay. Let's go to 779, if you would.

12   A:    Okay.

13   Q:    All right. Now, explain what, just generally,  
14          what this is first and then I want to show you  
15          another document.

16   A:    Sure. Again, each of the applications was  
17          developed as best we could tell, and we know  
18          that was certainly the case with Trident  
19          Medical Center, Trident Medical Center assumed  
20          there would be only one hospital applying, one  
21          hospital at most approved. It might get  
22          approved, it might not get approved. But at  
23          most, it's alone in this cycle and its numbers  
24          as a result only reflect one hospital. Roper  
25          followed the Trident into the cycle, was at the

1 same project review, it got a decision the same  
2 day. And their project also assumes, based on  
3 the financial numbers, that only one hospital  
4 is going to be approved. That's -- there's no  
5 other way to read their numbers. You can't  
6 make an argument that we're taking growth from  
7 other providers and it doesn't hurt them. If  
8 you think that another provider is building a  
9 new hospital and depending on their growth. I  
10 mean, that's simply, those two statements are  
11 inconsistent. So clearly, Trident was put  
12 together assuming there's only going to be one  
13 and its financials assume there's only going to  
14 be one. Roper has put together its financials  
15 assuming there's only going to be one hospital  
16 and it's going to be the one approved. And so  
17 what happens if both are approved? Well, if  
18 you think there are only going to be enough  
19 patients to fill about 30 to 35 beds coming out  
20 of Berkeley County, you know, into the future,  
21 into 2014-2015, they've got to be divided up  
22 among the two hospitals. And so we made  
23 assumptions that each of the hospitals would  
24 lose patient volume if both were built. Now,  
25 in the case of Roper, their numbers only showed

1 half a hospital. They only show the  
2 incremental. You know, those patients they  
3 were picking up from others. They didn't  
4 reflect any of that transfer from their own  
5 system. So actually, we only cut their numbers  
6 by half of the incremental. So we were  
7 actually cutting their volume by one fourth.  
8 In Trident's case, we cut it by one half. All  
9 right. So if anything, the Roper numbers would  
10 have looked even worse if we cut their numbers  
11 by as much as Trident numbers are. And there's  
12 only one reason for that, that's that slope I  
13 was talking about earlier. Each incremental  
14 patient admitted into the Roper system provides  
15 an amazing amount of net income in the model  
16 that Mr. Knapp developed. And so if you lose  
17 those patients, losses become very large very  
18 quickly.

19 Q: Let me stop you there. I can't remember if it  
20 was your deposition or not, but at some point  
21 it was suggested that the only thing you did  
22 here was you just cut the number of patients in  
23 half and did nothing with the expenses.

24 A: No, that's not true at all. Mr. Davidson who  
25 works, again, worked with me on this project

1 put together, at my direction, what I'll call  
2 a cost accounting model.

3 Q: Is that Petitioner's 31? Would you go to  
4 Petitioner's 31 for me?

5 A: That's in which book? The white one?

6 Q: Yeah. Right here.

7 **THE COURT:** Which book is that?

8 **MR. THOMAS:** I'll get you a new Exhibit, Your Honor.

9 A: Thirty-one? Okay.

10 Q: Do you recognize that this, Petitioner's 31 is  
11 the underlying --

12 A: Yes, this is a summary of the cost accounting  
13 methodology that he undertook which he did  
14 separately for each of the two hospitals. In  
15 other words, if a hospital loses patients, its  
16 revenues drop. But its expenses drop too. You  
17 don't need as many nurses if you don't have as  
18 many patients in the hospital. You don't use  
19 as many supplies if you don't have as many  
20 patients in the hospital. So, after we made an  
21 assumption about the drop in patient volume,  
22 which affects revenues, we wanted to come up  
23 with corresponding reductions in expenses. So  
24 that that would be factored in as well.

25 Q: Okay. And so what did the analysis show?



1 A: The analysis showed, which is on this page 779,  
2 that the two hospitals combined, even by the  
3 third year, would lose about 15 to \$16 million  
4 as opposed to each one making a small profit in  
5 the third year.

6 Q: And that's combined in the third year?

7 A: Correct.

8 Q: Okay. And so the total, it looks like --

9 A: And remember, each hospital is going to have  
10 all the capital expenses associated with a \$150  
11 million project. Roper is going to have  
12 depreciation. They're going to have interest  
13 expense. All right. Trident is going to have  
14 fixed expenses associated with building \$150  
15 million project. Those expenses are going to  
16 be there whether there are 15 patients showing  
17 up in year three or 30 patients in year three.  
18 So, if you have 30 patients, then you have  
19 enough revenue to cover those fixed expenses.  
20 If you have 15 patients, you don't.

21 Q: Okay. Thank you, Mr. Baehr. Turn to 780, 81,  
22 82, 83, 84 and 85. Now, we've talked a lot  
23 about access today. Could you just summarize  
24 what you did here?

25 A: Yeah. Probably the most significant one here

1 is 783. And again, in my new Exhibits, which  
2 we'll present later, there are some other  
3 comparisons.

4 Q: Your Honor, I put a color version up here.

5 A: But basically, the darker the shading, the  
6 higher the income area. So, for instance,  
7 there are a couple small.

8 THE COURT: Excuse me, sir.

9 Q: DHEC record 783.

10 THE COURT: Eighty-three?

11 MR. THOMAS: Yes, sir.

12 THE COURT: That's what I thought. I had it. Thank  
13 you.

14 A: Sorry, Your Honor.

15 THE COURT: Proceed.

16 A: Okay. If you look for instance at the dark  
17 blue, those are the highest income areas of the  
18 Charleston, Berkeley, Dorchester metropolitan  
19 area. Roper has a hospital dead center or in  
20 the middle of one of them, the Roper Mount  
21 Pleasant hospital, which is in the middle of  
22 one of those zones. And you have another one  
23 there which is somewhere between Roper St.  
24 Francis and Summerville Medical Center. The  
25 areas of income of 25 to 49,000 is that whole

1 northern section of Berkeley County. The area  
2 that would be served by Moncks Corner, by the  
3 Berkeley Medical Center. Look where Berkeley  
4 Medical Center is and look at all the area to  
5 the north of it, to the east of it, to the west  
6 of it. That area is a modest income area.  
7 It's below median income levels for the area,  
8 for the metropolitan area as a whole. Now, if  
9 you look at the area just below where St.  
10 Francis-Berkeley is going to come, that's not  
11 as high as Mount Pleasant area, but one of the  
12 higher income areas in the Tri-County region.  
13 So essentially, that area between the Roper St.  
14 Francis Berkeley location and Trident Medical  
15 Center location, is a more affluent area than  
16 the area surrounding Berkeley Medical Center in  
17 Moncks Corner.

18 Q: Okay. I'd like you to skip over 786, 87, 87  
19 and 89. And where --

20 A: Which page would you like me on?

21 Q: I'd like you to go to 790 for me.

22 A: Okay.

23 Q: And if you could explain this slide here.

24 A: Yeah, 789, yeah. The Roper system is now for  
25 the second time proposing to take beds from its

1 downtown location --

2 THE COURT: Hold on.

3 Q: Hold on.

4 THE COURT: You said 789 and I don't --

5 MR. THOMAS: I'm sorry. 790, Your Honor. I was  
6 looking at the wrong page here. I apologize  
7 for that.

8 THE COURT: All right.

9 Q: I'm sorry, 790.

10 A: Withdraw what I said. Okay. All right. The  
11 Roper application says it will not have  
12 material adverse impact on existing providers.  
13 I believe it will. And I don't think Trident's  
14 will. The Roper methodology explicitly states  
15 in the application, this is in the material the  
16 Department had to review, that 90 percent of  
17 the growth for non-Roper providers would be  
18 scooped by Roper in order to support its  
19 hospital in Carnes Crossroad. It's worth  
20 thinking about. That's basically all of the  
21 growth in the market. They're taking all of  
22 their own growth and they're taking basically  
23 90 percent of everybody else's growth to build  
24 their hospital. I don't see how you can  
25 conclude from that that there's no material

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1 adverse impact on other providers. Especially  
2 since you have another applicant in the cycle  
3 who's proposing to use that growth. Plus -- to  
4 build its new hospital. Plus, based on where  
5 Roper is located and the market shares of other  
6 providers in that area around where it's likely  
7 to draw its patients, I think it's highly  
8 likely that they will draw significant numbers  
9 of patients from existing providers,  
10 conceivably beyond the number that they project  
11 in the application.

12 Q: Okay.

13 A: Now --

14 Q: Go ahead.

15 A: Now, the Trident methodology, the second bullet  
16 point, projects that there's enough growth in  
17 the patient base of Trident System hospitals to  
18 support all of the volume at Berkeley Medical  
19 Center. But, even if there are patients taken  
20 from other providers, and I don't have a  
21 problem, you know, if Mr. Richardson had  
22 calculated adverse impact of Trident on Roper,  
23 I think he could have done that. He didn't.  
24 We never saw such an analysis, but had he done  
25 it, you could have come up with a calculation

1 of how many patients Trident, if it gets  
 2 approved in Moncks Corner would take from  
 3 existing providers. Didn't do that. But had  
 4 he done that, then you'd have to make a  
 5 comparison. Is the expansion of access to  
 6 patients in the northern part of Berkeley  
 7 County override or outweigh whatever adverse  
 8 impact might occur because that facility in  
 9 Moncks Corner might take some market share from  
 10 other providers. And I think clearly it does.  
 11 That's the test. You have to weigh and balance  
 12 the two. You consider them, but if the access  
 13 improvement is substantial and the adverse  
 14 impact is not even calculated by the other  
 15 provider in this case, that's a slam dunk.

16 Q: Go to the next page, 791. And does this page  
 17 include your conclusions that you set forth to  
 18 the Department at that project review meeting?

19 A: Yes.

20 Q: Okay. And what's the number one conclusion?

21 A: I do not believe the county can support two new  
 22 50 bed hospitals. If both are approved, I  
 23 think both of them will have substantial losses  
 24 and not meet the, will not be able to achieve  
 25 the numbers that are in their applications.

1 And between the two hospitals since I think  
2 only one should be approved, I think there's  
3 clearly a superior choice. And that's the  
4 hospital that actually does expand access to  
5 all the citizens of Berkeley County, including  
6 those who do not now have adequate access  
7 because they are more than 30 minutes drive  
8 time from existing facilities. That's what  
9 healthcare distribution is. The Department  
10 assumes if you take beds from downtown  
11 Charleston and move them to Berkeley, that of  
12 and by itself, has to be a good thing because  
13 Berkeley is growing faster than Charleston.  
14 But they put them right in an area where  
15 there's already good access, that's different  
16 than putting those beds in an area where access  
17 is not good. All right. They didn't do that.  
18 Roper is transferring beds from downtown to an  
19 area where they will simply over-bed an area  
20 that's well-served and only serve to make  
21 hospital services a bit more convenient to  
22 residents of an area. They didn't choose the  
23 location which would have resulted in access  
24 expansion..

25 Q: Okay. I'm going to switch to -- I want to go

1 back to the Roper DHEC record real quickly and  
2 we may be able to do this on the screen. We  
3 won't have to juggle notebooks, but if you go  
4 to Joint 2.

5 A: Okay. Give me one second.

6 Q: And like I said, I will try to put it on the  
7 screen.

8 A: Okay.

9 Q: All right. This letter is Roper St. Francis,  
10 a letter from Mr. Bowling, I believe, to Ms.  
11 Brandt dated May 28, 2009 and what I'm  
12 interested in here is -- yeah, page 1242. Do  
13 you have that document?

14 A: Okay.

15 Q: Okay. And did you review this analysis  
16 regarding Roper Hospital in downtown Charleston  
17 will maintain adequate capacity despite the  
18 proposed bed transfer to Berkeley County?

19 A: Yes.

20 Q: Okay. And down at the bottom, the Roper  
21 Hospital volume projections from 2009 to 2015,  
22 is it your understanding that that takes into  
23 account the fact that Roper St. Francis  
24 Berkeley will be in operation?

25 A: Yes.



1 Q: Okay.

2 A: And Mount Pleasant was well.

3 Q: Okay. Now, does anything change your opinions  
4 about Roper's capacity in the year 2015?

5 A: Yeah, they're running at 78 percent. The  
6 target occupancy for a hospital of Roper's size  
7 in 2015 is 70 percent. If you projected out  
8 their volume and their bed capacity in 2015  
9 using the State methodology, you'd come up with  
10 a fairly significant bed need. You'd come up  
11 with a bed need, just based on the current 78  
12 percent, and you would come up with a much  
13 larger bed need in the future. So, the  
14 argument has been made, these beds just really  
15 have no use downtown. They're all excess.  
16 Remember Roper only had an excess of 11 beds.  
17 Eleven beds, but they were transferring 50 out  
18 to Berkeley County. Okay.

19 Q: What does that mean?

20 A: Okay. It suggests to me that based on these  
21 numbers, at some future point, Roper could  
22 apply for new beds. Now, I know that in the  
23 transfer language which say you can use a  
24 transfer as a basis because the transferring  
25 facility will have less capacity, as a result

1 show more need so you can't use the transfer  
 2 itself for a basis for applying for new beds.  
 3 But I don't think that's through infinity. You  
 4 know, for time immortal. It's through some  
 5 period. So it's surrounding when the new  
 6 hospital is being built and developed. You get  
 7 out a few years from now, over the next decade,  
 8 Roper's got a bed need. I don't see anything  
 9 preventing them from applying for beds downtown  
 10 even though they've taken the capacity and  
 11 moved it to new locations which created this  
 12 bed need..

13 Q: Okay. And explain to the Judge a little bit  
 14 about this idea of a 70 percent occupancy  
 15 threshold. Why that's important.

16 A: Right. Again, I think the State, and this is  
 17 something I think is correct that they do. And  
 18 I'm critical of some things they do and I think  
 19 some of the things they've done make sense. I  
 20 think there should be different occupancy  
 21 standards for different sized facilities. For  
 22 a large hospital that has 500 beds, you can  
 23 make their target of occupancy higher than you  
 24 should for a 50 bed hospital. All right. And  
 25 the reason is if a 500 bed hospital is full at

1 75 percent, they still have 125 empty beds.  
2 All right. If you have a 50 bed hospital and  
3 you have a lower standard, still even with 65  
4 percent, you're only talking about 17 beds, you  
5 know, you have to work with. That could be  
6 beyond the number that you're filling. So, the  
7 State has a 65 percent standard for hospitals  
8 between basically zero beds and I think 174.  
9 And I think it's 70 percent between 175 and 349  
10 and then 75 percent from 350 on up. And I  
11 think that's a reasonable predation.

12 Q: All right. Is the reason for that, the  
13 different percentages to be able to -- so a  
14 hospital can deal with fluctuations in its  
15 utilization?

16 A: Correct. I mean for instance, if a hospital is  
17 70 percent -- say you've got a big hospital and  
18 it's 75 percent utilized all year. A big  
19 hospital like in Greenville or Richland  
20 Memorial. If they're 75 percent utilized,  
21 they're not going to be 75 percent utilized  
22 every day. They'll have higher census in some  
23 months than in other months. They'll have  
24 higher census usually Monday to Friday than  
25 they do Saturday and Sunday. They'll typically

1 have lower census around major holidays like  
2 Thanksgiving and Christmas. So, it's an  
3 average. Seventy-five percent year round could  
4 well mean that hospital is basically 80 percent  
5 Monday to Friday through most of the year. And  
6 that accounts for lower numbers at other times  
7 during the year.

8 Q: Okay. So, according to Roper's own letter to  
9 DHEC, in 2015 they're at 78 percent occupancy;  
10 is that correct?

11 A: Correct.

12 Q: Okay. And that means --

13 A: Eight percent above their standard.

14 Q: Okay. And that means they would have a bed  
15 need of 296, correct?

16 A: Just based on 2015. Not with any projection of  
17 volume going forward, which is how the State  
18 does it. The State projects five years  
19 forward.

20 Q: How many beds will they have in 2015 if the  
21 Roper St. Francis Berkeley project is  
22 permitted?

23 A: Only 266.

24 Q: I want you -- we're going to go back to Trident  
25 DHEC record, Joint 1.

1 A: Okay. All right.

2 Q: And if you'd go to page 793 for me.

3 A: Uh-huh (affirmative response). Okay.

4 Q: Okay. Do you recall this document?

5 A: Yes.

6 Q: Okay. And have you reviewed it?

7 A: Yeah, I actually heard the presentation. I was

8 there.

9 Q: Okay. You were there for the presentation.

10 Would you go to page 795 for me?

11 A: Sure.

12 Q: Okay. And the second paragraph, on 795, do you

13 have any thoughts about this paragraph? First

14 of all, just read the first few sentences for

15 me.

16 A: In the second paragraph?

17 Q: Yes.

18 A: The decision to place inpatient services in

19 Goose Creek rather than Moncks Corner was based

20 on both internal and external market analysis.

21 In both cases, Moncks Corner's population

22 growth would not support the inpatient volume

23 required to justify the expense.

24 Q: Okay. Read the last sentence for me. I'm

25 sorry, the next sentence.

1 A: Carnes Crossroad met the test for population  
2 density and growth.

3 Q: Okay. And Roper went on to say that -- it's  
4 important that they're going to continue to  
5 offer the outpatient services in Moncks Corner  
6 which have been well utilized with the  
7 exception of ambulatory surgery, correct?

8 A: Correct.

9 Q: Do you have any thoughts about that paragraph?

10 A: Yeah, I mean, during this presentation, Roper  
11 St. Francis basically told the Department that  
12 there's plenty enough to go around. There's,  
13 both hospitals can be successful. And that's  
14 what they said, but then look what's in the  
15 second paragraph. They're saying if they had  
16 gone to Moncks Corner alone, nothing in here  
17 about competition, if they had chosen Moncks  
18 Corner rather than Goose Creek as the site for  
19 their hospital, they couldn't make a go of it.  
20 But somehow Trident, they're telling the  
21 Department, can make a go of it even with Roper  
22 in Carnes Crossroads. So, in other words, if  
23 Roper had Moncks Corner to itself, it couldn't  
24 make a go of it. But if Trident is in Moncks  
25 Corner, and Roper is 11 miles down the road,

1 and basically grabbing share from the two zip  
2 codes that are critically important to the  
3 success of that Moncks Corner hospital, that  
4 everything is hunky dory. There's no problem.  
5 I just don't see how those statements can be  
6 reconciled. Moncks Corner can support a  
7 hospital or it can't. Roper is saying Moncks  
8 Corner couldn't support a hospital. And of  
9 course, one of the reasons is they drew a seven  
10 mile circle around Moncks Corner which is  
11 absurd. We're talking about a rural area. Why  
12 would you draw a seven mile circle with maybe  
13 a 15 minute drive time. The whole purpose is  
14 to serve a larger community. And, you know,  
15 we'll show later that if you look at a 50 mile  
16 drive time, 50 mile radius, 30 minute drive  
17 time, that there's significant population who  
18 wind up having improved access as a result of  
19 that. Yeah, if you just do seven miles, you  
20 get just basically the town of Moncks Corner  
21 and a little bit beyond. Not much.

22 Q: Okay.

23 A: And that's not a realistic way to judge whether  
24 you can have a successful hospital.

25 Q: Go to page 808 in Joint 2 for me.

- 1 A: Joint 2?
- 2 Q: Yes.
- 3 A: Okay.
- 4 Q: I'm sorry, Joint 1. That was my mistake.
- 5 A: Okay.
- 6 Q: Is this the -- I think you just referenced this
- 7 in your testimony. Is this the seven mile
- 8 radius analysis Roper showed to DHEC at the
- 9 project review meeting?
- 10 A: Yes.
- 11 Q: And it has Trident Berkeley Medical Center, you
- 12 know, the population would go from 19,259 to
- 13 2,671 radius around Moncks Corner?
- 14 A: Uh-huh (affirmative response). Correct.
- 15 Q: Okay. But that there would be a greater
- 16 population increase for Roper St. Francis
- 17 Berkeley around their seven mile radius?
- 18 A: Yeah, and I should say, I think Roper is wrong
- 19 to do a seven mile radius around the Carnes
- 20 Crossroad site. That's also inappropriate.
- 21 Why is seven miles meaningful? That's a
- 22 convenience standard. That's not a need or an
- 23 access standard. You're going to draw in a lot
- 24 fewer people if you draw a seven mile circle
- 25 than if you draw a 15 mile circle. Is that all



1           you're really proposing to serve? The patients  
2           in southern Berkeley County who already have  
3           access to two hospitals?

4   Q:   Okay.    If you go to 813 in the same, Joint  
5           Exhibit 1.

6   A:   Okay.

7   Q:   Okay.    And again, this was back in 2009,  
8           correct?

9   A:   Correct.

10   Q:   Okay.   The plan developments that Roper put up  
11           on the board.   In terms of Carnes Crossroads  
12           Crossing, it indicates 5,000 units, correct?

13   A:   On 813?

14   Q:   Yes.    Kind of right in the middle of the page.

15   A:   Let me look at that.   Yes.

16   Q:   Okay.   How many units did you see while you  
17           were there?

18   A:   I saw zero.

19   Q:   And that was back in the Fall, correct?   2011?

20   A:   Yes, this was in late October, I think, 2011.

21   Q:   Okay.   And the Parks at Berkeley?   Did you  
22           visit that property?

23   A:   Yes.

24   Q:   How many of the 30,000 homes did you see there?

25   A:   I didn't see any.

1 Q: Okay. Look at 821 on the document for me.

2 A: Sure.

3 Q: Joint 1.

4 A: Okay. I've got it.

5 Q: In your opinion, was Roper's project  
6 conservative from the perspective of market  
7 share capture?

8 A: Yes.

9 Q: Okay. Why?

10 A: Because I think based on where they're locating  
11 and what the existing shares of providers are  
12 in the market, that they're likely to obtain a  
13 larger share of patient volume from existing  
14 providers and need to rely less on redirection.

15 Q: And is the fact that Roper is locating in an  
16 area where it currently has no operations, is  
17 that significant from a market share  
18 perspective?

19 A: Well, it's a new provider in the market. You  
20 shake things up more when you have a new  
21 provider. For instance, Summerville adding 30  
22 beds at a site where they've already been in  
23 business for close to 20 years and they have 94  
24 beds is a lot different than putting up a new  
25 50 bed hospital in the new location.

1 Q: Okay. Why?

2 A: Market share changes -- again, this is just my  
3 experience having looked at what happens when  
4 new hospitals are built over the too long of a  
5 period I've been doing this, they -- there is,  
6 there are greater changes with new locations  
7 that occur with simply add-ons to existing  
8 locations. Why would you spend \$150 million if  
9 it's just to maintain share?

10 Q: Okay.

11 A: I mean if your purpose is to serve the  
12 community, you expand access, you may take some  
13 risks. It may take longer to make some money.  
14 I think that's what Trident is doing.

15 Q: Okay. Turn over to 824 for me in the Trident  
16 DHEC record. Let me know when you're ready.  
17 Are you there Mr. Baehr?

18 A: Yes.

19 Q: Oh.

20 A: I'm sorry.

21 Q: No, that's all right. This chart references  
22 Trident's charges, correct?

23 A: Yes.

24 Q: At the time? Do you have any opinions about  
25 the reasonableness of this slide?

1 A: Yeah, I haven't looked at the backup on this  
2 but the major thing is there are a smaller  
3 percentage of patients every year who pay the  
4 full freight. Who actually pay the listed  
5 charge. And the healthcare business is a very  
6 odd business. There's a price and then there's  
7 what you get paid. There's a price you list  
8 when you send a bill to Medicare, but you know  
9 you're going to get paid from Medicare  
10 according to a formula. They're going to pay  
11 you based on the case type and according to the  
12 geographic area in which you area. Okay. So,  
13 a fixed amount whether you charge them 50,000  
14 or 100,000, they will pay you 25,000 for an  
15 open heart surgery case or whatever the amount  
16 is. That's true for a lot of other payers.  
17 Even some of the managed care companies, they  
18 have negotiated rates, but they're not  
19 percentage of charges. So, it's not a question  
20 of as the charge goes up, the hospital  
21 automatically is going to receive more money as  
22 a result of that. So simply because a hospital  
23 has higher list prices doesn't necessarily mean  
24 that there's any significant difference in  
25 what's costing the third-party payers or the

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1 community. It might to some segment of the  
2 community, but not to a large one.

3 Q: Okay. Thank you. If you would go to the next  
4 page, 825 in the Trident DHEC record, did you  
5 review this slide regarding Roper St. Francis'  
6 community-based charity care?

7 A: Yes..

8 Q: And what if any opinions did you form about  
9 this?

10 A: I think for the size of the system, I think I'd  
11 say it's fairly modest. And some of these  
12 things, I mean every hospital has un-reimbursed  
13 cost of Medicaid. Medicaid simply doesn't pay  
14 adequate rates. Charity care is the number  
15 that's worth considering. It's a real number  
16 you can look at. And hospitals all do  
17 community outreach. I don't know how you  
18 measure that. Do you, do you have some  
19 standard of time that you use to measure the  
20 employee contributions or exactly what's being  
21 paid.

22 Q: Isn't community outreach -- well, to some  
23 degree isn't a euphemism for marketing?

24 A: Yeah, I think a lot of community outreach is  
25 marketing.

1 Q: Okay.

2 A: I mean, it's not to deny that there can be  
3 positive benefits that come from it.

4 Q: Sure.

5 A: You know, if you have a blood pressure  
6 screening and stuff, that can provide service  
7 to the people that show up.

8 Q: Okay. Now, Mr. Baehr, after you went to  
9 project review, and you made your presentation  
10 and saw Roper's presentation, did you submit  
11 anything to DHEC?

12 A: Yes, I submitted two letters. One dated at the  
13 end of May and one in -- June 23rd. I think  
14 May 28th may have been the first one. I don't  
15 remember exactly.

16 Q: Let's go to that one first if we could. And  
17 it's in 832 of DHEC Trident record.

18 A: Joint 1?

19 Q: Joint 1.

20 A: What's the page number again?

21 Q: 832 Bates.

22 A: Okay. Okay. I've got it.

23 Q: Okay. Now, did you prepare this letter?

24 A: I did.

25 Q: Okay. And did it summarize some of your

1 opinions --

2 A: Yes.

3 Q: -- that you presented? Now, could you take the  
4 Court through, generally, because I know some  
5 of this is already in your project review  
6 slides --

7 A: Uh-huh (affirmative response).

8 Q: -- generally through what you presented to the  
9 Department.

10 A: Yeah, I think number one is the most important.  
11 If the Department treated the volume in  
12 Berkeley County, the volume of hospital days  
13 coming out of Berkeley County in the same way  
14 they treated individual hospitals in their  
15 patient model, all right? The way they -- not  
16 in their hospital model when they calculate  
17 their bed need. They could have made a  
18 calculation of how much growth was expected in  
19 Berkeley County. They know the number of  
20 resident days coming out. They know the growth  
21 rate. They could have done the calculation and  
22 they would have come up with a number that says  
23 there's enough need, there's enough growth to  
24 support one 50 bed hospital. Not two. One.  
25 Okay. Satisfying need is not saying you're

1 transferring beds into a new community and you  
2 can fill them. You fill them by taking  
3 patients away from other hospitals, that's not  
4 need. That's just market share capture. All  
5 right. There's only enough need to justify  
6 one. Neither hospital is going to reach its  
7 projected financial goals if both are built.  
8 That was the first point. The second one is  
9 the comparative one. Again, I don't want to be  
10 repetitive and it's a long time -- a long, long  
11 day today, but basically there's a significant  
12 difference in the access improvement between  
13 what Berkeley Regional Medical Center would  
14 offer in Moncks Corner versus what the Carnes  
15 Crossroad facility would be. Especially given  
16 all of their attention to Goose Creek. They  
17 keep talking about Goose Creek and it's the new  
18 center of the community. And Goose Creek  
19 almost abuts Trident Medical Center. I mean  
20 this is not a community that doesn't have  
21 hospital service. I mean the gentleman that  
22 was here from Moncks Corner the other day was  
23 basically saying, you know, it's basically  
24 three to five miles from Trident Medical  
25 Center. A lot of residents of Goose Creek



1 right now. I mean that's good access. I mean  
2 that's better access than most people have in  
3 most locations in the state. Okay. So,  
4 southern Berkeley County is already well-  
5 served. Approval of Roper St. Francis'  
6 application to place a hospital right in that  
7 area is duplicative, expensive, duplicate  
8 service and would result in material adverse  
9 impact on the Berkeley Regional Medical Center  
10 application and if it were the only hospital  
11 approved, it would impact Trident Medical  
12 Center and Summerville, which again are the  
13 places that are going to lose patients where  
14 the market share gains are going to come from  
15 for Roper St. Francis.

16 Q: Let's go to your next letter, which I think is  
17 Trident DHEC record 900.

18 A: Okay.

19 Q: That was dated June 23, 2009.

20 A: Okay.

21 Q: Did you prepare this letter?

22 A: I did. I wrote it.

23 Q: And where did the information come from for  
24 this document?

25 A: Okay.

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RECORD 001836

1 Q: I tell you what, turn to Petitioner's 177 for  
2 me real quick.

3 A: Okay. 177?

4 A: Yes. Okay.

5 Q: And, Judge, I can get you a loose-leaf if that  
6 would be more helpful. What is this document

7 --

8 A: This is --

9 Q: -- in Petitioner's 177?

10 A: This is the backup to the calculations on  
11 adverse impact. Which rely on two things. One  
12 is we know the expected volume, anticipated  
13 volume for the Roper St. Francis Berkeley  
14 facility in Carnes Crossroads. We know the  
15 total number of patients they expect to serve  
16 in each year. We know the total outpatient  
17 volume. And there's roughly a one to one ratio  
18 between the two. For every one dollar of gross  
19 revenue inpatient, they have about a dollar of  
20 gross revenue outpatient. So, you can  
21 translate days into adjusted days by  
22 multiplying by two, basically.

23 Q: Okay.

24 A: So, we know what their volume is going to be.  
25 We also know what their start of market shares

1 are for the existing providers in the market.

2 Q: Let me stop you right here real quick. So, I  
3 just want to get it for the record. Petitioner  
4 177 is the backup or the underlying data that  
5 supports your letter in Joint 1 at page 900?

6 A: Correct. If you look at the first page, if you  
7 look at page 000432, which I guess is  
8 Petitioner's 177-002.

9 Q: Correct. 177.

10 A: You'll see about the middle of that table,  
11 there's projected and adjusted admissions for  
12 Roper St. Francis Berkeley: 2,943; 5,045;  
13 5,886. Trident's historic market share is  
14 about 53 percent. So, the way this calculation  
15 is made is that if Roper comes into the market,  
16 it can expect to take volume from other  
17 providers in accordance with their starting  
18 shares in the market. The other way to think  
19 about that is in the absence of a new hospital,  
20 if Roper St. Francis were not built, then each  
21 hospital would be expected to grow according to  
22 population. So, if you had a 23 percent share  
23 in the future, you'd have a 23 percent share,  
24 if you had a 23 percent share historically,  
25 you'd expect to have a 23 percent share in the

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1 future, but have a bigger number of days  
 2 because the market is growing. Okay. So, each  
 3 hospital is anticipating base volume plus  
 4 growth to get the future volume. If, on the  
 5 other hand, a new hospital comes into the  
 6 market, it basically upsets the apple cart.  
 7 The volume that would have gone to existing  
 8 providers is instead to some extent being  
 9 diverted to the new provider. So, the question  
 10 is, where is that new provider taking patients  
 11 from. The most conservative approach, which is  
 12 the one, the only one based on history -- I  
 13 mean I can come up with a forecast and say this  
 14 is how Trident is going to fill its beds. Mr.  
 15 Richardson can come up with a forecast and say  
 16 this is how Roper is going to fill its beds.  
 17 But if you're trying to do apples versus  
 18 apples, the conservative approach is to say a  
 19 new hospital comes in a market, it fills its  
 20 beds, that volume would otherwise have been  
 21 seen by other providers if it had never been  
 22 built, so how do you allocate the damage?  
 23 Well, you allocate the damage based on the  
 24 historic share. So, if Trident historically  
 25 had 53 percent of the patients in the county,

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1 then they would lose 53 percent of the patients  
2 required to get Roper St. Francis up to the  
3 volume they projected in their application.  
4 So, that's what we have there in the number  
5 reduction in Trident system in adjusted  
6 admissions.

7 Q: Okay. And is that in page 902 of the letter?

8 A: Yes.

9 Q: Or to the DHEC record?

10 A: And then right below it is the contribution  
11 margin for adjusted admission. And for that  
12 number, we relied on information that was  
13 provided to us --

14 Q: Let me stop you really quickly. Just for the  
15 Court's knowledge and the record, explain what  
16 contribution margin is.

17 A: Contribution margin means the next patient who  
18 comes into the hospital, there's additional  
19 revenue and there's some additional expense to  
20 treat them. You've got supplies expense. You  
21 may have additional nursing cost and so on.  
22 Alternatively, if a patient that you expected  
23 to come in doesn't come in, you lose revenue.  
24 You might not staff quite as much. You might  
25 not use supplies to treat that patient.

1 Contribution margin is the difference between  
2 new revenue and new expense associated with the  
3 next patient who comes in the door. Or  
4 alternatively, it's how much margin you lose if  
5 you lose the revenue associated with a patient  
6 and you can reduce your expenses somewhat, but  
7 not as much as the loss of revenue. Okay.

8 Q: I want to ask you real quickly, is this  
9 contribution method kind of the accepted method  
10 when doing an adverse impact analysis?

11 A: Yes, I've been doing this for decades.

12 Q: Okay. Thank you. Go ahead.

13 A: Okay. Now for this we needed internal  
14 financial information and assistance from  
15 Trident because we had to get an estimate of  
16 their contribution margin. They provided us  
17 information on various categories. Estimates  
18 were made on the variable percentage of cost.  
19 These estimates were actually our estimates  
20 that we made. The amounts come from Trident  
21 themselves. The variable percentages were  
22 estimates that we made. And as a result, you  
23 come up with a contribution margin and you can  
24 calculate how much impact there is if Trident  
25 loses volume to a new Roper St. Francis

1 Berkeley facility.

2 Q: And what did you find in that? What did you  
3 find that would be based on your analysis?

4 A: It's substantial. By the third year, it's  
5 slightly over \$14 million.

6 Q: Okay. Go back on to page 900 of your letter  
7 for me.

8 A: Okay.

9 Q: June 23, 2009.

10 A: Let me close this.

11 Q: Okay.

12 **THE COURT:** I didn't hear you.

13 Q: Yes, sir. It's Trident DHEC record 900, so  
14 Joint 1.

15 A: Okay.

16 Q: Let's let the Court get there.

17 A: I've got it.

18 Q: Okay. And right under discussion, you  
19 mentioned something about projecting the  
20 population growth in Berkeley County. And what  
21 it will generate in terms of additional census.  
22 Can you talk to the Court a little bit about  
23 this concept?

24 A: Yeah. This is actually a number that comes  
25 right from the proposed Roper St. Francis

1 Berkeley project. That's where the estimate of  
2 three per day comes from. If you're adding the  
3 three average daily census of three per day,  
4 all right, and you've got two 50 bed hospitals,  
5 you need to get to about 20 some odd years to  
6 get to census of 60 for the two to fill 100  
7 beds. All right. Nine years, you get to 27.

8 Q: Is that number of years a reasonable planning  
9 horizon?

10 A: No, I don't think you would do that at this  
11 point. I think that's wasteful. And the other  
12 thing is, if you use the State's, the State's  
13 methodology, you come up with a larger increase  
14 per day. And that's because the State actually  
15 does it slightly differently than either Mark  
16 or I did in the application. We just looked at  
17 the overall use rate. We just looked at the  
18 total population, total number of patient days.  
19 The State actually does a little more refined  
20 analysis. They look at a use rate within age  
21 segments. And the updates that Mr. Richardson  
22 and I did, we both did it exactly the way the  
23 State did. And what does that show? That  
24 showed about 12,000 days over a period of seven  
25 years; 12,000 days is a census of about 35.



1 Just about right for a 50 bed hospital. One 50  
2 bed hospital.

3 Q: Okay. Let's go to Trident DHEC record 871.

4 A: Okay.

5 Q: We are going backwards, but the actual  
6 chronology is going forwards.

7 A: Okay.

8 Q: Now, is this the decision letter Mr. Rardin  
9 received on June 26, 2009?

10 A: Yes.

11 Q: Okay. What were your general impressions of  
12 this decision letter?

13 A: Well, the first line was, I think, a little bit  
14 of a shocker. That the Department has  
15 determined that the two applications are not  
16 competing. And the explanation. They're not  
17 competing because the beds used for Roper don't  
18 result in a bed increase in the Tri-County  
19 Area. Therefore the bed need will not be  
20 exceeded. The bed need where? You're putting  
21 beds in Berkeley County. So, is there a need  
22 for those additional 50 beds in Berkeley  
23 County? Can you take beds if you're a  
24 transferring facility and put them anywhere  
25 regardless of the need for beds in that

1 location? The hospitals chose service areas  
2 for these projects. They each identified  
3 service areas. It's the county. So the idea  
4 that somehow because you're taking beds from A  
5 and you're moving them to B so there's no  
6 overall increase in beds, that that means you  
7 can't have a duplicative facility. You can't  
8 have excess beds in the area where you're  
9 plopping them down, that's wrong. It's just  
10 plain wrong. Even the transfer language  
11 requires proof that there's need for those  
12 beds. Was there proof provided that there's  
13 need for those beds and the need for Trident?  
14 No. That's never been demonstrated by Roper,  
15 which is the only applicant here that made an  
16 argument that both hospitals could be approved.

17 Q: In terms of the -- let's turn over to, if we  
18 could, 882 of this letter. First of all, go to  
19 875 in the DHEC record.

20 A: Okay.

21 Q: All right. And this is the findings, the  
22 certificate of need summary, Department  
23 findings, which was actually attached to the  
24 decision letter; is that right?

25 A: Correct.

1 Q: Okay. And if we turn over to 882 --

2 A: Okay.

3 Q: In terms of what the Department found and  
4 obviously they approved both projects, but in  
5 terms of compliance with the South Carolina  
6 Health Plan, in your opinion does Trident's  
7 project and CON application comply with the  
8 South Carolina Health Plan?

9 A: Yes, I believe it does.

10 Q: Okay. Why?

11 A: It's consistent with the Plan. It's using an  
12 existing bed need to create this new hospital.  
13 It's improving access. It's a good  
14 distribution of the resources of the bed supply  
15 need within the system. I think it promotes  
16 cost containment given the system and the  
17 history of how these projects are developed  
18 within HCA and how they're managed going  
19 forward. I mean it meets all basic standards.

20 Q: And I just want to touch on each one. In terms  
21 of community need, all right. And based on  
22 that project review criteria, do you have an  
23 opinion as to whether there's community need  
24 for this project?

25 A: Yeah, there are a significant number of

1 residents of northern Berkeley County who are  
2 not now within 30 minutes drive time of an  
3 existing facility. They would be if the Moncks  
4 Corner facility were constructed. That's a  
5 real access improvement.

6 Q: And if it's the only facility built, do you  
7 have an opinion as to whether or not it would  
8 be well utilized?

9 A: Yes, I think it will be utilized. I think it  
10 will reach an acceptable volume in the low to  
11 mid-thirties within the first few years, which  
12 would enable it to earn a small net income.

13 Q: Okay. And I think we, we've maybe mention this  
14 quite a few times in terms of accessibility.  
15 Did, do you have an opinion as to that?

16 A: Yeah, I think this improves accessibility. You  
17 know, these are residents of this county who  
18 have not had that kind of access until this  
19 facility was built. And won't have until this  
20 facility is built. And won't have it if it's  
21 not built.

22 Q: In terms of financial feasibility, do you have  
23 an opinion as to whether the project will be  
24 financially feasible on its own?

25 A: Yeah, I think the hospital satisfies two tests.

1 It has the resources to complete the project  
2 and finance it. And it generates a positive  
3 net income within the projected time frame.

4 Q: And acceptability. What's your opinion with  
5 relevance to that project review criteria?

6 A: Yeah, there's very strong community support as  
7 well as support from competitive providers in  
8 the Tri-County market.

9 Q: All right. Mr. Baehr, in terms of adverse  
10 impact? Will the project adversely impact  
11 existing providers?

12 A: Yeah, I think there could be some adverse  
13 impact on existing providers, but I think it  
14 would be modest and it's outweighed by the  
15 improvement in access for the residents of  
16 northern Berkeley County, which are substantial  
17 in number.

18 Q: Okay. You haven't seen the adverse impact  
19 analysis done by Roper, have you?

20 **THE COURT:** Excuse me, just a moment.

21 **MR. THOMAS:** Yes, sir.

22 **THE COURT:** Unless there's some objection, I'm going  
23 to ask that you stick your head out the door  
24 and tell the security guard that he can leave.

25 **MR. THOMAS:** Okay.

1 THE COURT: I don't think we need him.

2 MR. THOMAS: Okay.

3 THE COURT: Thank you, sir.

4 Q: I'm sorry, we just mentioned adverse impact.  
5 Were you done with that statement?

6 A: Yes.

7 Q: And distribution of the 17 beds?

8 A: Yeah, I think this is an intelligent use of the  
9 resources in the system. Putting 50 beds in  
10 Moncks Corner is preferable to adding capacity  
11 at the Trident Medical Center. Because the  
12 access improvement is more achievable.

13 Q: Okay. One second. All right. Now we're going  
14 to go into Joint 2.

15 A: Okay.

16 Q: Joint Exhibit 2.

17 A: All right.

18 Q: And I ask you to go to page 1262.

19 A: Okay. Okay.

20 Q: And I want to wait for Judge McLeod to get  
21 there as well.

22 A: Sure.

23 THE COURT: I have it. Thank you.

24 Q: All right. Did you have an opportunity to  
25 review on June 26, 2009, the letter that was

1 sent to Roper St. Francis Berkeley, on which  
2 Trident Health System was copied, the decision  
3 letter for the Roper St. Francis Berkeley  
4 project?

5 A: Yes.

6 Q: Okay. Now, what were your impressions when you  
7 read this letter?

8 A: I think there are misstatements throughout.

9 Q: Okay. In terms of the competing application  
10 issue, what did you understand the Department's  
11 decision to be?

12 A: The decision was that they are not competing  
13 and the reason is that only one hospital is  
14 proposing new beds. The other is transferring  
15 in beds. So, that doesn't compete with a  
16 project that's adding beds.

17 Q: Okay.

18 A: Though it seems to me your adding beds in the  
19 same region.

20 Q: Go to page 1,268 for me if you would.

21 A: Okay.

22 Q: And if you look at the, it's the second  
23 paragraph, there's a reference to only four  
24 other counties that are without hospitals in  
25 South Carolina, including Calhoun, Lee,

1 McCormick and Saluda with limited population in  
2 each of those. How does this situation differ  
3 from the situation in Calhoun, Lee, McCormick  
4 and Saluda?

5 A: None of them have a tertiary facility with  
6 almost 300 beds located on the doorstep of the  
7 county a mile away. I mean it's an absurd  
8 comparison.

9 Q: And in terms from being a mile away from the  
10 population epicenter of that county?

11 A: Right. And in a location that the community  
12 leaders of Berkeley County and Dorchester  
13 County agreed on would be the best location to  
14 serve those communities when they closed their  
15 community hospitals.

16 Q: Now, go down -- now this is in the DHEC, also  
17 kind of the certificate of need summary of  
18 Department findings, right? This was attached  
19 to the decision letter?

20 A: Yes.

21 Q: Go down to the bottom of the page 1,268. And  
22 you've got five bullets there.

23 A: Uh-huh (affirmative response).

24 Q: Have you seen any of these bullets before?  
25 Bullet points?



1 A: Yeah, they came right out of the application by  
 2 Roper St. Francis. The first one is kind of  
 3 funny. Because the first one would be true  
 4 only if the sent a letter to Roper three  
 5 minutes and 30 seconds before they sent it to  
 6 Trident. Since both were approved, the  
 7 Department is approving two hospitals, which  
 8 one gets to be first. I don't know. Did they  
 9 mail one in one mailbox and one in another? I  
 10 don't know. I mean that's a strange comment to  
 11 make on a day when you're approving two  
 12 hospitals in a market. That, you know, first  
 13 assuming that they don't acknowledge that  
 14 Trident Medical Center exists. In other words,  
 15 to believe that first comment, you've got to  
 16 believe Trident Medical Center doesn't exist  
 17 and doesn't provide service to Berkeley County  
 18 and the second is, they would be the first one.  
 19 How are they the first? You're approving two.  
 20 I mean, I mean this seems to be cut and paste  
 21 which we've seen evidence of last week and  
 22 occurred in other places in these decisions.

23 Q: Go to -- under market share on page 1,269 for  
 24 me, Mr. Baehr.

25 A: Sure.

1 Q: There's a, there is a sentence here I'm  
2 interested in. The third one. I'm sorry.  
3 East Berkeley County residents, it says, have  
4 made the decision not to go to Trident in North  
5 Charleston or Summerville in Dorchester County,  
6 but rather to drive even further to Roper  
7 facilities. Do you agree with that statement?

8 A: I think that's -- we talked about speculation  
9 before. Since I think most patients are  
10 directed by their physician, and we know, we  
11 have evidence that the Moncks Corner Medical  
12 Center, the Roper Moncks Corner emergency room,  
13 where those patients are directed, it certainly  
14 doesn't appear to be a pro rata distribution of  
15 facilities across the region based on either  
16 their location or their size. Seventy-five to  
17 80 percent are transferred to Roper. I don't  
18 think that's accidental or by chance. The idea  
19 that every patient who is going downtown has  
20 made an independent decision to do that, that  
21 they have personally chosen to bypass existing  
22 facilities suggest that the physician was not  
23 a component of the ultimate decision of where  
24 that patient goes.

25 Q: And that does comport with your experience and

1 knowledge?

2 A: Yes.

3 Q: And now, we talked a little bit about the  
4 applicable standards and if you look on page  
5 1,270 of the Roper St. Francis letter --

6 A: Uh-huh (affirmative response).

7 Q: Excuse me, 1,270 of the letter, E, applicable  
8 standards.

9 A: Uh-huh (affirmative response).

10 Q: Now, have you had the, the opportunity to  
11 review the transfer standard section and Joint  
12 Exhibit 4?

13 A: Yes.

14 Q: All right. Let's go there real quick if we  
15 could.

16 A: Okay. I've got to change books.

17 Q: Joint Exhibit 4.

18 **MR. LONG:** Your Honor, I'm going to object to Mr.  
19 Baehr being able to testify about the transfer  
20 provision in the State Health Plan because if  
21 he's going to ask him what it means -- that's  
22 a legal determination. The Department has  
23 already set the brackets together, has already  
24 testified from a factual point of view about  
25 how they applied it. And also the historical

1 basis for the Roper -- for the DHEC Board's  
2 statements about it. So really what Mr. Baehr  
3 thinks about it is irrelevant in the  
4 proceedings.

5 **THE COURT:** Well, to start with, how do you know  
6 what question he's going to ask?

7 **MR. LONG:** Well, just by directing him to the issue.  
8 I mean the entire issue is settled --

9 **THE COURT:** Well, I can't rule on it until the  
10 questions are more specifically asked. So --

11 **MR. LONG:** I'll pause and I'm sorry if I jumped to  
12 quick, Your Honor. I'll wait.

13 **MR. THOMAS:** I have a feeling he'll be standing up  
14 again, Your Honor.

15 Q: But are you in Joint Exhibit 4?

16 A: I am.

17 Q: On page II-9?

18 A: Uh-huh (affirmative response).

19 Q: Okay. And I guess J, is that the, is this what  
20 you understand to be the beginning of the bed  
21 transfer provision?

22 A: Yes.

23 Q: Okay. If we could go to the next page.

24 A: Excuse me. Mine is H, it looks like the  
25 section.

1 Q: Is that right?

2 A: I'm in 3.

3 Q: No, 4.

4 A: It's supposed to be 4? Okay. What page?

5 Q: II-9. II-9.

6 A: Okay. All right. I've got it.

7 Q: And it goes over to II-10. Have you seen this  
8 standard before?

9 A: Yes.

10 Q: Okay. And did you agree with DHEC's  
11 interpretation of the standard?

12 **MR. LONG:** Objection, Your Honor, again it's the  
13 same objection I just made a couple minutes  
14 ago. Mr. Baehr is an expert on healthcare  
15 planning. This involves the interpretation of  
16 the State Health Plan. The DHEC witnesses have  
17 testified to it factually. The DHEC Board has  
18 already stated what it means. It doesn't  
19 matter what he think it means. If it is --  
20 Your Honor will -- ultimately there will have  
21 to be a decision made as to whether the  
22 provision allows the transfer, whether or not  
23 it's ambiguous. If it's not ambiguous, if it  
24 is ambiguous, the person who drafted the  
25 documents statement as to what it means is

1       dispositive as to what it means. Mr. Baehr  
2       can't testify as to what the provision means.  
3       The DHEC Board wrote it or passed it.

4       **THE COURT:** I don't think he's testifying as to what  
5       it means. He's testifying as to what it means  
6       to him as a healthcare planner.

7       **MR. THOMAS:** And, Your Honor, if I could just add, I  
8       don't necessarily agree with what Mr. Long is  
9       saying in terms of the rules of statutory  
10      construction because there were a lot of them.  
11      And just because you drafted it doesn't  
12      necessarily mean that your interpretation  
13      rules. When I say you, the drafter. Secondly,  
14      the Department didn't designate an expert in  
15      this case. Okay. The State Health Plan is  
16      subject to interpretation by experts on health  
17      planning. And, you know, I think I'm entitled  
18      to take Mr. Baehr through the language so he  
19      can talk about what his understanding of the  
20      bed transfer section means and there are  
21      several different policy type things that I'm  
22      going to touch on with him as well. Because I  
23      think that's going to illuminate for this  
24      Court, you know, the reason why we think, that  
25      Trident thinks that DHEC's position is

1 incorrect. And we did file a motion for  
2 summary judgement and the Court wanted  
3 additional facts that would come out during the  
4 trial process. So, that's what we're  
5 attempting to do here.

6 **THE COURT:** I'm going to overrule the objection.

7 **MR. LONG:** Thank you, Your Honor.

8 **Q:** All right. Mr. Baehr, what is your  
9 understanding of how the bed transfer section  
10 is supposed to operate with respect to health  
11 planning?

12 **A:** Yeah, I thought -- I was here last week and  
13 when Mr. Summer was questioning and Ms. Brandt  
14 was talking about the two Palmetto facilities  
15 consolidating a unit and moving beds from one  
16 to the other, that type of transfer perfectly  
17 fits the language that's in this section.  
18 Perfectly fits it. In other words, if you were  
19 writing a section to describe that, this is  
20 what that does. There's no ambiguity about it.  
21 It's, the language is clear. That's what it  
22 does. To allow it to be used to take beds from  
23 facility A to create a brand new facility where  
24 nothing now exists seems to me to be on its  
25 face, impossible to accept given this language.

1 THE COURT: I want to stop you right there because I  
2 understand the law and the rules. I'm somewhat  
3 of a gatekeeper here.

4 A: I understand. Wrong word. Take it back.

5 THE COURT: Are you basing your testimony on your  
6 experience or is this entirely new to you?

7 A: No, I have testified about this before. This  
8 issue came up in the Parkridge case when I was  
9 involved. And I looked at it then and I said  
10 it doesn't work. That language can't justify  
11 what they're proposing to do there. There they  
12 weren't transferring beds from Richland to  
13 Baptist, but they were taking beds from Baptist  
14 and moving it to a place where there's nothing.  
15 Okay. So this --

16 MR. LONG: Excuse me. Your Honor, he has testified  
17 about it before, but that's irrelevant. Okay.  
18 What's important is, what is his experiences,  
19 particularly in South Carolina in regards to  
20 the Health Plan, which are zero. Because he's  
21 not on the Health Planning Committee, he  
22 doesn't participate, he doesn't work for the  
23 Department. He's just a health planner.

24 MR. THOMAS: Your Honor, this is a document that  
25 actually controls what he does as a health



1 planner.

2 **THE COURT:** I agree with your assessment of it, but  
3 I want to make sure you don't get beyond your  
4 field of expertise.

5 A: I understand. That's fair. Let me try to  
6 describe it this way. The kind of transfer  
7 that's at issue in this case, and the kind of  
8 transfer that was at issue in the Palmetto  
9 Parkridge case, both of which involved  
10 transferring beds to a site where there is  
11 nothing. Where there is no receiving facility,  
12 where there's no historic utilization pattern.  
13 Where there can be no projected utilization  
14 pattern for a facility that doesn't exist.  
15 Okay. That strikes me as inconsistent with  
16 this language. Now, departments can chose to  
17 follow language and interpret it differently  
18 than I might. Okay. I accept that. But even  
19 accepting that they're using this transfer  
20 section to support this particular move, they  
21 didn't do their job. They didn't demonstrate  
22 that the location where there is a receiving  
23 facility, assuming the new hospital is the  
24 receiving facility, that there's a need for  
25 those additional beds. Is there a need for one

1 50 bed hospital in Berkeley County? Or two 50  
2 bed hospitals in Berkeley County. Just because  
3 you're not increasing the total bed supply in  
4 Charleston, Berkeley or Dorchester by  
5 transferring 50 beds, that doesn't mean you  
6 don't have to satisfy that there's a need for  
7 that facility being moved into Berkeley County  
8 and those beds being moved there.

9 **THE COURT:** Wait a minute. Forgive me, Mr. Thomas.

10 **MR. THOMAS:** That's fine.

11 **THE COURT:** But I need to ask a question here. It  
12 seems to me you're disregarding the fact that  
13 the service area is a three county area and  
14 trying to confine it to Berkeley County.

15 **A:** You are correct. There's a tri-county service  
16 area and that's why the Department says there's  
17 no net increase in beds. But, if you look at  
18 specific components of this particular section,  
19 for instance facility receiving the beds must  
20 demonstrate the need for the additional  
21 capacity based on historical and projected  
22 utilization patterns. Well, we know there's  
23 not a historical pattern. So what's the  
24 projected pattern? Well, the projected  
25 pattern is how much utilization is there going

1 to be versus how much capacity there is. Is a  
2 second hospital excess capacity where they're  
3 proposing to move it. Because the whole reason  
4 for this transfer is supposedly to make the  
5 system more efficient. To take beds where  
6 they're not needed and move them where they're  
7 needed. But that's suggesting that you've got  
8 to show they're needed where you're moving  
9 them.

10 **THE COURT:** I don't want to appear argumentative,  
11 but I need to understand and make sure that  
12 you're not exceeding your field. But the fact  
13 that there's no bed increase within the three  
14 county area seems to be okay. Am I mistaken  
15 there?

16 A: No.

17 **THE COURT:** It's only when you assign it to the  
18 Berkeley County boundaries that it becomes  
19 objectionable; is that right?

20 A: That's correct. The whole point of the  
21 transfer section is you're not increasing  
22 overall beds, but you're moving them from an  
23 area that doesn't need them to an area that  
24 does. So, if you're moving the beds from an  
25 area that doesn't need them to an area that

1 does, that in and of itself suggests you have  
2 to show that the area that's getting them needs  
3 them. Which means in this case you have two  
4 application, both of which have identified  
5 Berkeley County are 100 beds too much.

6 **THE COURT:** Continue, Mr. Thomas.

7 Q: Let me ask you this, Mr. Baehr. Based on --  
8 well, MUSC actually has greater market share in  
9 that certain kind of heavily populated area in  
10 southern Berkeley County; is that correct?

11 A: Roper has a bigger market share than MUSC  
12 county-wide.

13 Q: Right.

14 A: But in the specific zip codes within that seven  
15 mile circle, MUSC appears to have a slightly  
16 larger market share than Roper.

17 Q: Let me ask you this, in your opinion, based on  
18 what you've heard from DHEC's witnesses, could  
19 MUSC have successfully applied at the same time  
20 with Roper and Trident to build another 50 bed  
21 facility in Berkeley County claiming and using  
22 as the justification a redirection of patients  
23 and a modest market share increase?

24 A: MUSC-aligned patients, because if there are  
25 Roper-aligned patients, there are MUSC-aligned

1 patients. And again, if they move 50 beds from  
2 downtown into Berkeley County, there's no  
3 overall increase in the number of beds in the  
4 tri-county area, but there is an increase in  
5 Berkeley County. So, the question is how much  
6 is enough for Berkeley County.

7 Q: So now we would have three hospitals?

8 A: Then you would have three.

9 Q: A hundred and 50 beds?

10 A: That's correct.

11 Q: Okay. Does that seem like a reasonable  
12 position in terms of the competing application  
13 issue?

14 A: No.

15 Q: Why not?

16 A: Because I think these two hospitals compete.  
17 Okay. Same county, same services, same road,  
18 same zip code. Basically the same type of  
19 hospital. Same service area. A high degree of  
20 overlap between the service areas. I mean I  
21 don't see what test of competing they don't  
22 meet. And then you add the killer which is  
23 there's not enough beds, there's not enough  
24 need given the population growth in Berkeley  
25 County for two 50 bed hospitals. There's only

1 enough for one. So, that's the very definition  
2 of competing. Two facilities in the same  
3 market area, same services and if both succeed  
4 and build, there's too much. It's duplicative.  
5 You have one too many.

6 Q: Okay. So in your opinion, does Roper St.  
7 Francis' project comply with the State Health  
8 Plan?

9 A: I don't believe it does. I don't think they've  
10 demonstrated a need and they certainly haven't  
11 shown access improvement. They didn't even  
12 identify their service area. I mean the  
13 application is missing a lot of things that  
14 you'd need to have even for the State to  
15 attempt to try to argue that this is a positive  
16 redistribution of beds in the Roper system.

17 Q: Okay. On page 1,270 of the DHEC record, Joint  
18 2, Roper DHEC record.

19 A: Twelve seventy?

20 Q: Yes.

21 A: Okay.

22 Q: Let me give the Court just a moment.

23 **THE COURT:** I have it.

24 Q: All right. Now, down at the bottom of the  
25 page, you've got financial feasibility there.

1 In terms of the project being financially  
2 feasible, do you have an opinion as to Roper  
3 St. Francis' project standing alone?

4 A: If the test of financial feasibility study,  
5 financial feasibility is a positive net income  
6 in year three, I think Roper will not pass the  
7 test because they used the wrong assumption on  
8 incremental volume in the model they developed.  
9 The incremental model is the one they selected.  
10 It's not the one the Department forced on them.  
11 It's not one Trident or anyone else told them  
12 they had to do. It's the one they chose. That  
13 model has a very small amount of net income in  
14 the third year. If they don't have enough  
15 incremental volume, they're not going to hit  
16 that net income number. They would have a loss  
17 in year three and by the test of feasibility,  
18 they would not have satisfied.

19 Q: Okay. Go to 1,272 for me if you would.

20 A: Okay.

21 Q: You set out the staff findings and we've  
22 already gone over the compliance issue. And in  
23 terms of community need documentation --

24 A: Uh-huh (affirmative response).

25 Q: Do you have an opinion with respect to Roper

1 St. Francis' project standing alone as to  
2 community need?

3 A: Yes.

4 Q: What is it?

5 A: I don't think they satisfied that. I don't  
6 think there's significant access improvement.  
7 I don't think they documented a need for their  
8 facility in the area in which they're proposing  
9 to serve. They've indicated what they call a  
10 need for what they call Roper-aligned patients  
11 to not have to drive downtown. That's their  
12 mean of justification.

13 Q: Why is that, in your opinion wrong?

14 A: One is, I'm not sure you could pick out who  
15 Roper-aligned patients are. It's not a  
16 distinct geographic area. It's a collection of  
17 patients in one year or another year. It's not  
18 the kind of thing that's in the South Carolina  
19 State Health Plan. There's nothing addressing  
20 aligned patients. There's need arguments.  
21 There are arguments about geographic access.  
22 About financial access. About accessibility.  
23 When you have hospitals that are a few miles  
24 away but you prefer to go downtown or your  
25 doctor sends you downtown and you wish the



1 downtown hospital would have one closer by so  
2 you build another hospital right on top of the  
3 two existing ones that are just outside the  
4 county line, I don't think that's a need  
5 argument. That's hospital-specific planning or  
6 specific planning to cater to the needs of some  
7 patients who are seeing one system as opposed  
8 to another.

9 Q: Go to the Roper DHEC record 1,273. Now, this  
10 distribution project review criteria, that's,  
11 that's basically the same exact paragraph that  
12 was in the Trident Medical Center letter,  
13 wasn't it?

14 A: Yeah, I saw this the other day and pointed it  
15 out, but it looks like they didn't include  
16 language for the Roper application, but the  
17 Trident-Berkeley application in this section.

18 Q: Okay. Nonetheless, in terms of Roper St.  
19 Francis Berkeley project, do you have an  
20 opinion as to the distribution or accessibility  
21 of that project standing alone?

22 A: Yeah, I think this is -- if you wanted to  
23 satisfy the distribution requirement under the  
24 argument you have too many beds downtown, and  
25 you want to move them into an area that's got

1 faster growth than downtown, that will also  
2 serve the community, not just essentially  
3 enable you to pick up market share at the  
4 expense of existing providers, you wouldn't  
5 locate, you would locate in Carnes Crossroads  
6 if your goal is market share gains. You locate  
7 in Moncks Corner if your goal is to improve  
8 distribution, improve the accessibility,  
9 improve the service to residents who are now  
10 under served.

11 Q: And acceptability, we touched on that earlier,  
12 right?

13 A: Yeah, they've got letters from the community.  
14 I mean there are people in Goose Creek who are  
15 excited that, you know, to having a hospital  
16 there, but they didn't get letters of support  
17 from other facilities and in fact, I did read  
18 a letter from the administrator at the Medical  
19 University explaining that he wasn't -- he  
20 could have just ignored it, but he actually  
21 wrote a letter saying he wasn't going to  
22 endorse it.

23 Q: Okay. In terms of adverse impact, at the time  
24 this was written, you had sent your letter in  
25 regarding adverse impact, correct?

1 A: Yeah, I actually sent two letters in. I  
2 remember when, I think it was Ms. Brandt was on  
3 and Mr. Long was questioning her about I sent  
4 a letter on June 23rd, that was the first time  
5 she had ever seen it. Well, that's not really  
6 accurate because in my earlier letter I  
7 specifically referenced that kind of adverse  
8 impact. Essentially the adverse impact on  
9 existing providers and during the presentation,  
10 during project review I talked specifically  
11 about the inadequate numbers that are going to  
12 result in volume and in losses that will occur  
13 financially if two hospitals are built because  
14 there are not enough patients to go around.  
15 All I can say is, you know, I've put together  
16 financial projections for the Department before  
17 and there have been cases where people will say  
18 they don't understand what I wrote, it's too  
19 complex, this is a complex area. There's a lot  
20 of -- if you don't deal with this stuff all  
21 along, it's not the same as Rick Knapp and I  
22 talking in an elevator about stuff that would  
23 bore 99.9 percent of the population to death,  
24 but I've had people from the Department contact  
25 me and say they didn't understand something.

1 In fact, one of the people in the Department  
2 actually asked me to come in, make a visit and  
3 walk her through an adverse impact analysis.  
4 That was in the case, the Parkridge case.  
5 Which I did. And you know, you take you time  
6 and I think at the end of that period of time  
7 the person was respectful, understood what I  
8 was trying to do. The impression I got here is  
9 we provided information on adverse impact.  
10 Some of it may not have been understood, but  
11 there was no attempt to reach out and get  
12 clarification or even a phone conversation  
13 about what some of this was about.

14 Q: Your Honor, we've got --

15 **MR. SUMMER:** Your Honor, Mr. Thomas has got a good  
16 bit more to do and I'm thinking that it may be  
17 good for us to sit down and kibbitz a little  
18 bit about trying to pare down some of this a  
19 little bit and I know the witness is probably  
20 pretty tired having flown this morning. So, if  
21 we have no objection of calling it a day or do  
22 we want to keep going?

23 **MS. BIGGERS:** I have no objection.

24 **MR. LONG:** I'd like to know how much more he's got.

25 **MR. THOMAS:** I mean, I think, Your Honor, probably,

1 if I had to guess, an hour and a half, two  
2 hours. And I may be able to pare that down.

3 **THE COURT:** I don't think we can finish that today  
4 in any event.

5 **MR. LONG:** No, sir. We would not. No objection. We  
6 wouldn't finish today.

7 **THE COURT:** All right. Then do we want to come in  
8 at 9:30 in the morning? That being the case,  
9 we will recess until 9:30 in the morning.

10 (There being nothing further, the hearing recessed at  
11 5:31 p.m.)

12 **DAY 7 - TUESDAY, FEBRUARY 7, 2012**

13 **THE COURT:** Ladies and gentlemen. Thank you. Be  
14 seated please. Lawyers, on last evening I  
15 tried to resurrect in my mind Mr. Long's  
16 objection to testimony regarding the transfer  
17 of beds. I was unable to. I customarily think  
18 over things after the end of the day. - I'm  
19 going to revisit that issue. I've ask the  
20 court reporter to transcribe that brief portion  
21 of the transcript for me so I could look at it  
22 and read it and we will have this done and we  
23 will discuss it before Mr. Baehr leaves. I  
24 presume he'll be here for the duration, will he  
25 not?

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1 MR. THOMAS: Yes, Your Honor.

2 THE COURT: Okay.

3 MR. THOMAS: Are you ready, Your Honor?

4 THE COURT: Yes.

5 MR. BAEHR - CONTINUATION OF DIRECT EXAMINATION BY MR.

6 THOMAS:

7 Q: Good morning, Mr. Baehr.

8 A: Good morning, Mr. Thomas.

9 Q: I'd like to talk a little bit about -- kind of  
10 the Mount Pleasant area of the service area and  
11 ask you are you aware of what occurred in the  
12 Mount Pleasant area of this tri-county service  
13 area in the last five years from a health  
14 planning perspective?

15 A: Generally, yes.

16 Q: Okay. In your opinion does it have any  
17 relevance to the facts in this case?

18 A: Yeah, I think what happened there is kind of a  
19 warning signal about what I think were bad  
20 planning decisions that shouldn't be repeated.

21 Q: What's your understanding of what occurred in  
22 East Cooper a few years back?

23 A: My understanding is that East Cooper Medical  
24 Center was a 100 bed hospital that showed a  
25 need for one bed as I understand it. In the,

1 I believe it was the 2004-2005 Plan. And they  
2 applied for a replacement hospital, basically  
3 across the street from their existing facility.  
4 With an increase of 40 beds. So, in other  
5 words, they used the one bed need to apply for  
6 40 additional beds to replace the hospital and  
7 become a 140 bed hospital at the same location  
8 basically. Within a couple months, I think it  
9 may have been two months, Roper applied for an  
10 85 bed hospital under the transfer rule. About  
11 seven miles away from East Cooper. So, in  
12 essence, what was a one bed need for East  
13 Cooper turned into 125 net new beds in the  
14 service area. Forty additional beds for East  
15 Cooper, 85 additional beds for Mount Pleasant.  
16 And the impact of that so far, obviously these  
17 hospitals in their new facilities haven't been  
18 there very long, doesn't look very encouraging  
19 as to the fact, as to whether those two  
20 hospitals will be able to attract enough  
21 volume. In other words, the same argument was  
22 made. Explosive growth and as a result, that  
23 justified Roper's moving beds from downtown to  
24 Mount Pleasant. East Cooper must have thought  
25 they needed more beds than the one bed need.

1 So far the volume numbers suggest that these  
2 hospitals are going to have lots of excess  
3 capacity going forward and I think that  
4 combined capital costs was in the nature of  
5 \$300 million. So, one bed need resulting in  
6 \$300 million in projects and so far, it looks  
7 like about the same volume that existed when it  
8 was just the East Cooper and 100 bed hospital.

9 Q: Do you have like a pen and paper back there Mr.  
10 Baehr?

11 A: Yes, I have paper. I need a paper.

12 Q: I might ask you to jot down a few things. And  
13 ask you to go into Joint Exhibit 15. I'm going  
14 to try to do this on the screen if we could and  
15 if not, we can --

16 **THE COURT:** I need a copy. Is it 15 you say?

17 Q: Yes, sir. So we're going to page, if you look  
18 in the top right hand corner, you'll see some  
19 page numbers there. And I've asked you to go  
20 to page 68.

21 A: Fifty?

22 Q: Yeah, on Exhibit 15.

23 A: Okay. 2007.

24 **THE COURT:** Page what?

25 **MR. THOMAS:** Yes, sir. At the top, yes, sir.



- 1 Q: All right. Mr. Baehr, it should be the 2008  
2 discharge days on this page.
- 3 A: I want to make sure I'm on the right page. Is  
4 this JARs 00573?
- 5 Q: Yes, it is. 68, right there.
- 6 A: Okay. I see.
- 7 Q: Okay. All right. Are you there?
- 8 A: Yeah.
- 9 Q: Okay. I apologize for this. Have you had an  
10 opportunity to review some of the East Cooper  
11 JAR reports?
- 12 A: Yes.
- 13 Q: Okay. And in 2008, if you look at the column  
14 here, on the right-hand side, you've got total  
15 patient days there and right below that  
16 discharge includes death and you've got 2008-  
17 2009, do you see that, Mr. Baehr?
- 18 A: Uh-huh (affirmative response). Yes.
- 19 Q: Okay. And if you, turn over, excuse me here.  
20 Turn the page -- no, right down at the bottom.  
21 What does it say for 2008 in terms of the total  
22 discharges?
- 23 A: Total discharges on 069?
- 24 Q: On 068 right at the bottom. It says grand  
25 total.

1 A: Okay. Discharge for 2008, 5,428.

2 Q: Okay. Can you write that down?

3 A: Sure.

4 Q: And right next to that there's a number for  
5 2009, isn't there?

6 A: Yes.

7 Q: And what is that?

8 A: 4,993.

9 Q: Okay. And in this same Exhibit if you would  
10 turn over to JARS 10 in the bottom right-hand  
11 corner --

12 **THE COURT:** Before we leave that, what hospital is  
13 this?

14 Q: Oh, I'm sorry. What hospital?

15 A: East Cooper Medical Center.

16 Q: Okay. And where is it located?

17 A: It's in the Mount Pleasant area.

18 Q: Okay. And that's the hospital that did its  
19 replacement with a \$150 million property?

20 A: Correct.

21 Q: Okay. And if you would turn over again to JARS  
22 600 and this is the 2010 JAR report for East  
23 Cooper Regional Medical Center.

24 A: Okay.

25 Q: And then go to 601 for me and if you could tell

1 me what the grand total number of discharges  
2 was in 2010?

3 A: Okay. Let me find that number on here, 4,799.

4 Q: Okay. Would you write that number down?

5 A: Sure.

6 Q: Sara, if you could go to Petitioner 4.  
7 Petitioner 234 the loose-leaf copy. Did you get  
8 an opportunity to review the certified data you  
9 received from East Cooper Regional Medical  
10 Center recently with their 2011 discharge data?

11 A: Yes.

12 Q: What does it say for 2011?

13 A: The discharges are 4,558.

14 Q: Okay. All right. So, in terms of the decline  
15 from 2008 to 2011, can you tell us about what  
16 the percentage is on that Mr. Baehr?

17 A: From 2011 to 2009?

18 Q: Well from 2008.

19 A: Oh, from 2008, it's a drop of 870. It's about  
20 16 percent.

21 Q: Okay.

22 A: Sixteen to 17 percent.

23 Q: And what's been occurring in Mount Pleasant in  
24 terms of population?

25 A: Well, the projections continue to indicate that

1 there's substantial growth going on and  
2 expected to continue.

3 Q: All right. Put up Joint 168 for me please,  
4 Sara. I'm sorry. Petitioner's 168. Thank  
5 you. All right. And have you seen this table  
6 before Mr. Baehr?

7 A: Yes.

8 Q: Okay. And can you tell us -- are we going --  
9 the latest data we've seen for Roper Mount  
10 Pleasant is through August of 2011, correct?

11 A: Yes.

12 Q: Okay. In terms of the occupancy rate at  
13 Roper's Mount Pleasant hospital through August  
14 of 2011, what is it?

15 A: Eleven percent.

16 Q: Okay. And this is all Roper-Berkeley 4641,  
17 correct?

18 A: Correct.

19 Q: And 11 percent, what does that mean? Like out  
20 of 85 beds, how many on average were occupied  
21 through August of 2011 at Roper St. Francis?

22 A: Nine plus a fraction.

23 Q: Okay. Nine beds out of 85. And if you look  
24 back just quickly at Petitioner's 234.

25 A: Yes.

1 Q: What's the average daily census at East Cooper  
2 Medical Center for the year 2011?

3 A: Just a second.

4 Q: I think it's actually on that number one.

5 A: Oh, yes, 41.70.

6 Q: Okay. So, in those two --

7 **THE COURT:** Before you go ahead, where did the 11  
8 percent come from? I'm looking at what's on  
9 the screen?

10 **MR. THOMAS:** Right here, Your Honor.

11 **THE COURT:** The last one. I'm sorry. I was not  
12 clear on it.

13 **MR. THOMAS:** Not a problem. Things start to run  
14 together, for me at least.

15 Q: All right. So, if in terms of the 225 beds,  
16 based on the most recent data we have for both  
17 institutions, how many were full in 2011?

18 A: If you take the Mount Pleasant numbers for 8  
19 months and you use that as the 2011 number, and  
20 it could be higher in the last couple months of  
21 the year, generally new hospitals do have some  
22 build up. But, if you take the number through  
23 eight months, which is 11, let's assume and you  
24 add roughly 42 for East Cooper, you have a  
25 combined average daily census of 53 with

1 capacity of 225.

2 Q: Okay.

3 A: Which is 23 and a half percent.

4 Q: 23.5 percent? If you continue to look at 234,  
5 Petitioner's 234 for me, what's the number of  
6 emergency department visits from January 1,  
7 2011, to December 31, 2011?

8 A: 14,755.

9 Q: Okay. And Sara, would you go back to  
10 Petitioner's -- I guess it would be Joint 15  
11 for me? And this one may show up better on the  
12 screen for us.

13 MR. LONG: What's the Bates page?

14 Q: Yes, it's Bates page 604. And can you see that  
15 Mr. Baehr?

16 A: Yes.

17 Q: What does it say for East Cooper Medical  
18 Center, the number of ED visits was in 2010?

19 A: 15,079.

20 Q: All right.

21 THE COURT: Wait just a minute please. What's the  
22 JARs number again?

23 MR. THOMAS: It's 604.

24 THE COURT: What?

25 MR. THOMAS: It's JARs 604, Your Honor, Joint 15.

1 Q: What's the total number of emergency room  
2 visits, Mr. Baehr?

3 A: In 2010?

4 Q: In 2010.

5 A: 15,079.

6 Q: Okay. So that's the true emergency visit?

7 A: Yes. Total visits is a higher number.

8 Q: Okay. And what is the total visit number?

9 A: 18,268.

10 Q: Okay.

11 A: There's no complementing number on the 2011  
12 page.

13 Q: Got you. Thank you. And regarding what I was  
14 -- numbers as used, it is an increase or a  
15 decrease from 2011 to 2012?

16 A: Well, from 2010 --

17 Q: Excuse, 2011 to 2010.

18 A: Yeah, 2010 to 2011 is about, it's a decline of  
19 about two percent.

20 Q: Okay. And if 18,268 is the number, what would  
21 that decline be?

22 A: Well, unless I knew a comparable number for  
23 2011 it would be -- I'd just be guessing.

24 Q: Okay.

25 A: If that's the real number for emergency visits

1 then you have a substantial decline on the  
2 order of 20 percent.

3 Q: Okay. And it's your understanding that at the  
4 East Cooper, Roper Mount Pleasant hospital  
5 there is an ED department there, correct?

6 A: Yes.

7 Q: Okay.

8 A: This 18,268 could be the comparable number to  
9 this 14,755 since this one is, presumably 2011  
10 is a complete visit number.

11 Q: Okay.

12 A: You do have visits to emergency room which are  
13 classified differently depending on the  
14 severity of the patient.

15 Q: Okay. This one says the emergency department  
16 visits on Petitioner's 234, correct?

17 A: Right.

18 Q: It doesn't say true emergency visits, does it?

19 A: Correct. It's a small, it's a subset. So if  
20 you looking at the visit number of 18,268  
21 versus 14,755, that's a drop of 3500 which is  
22 almost 20 percent in one year.

23 Q: And do you have an opinion as to what could  
24 have caused the 20 percent decline in emergency  
25 department visits at East Cooper Regional



1 Medical Center from 2010 to 2011, in one year's  
2 time?

3 MR. LONG: Your Honor, objection. How can you give  
4 an opinion when he doesn't know what the number  
5 means?

6 MR. THOMAS: Well, he does know what it means.

7 MR. LONG: He doesn't.

8 MR. THOMAS: It says emergency department visits  
9 14,755 and that says visits at the top.

10 MR. LONG: I know. And he just said he thought it  
11 could be one percent and then it wasn't another  
12 percentage because he doesn't know what the  
13 document that's Petitioner's 234 means. He's  
14 admitted that he doesn't -- that he can't  
15 compare these documents. I don't think he's  
16 laid a foundation to give an opinion on it.

17 THE COURT: Well, I think it is a matter of  
18 foundation.

19 MR. THOMAS: Okay. Well, let me ask this question.

20 Q: Mr. Baehr --

21 THE COURT: I sustain the objection on that basis.

22 MR. THOMAS: Thank you.

23 Q: Number four which is emergency department  
24 visits in 2011, it doesn't say true emergency  
25 visits, does it?

1 A: No. It could be a total.

2 Q: Okay.

3 A: I mean, not knowing otherwise that would be the  
4 assumption one would make.

5 Q: Okay. How about we do it this way. Do you  
6 have -- based on -- what else has been going in  
7 the East Cooper market since 2007 in terms of  
8 physician employment?

9 A: There have been acquisitions of physician  
10 practices by Roper.

11 Q: Okay. And over the years what we've seen, and  
12 I believe you've written the numbers down,  
13 we've seen a decline in discharges, correct,  
14 from East Cooper Regional Medical Center?

15 A: Correct. About 16 percent in three years.

16 Q: Okay. And during that time has Roper been  
17 inquiring physician practices?

18 A: Yes.

19 Q: Okay. In the Mount Pleasant area?

20 A: Yes.

21 Q: Okay. And its hospital opened, what's your  
22 understanding of when its hospital actually  
23 opened?

24 A: I believe the Mount Pleasant facility opened in  
25 November of 2010.

1 Q: Okay. Do you have an opinion of what has  
2 likely caused the decline in patient discharges  
3 at East Cooper Medical Regional Medical Center  
4 from 2008 to 2011?

5 A: There's another hospital in the service area  
6 that's available to attract patients. Also a  
7 new facility.

8 Q: Okay. In your opinion do you believe that  
9 could occur in Berkeley County if two hospitals  
10 are simultaneously approved?

11 A: Yes.

12 Q: Okay. Why?

13 A: Again, if they're in relative proximity and  
14 they're competing for patients in similar  
15 market areas, they're going to have an impact  
16 on each other.

17 Q: Mr. Baehr, have you done any further expert  
18 analysis with respect to the CON applications  
19 at issue in this case in which you've formed  
20 opinions relative to the project review  
21 criteria?

22 A: Yes.

23 Q: Okay. And I believe you put together some  
24 slides to be found at Petitioner's 46, Your  
25 Honor. Mr. Baehr, is this your work product at

1           Petitioner's 46?

2       A:    Yes.

3       Q:    All right.   Starting with 1592, Baehr 1592,  
4           Petitioner's 46, can you give the Court an  
5           overview of what you did and then we'll go into  
6           the slides themselves?

7       A:    Right.   These Exhibits fall into four sections.  
8           One deals with improvement in patient access.  
9           We look at what improvement would occur as a  
10          result of the Moncks Corner facility being  
11          built, what improvement in patient access would  
12          occur as a result of the Roper St. Francis-  
13          Carnes Crossroads project being built.   The  
14          second is we look at utilization trends and  
15          what we just have seen in the Mount Pleasant  
16          area where there's been a low average occupancy  
17          rate and volumes that don't seem consistent  
18          with a market area that's supposedly is growing  
19          very rapidly.   We're seeing some of the same  
20          thing in Berkeley County where, despite  
21          population increases and given a census number  
22          for 2010, which was surprisingly large to a lot  
23          of people, it was a bigger number than some  
24          people expected, nonetheless, inpatient  
25          utilization coming out of Berkeley County has

1 declined the last few years. Which is  
2 indicative that despite population rising that  
3 doesn't automatically mean that patient volume  
4 will rise. That's, in a sense, both the Moncks  
5 Corner model and the Roper model are based on  
6 the expectation that population growth will  
7 drive increases in volume going forward. As  
8 I've said, I don't think there's enough volume  
9 to support two hospitals, it can only support  
10 one. But if it turns out that patient  
11 population growth is not going to drive  
12 utilization growth to the extent that we  
13 imagined, that makes the case even stronger I  
14 think that two hospitals would be excessive.  
15 So that's area number two. Number three deals  
16 with financial issues related to the approval  
17 of two hospitals. Since each hospital's  
18 financial projection was based on the  
19 assumption that they would be the only hospital  
20 building, in the case of Roper that's a little  
21 surprising because they were second in the  
22 batch so presumably you make an argument yours  
23 is better and, therefore, we're the only one  
24 otherwise you're just ignoring the other  
25 application. In the case of the Moncks Corner

1 facility, they applied and as far as they knew  
2 they were going to be the only one applying.  
3 But if you have two, there's nothing in these  
4 projection sets to model what the impact of two  
5 is instead of one. If you don't get the volume  
6 you project, how much will financial  
7 performance suffer. So we've tried to analyze  
8 that in section three.

9 Q: All right. What about four?

10 A: In section four it looks a different issue.  
11 Let's assume just one hospital is approved.  
12 That hospital that's approved will likely have  
13 some impact on existing providers. So we  
14 attempted to measure what that impact will be.  
15 If it turns out to be the Moncks Corner  
16 facility or if it turns out to be Roper St.  
17 Francis facility.

18 Q: Okay. Let me ask you a couple of questions  
19 before we go into section one of the  
20 improvement of patient access. We looked at  
21 the decision letters yesterday and was there an  
22 accessibility finding actually included in  
23 Roper St. Francis Berkeley's decision letter?

24 A: Yes.

25 Q: Okay. What did it reference?

1 A: Basically that they're moving to a higher  
2 growth area.

3 Q: Well, actually --

4 A: And dealing with their aligned patients. I  
5 mean, they basically adopted the -- whatever  
6 the language was in the application.

7 Q: Okay. Well, in the Roper St. Francis decision  
8 letter by DHEC they actually referenced  
9 Berkeley.

10 A: Oh, the Berkeley one, yeah.

11 Q: Okay.

12 A: But I mean there are two different parts.  
13 There's the decision letter and then there's  
14 the additional comments, correct.

15 Q: Okay.

16 A: Yeah, they used -- they cut and pasted the  
17 Berkeley section instead of a new Roper  
18 section.

19 Q: Okay. Well, do you recall any reference in the  
20 Roper St. Francis Berkeley decision letter to  
21 a 30 minute travel time standard which was  
22 weighed against the adverse impact?

23 A: No.

24 Q: Okay. Turn to page 1593 for me, Baehr 1593 in  
25 --

1 A: Sure.

2 Q: -- Petitioner's 46.

3 A: Sure.

4 Q: Let me go back one step. When I just asked you  
5 the question about the 30 minute travel time  
6 standard weighed against the adverse impact,  
7 why is that an important concept?

8 A: If you're going to weight equally improvements  
9 in access and adverse impact, there are ways to  
10 measure adverse impact but how do you measure  
11 access improvement. If there's no travel time  
12 standard, then in essence it's whatever an  
13 applicant says it is, which is not an objective  
14 criteria and it means the State's decisions are  
15 pretty arbitrary. And the 30 minute language  
16 is there in that section of, in the acute care  
17 section of the State Health Plan, it's been  
18 there for a long time. I take it as guidance  
19 as the equivalent of a standard.

20 Q: All right. Back to 1593. Could you kind of  
21 take the Judge through your slides here and  
22 your opinions that are related to --

23 A: Sure. This is kind of an important section.  
24 Basically, again, as I said yesterday, I don't  
25 think drawing a seven mile radius around a



1 hospital has any meaning whatsoever as far as  
2 health planning. That's not something that's  
3 mentioned in the State Health Plan here or  
4 anywhere else. It just seems like an arbitrary  
5 number to choose. It may mean a 15 minute  
6 drive time, but it was selected by Roper as  
7 somehow being a meaningful way to look at the  
8 service area. I think the 15 mile, which is  
9 more equivalent to 30 minute drive time, is  
10 much more meaningful. And so what we wanted to  
11 do was we wanted to draw circles around each of  
12 the proposed applicant's sites and then see how  
13 much overlap there was essentially in the  
14 service area, as defined by either the seven  
15 mile radius or a 15 mile radius with similar  
16 sized circles for existing hospitals. So for  
17 instance, you have Trident Medical Center and  
18 you have Summerville Medical Center and if you  
19 drew a 15 mile circle around those hospitals,  
20 there's a significant amount of area in  
21 Berkeley County that's covered. So the  
22 question is when you overlay on that map a new  
23 hospital, either in Moncks Corner or Goose  
24 Creek, how much of the service area of that new  
25 hospital is really just an overlap of existing

1 facility service areas and how much of it is  
2 net new, essentially new patients who don't now  
3 have access within 30 minutes drive time who  
4 would. It turns out when you do this analysis  
5 that there's substantially more individuals who  
6 gain access as a result of the Moncks Corner  
7 facility than the Roper St. Francis facility.  
8 And so --

9 Q: Can you explain how you made that  
10 determination?

11 A: Yeah. Well, start on page 1594, and again,  
12 these are seven mile circles around Trident  
13 Medical Center, Summerville Medical Center and  
14 the Berkeley Medical Center in Moncks Corner.  
15 And you can see that if you draw seven mile  
16 circles, there's no overlap whatsoever between  
17 the Berkeley Medical Center and the two  
18 existing Trident facilities. So whatever  
19 service area is within that circle is  
20 essentially all net new if you regard the seven  
21 mile circle as meaningful. Now, if you draw a  
22 15 mile circle, which I think is a much better  
23 test, which is on page 1595, this entire sort  
24 of a two-thirds of the area to the top here in  
25 blue is the new service area served by the

1 Moncks Corner facility that is not now within  
2 the 15 mile radius of either Summerville  
3 Medical Center or Trident Medical Center. So  
4 that is an access enhancement area. So the  
5 people who live in that area to the north  
6 there, above the two circles to the south, are  
7 patients who have improved access as a result  
8 of locating a hospital in Moncks Corner.

9 Q: Okay.

10 A: Now, we made calculations of how many people  
11 live within those circles.

12 Q: Is that on Baehr 1596?

13 A: Yes.

14 Q: Okay.

15 A: And this was done using census block groups  
16 because, again, some of the zip codes, some of  
17 the areas are not exact in terms of --

18 Q: Let me stop you right there. In terms of the  
19 backup for these slides, can that be found in  
20 Petitioner's 39, the census block group data  
21 that you were referring to?

22 A: Yes.

23 Q: Petitioner's 40, the 15 mile analysis in the  
24 raw data?

25 A: Yes.

1 Q: And 41, seven mile radius actual math and the  
2 raw data?

3 A: Yes.

4 THE COURT: Before we proceed.

5 MR. THOMAS: Yes, sir.

6 THE COURT: On the drawing map of 1595.

7 A: Yes, sir.

8 THE COURT: I see that Roper St. Francis Berkeley  
9 Medical Center has an arrow pointing toward it.

10 A: I'm having trouble hearing you, Your Honor.

11 THE COURT: Excuse me. I see that Roper St. Francis  
12 Berkeley Medical Center has an arrow to the  
13 left of the tab there on the page.

14 A: Correct.

15 THE COURT: But I don't see any indication of the  
16 location of the proposed center nor a circle  
17 corresponding.

18 A: Correct. Yeah. What I did -- good question.  
19 What I did is I compare first the new Berkeley  
20 Medical Center alone and how it overlaps with  
21 the two existing facilities. Then I do the  
22 same with Roper St. Francis and the two  
23 existing facilities.

24 THE COURT: You're getting ready to do that?

25 A: Yeah. And then finally I do what you asked

1 which is to have all four hospitals in it  
2 together so you can see if both new hospitals  
3 are built, what's the net addition from Roper  
4 and what's the net addition in terms of access  
5 from the Moncks Corner facility.

6 **MR. THOMAS:** And, Your Honor, I think I understand  
7 one thing you were saying as well. This one  
8 shows up a little better than the pages you've  
9 got in front of you. It says Roper St. Francis  
10 Berkeley right here, the arrows there, and then  
11 there's the faint outline of the hospital which  
12 would be right there on 1595.

13 **THE COURT:** Okay.

14 **Q:** What page are you on now, Mr. Baehr?

15 **A:** Okay. So on 1596 there are approximately  
16 30,000 who are in that northern sector on the  
17 map on 1595, that whole blue section to the  
18 north. That encompasses 30,000 population who  
19 do not now have access to a hospital within 15  
20 miles, with 15 miles or 30 minutes drive time  
21 who now would. So that's an improvement in  
22 access of that number of population,  
23 approximately 30,000. It's a smaller number  
24 with seven miles because it's a smaller number  
25 of people incorporated within a seven mile

1 area. But again, I don't think you would ever  
2 build a hospital in a rural area of northern  
3 Berkeley County and define your service area as  
4 seven miles. That wouldn't make any sense.

5 Q: Okay. Are we on 1597?

6 A: Right. Now, I did the same thing with the  
7 Roper St. Francis Berkeley. And here we get a  
8 different picture and the reason is that even  
9 the seven mile service area for Roper St.  
10 Francis Berkeley has fairly significant overlap  
11 with the existing seven mile circles for  
12 Summerville Medical Center and Trident Medical  
13 Center. So remember, seven miles is what the  
14 applicant, Roper St. Francis, chose to draw.  
15 They didn't draw a 15 mile map, they drew a  
16 seven mile map. And if you draw a seven mile  
17 map, I mean you get roughly 100,000 population,  
18 but most of that population is within similar  
19 circles for Trident Medical Center and for  
20 Summerville Medical Center. The other thing is  
21 about one-third or slightly more than one-third  
22 of the population within the Roper seven mile  
23 circle isn't even in Berkeley County, it's in  
24 Dorchester County or Charleston County, in  
25 areas much closer, again, to existing Trident

1 facilities. We also drew the 15 mile circle  
2 and what you find is there's a very high degree  
3 of overlap between the 15 mile circle for the  
4 Roper facility and the facilities, the 15 mile  
5 circles around Trident Medical Center and  
6 Summerville Medical Center.

7 Q: Is that on 1599 that you're referring to?

8 A: Yeah, 1598 is first the seven mile band. So if  
9 you see where the Roper St. Francis facility  
10 is, it's within the seven mile circle for  
11 Trident Medical Center, it's just outside the  
12 circle for Summerville Medical Center, and  
13 basically the southern half of the Roper  
14 circle, which is where most of the population,  
15 more than half the population of the 100,000  
16 live, is completely covered by either the  
17 Trident circle or the Summerville circle. So  
18 again, they chose this seven mile test and  
19 suggest that a large part of that area  
20 including the most populous part of it is  
21 already covered by two existing hospitals'  
22 seven mile circles.

23 Q: Okay. Well, 1599?

24 A: Well, 1599 shows you with a 15 mile test, which  
25 I think again is the appropriate one. The only

1 new area provided by the Roper St. Francis  
2 facility is this sort of orange sort of  
3 crescent at the top. Okay? And all the  
4 remaining part of their 15 mile circle is  
5 within either Summerville Medical Center's 15  
6 mile circle or Trident's 15 mile circle or  
7 both.

8 Q: Okay. And 1599 just doesn't include Berkeley  
9 Regional Medical Center --

10 A: It does not. So far we're only testing one new  
11 hospital at a time with the two existing  
12 providers.

13 Q: Okay. Explain the chart on Baehr 1600.

14 A: Right. Basically that crescent at the top  
15 there, that orange crescent has about 14,000  
16 people. So in other words in a seven mile  
17 circle, that's 100,000 population. Only 14,000  
18 are essentially not covered within 15 miles of  
19 an existing provider. So that 86 percent of  
20 the population of that seven mile circle  
21 service area is already within the service  
22 areas of existing providers, most of them  
23 within two. That's not the case for the Moncks  
24 Corner facility where a much larger percentage  
25 of the population is, in fact, new, it's not



1 now covered by anyone.

2 Q: Okay. There's a chart on, excuse me, graphs on  
3 1601.

4 A: Yeah. Finally you get to 1601 and this is a  
5 really, I think an important table because if  
6 you're going to -- if both hospitals are built,  
7 what net new area does Berkeley Medical Center  
8 in Moncks Corner serve? It's that blue area at  
9 the top. That blue area which is a lot of the  
10 area around the lake is not covered by the  
11 Roper St. Francis circle, it's not covered by  
12 the Summerville Circle, it's not covered by the  
13 Trident 15 mile circle. That's net new. Okay?  
14 What's the net new for Roper if the Berkeley  
15 Regional Medical Center is built? It's that  
16 tiny pie piece on the left.

17 Q: Are you talking about this piece right here?

18 A: That little piece, which has a population of  
19 940, so in other words if both hospitals are  
20 built, the improvement in access provided by  
21 Roper St. Francis Berkeley that's not also  
22 provided by the Berkeley Medical Center, is 940  
23 people. So in other words, if Berkeley Medical  
24 Center is approved -- and one of the  
25 interesting things about this case is the Roper

1 people seem to think that the Trident facility  
2 deserves an approval. That seemed to be what  
3 Mr. Long was saying in his opening statement.  
4 East Cooper believes that Berkeley Medical  
5 Center is needed. Medical University of South  
6 Carolina believes it's needed. Obviously  
7 Trident believes it's needed. The State  
8 believes it's needed. There's not a lot of  
9 doubt, it seems to be fairly unanimous that the  
10 Berkeley Hospital in Moncks Corner serves a  
11 valuable purpose in improving access. You get  
12 to the Roper facility and basically Roper  
13 supports the idea and the State approved it.  
14 And what is, in fact, the benefit? The benefit  
15 is in that little area, it's 940 people. So do  
16 you approve 100, a second 115 million people --  
17 million dollar project to provide access to 940  
18 people. And are these people really  
19 desperately lacking in access? I mean, if  
20 they're not within a 15 mile circle, they're  
21 not much further beyond. I'd argue that most  
22 of them are probably within 17, 18 miles, so a  
23 few minutes beyond 30. On the other hand if  
24 Berkeley Regional Medical Center is the  
25 facility that's built and it's the only one

1 that's built, you have essentially all of the  
2 net new that Roper St. Francis would add plus  
3 all of that blue area. So you get that area  
4 just below the blue, which is I don't even know  
5 what color that would be, but the area that  
6 Roper St. Francis would serve if Berkeley  
7 wasn't there, is also covered by Berkeley. So  
8 Berkeley basically picks up all of the access  
9 improvement that Roper would propose to add  
10 with the exception of those 940 people, that  
11 tiny little segment on this map.

12 Q: And this is based on what standard in the State  
13 Health Plan?

14 A: This is based on 30 minute drive time.

15 Q: Okay. All right. And are those opinions also  
16 set forth on pages looks like 1602 and 1602A?

17 A: Yes. You can see if both hospitals are built,  
18 940 population would be added by Roper that  
19 wouldn't be added by Berkeley Regional Medical  
20 Center. And if Berkeley's built and Roper's  
21 built, there's an additional 14,000 beyond what  
22 Roper adds. And I might add if Berkeley is  
23 built and Roper isn't, then you get 29,000. So  
24 essentially all of the improvement that Roper  
25 would provide on its own is within what

1 Berkeley would provide except for those 940  
2 people. I mean, there's basically nothing  
3 extra, almost nothing extra you get from Roper  
4 as far as access improvement.

5 Q: Okay. Let's go to Baehr 1603. And before you  
6 go into this, you've got a concept here called  
7 financial access, correct?

8 A: Correct.

9 Q: I want to hand you the project review criteria  
10 relative to access and could you read project  
11 review criteria and 61-15 for me, 3(f) and (g)?

12 A: Sure. 3(f) is, the applicant should address  
13 the extent to which all residents of the area  
14 and in particular low-income persons, racial  
15 and ethnic minorities, women, the elderly,  
16 handicapped persons, and other medically  
17 underserved groups, are likely to have access  
18 to those services being proposed. And 3(g) is,  
19 the facility providing the proposed services  
20 should establish provisions to ensure that  
21 individuals in need of treatment as determined  
22 by a physician have access to the appropriate  
23 service regardless of the ability to pay.

24 Q: Okay. You understand those to be the financial  
25 access provisions --

1 A: Yes.

2 Q: -- in the project review criteria?

3 A: Yes.

4 Q: And why are those concepts generally important  
5 in health planning?

6 A: Well, the question is if you have a new capital  
7 expenditure, one of the ways to measure whether  
8 this is something that's needed by the  
9 healthcare system, whether it's a positive thing  
10 for the healthcare system, is whether it not  
11 only improves access to sort of the population  
12 at large, but whether it provides improved  
13 access to populations that are considered  
14 historically underserved.

15 Q: And before we go into this, in terms of the  
16 backup for these tables, could that be found in  
17 Petitioner's 58, it's a zip code by age, excuse  
18 me, zip code by population and income?

19 A: Yes.

20 Q: Okay. Could you take the Court through these  
21 slides, please?

22 A: Sure. If you look at 1604, this is a map  
23 similar to one that was in project review that  
24 we talked a little bit about yesterday, that  
25 considers particular sub areas within the tri-

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1 county area based on their median household  
2 income characteristics. So again, the orange,  
3 the redder area which is around Mount Pleasant  
4 is the highest in the tri-county area.

5 Q: And who's got a facility there now?

6 A: Mount Pleasant does.

7 Q: Roper Mount Pleasant?

8 A: Yeah.

9 Q: Okay.

10 A: And East Cooper is certainly there too. The  
11 orange area is the area that's just below on  
12 the income scale but also above average in  
13 terms of the tri-county area. And then the  
14 yellow area, which is most of the service area,  
15 is the 25,000-49,000 range. And then there are  
16 a couple of tiny pockets which are kind of hard  
17 to read which are the lowest income areas,  
18 which are actually in Charleston itself.

19 Q: Okay.

20 A: We did the same thing for 2016 and that map  
21 actually looks very similar.

22 Q: Okay. Are we on Baehr 1605?

23 A: 1605, correct.

24 Q: Okay.

25 A: Though there are a large number of people who

1 live within a seven mils radius of the proposed  
2 Roper facility, roughly 100,000, and several  
3 times that number who live within 15 miles,  
4 most of those people, a, already enjoy good  
5 geographic access to hospital services, and  
6 there is relatively minimal improvement and  
7 access for the lower income populations that  
8 Roper adds that are not now served either by  
9 Summerville Medical Center or Trident Medical  
10 Center. That's not the case with Berkeley  
11 Medical Center. The same way that they bring  
12 more people into the 15 mile radius zone, more  
13 people within 30 minutes drive time who don't  
14 now have that service, they do the same thing  
15 for a greater number of low-income people than  
16 the Roper St. Francis Berkeley facility does.

17 Q: Okay. Now I want to direct your attention to  
18 Petitioner's 222, if I could. Did you create  
19 this --

20 A: Yes.

21 Q: -- this Exhibit?

22 A: I did.

23 Q: Okay. And could you -- and is the backup  
24 contained within the Exhibit itself?

25 A: Yes, I mean, it's the Claritas information

1 again; household income, distribution, tables  
2 that we referred to earlier.

3 Q: Okay. Could you take the Court through this  
4 Exhibit and --

5 A: Yeah.

6 Q: -- it's 222.

7 A: There are a couple pages here. The first one,  
8 which is labeled 1854, shows that within a  
9 seven mile radius of either the Trident  
10 facility in Moncks Corner or the Roper facility  
11 in Carnes Crossroads, approximately 2,000  
12 households who do not now have access to a  
13 hospital within seven miles would now have it  
14 as a result of one or the other facility being  
15 built. So what that suggest is that even  
16 though the population in the Roper seven mile  
17 circle is about five times as large as it is in  
18 the Moncks Corner circle, seven mile circle,  
19 they each provide access to about the same  
20 number of net new population who are low  
21 income, who don't now have access within seven  
22 miles. But again, seven miles I don't think is  
23 the test, 15 miles is. And there you see on  
24 the right that there are more than three times  
25 as many households, 3,247 in the case of the



1 Moncks Corner facility, just over 1,000 for the  
 2 Roper facility, who are low-income households  
 3 within 15 miles of an applicant that are not  
 4 within 15 miles of an existing hospital. Those  
 5 -- that's the access improvement for the lower  
 6 income populations as a result of one or the  
 7 other facility being built. So for instance,  
 8 an average household size is usually a little  
 9 bit less than three. And I actually checked in  
 10 Berkeley County, it's about 2.7 is the average  
 11 household size. So 3,200 means roughly 9,000  
 12 population, 1,000 is roughly about 2,700, 2,800  
 13 population. That's the, the size of the  
 14 population in the case of Berkeley of the  
 15 29,000 net new almost a third are low-income  
 16 people who are being brought in. That shows  
 17 how much this facility not only helps people  
 18 who are not within 15 minutes, but also people  
 19 who are low income, who are not within 15  
 20 minutes and it's a much smaller number in the  
 21 case, and percentage of the total in the case  
 22 of Roper.

23 Q: And according to the definition 61-15 and 3(f),  
 24 low-income persons are considered medically  
 25 underserved groups, right?

1 A: Correct.

2 Q: All right. You have some other tables here in

3 222 --

4 A: yeah.

5 Q: -- is that something you want to go through?

6 A: Sure. 1585 and 1586 --

7 Q: Well, hold on. I'm sorry. 1855 and 1856?

8 A: 1855, yeah. I'm sorry.

9 Q: I just wanted to have that clear for the

10 record.

11 A: Okay. My mistake. We wanted to actually see

12 where the people lived who are under \$25,000

13 household incomes who are going to be served by

14 the new facility in Moncks Corner. And you can

15 see that the largest number in Moncks Corner is

16 over 1,000 in St. Stephen and some of the

17 numbers are smaller because the communities

18 themselves are smaller. But the meaningful

19 number is really on the following page, which

20 is 1856, which tells you the percentage of all

21 of the households who fall into one of these

22 low, essentially fall into this low-income

23 screen of 25,000 household income or less.

24 Now, look at the far right and you see that the

25 Berkeley County total is 22.7 percent. So

1 essentially a little over a fifth of all  
2 Berkeley County households are under \$25,000  
3 income. What every one of these towns and  
4 communities around the lake, the communities  
5 that we picked as the high market share zip  
6 codes for the Berkeley Regional Medical Center,  
7 they're all higher than the county average,  
8 some of them substantially higher. St. Stephen  
9 over 40 percent. Cross over 40 percent.  
10 Pineville over 40 percent. Jamestown over 40  
11 percent. Essentially more than four in ten of  
12 the households are under the \$25,000 household  
13 income. These are the communities that are  
14 going to be served the Moncks Corner facility.  
15 Now, for comparative purposes I looked at Goose  
16 Creek, the community of Goose Creek, which is  
17 mentioned throughout the Roper application as  
18 another community that they're serving. And  
19 the growth in Goose Creek is much bigger as a  
20 community than Moncks Corner, and Goose Creek  
21 the percentage of low-income households is just  
22 over 18 percent. So Goose Creek is below the  
23 countywide average, every community on the  
24 other hand served by the facility in Moncks  
25 Corner is above the average and in many cases

1 well above the county average. I mean, this is  
2 a substantial difference in essentially the  
3 provision of improved financial access between  
4 the two hospitals.

5 Q: In terms of the household incomes, household  
6 incomes of less than \$25,000, based on your  
7 experience as a health planner and healthcare  
8 finance what typically, how do those folks pay  
9 for healthcare?

10 A: Some of them are on Medicaid, some of them are  
11 charity cases, some of them are uninsured and  
12 become bad debts. Some of them are Medicare.

13 Q: All right. Let's go --

14 A: Some of them are dual-eligibles, they're  
15 Medicare and Medicaid.

16 Q: If we could switch back to Petitioner 46.

17 A: Okay.

18 Q: And page 1606.

19 A: There are a couple of other pages in the other  
20 section, but I guess --

21 Q: Okay. Well --

22 A: Yeah, there are two other pages in that  
23 section, 222, that I think are worth examining  
24 if you have them.

25 Q: Okay. We can --

1 A: 1857 and 1858.

2 Q: I'm sorry about that.

3 A: And if you look at the top of 1857, there  
4 again, I have a lot more households --

5 Q: Mr. Baehr, could you give the --

6 A: I'm sorry.

7 Q: -- Judge just a second to get there.

8 A: I apologize.

9 **THE COURT:** Which Exhibit number?

10 **MR. THOMAS:** I'm sorry, Judge, it's 222 and it's  
11 page 1857.

12 **THE COURT:** I have it.

13 **MR. THOMAS:** Okay.

14 A: If you look at the top half you can see that  
15 there are many more households within the Roper  
16 St. Francis Berkeley area with seven miles than  
17 there are with Berkeley Regional Medical  
18 Center. Essentially this is the 100,000 versus  
19 the 20,000 population and household numbers  
20 reflect that. But if you look at the number of  
21 low income households who have improved access,  
22 who are not now within seven miles of another,  
23 look at the bottom half and you can see under  
24 15,000, 1,161 for the Berkeley Regional Medical  
25 Center, 1,140 for Roper, \$15,000 to \$25,000, a

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1 couple more for Roper, that's why each is about  
2 2,000 total for seven miles or less. But the  
3 next page provides the improvement in access  
4 for those who are not now within 15 miles of a  
5 hospital. And again, look at the bottom half,  
6 you can see Roper improves access for 618  
7 households under \$15,000 and another 439  
8 between \$15,000 and \$25,000. Berkeley Regional  
9 Medical Center is roughly three times as large  
10 in each of those, Berkeley Regional is about  
11 three times the size in each of those income  
12 categories.

13 Q: What's the significance of that?

14 A: The significance again is there is much more  
15 significant improvement and financial access  
16 offered by the Berkeley Regional Medical Center  
17 project than the Roper project.

18 Q: Okay. Now, can we go back to 1606?

19 A: Sure.

20 MR. THOMAS: Your Honor, excuse me. Baehr's 1606 in  
21 Petitioner's 46.

22 Q: Let's give the Court an opportunity to get  
23 there.

24 THE COURT: I have it.

25 Q: Okay. Are these your conclusions, Mr. Baehr,

1 and your opinions regarding financial access?

2 Q: Yes. Though there are large populations in the  
3 Roper St. Francis Berkeley service area. Most  
4 of those low income populations are now  
5 essentially in the service areas of other  
6 hospitals. So they add relatively little to  
7 the equation in terms of bringing access  
8 improvement to new households not now within 15  
9 miles. By contract, Berkeley Regional Medical  
10 Center does a much better job of enhancing  
11 access to low-income individuals.

12 THE COURT: All right. I have a question at this  
13 point. Is the fact that Roper is a not-for-  
14 profit hospital come into this at all?

15 A: I think you have to judge hospitals by how they  
16 behave rather than by their for-profit or not-  
17 for-profit status. I don't think one can make  
18 a general conclusion that not-for-profits  
19 behave one way and for-profits behave another.  
20 Best I can tell both of these hospitals are  
21 interested in doing well financially. But here  
22 you have, I think, a fairly straightforward  
23 example of how the two systems behave  
24 differently in terms of how they approach what  
25 would be considered a market opportunity in

1        Berkeley County. One chose an area that's  
2        well-served, a much more affluent population.  
3        The other chose an area with a substantially  
4        larger number of population who are not now  
5        well served and a substantially larger low-  
6        income population that's not now served. In  
7        this case the for-profit hospital acted much  
8        more like a steward of community need and  
9        interest.

10      Q: Thank you, Mr. Baehr.

11      **THE COURT:** Thank you.

12      Q: On Petitioner's 46, it's part two of your  
13        analysis utilization trends. Could you take  
14        the Court through these slides, Mr. Baehr?

15      A: Sure. If you're looking at 1607, these are  
16        conclusions and then we have some graphs to  
17        elaborate. Between 2008 and 2010, again,  
18        looking at non-tertiary, non-specialty  
19        discharges in patient days, these are the kind  
20        of days, these are the kind of patients who  
21        will show up at either the new Roper facility  
22        or the new Moncks Corner facility. Tertiary  
23        patients are not going to be served by these  
24        hospitals. So the volume of non-tertiary  
25        patients coming out of Berkeley County declined



1 between 2008 and 2010, and all evidence is that  
2 the population was continuing to grow during  
3 those periods which suggests that the use  
4 rates, in other words, the number of people who  
5 are winding up in hospitals per 1,000  
6 population dropped. Now, one of the things  
7 that's assumed in the most recent projections  
8 prepared both by Mr. Richardson and myself was  
9 that actually the overall use rate would  
10 slightly be increasing because there would be  
11 an increasing share of the total population in  
12 the older age categories who have the highest  
13 use rate. That's the same thing that shows up  
14 in the State's forecast when they come up with  
15 bed need by individual hospital. Yet, instead  
16 of seeing a rising use rate you're seeing a  
17 declining use rate and a decline in actual  
18 volume. Okay? So in other words, the decline  
19 in use rates is significant enough so that  
20 patient volume has actually declined. And that  
21 is, what I think, made one cautious about  
22 relying on population driven models going  
23 forward to support two new hospitals in a  
24 market where the population model itself only  
25 leads you to believe that there's enough growth

1 for one. So if the population model works and  
2 you get one, but the population model doesn't  
3 look like it's working and, in fact, use rates  
4 may be declining or not growing as rapidly as  
5 expected, it certainly argues against two  
6 hospitals.

7 Q: All right. You've got some charts here?

8 A: Yes.

9 Q: Review those for the Court, and before you do,  
10 just so we've got it for the record, on 1608  
11 the backup for that would be South Carolina  
12 state and county population projections  
13 contained in Petitioner 42, correct?

14 A: Correct.

15 Q: Okay.

16 A: And also U.S. Census data.

17 Q: Okay. And then in terms of page 1609, that's  
18 also backed up by Petitioner's 42, the  
19 population data?

20 A: Yes. The one thing to note, Your Honor, is  
21 that South Carolina actually provides an  
22 estimate of each year of what the population  
23 is. The census bureau gives you their  
24 population number every ten years. So if you  
25 have the 2000 number and you have the 2010

1 number, you can interpolate. In other words,  
2 you can make an assumption about what the  
3 growth rate was between 2000 and 2010 to get a  
4 number for those intermediate years. That's  
5 what we did for 2008 and 2009, we assumed  
6 essentially a constant growth rate within the  
7 period of 2008 to 2010.

8 Q: Okay. Would you take him through the --

9 A: Yes. If you look at page 1608, you can see  
10 again the use rate which is, first on 1608 is  
11 the number of patient days per 1,000. It  
12 dropped based on the South Carolina population  
13 numbers from 347 in 2008 to 321. That's a  
14 decline of seven to eight percent. And based  
15 on the U.S. Census numbers it declined from 338  
16 to 307 which is a decline of almost ten  
17 percent which is really significant for two  
18 years.

19 Q: What do you think explains that?

20 A: A couple of things. One is obviously 2008 was  
21 a bad year for the economy, especially the  
22 second half of the year, and that carried over  
23 certainly the first half of 2009 and it does  
24 appear that hospital volume is impacted by what  
25 happens in the economy. I do not agree with

1 statements made that hospital demand is  
2 inelastic. Regardless of any other factors,  
3 it's going to just keep continuing to grow  
4 because that's the nature of the beast. It  
5 appears that just as other areas of the economy  
6 experience slowing, so too did hospital volume  
7 which could mean some patients didn't appear at  
8 doctor's offices to begin the process which  
9 might have led to a hospitalization. I can  
10 tell you an example which I think is related.  
11 My daughter's a veterinarian and the amount,  
12 the veterinarian business has fallen off the  
13 cliff between 2008 and 2011 and veterinarians  
14 are seeing patients, essentially individuals  
15 with dogs coming in once a year instead of  
16 twice a year. More animals are being left at  
17 shelters and not going to private clinics. And  
18 it's clearly related to the nature of the  
19 economy. And that, I think is a similar issue  
20 with what's happening in adult medicine and  
21 pediatric medicine.

22 Q: All right. Turn to 1609 for me.

23 THE COURT: Before we go on to that --

24 MR. THOMAS: Yes, sir?

25 THE COURT: -- let's take about a five minute break.

1 MR. THOMAS: Yes, sir.

2 (Off the Record)

3 THE COURT: We're back on the record, please.

4 Q: All right. Mr. Baehr, I think we were on  
5 Exhibit 46, Baehr 1609. If you could just  
6 explain this graph to the Judge, please.

7 A: Yeah. Just as a prior page was the use rate  
8 expressed in terms of patient days per 1,000  
9 population, here it's expressed in terms of  
10 discharges per 1,000 population and the same  
11 trend.

12 Q: It's also going down?

13 A: It's mostly going down, yeah.

14 Q: And before we get to 1610 I just want to, for  
15 the record, confirm that the backup for 1610 is  
16 --

17 THE COURT: 1609 and 1610, please.

18 Q: Yeah, Baehr 1610, that is contained, it's the  
19 building permit file contained in Petitioner's  
20 37?

21 A: Yes.

22 Q: Okay. Could you explain this graph to the  
23 Judge and why you think it's significant?

24 A: Yeah, between 2000 and 2010 if you look at the  
25 U.S. Census data, the population of Berkeley

1 County increased from 142,000 to 177,000.  
2 That's a 35,000 increase, that's about a 25  
3 percent rise which is significant. The  
4 question is when did that increase actually  
5 occur? There are two reasons why population  
6 increases in a location, city, county, state.  
7 One is the difference between births and  
8 deaths. That's what you call the natural  
9 increase in population just resulting from  
10 those who were there at the beginning of the  
11 period and the number of births and deaths.  
12 That's what you call the natural increase in  
13 population just resulting from those there at  
14 the beginning of the period and the number of  
15 births and deaths. The second is in-migration  
16 versus out-migration. Berkeley County has been  
17 a community that's grown significantly through  
18 in-migration and growth and development and the  
19 number of new, single-family homes that are  
20 built are a measure of how many new people were  
21 coming into a community over a period of time.  
22 So, for instance, if you look at 2006 on this,  
23 Baehr 1610, 1,201 single-family homes building  
24 permits in that year, if you have an average  
25 family size of about 2.7, that means that the

1 number, of single family homes, if sold and  
 2 occupied, would increase the population about  
 3 3,300. Now, if you look at 2011, and here we  
 4 only had data for six months so we took the  
 5 number of housing permits, building permits for  
 6 six months and doubled them to come up with an  
 7 annual number, the number is fewer than 400.  
 8 So in other words, if the population would have  
 9 grown about 3,300 in 2006 for these new homes,  
 10 it can be expected to, in the next year, grow  
 11 by maybe 1,100 as a result of the new homes  
 12 constructed in 2011, assuming they're sold. So  
 13 this would suggest that more of the increase in  
 14 population in Berkeley County occurred in the  
 15 first half of the decade and continuing  
 16 probably to 2006 and 2007, and this slow down  
 17 from 2008 and now continuing into 2011 suggests  
 18 that the population growth rate in the county  
 19 may not be as high as it was earlier in the  
 20 decade, in the last decade, and not as high as  
 21 the average growth rate for the ten years. So  
 22 if the population growth rate going forward  
 23 reflects more of these 2011, 2010, 2009-type  
 24 levels of new housing, that's only about half  
 25 the growth or slightly less than that of what

1 was experienced in earlier years. If the  
2 growth's not going to be there, again, that  
3 makes any model of new hospital activity based  
4 on additional patient volume driven by  
5 population growth more suspect. So based off  
6 that 2011 number it would be much more  
7 difficult if that number continues for a couple  
8 years, or even the 2009-2010 numbers become the  
9 new norm, you simply wouldn't see the kind of  
10 population growth numbers in Berkeley County in  
11 the next decade that you had in the last  
12 decade.

13 Q: And it also shows that development hasn't been  
14 active, correct?

15 A: Correct. And that's evidenced in part by some  
16 of those developments near the Carnes  
17 Crossroads site where there's been no activity  
18 since 2008.

19 Q: Okay. Would you turn to Baehr 1611 within  
20 your, in Petitioner's 46.

21 A: Right. A lot of numbers in this section for  
22 which I apologize, Your Honor. But it's  
23 probably worth going through what's on this  
24 slide, just an introduction the tables that  
25 will follow. Both hospitals --



1 Q: Well, first of all, what's the title of this?

2 A: Approval of two hospitals will likely result in  
3 the financial failure of both.

4 Q: Okay.

5 A: To begin, both hospitals projected very slender  
6 net incomes in year three at \$69,000 in one  
7 case, a little less than \$300,000 in the other  
8 case. And that's when both hospitals have  
9 achieved 70 percent utilization. At lower  
10 volumes in years one and two, remember each  
11 hospital put together a three year forecast of  
12 utilization and a three year financial  
13 forecast. At lower volumes in years one and  
14 two both projects forecast multi-million dollar  
15 losses. If because you have two hospitals  
16 instead of one and the volumes in year three,  
17 four, five, are more like the volumes in years  
18 one and two, then instead of getting small  
19 profitability which grows over time you're  
20 likely to get multi-million dollar losses going  
21 on out into the future.

22 Q: Okay.

23 A: So in essence you have a model for how these  
24 hospitals do if they don't achieve their volume  
25 numbers. It's the forecast for years one and

1 two. And if neither hospital was able to fill  
2 its hospital to 70 percent because each  
3 hospital is taking patients away from the  
4 other, then that's what you're likely to see  
5 repeated beyond year one and two into years  
6 three, four, and five. The losses for Roper  
7 St. Francis Berkeley will likely be larger than  
8 shown because we think the financial  
9 projections for the Roper project are I believe  
10 unrealistically optimistic.

11 Q: You explained that yesterday?

12 A: Yes. We'll show it again, there's a slide I  
13 have, an Exhibit I have that shows the net  
14 revenue that's incorporated in the Roper  
15 forecast is simply substantially higher than  
16 comparable to the other facilities in the Roper  
17 system. In other words, this facility in  
18 Berkeley County has so much higher net revenue  
19 for whatever standard you use for patient days,  
20 for adjusted patient days, per admission, per  
21 adjusted permission, than the other Roper  
22 facilities, then you have to conclude one of  
23 two things. It either has such a golden payer  
24 mix, that they're only going to be attracting  
25 the best payers, or it's just too optimistic.

1 The numbers simply don't make sense and I think  
2 it's more the second than the first. The  
3 fourth, and this is again really important, why  
4 each hospital I think doesn't make it if both  
5 are built is because each hospital's forecast  
6 model assumed it was the only one in the  
7 market. All right? So Roper assumed it would  
8 get its 12,000 patient days and a little over  
9 11,000 of them from Berkeley County. The  
10 Berkeley project for Trident Medical Center  
11 assumed they'd get 12,000 days and a little  
12 less than 11,000 of those days would come from  
13 Berkeley County. If the two hospitals are  
14 expecting there to be 23,000 days between them  
15 or 22,000 days between them coming out of  
16 Berkeley County and the growth in the Berkeley  
17 County market is only 12,000 days, it doesn't  
18 work. There's 10,000 days that are not there  
19 to support one or the other project. Now, in  
20 my view, the facility that's going to be  
21 impacted more is going to be the Berkeley  
22 Regional Medical Center project.

23 Q: Why?

24 A: Because of where the Roper project is located  
25 it does significant damage to Berkeley Regional

1 Medical Center's ability to draw a significant  
2 number of patients from zip code 29483, which  
3 is just the other side of the road basically  
4 from where Roper is, or even from large  
5 sections of 29461 which would be as close or  
6 closer to Roper than they are to the Moncks  
7 Corner facility. /

8 Q: Okay..

9 A: Again, and this is an important point, while  
10 Goose Creek may be part of the service area for  
11 Roper and it's not really a prime zip code for  
12 Moncks Corner, these other two zip codes I  
13 mentioned are clearly important zip codes to  
14 both hospitals and Roper by maintaining its  
15 outpatient facilities in Moncks Corner is  
16 clearly not conceding the business in the  
17 northern part of the county from where they've  
18 gotten patients to their emergency room,  
19 ambulatory surgery facility, and outpatient  
20 facility since they've had that operation. So  
21 it's not as if one hospital is safely up here  
22 in the north and they'll get the patients from  
23 there, the other hospital is in the south,  
24 there's no overlap, they'll get their patients  
25 from there. That's simply not the reality.

1 Both hospitals indicate they're serving the  
2 entire county. There's an emphasis that might  
3 be a little bit different but there are also  
4 areas that are clearly going to be competitive  
5 and that's most of the zip codes in the county.

6 Q: And --

7 A: I mentioned --

8 Q: Go ahead.

9 A: Before this is I think one, two, three, four,  
10 sixth bullet point, 12,269 incremental patient  
11 days, that's based on a growth model that  
12 exactly resembles the one that the State uses  
13 to come up with bed need in the State Health  
14 Plan. So it's based on population, growth,  
15 over on top of existing use rates by age  
16 category, 12,269 days gets you an average daily  
17 census of about 35 which is perfect for about  
18 one 50-bed hospital, not two.

19 Q: In Berkeley County?

20 A: In Berkeley County. And if two 50 bed  
21 hospitals are constructed, patient days  
22 required to the second would have to come by  
23 either reducing the current levels of inpatient  
24 utilization of existing providers, or I think  
25 much more likely by neither of the two

1 applicants coming anywhere close to the volumes  
2 that they expect in their new facility.

3 Q: All right. What's that on Baehr 1612? Could  
4 you explain this slide to the Court?

5 A: Again, the Berkeley, the Roper St. Francis  
6 Berkeley model is based on incremental days  
7 which are new days that are not essentially  
8 transferred from the Roper system. This is not  
9 the redirection days. These are the patient  
10 days that reflect the market share gains at the  
11 expense of other providers. And their  
12 financial model assumes that's 50 percent of  
13 all days. Now, again, as I pointed out  
14 yesterday, that was a mistake. In fact, the  
15 number of incremental days is going to be  
16 somewhere between 36 percent and 46 percent of  
17 the number of days because we don't know about  
18 those ten percent from out of the county,  
19 whether those are redirection days or whether  
20 they're days picked up from other providers.  
21 It could be one or the other or both.

22 Q: That wasn't specified in the application?

23 A: That's correct. But in any case, if you're  
24 relying on a certain number of patient days to  
25 create this financial projection, you don't

1 have that many days because you're not having  
2 50 percent net new days, then the income  
3 numbers will be lower presumably in every one  
4 of these three years. But this is the  
5 important thing. I mentioned yesterday the  
6 slope of this line is pretty steep. And look  
7 at --

8 Q: Explain what the line represents.

9 A: Yeah. Look for instance at the bottom where it  
10 says 3,194 and then in parentheses 11,765,000.

11 Q: Right.

12 A: These are numbers taken directly from the Roper  
13 St. Francis Berkeley application. When the  
14 number of incremental days is just a little  
15 over 3,000 in year one, they're expected to  
16 lose \$12,000,000. By year three, if you look  
17 up on the top right, when they get up to  
18 6,388, if you can see that number just above  
19 the line, they made \$285,000. What that means  
20 is patient days, essentially the incremental  
21 days or the new days that they pick up from  
22 others, grow by 3,200 and net income improves  
23 by \$12,000,000. What is that slope, that slope  
24 is about \$4,000 per incremental day. I cannot  
25 recall a financial model or projection I have

1           seen where the slope is that high.

2       Q:   All right.   Now, I'm going to direct you to  
3           Exhibit 220.

4       A:   Yes.

5       Q:   It's related.

6       A:   220?

7       Q:   Yeah.

8       A:   All right.

9       MR. THOMAS:   Judge, do you have a notebook up there?

10      THE COURT:   Give me a second.

11      MR. THOMAS:   All right.   You may be able to look at  
12                   the screen on this one if you think it's clear  
13                   enough.

14      THE COURT:   I can see that up here.

15      MR. THOMAS:   Okay.

16      Q:   Mr. Baehr, did you create this chart?

17      A:   Yeah.   And this one, what we did here was you  
18           see this dramatic improvement in net income  
19           with only a gain of 3,000 days.   So we wanted  
20           to see what does it look like if you want to  
21           present a model of the full hospital at its  
22           site.   In other words, let's stop worrying  
23           about incremental days versus redirected days.  
24           Let's just see how much money this new hospital  
25           makes at this location.   And the way to do that



1 is essentially to assume all of the days are  
2 new days. Okay? And if you do that, then  
3 basically what you do is you double the number  
4 of days for each year.

5 Q: Patient days, right?

6 A: Patient days, because they assume that half of  
7 them are redirected and half of them were net  
8 new days. And what you find out is that this  
9 slope of almost \$4,000 a day means that when  
10 the hospital is full and has in excess of  
11 12,000 days, full meaning average daily census  
12 is about 35, it would make \$24 million. So the  
13 incremental model suggests it's break even.  
14 But if you actually figure out what their  
15 financial model would mean, if you wanted to  
16 look at the real numbers for that hospital as  
17 a standalone facility, in other words, don't  
18 take half the days and just figure that they're  
19 a wash between the existing facility and the  
20 new facility, put all of the days into the new  
21 facility that's actually going to be served  
22 there because they're not serving 6,000 days,  
23 they're serving 12,000. All right? And what  
24 do the financials look like for 12,000 days?  
25 Well, you've got this \$24 million number and

1 again I have been in this business way too  
2 long, but I am unfamiliar with ever seeing a 50  
3 bed hospital, a new 50 bed hospital with the  
4 kind of capital costs this one has with an  
5 average daily census of 35 with this kind of  
6 net income number. I have not seen it. And  
7 again, you asked me about it when I evaluate  
8 other financial pro formas put together by  
9 others, one of the things you look for is a  
10 reasonableness test. Is it reasonable to  
11 assume a 50 bed hospital would make \$24 million  
12 in Berkeley County in year three. And my  
13 answer would be no. There's something wrong  
14 with the pieces and the assumptions that built  
15 up this model that get you to that kind of  
16 number. And if it turns out that the financial  
17 forecast is too high, what it means is what  
18 they submitted to the Department, which was  
19 just incremental, is also too high and as a  
20 result they would not have had a positive net  
21 income in year three. And this again, you  
22 would think that the Department would look at  
23 those kind of numbers on the financial pro  
24 forma and give it a reasonableness test. Does  
25 it make sense that they go from 3,000 to 6,000

1 days and their net income improves by \$12  
2 million? Well, I don't think it is reasonable.  
3 I think a lot of people looking at that would  
4 have concluded the same thing.

5 Q: Did the pages behind Baehr 1848 backup the  
6 model?

7 A: Yes. The most interesting one is 1850. Again,  
8 I mentioned that what I think is the primary  
9 source of what the problem is here, is that  
10 remember that a hospital has two different  
11 kinds of revenue; there's gross revenue and net  
12 revenue. Gross revenue reflects the charges  
13 the charges that are on a bill that they send  
14 to a patient or to Medicare or to Medicaid or  
15 to a third-party payer, but they don't expect  
16 to actually receive payment at that level.  
17 Medicare has essentially a system so it will  
18 pay based on what type of case it is. Medicaid  
19 will significantly underpay what that charge  
20 is. Even among people who are insured with  
21 commercial carriers, there are negotiated rates  
22 by HMOs and preferred provider organizations.  
23 So there are big discounts from what I will  
24 call the list price to what is the amount  
25 that's received. So net revenues is an

1 important number. Net revenue reflects the  
2 real money that a hospital expects to get in  
3 the door from its patient activity. And if you  
4 look at page 1850 and look over at the forecast  
5 years, 2014, 2015, and 2016, one of the things  
6 that's in the pro formas is not only a forecast  
7 for the new hospital but also for the system.  
8 So the top line represents the Roper forecast  
9 for the system and you can see that the net  
10 revenue per adjusted patient day, which is  
11 essentially the net revenue to take account of  
12 both inpatient and outpatient activity, goes  
13 from 2013 and 2014 to 2,050 to 2,087. It's a  
14 growth of a little less than two percent a  
15 year.

16 Q: So that's the blue bar on the --

17 A: That's the blue bar. Okay? Very modest  
18 growth. Now, the Roper St. Francis Berkeley  
19 there was an early draft and then there was the  
20 numbers in the application. If you look at the  
21 early draft the numbers for Roper St. Francis  
22 Berkeley start at 2,082, then they go to --  
23 this is the orange, they go to 2,145 and then  
24 to 2,209. That's a growth rate of about three  
25 percent a year starting from a higher base.

1 Q: And that early draft is found in Petitioner's  
2 62, correct?

3 A: Correct.

4 Q: Okay.

5 A: Now, I don't have a problem with the forecast  
6 for Roper St. Francis Berkeley being slightly  
7 better for net revenue per adjusted patient day  
8 than the system as a whole because I think the  
9 payer mix, where they've located their facility  
10 in the southern part of Berkeley County is a  
11 generally more affluent area. So they should  
12 expect to get relatively more patients with  
13 commercial insurance and relatively fewer with  
14 Medicaid or bad debts, or Medicare. So it  
15 should be a little bit higher. But then look  
16 at this bottom line which is actually what's  
17 been submitted. This is what's in the  
18 application, \$2,456 in 2014; \$2,599; and then  
19 \$2,750. That's a full 30 percent higher in  
20 year three than the Roper system as a whole.  
21 In other words, for every dollar that Roper's  
22 going to get per adjusted patient day, Roper  
23 St. Francis Berkeley is going to get about  
24 \$1.30. And I don't see any reason to expect a  
25 difference of that magnitude to occur, even if

1 the payer mix is a little bit better in the  
2 southern part of Berkeley County than it is for  
3 Roper's system as a whole, remember by 2016  
4 they're also projecting volume at Mount  
5 Pleasant which is built up from when the  
6 facility opened in 2010 and the Mount Pleasant  
7 facility has an even better affluent level,  
8 affluence level than the southern part of  
9 Berkeley County. So the Roper numbers for the  
10 system as a whole include Mount Pleasant. So  
11 to get Roper St. Francis Berkeley this far off  
12 the charts, basically about a third higher than  
13 the system as a whole, simply doesn't make  
14 sense. I would expect those numbers to be  
15 substantially lower, probably much closer to  
16 the kind of numbers that you see under the  
17 Roper St. Francis Berkeley draft. And if  
18 that's the case, roughly about 20 percent of  
19 patient revenue is just going to disappear from  
20 the financial projections, and that obviously  
21 for this incremental model would have a  
22 devastating impact.

23 Q: And just for the record, the other backup on  
24 this page is Petitioner's 66, which is Mr.  
25 Knapp's, I believe, worksheets?

1 A: Yes.

2 Q: Okay.

3 A: I think that's it for this.

4 Q: All right. Anything else in this Exhibit?

5 A: No, that's the major.

6 Q: Okay.

7 A: I mean, the one thing I'll note is that earlier  
8 draft had substantial losses in year two and  
9 year three. It didn't show a small net income  
10 in year three, it still showed a substantial  
11 loss. And that's my point, is if you don't  
12 have those inflated revenue numbers, you're not  
13 going to get a hospital to break even with only  
14 17 patients. That's the thing, they've decided  
15 to forecast, to present their forecast this  
16 way, to only look at half the volume which I  
17 think is not the best way to do it. I think  
18 the best way is for every applicant, in the  
19 future if the State's going to look at changes  
20 in the State Health Plan, to require a full  
21 venue number, to have full profit and loss for  
22 a new hospital. It's the most -- it's the  
23 easiest way for comparability and I don't know  
24 why they don't require it now because it, you  
25 know, I spent a lot of time, the gentleman that

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1 worked with me on this case spent a lot of time  
2 trying to get inside these numbers, it's  
3 difficult. It would make it a lot easier if  
4 there was easier comparability.

5 Q: Would you turn back to Petitioner's 46 and go  
6 to Baehr 1614?

7 A: Forty-six?

8 Q: Yes.

9 A: All right. Okay.

10 Q: All right. Can you explain -- actually, I'm  
11 sorry, go to back to Baehr 1613, one page  
12 before.

13 A: Sure.

14 Q: And this is the relationship between the  
15 patient days and the projected net income for  
16 Berkeley Regional Medical Center, correct?  
17 Under the slope line?

18 A: Correct. Yeah, and their slope is a lot  
19 different. Look at; for instance, in year one  
20 with 7,200 patient days they lose a little less  
21 than five, they lose four and a half million  
22 dollars. At 11,700 days they basically do a  
23 little better than break even. So 4,500 days,  
24 an improvement of about \$4.6 million. So their  
25 slope is about an improvement in net income of



1 about \$1,000 for each additional patient day.  
2 The Roper model is about \$4,000 for each  
3 additional incremental day in their model. And  
4 it's just hard to imagine how two hospitals in  
5 the same county, same size, same capital costs,  
6 could come up with numbers that are that  
7 different.

8 Q: Same zip code, too, right?

9 A: Same zip code.

10 Q: If you would turn the page to 1614, please.

11 A: Correct. And as always I noticed I one error,  
12 one glitch in 1614. And the zip code 29483  
13 where you see the number 787, that should be  
14 1,122, not 787.

15 Q: Okay.

16 A: There are more projected admissions coming from  
17 29483 than from 29461.

18 Q: And for this Exhibit the backup is Petitioner's  
19 45 and 166, correct?

20 A: Correct.

21 Q: The Claritas information? All right. Well,  
22 explain to the Judge what --

23 A: Yeah. Again, I mentioned that there is  
24 substantial overlap between the projects for  
25 the Berkeley Medical Center in Moncks Corner

1 and with Roper's historical volumes that come  
2 out of Berkeley County. Now, ideally you would  
3 want to compare the projections for where the  
4 Berkeley Medical Center in Moncks Corner is  
5 going to get its patients with the projection  
6 for where Roper St. Francis is going to get its  
7 patients, but Roper didn't provide that. They  
8 didn't tell you how many patients they're going  
9 to get from any particular zip code. They  
10 simply said we'll expect to get 90 percent from  
11 the county. Not knowing where they're  
12 projecting to get their patients from, the best  
13 guide to where they'll get their patients from  
14 is where they're getting them from now. And if  
15 you look at 1615 this shows you that the three  
16 leading zip codes that either straddle Berkeley  
17 County or are at least half in Berkeley County  
18 from which they draw the largest number of  
19 patients is 29461, which is the Moncks Corner  
20 zip code in which both new hospitals would be  
21 located, 29483, which is the zip code for which  
22 is the leading zip code, the one on which  
23 Berkeley Medical Center is most dependent. And  
24 in the case of Roper, also the Goose Creek zip  
25 code, 29445. Trident did not expect that their

1 Moncks Corner facility would get a lot of  
 2 patients from Goose Creek. In the model we  
 3 developed that's what we assumed as well. So  
 4 that zip code, I don't think there would be a  
 5 lot of direct competition. But the other two  
 6 zip codes there would be as well as the zip  
 7 codes around the lake because Roper is not  
 8 foregoing their outpatient investment or their  
 9 outpatient facilities or conceding the  
 10 outpatient volume they're now getting which  
 11 would continue to provide a resource to get  
 12 patients into their hospital in Carnes  
 13 Crossroads from the north when those patients  
 14 arrive at their facility.

15 Q: And quick interlude here. As far as the Goose  
 16 Creek population goes and I think we've seen  
 17 some Exhibits that show a lot of that  
 18 population and Roper's seven mile radius south  
 19 of the Carnes Crossroads?

20 A: Yes.

21 Q: So is Roper St. Francis Berkeley expecting that  
 22 patients are going to drive north to their  
 23 hospital from Goose Creek to use it?

24 A: Yes.

25 Q: Okay. And just on Baehr 1615, the source of

1 this, the Roper discovery, that can be found on  
2 Petitioner's 166, correct?

3 A: Correct.

4 Q: Explain Baehr 1616 for me.

5 A: Okay. I've thrown out the number 12,289 as the  
6 projected number of, the projected increase  
7 inpatient days in Berkeley County if you assume  
8 that the current use rates for each age group  
9 are maintained and population drives future  
10 growth and patient activity. If you make those  
11 two assumptions, you get 12,200 incremental  
12 days in Berkeley County. And where would those  
13 days go? Well, in the absence of the new  
14 hospital, presumably each system would grow and  
15 maintain its market share. And the market  
16 shares have been fairly stable over the last  
17 few years. If you look at the Trident numbers  
18 are 52 percent, 53 percent, 54 percent, I mean  
19 they tend to be within about a two percent  
20 boundary. So I think that's a useful way to  
21 project where the patient activity would be and  
22 how much growth there would be for each system  
23 in the absence of a new hospital. And you can  
24 see the Trident system would grow about 6,700,  
25 almost 6,700 days. Roper's system a little

1 over 3,100, and all others; Medical University  
2 of South Carolina, other providers, East  
3 Cooper, Mount Pleasant, 2,488. Now, this is an  
4 important thing to note, remember each hospital  
5 is projecting they're going to get either  
6 slightly over or slightly less than 11,000  
7 patient days out of Berkeley County. Trident's  
8 projecting they're going to get a little bit  
9 less than 11,000 days out of Berkeley County,  
10 about 10,700. The growth in the Trident system  
11 accounts for 6,700 of it. So really there's  
12 only 4,000 days beyond their growth they need  
13 to get from somewhere else. Now, is that,  
14 would that be difficult to transfer from  
15 existing Trident facilities? Well, the Trident  
16 base volume is about 29,000 patient days in the  
17 County. So it's about one-seventh beyond  
18 growth that would have to be transferred for  
19 them to hit their number in Berkeley County.  
20 If you look at Roper, they're projecting  
21 11,500, about 11,500 days in Berkeley County.  
22 Only 3,100 days come from their growth.  
23 They've got to find another 8,400 days. Now,  
24 some of it they're projecting, a significant  
25 amount of it will come from redirection, but

1 their base that's available for redirection is  
2 a lot lower, they don't have as large a share  
3 in the county. So they need to redirect not 14  
4 percent of the base volume beyond growth, but  
5 more than double that. So it's tougher.

6 Q: If they don't redirect it, where would they  
7 have to get it from?

8 A: They would have to -- if they're going to meet  
9 their utilization target, they would have to  
10 get it from market share gains taken at the  
11 expense of other hospitals in the market.

12 Q: Okay. And the backup for 1616 is Petitioner's  
13 45 for the population data?

14 A: Correct.

15 Q: Okay. Can you explain 1617?

16 A: Okay. 1617 starts from the assumption that the  
17 market is going to grow by 12,269 days,  
18 essentially the number that we showed earlier.  
19 If there's only one new hospital built and that  
20 hospital gets roughly 90 percent of its volume  
21 for a 50 bed hospital from Berkeley County,  
22 they need roughly 11,500 days from the county.  
23 What that means is that if the county's volume  
24 out of Berkeley County, the number of patients  
25 coming out of Berkeley County grows by 12,269

1 and one new hospital requires 11,500, there's  
2 a tiny amount of growth left for other  
3 providers above and beyond what's required to  
4 fill that one hospital. Okay? In essence it's  
5 a wash. The county grows enough to support one  
6 50 bed hospital if you assume, as both these  
7 applicants do, that the overwhelmingly large  
8 share of their patient population is going to  
9 come out of Berkeley County.

10 Q: Does that bring us to 1618?

11 A: 1618 shows a second scenario and that is not  
12 one hospital is built but two hospitals are  
13 built.

14 Q: Which is what the Department has approved,  
15 right?

16 A: Has just approved. Now, there are two things  
17 -- if you think that the two hospitals require  
18 22,000 or 23,000 days between them and there's  
19 only 12,000 to go around, you're short 11,000  
20 days. There's one of two things that can  
21 happen. One is that the applicants themselves  
22 don't meet their volume standards. That's  
23 actually what I think will happen and I'll show  
24 on the next page.

25 Q: Okay.

1 A: This particular table says both hospitals  
2 reached their volume. They each fill their  
3 hospital despite the fact that there are not  
4 enough days to go around in terms of growth.  
5 Well, the only way they can do that is taking  
6 from the base volume from the existing  
7 providers to fill that second hospital. So  
8 you'd have to take 11,000 days from other  
9 hospitals including Medical University of South  
10 Carolina, not in this food fight, and there  
11 would be fairly significant losses of patient  
12 days compared to the base volume at those  
13 hospitals. Again, I think the more realistic  
14 model of what happens if both hospitals are  
15 built is on the following page, which is 1619.

16 Q: Okay.

17 A: And here we took a different approach than what  
18 we sent to the Department, which we presented  
19 at project review and then followed up in a  
20 letter I sent, I believe the date was May 28th.

21 Q: Okay. Why did you take a different approach?

22 A: We wanted to basically look at greater  
23 variability. In other words, in what we've  
24 sent to the Department we made the following  
25 assumption. Trident would lose half of its



1 patient volume and Roper would lose of its  
2 incremental volume. So basically Trident loses  
3 6,000 days, Roper loses 3,000 incremental days,  
4 and conceivably, you know, conceivably they  
5 might lose some other days among the transfers  
6 as well, redirection, but we just looked at the  
7 top line, above the line. But there are  
8 different combinations. The hospitals don't  
9 have to lose the same number of patients  
10 equally. And if you look at the full volume,  
11 each hospital is expecting 11,000, 12,000 days,  
12 it could be that Trident loses 7,000 and Roper  
13 loses 4,000 or Trident loses 6,000 and Roper  
14 loses 5,000. Or they don't lose quite as much  
15 combined and there simply is a bigger impact on  
16 the existing providers, that's possible too.  
17 Okay? So what I wanted to provide in this  
18 table were a lot of different calculations to  
19 look at different possible scenarios. So for  
20 instance, if instead of Berkeley Regional  
21 Medical Center getting almost 12,000 days it  
22 got say 7,500 days, okay, you look over at the  
23 bottom and you'll see the 3,750/7,500, the  
24 reason that 3,750 is there is remember the  
25 Roper model is an incremental model. If there

1 are two days total, only one of their days is  
2 considered incremental. If Berkeley only got  
3 7,500 days instead of almost 12,000, they'd  
4 lose a \$4,348,000. If Roper, instead of  
5 getting 6,300 incremental days got 3,700  
6 incremental days, they'd lose almost \$10  
7 million. Why would their loss be so drastic,  
8 because of that slope, because I think the  
9 model was built wrong. It's too optimistic,  
10 there's too much net revenue, and as a result  
11 if they don't get all their days, the drop off  
12 in revenue is steep and as a result the drop  
13 off in net income is also fairly significant.  
14 So you can mix and match. You can pick a Roper  
15 number from the top in any one of these cells  
16 and a Berkeley Regional Medical Center from the  
17 bottom. But my overall feeling is that there's  
18 likely to be a bigger decline for Berkeley than  
19 for Roper.

20 Q: Why?

21 A: Given the fact that over 60 percent of  
22 Berkeley's projected volume comes from those  
23 two zip codes, which are going to be I think  
24 significant, one of them, 29483, would be  
25 largely lost if Roper St. Francis is built

1 because all of it is on the other side.  
2 Essentially Roper St. Francis would be between  
3 that zip code, except for a small section of  
4 it, and the Moncks Corner facility. And then  
5 in the Moncks Corner facility itself, 29461,  
6 there's two hospitals competing. One is at the  
7 top, one is at the bottom of that zip code.  
8 There's some midpoint between and patient  
9 activity maybe from the mid point down goes in  
10 one direction and from the midpoint up goes in  
11 the other direction. In any case, they're not  
12 going to get as many as they projected out of  
13 that zip code. And I think it's possible that  
14 they wouldn't get as many as they projected in  
15 some of the northern zip codes because Roper,  
16 if they had a facility in Carnes Crossroads and  
17 they maintain their outpatient facilities in  
18 Moncks Corner, the patients who show up in  
19 Moncks Corner will continue to go to Roper  
20 facilities and that could include the Roper St.  
21 Francis-Berkeley facility.

22 Q: Well, Mr. Baehr, in your opinion if both  
23 projects are ultimately approved, will the need  
24 for these two hospitals be exceeded in this  
25 portion of the service area?

1 A: I believe it is which is why I believe that  
2 these hospitals are competitive and require one  
3 to be selected because, in addition to being  
4 the same services, same location, effectively  
5 the same location and a great degree of  
6 overlapping service areas, you have essentially  
7 that excess and duplicative nature of the fact  
8 that there's enough incremental need, enough  
9 growth in the market to support one but not  
10 two.

11 Q: Do you believe it's an unnecessary duplication  
12 of services?

13 A: I do. And clearly if one was selected, given  
14 the comparative data we've shown on access  
15 improvement for those who are not now within 15  
16 miles of the facility and those who have  
17 financial access issues, who have low income  
18 and are not within 15 miles, the Berkeley  
19 project is far superior to the Roper site.

20 Q: Unnecessary duplication of services is tied to  
21 adverse impact, isn't it?

22 A: Correct.

23 Q: Okay. Is that what part four is regarding --

24 A: Yes.

25 Q: -- your analysis?

1 A: Yes. In other words, if you follow the logic  
2 and you believe that two facilities is one too  
3 many, right?

4 Q: Right.

5 A: And that as a result the Department should have  
6 selected one, then you need to test what  
7 happens if that one facility is built.

8 Q: Okay. Is that what you do in --

9 A: Yeah.

10 Q: -- section four?

11 A: Yeah. We basically do a comparative analysis  
12 of the impact of the Roper St. Francis facility  
13 on existing Trident facilities for which we  
14 actually assigned a dollar value, which is  
15 similar to the number that was provided to Ms.  
16 Brandt back in 2009. We add a small component  
17 which is the impact of lost tertiary cases  
18 because if Roper's non-tertiary volume grows,  
19 we also expect their tertiary volume to grow in  
20 the county and a share of that will also be  
21 lost, we believe, for Trident Medical Center.  
22 But we also believe there's an impact of the  
23 new Trident facility on Roper. Roper never  
24 made any calculation like that. Now, maybe  
25 that's because they were supporting the Trident

1 project, but they never made one. We actually  
2 provide numbers under a consistent methodology  
3 for how Roper would impact the Trident  
4 facilities and how the Berkeley Moncks Corner  
5 facility would impact Roper facilities. And  
6 not surprisingly the impact of the Trident, of  
7 the Roper project is much higher, there's much  
8 more adverse impact of Roper on Trident than  
9 Trident on Roper, than the Trident new facility  
10 on Roper. And the reason is Trident's got a  
11 much bigger market share. So if a new hospital  
12 comes into a market and in a sense takes volume  
13 away from existing providers and one hospital  
14 provides, one system provides 54 percent of the  
15 volume, that system is likely to lose that  
16 share of the new volume that's essentially  
17 redirected or moved to a new hospital.

18 Q: And you've read, I think you've already read  
19 the definition for the project review criteria  
20 of adverse impact?

21 A: Correct.

22 Q: Does it, is the impact on current volume as  
23 well as what?

24 A: Projected volume. And again, that has to be  
25 the case because bed need, as defined in the

1 State Health Plan, is based on projected  
2 growth, it's based on current volume with an  
3 add-on of projected growth versus a standard  
4 for occupancy level. So, you know, if  
5 somebody, if the Department tells, for  
6 instance, Summerville Medical Center in a  
7 particular State Health Plan that it has a need  
8 for 24 beds, that need assumes that it's going  
9 to get its historic market share in the area it  
10 serves and experience growth that it would  
11 likely expect on top of its historic volume.  
12 So if they don't get it because there's a new  
13 competitor, that's adverse impact. Because  
14 they're building or proposing to build based on  
15 the projection of growth which has been  
16 provided by the State.

17 Q: Okay. Now, have you gone over, let's go over  
18 some more of these bullets here --

19 A: Sure.

20 Q: -- just as the conclusion and then we can get  
21 into your analysis.

22 A: Sure.

23 Q: On page Baehr 1620, just for the record.

24 A: Yeah. Again, it's my sense that if one  
25 hospital's approved and you want to make a

1 calculation of adverse impact, the important  
 2 thing to do is to be consistent in how you  
 3 evaluate adverse impact. In other words, Roper  
 4 made an assumption about how they'd fill their  
 5 beds. Trident made an assumption about how  
 6 they'd fill their beds. Each one of them  
 7 relies, to a significant extent, on  
 8 redirection. They rely on growth in their  
 9 system's volume, additional redirection and, in  
 10 the case of Roper, also on market share gains.  
 11 But when you're comparing if A is approved  
 12 whether B is approved, at that point I think  
 13 the appropriate way to evaluate adverse impact  
 14 is not to look at the applicant assumed,  
 15 because that can be self-serving, but to look  
 16 at a more conservative and consistent approach.  
 17 And that approach is look at the historic  
 18 distribution of patients in the market. So for  
 19 instance, the new hospital comes into a market  
 20 and they project they're going to get 10,000  
 21 patient days, who are they going to take them  
 22 from? If hospital A has a market share of 50  
 23 percent and hospital B has a market share of 25  
 24 percent and hospital C has a market share of 25  
 25 percent, if a new hospital comes into a market



1 and wins 10,000 days, that's how many days it  
2 gains for its facility, the way the model I've  
3 used in this section would work it says, all  
4 right, well hospital A has a 50 percent share  
5 historically so they'll lose 50 percent of  
6 those 10,000 days. They would have had 5,000  
7 days that are now going to the new hospital.  
8 Hospital B, its historic share was 25 percent,  
9 so 25 percent of the days or 2,500 are lost to  
10 them. And hospital C had a 25 percent historic  
11 share. They lose similarly and 2,500 days are  
12 taken from them. In essence, we carry the  
13 market shares forward and for comparability we  
14 do it exactly the same way of the impact of new  
15 hospital A on existing providers or new  
16 hospital B on existing providers.

17 Q: Is that how you traditionally have done it in  
18 the past?

19 A: That's how I do it when I calculate adverse  
20 impact in that manner, yes.

21 Q: Okay. What did you find in the last bullet  
22 point on the page?

23 A: The last bullet point suggests that if the  
24 Roper St. Francis facility is the only one  
25 built and it achieves its volume of roughly 35

1 patient days and an equivalent amount of  
2 outpatient activity, right, so its adjusted  
3 patient days would be roughly 70, okay. About  
4 54 percent of 53 percent of that volume would  
5 come from what otherwise would be seen at  
6 Trident Medical Center or Summerville Medical  
7 Center because that's the historic share for  
8 those two providers. And when you calculate  
9 what the loss of that level of volume would be  
10 to Trident Medical Center and Summerville, you  
11 come up with this calculation of about \$16  
12 million in year three.

13 Q: Okay. Could you explain to the Judge how you  
14 came up with that on a more technical basis?

15 A: Sure. Starting on 1621, and again, remember  
16 that I not only did a calculation of Roper's  
17 impact on Trident in terms of volume loss, I  
18 also did a calculation of Trident, if Trident  
19 is built in Moncks Corner, it would have some  
20 impact on the Roper facilities downtown under  
21 the methodology that I'm using here, which is  
22 consistent for both, either of the two new  
23 hospitals. So in order to make the calculation  
24 of the Trident impact on Roper I have to  
25 project out the volume growth for the Trident

1 facilities and measure the impact, particular  
2 in regards to Berkeley County which really  
3 seems to be the topic of discussion here  
4 because each hospital proposes 90 percent of  
5 their patient volume, or close to it, will come  
6 from Berkeley County.

7 Q: And before you go into this, the backup for  
8 these pages on 1621 is Joint 9, Summerville  
9 Medical Center application and Petitioner's 45,  
10 the raw data, correct?

11 A: Correct. And 1621 assumes that the Berkeley  
12 County, Trident's market share in Berkeley  
13 County stays at what it was historically. In  
14 1622 we did a sensitivity analysis to assume  
15 that Trident's market share would grow.

16 Q: What's a sensitivity analysis?

17 A: It means you look at something in slightly  
18 different fashion to see what impact it has if  
19 you modify the assumption somewhat. Now  
20 remember, Roper's assuming a fairly significant  
21 market share increase from 23 percent to 31  
22 percent overall in Berkeley County. Here we  
23 assume that Trident's market share rather than  
24 growing by eight percent would grow by three  
25 percent.

1 Q: Okay.

2 A: If you look at page 1623, in essence Roper St.  
3 Francis, look at the top, these are the number  
4 of patient days that they're expecting to get  
5 from Berkeley County in the first three years.  
6 All right? And here we're not distinguishing  
7 between redirected days and days gained from  
8 others, this is simply their volume forecast.  
9 So I'm not starting out here looking at  
10 incremental days, I'm looking at how many days  
11 they're projecting to get. They're a new  
12 provider in the market, they're projecting a  
13 certain level of patient activity, where are  
14 they going to get it from. I think there would  
15 be some redirection, but the redirection is  
16 equivalent to what Roper's historic market  
17 share is.

18 Q: Which is what?

19 A: About, in this case about 25 percent and that  
20 accounts for basically one quarter of their  
21 patient activity, projected patient activity.  
22 The other three quarters have to come from  
23 somewhere else, either from Trident or from  
24 other area hospitals, primarily, principally  
25 Medical University of South Carolina. And as

1 you see at the bottom, if Roper gets 11,498  
2 days in Berkeley County in 2017, had it not  
3 been built we would expect Trident to get 6,257  
4 more days than it would in the absence that  
5 would not occur if the Roper facility is built.

6 Q: Okay.

7 A: Now, page 1624 is the reverse calculation. In  
8 other words, how much impact does the new  
9 Trident facility have on the two Roper downtown  
10 facilities. Now, again, Roper didn't choose to  
11 make an issue of adverse impact of Trident on  
12 Roper. And I don't know the internal  
13 contribution margin of the Roper system to be  
14 able to dollarize this. This is something that  
15 the Roper people would have had to have done  
16 just as when I attempted to put a dollar value  
17 on adverse impact, I made use of the hospital's  
18 information system and decision support  
19 products and working with their financial  
20 people to give us an estimate of what the  
21 contribution margin was. If Roper wanted to  
22 make an estimate of contribution margin loss  
23 because Trident's building in Moncks Corner,  
24 they could have done it.

25 Q: But they didn't?

1 A: But they didn't. They made no attempt, for  
2 instance, at the Department to argue that we're  
3 better because say adverse impact of Trident's  
4 going to have on us. They didn't make that  
5 argument. You know, at project review they  
6 were arguing for both hospitals, there's enough  
7 to go around for both hospitals. I don't think  
8 the facts show that, you know, which is why the  
9 transfer argument doesn't work because there's  
10 not sufficient need where the beds are being  
11 dropped, that's why they're competitive. But  
12 adverse impact matters and it has to be viewed  
13 in the context of access improvement versus  
14 adverse impact. So if you have minimal to non-  
15 existent improvement in access, which is what  
16 I think you have with the Roper project given  
17 the existing hospitals in the market, and the  
18 fact that the Berkeley Medical Center project  
19 was already in the cycle, that one is fairly  
20 easy to make a decision on. What's a bigger  
21 deal here, the adverse impact or the access  
22 improvement? The Roper project creates  
23 substantial adverse impact, minimal access  
24 improvement. The Trident project does create  
25 some adverse impact but substantial access

1 improvement. So there, I think, the scale  
2 weighs heavily towards the access improvement  
3 being more important than whatever adverse  
4 impact is. And again, Roper never attempted to  
5 make that an issue or even calculate it.

6 Q: So that's 1624?

7 A: Yes.

8 Q: All right. I think I want you to skip to 1626  
9 and we'll come back to 1625.

10 A: Okay. 1624 --

11 Q: Are you on 1624?

12 A: 1626.

13 Q: Okay.

14 A: The first line here is the projected loss in  
15 Trident system inpatient days resulting from  
16 the opening of the Roper St. Francis Berkeley  
17 project. And this is what we calculated a  
18 couple pages earlier. We simply took Roper's  
19 projected days multiplied it by Trident's  
20 historic market share. So if Roper's opening  
21 a new hospital and Trident's got a 54 percent  
22 market share, Trident loses 54 percent of the  
23 days at the new hospital.

24 Q: Okay.

25 A: That's how this calculation is made. Based on

1 an average length of stay you can come up with  
2 a reduction in Trident system admissions. Now,  
3 remember that you don't only lose inpatient  
4 activity, you're going to lose outpatient  
5 activity. All right. The hospital not only  
6 has inpatient activity but outpatient activity.  
7 And the Roper forecast suggests that they're  
8 about the same dollar level in terms of gross  
9 revenues. There's just about as much inpatient  
10 activity as outpatient activity. So if you're  
11 going to lose in year two almost 1,500  
12 inpatient admissions, the adjusted admissions  
13 to include a factor for outpatients is almost  
14 2,900, 2,883 lost adjusted admissions to  
15 Trident. Well, what does that cost? With that  
16 information which we provided the backup on --

17 Q: And that's, the backup in terms of that is  
18 Petitioner's 211.

19 A: Yes.

20 Q: Okay.

21 A: And the contribution margin per non-tertiary,  
22 non-specialty adjusted admission is about  
23 \$4,985 for Trident. That number is not a lot  
24 different than the number that was calculated  
25 in 2009 which was, I think, about \$4,522.



1 Q: Again, just for the Court's edification and to  
2 make it clear on the record, just briefly tell  
3 us what the contribution margin is.

4 A: The contribution margin, again, is if you have  
5 essentially an incremental, a new adjusted  
6 admission coming into the hospital, you have a  
7 new patient coming into the hospital, there's  
8 revenue associated with that and there are also  
9 some expenses associated with it; staffing  
10 costs, nursing, supplies, and so on. It works  
11 the same way if you lose a patient and that's  
12 really what's an adverse impact. If you lose  
13 ten patients and you lose the outpatient  
14 equivalent of those ten patients, you're losing  
15 the equivalent of 20 adjusted patients.  
16 There's revenue associated with that that's  
17 gone, but presumably you wouldn't spend quite  
18 as much. You wouldn't have the supply cost for  
19 those patients, you might not have as many  
20 nurses coming in to work because you knew you'd  
21 be having lower volume. So the difference  
22 between essentially the revenue associated with  
23 those lost patients and the expenses that you  
24 can reduce as a result of having, not having as  
25 many patients, that's the margin, that's the

1 contribution margin. It reflects, essentially  
2 the variable revenue and the variable costs of  
3 doing business. Because some expenses at the  
4 hospital are fixed. Depreciation doesn't  
5 change whether you have 1,000 patients or 2,000  
6 patients. The interest cost is not going to  
7 change. The cost of maintenance, repairs of  
8 equipment is probably not going to change.  
9 Okay? Administrator salaries is probably not  
10 going to change. It might in year two if you  
11 lose half your patients, but not in the short  
12 term, but certain things do change. There are  
13 variable expenses that are associated with  
14 changes in volume. So that's what a  
15 contribution margin is, it's the difference  
16 between the revenue you lose when you lose a  
17 certain number of patients and the costs that  
18 disappear when you lose a certain number of  
19 patients. And it obviously works the other way.  
20 If you get extra patients, you have new revenue  
21 and you have some new costs associated with  
22 those patients. So in this case Trident has  
23 calculated that their contribution margin per  
24 adjusted admission is a little bit less than  
25 \$5,000. And when we made that similar

1 calculation in 2009, there we had actually  
2 made, we got all the data on all the expenses  
3 by category and we made assumptions about what  
4 percentage of it was variable. Here we relied  
5 actually on the decision support model provided  
6 by the financial people at the hospital and the  
7 numbers turned out to be not dissimilar to what  
8 we had come up with a couple years earlier,  
9 which suggests that we didn't do a bad job when  
10 we estimated ourselves.

11 Q: Okay. So tell the Court what the adverse  
12 impact is on --

13 A: Yeah, the adverse impact --

14 Q: -- 1626.

15 A: -- for the loss of almost 3,000 adjusted  
16 admissions in year three is a little over \$14  
17 million for the non-tertiary, non-specialty and  
18 related outpatient activity. To that we also  
19 made a calculation of the impact of lost  
20 tertiary cases because if you have a new  
21 provider in the market and Roper proposes  
22 they're going to put a new hospital in the  
23 market and the market share for Roper will grow  
24 from 23 percent to 31 percent. If it grows for  
25 non-tertiary volume, I would expect that their

1 market share would also grow for tertiary  
2 volume.

3 Q: Based on what?

4 A: Because a certain percentage of non-tertiary  
5 volume turns out to be tertiary volume. In  
6 other words, there's a historic ratio of one to  
7 seven, one to eight for these two systems and  
8 they're actually very close. Somewhere between  
9 12 and 14 percent of admissions turn out to be  
10 tertiary admissions. So if you're losing a  
11 certain volume, if you're losing 1,000 non-  
12 tertiary admissions, we'd expect you'd also  
13 lose some additional tertiary admissions  
14 because if the non-tertiary patients would have  
15 been seen at existing hospitals, so to some of  
16 the tertiary patients would have been seen at  
17 existing hospitals.

18 Q: And there's going to be a new ED at the Carnes  
19 Crossroads location --

20 A: Correct.

21 Q: -- correct? A tertiary care patient presents  
22 there, where do you expect that patient --

23 A: They're not going to stay there.

24 Q: Right.

25 A: But they'd be referred in much the same way

1 that they're being referred right now out of  
2 Berkeley County, both non-tertiary and tertiary  
3 patients are coming out of the County who are  
4 Roper patients from the Moncks Corner ED and  
5 from their physicians, so we simply took the  
6 historic ratio and we got, again, a calculation  
7 from the hospital's decision and support system  
8 of what the contribution margin was for  
9 tertiary admissions and here it's larger.

10 Q: What is it?

11 A: It's about \$10,000 per tertiary admission and  
12 that's not unexpected, again, because these are  
13 more complex cases, the revenues associated  
14 with those cases are higher, they're bigger;  
15 neurosurgery, open heart surgery, those are  
16 very expensive cases in a hospital. So you have  
17 more revenue for an individual case you expect  
18 more margin. So it adds a little bit, not,  
19 it's not a major part of the adverse impact,  
20 about an eighth of the adverse impact comes  
21 from tertiary. But in total you come up with  
22 a little over \$16 million.

23 Q: Okay. And do you find that to be a significant  
24 number?

25 A: I think it's very significant and material.

1 Q: Based on what?

2 A: Based on the fact that this is a hospital which  
3 had pre-tax net income I believe in 2010 of \$70  
4 million or thereabout. This is more than 20  
5 percent of that. I mean, the healthcare  
6 industry is also an industry in flux. There  
7 are as many opinions as there are people in a  
8 room as to whether the business model is going  
9 to get better or worse over the next few years  
10 and whether healthcare reform will help or hurt  
11 or whether healthcare reform is even going to  
12 come into being. But there's risk involved in  
13 being in this business and no hospital would  
14 willingly simply say take \$16 million off my  
15 net income so that another hospital can come  
16 into a market which basically has minimal  
17 improvement in access. Why would that be a  
18 good thing to do?

19 Q: And that's the test under the State Health  
20 Plan?

21 A: That is the test.

22 Q: In terms of the access what is your  
23 understanding of that test?

24 A: I think the access issue is the 30 minute drive  
25 time. And I don't think that language, as well

1 as this following sentence about adverse impact  
2 being weighed to include against access  
3 improvement. Those sensors are together. I  
4 read them as essentially one combined  
5 statement.

6 Q: Okay. I want to ask you to turn to  
7 Petitioner's 225 for me.

8 A: Okay.

9 Q: And can you explain what this chart is? First  
10 of all, is this a summary of Petitioner's 45?

11 A: Yeah. This is using the South Carolina State  
12 database that was provided to us shows the  
13 number of Trident system discharges, total  
14 number of discharges in the Trident market  
15 share. One of these zip codes surprised me  
16 when we saw it, the 29456. It was an 88  
17 percent share because we've seen other runs in  
18 prior years where that number was in the 60  
19 percent range. We went back and looked at the  
20 data that was provided to us, these are the  
21 numbers that were provided to us. If it turns  
22 out that that number is more in the 60s than it  
23 is 88 percent, it would reduce the average  
24 percentage a couple points below the 65  
25 percent. But the key number here is if